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E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 2 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 3 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: All staff had not been trained on the facility's EP plan. Review on 6/10/19 of the facility's EP plan (updated 5/7/19) and training documentation (dated 8/17/18) did not indicate all staff currently working at the home had received training regarding the EP plan. During an interview on 6/11/19, the Home Manager confirmed some staff working at the home had not been trained on the facility's EP plan since the plan was initiated.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:	E 039		

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E 039	Continued From page 4 *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:	E 039		

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E 039	Continued From page 5 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 6/10/19 of the facility's EP plan (updated 5/7/19) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3)	W 120		

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W 120	Continued From page 6 The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure outside services meet the needs of 2 of 4 audits (#4, #5). The finding is: Two of three day programs were not provided with current copies of each client's Individual Program Plans (IPP). a. Review on 6/10/19 of documentation provided at client #4's day program revealed an IPP dated 8/23/16. No current IPP was available. Interview 6/10/19 with Staff G from the day program revealed the documents on file for client #5 were the most current. b. Review on 6/10/19 of documentation provided at client #5's day program revealed no IPP from the group home. No current IPP was available. Interview on 6/10/19 with the Vocational Program Manager at the day program revealed no IPP was made available from the group home. Interview on 6/11/19 with the Home Manager (HM) indicated the day programs had previously been provided current copies of each client's IPP.	W 120		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs,	W 227		

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W 227	Continued From page 7 as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #6's Individual Program Plan (IPP) included objectives to address his needs. This affected 1 of 4 audit clients. The finding is: Client #6's IPP did not include objectives to address his money management needs. Review on 6/10/19 of client #6's record revealed he had previously worked on a goal for money management from Jan '18 - May '18. Additional review of the client's IPP dated 3/27/19 revealed, "[Client #6] has limited money management skills...Support will provide informal and formal training to assist [Client #6] in further developing his money management skills." Further review of his current IPP did not include training in the area of money management. Interview on 6/11/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 continues to have needs in the area of money management; however, no formal training has been implemented.	W 227		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence.	W 240		

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W 240	Continued From page 8	W 240		

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 4 audit clients (#1, #4) include information to support their independence regarding the use of their adaptive equipment. The findings are:

1. Client #1's IPP did not include information regarding the use of his gait belt.

During observations in the home on 6/10/19 at 4:05pm, client #1 wore a gait belt around his waist as he exited the van and entered the home. After entering the home, the gait belt was removed. During observations in the home on 6/11/19 at 8:40am, the Home Manager (HM) secured a gait belt around his waist just before he was assisted to the van for transport to the day program.

Review on 6/11/19 of client #1's IPP dated 3/27/19 revealed, "Continue Fall Prevention and Safety Guidelines with addition of gait belt." The IPP did not include any other information regarding client #1's gait belt.

Interview on 6/11/19 with the HM revealed client #1 does not have fall prevention guidelines; however, the Physical Therapist (PT) had recently discussed the gait belt with staff and trained them on how it should be used. The HM indicated no specific information has been included in client #1's IPP regarding the PT's training.

2. Client #4's IPP did not include all relevant information regarding his adaptive dining

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W 240	Continued From page 9 equipment. During dinner and breakfast observations in the home on 6/10 - 6/11/19 at 4:43pm and 6:40am, respectively, client #4 utilized a high sided dish, weighted cup with a straw, regular utensils and a rocker knife, as needed. Review on 6/10/19 of client #4's IPP dated 8/3/18 revealed he used only weighted utensils at meals. No other adaptive dining equipment was included in the plan. Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4's IPP should also include adaptive dining equipment of a high sided dish, weighted cup with a straw, rocker knife, dycem mat and rocker knife.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 2 of 4 clients (#4, #6) received a continuous active treatment plan consisting of needed interventions and	W 249		

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W 249	Continued From page 10 services as identified in the Individual Program Plan (IPP) in the areas of food preparation and grooming. The findings are: 1. Client #4 was not involved in cooking tasks. During observations in the home on 6/10/19 at 3:55pm, Staff F began preparing food items for dinner. The staff obtained two frozen pizza, unwrapped them and placed them in the oven. The staff also began to open up cans of carrots and diced potatoes. During this time, no clients were in the home. At 4:00pm, clients began arriving home from the day program. Staff F continued to prepare food items by draining the canned vegetables, pouring them into a pot and placing the pot on the stove. At 4:14pm, client #4 was prompted to place cups of applesauce on the table and to set the table for dinner. Additional observation of a chore schedule posted in the kitchen indicated tonight was client #4's turn to "Help cook dinner and set the table". Client #4 was not prompted or assisted to participate with any cooking tasks. Interview on 6/10/19 with Staff F revealed clients can assist with setting the table, retrieving items from cabinets and loading the dishwasher. The staff indicated they would be afraid to allow the clients to be around the stove. Review on 6/11/19 of client #4's Community/Home Life Assessment (CHLA) dated 4/23/18 revealed he requires physical assistance to make foods with no cooking, with cooking and no mixing and with cooking and mixing. The assessment also indicated the client uses measuring/mixing devices, toasters, microwaves, stove/oven, and coffee maker given physical	W 249		

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W 249	Continued From page 11 assistance. Additional review of a chore schedule posted in the kitchen noted, "Staff should assist the consumers with completing all of their chores as needed. Remember: 'doing with' instead of 'doing for' promotes independence." Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 could have assisted with cooking tasks if prompted. 2. Client #6's fingernails were in need of grooming. During observations throughout the survey in the home on 6/10 - 6/11/19, client #6's fingernails were long and extending well beyond his fingertips. Interview on 6/11/19 with the Home Manager (HM) indicated client #6's fingernails are generally cut by 2nd shift staff on a weekly basis. Review of client #6's IPP dated 3/27/19 revealed an objective to prepare to trim his nails with 60% completion for 6 consecutive months (implemented 3/1/09). Additional review of the client's June '19 data sheet for the objective indicated no documentation. Further review of client #4's appearance checklist from May 11, 2019 - June 11, 2019 indicated, "No" under finger and toe nails trimmed. During an interview on 6/11/19, the QIDP acknowledged client #6's fingernails needed to be assessed for grooming.	W 249		
W 255	PROGRAM MONITORING & CHANGE	W 255		

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W 255	Continued From page 12 CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #6's Individual Program Plan (IPP) was reviewed and/or revised after he had completed an objective. This affected 1 of 4 audit clients. The finding is: Client #6's IPP was not revised after he had completed 1 of 2 behavior goals. Review on 6/10/19 of client #6's IPP dated 3/27/19 revealed an objective to exhibit 0 episodes of non-compliance/failure to cooperate per month for one year. The objective was dated 3/9/17. Additional review of progress notes for the objective from June '17 - February '19 revealed client #6 had exhibited 0 noncompliance/failure to cooperate behaviors over the past 30 months. Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective's criteria had been met.	W 255		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is	W 257		

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W 257	Continued From page 13 failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Individual Program Plan (IPP) was reviewed and revised as necessary. This affected 3 of 4 audit clients (#1, #4, #6). The findings are: Each client's IPP was not reviewed as needed. a. Review on 6/10/19 of client #1's IPP dated 3/27/19 revealed an objective to pack a bag when he has an overnight stay (implemented 6/1/19) and other objective to brush his teeth, participate in fire drills and assist with administering his medications (implemented 3/1/19). Additional review of progress notes for the objectives revealed the last monthly progress review had been completed February '19 and the last quarterly progress review was completed January '19. b. Review on 6/10/19 of client #4's IPP dated 8/3/18 revealed an objective to go on a community outing of his choice weekly (implemented 6/1/19) and other objectives to take out the trash, brush his teeth, and purchase items of his choice (implemented 3/1/19). Additional review of progress notes for the objectives revealed the last monthly progress review had been completed February '19 and the last quarterly progress review was completed January '19. c. Review on 6/10/19 of client #6's IPP dated 3/27/19 identified an objective to go on a	W 257		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 257	Continued From page 14 community outing of his choice weekly (implemented 6/1/19) and other objectives to trim his nails, assist with administration of his medications, and brush his teeth (implemented 3/1/19). Additional review of progress notes for the objectives revealed the last monthly progress review had been completed February '19 and the last quarterly progress review was completed January '19. Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he he had began working at the home at the end of February 2019 and was in the process of reviewing the objectives; however, he could not be sure if progress had been made over the past quarter.	W 257		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive Behavior Support Program (BSP) was only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#6). The finding is: Client #6's BSP did not include a current written informed consent from his legal guardian. Review on 6/10/19 of client #6's record revealed	W 263		

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	34G061	A. BUILDING _____ B. WING _____	06/11/2019

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W 263	Continued From page 15 a BSP dated 3/9/17. The BSP addressed physical aggression and noncompliance/failure to cooperate. Additional review of the BSP identified the use of Ability, Paxil, Ativan and Melatonin. Further review of the record revealed the guardian had signed a consent dated 3/9/18. The consent also indicated, "I understand that this authorization will expire on 3/8/19 and will not exceed one year from the date of my original authorization. The record did not include a current written informed consent signed by the guardian. Interview on 6/11/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6's consent had expired and no current written informed consent had been obtained.	W 263		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all drugs were administered without error. This affected 2 of 5 clients observed receiving medications (#4, #6). The findings are: 1. Client #4's Aldactone was not administered as ordered. During observations of medication administration in the home on 6/11/19 at 6:12am, client #4 ingested two Aldactone 25mg tablets.	W 369		

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W 369	Continued From page 16 Review on 6/11/19 of client #4's physician's orders dated 5/28/19 revealed an order for Aldactone 25mg, take one tablet by mouth once daily. Interview on 6/11/19 with the Home Manager (HM) confirmed client #4 should have received one Aldactone 25mg tablet as this medication dosage had recently been changed. 2. Client #6 did not receive Gavilax during the morning med pass. During observations of medication administration in the home on 6/11/19 at 6:35am, client #6 ingested one Abilify 10mg, one multivitamin with minerals and one bottle of Ensure supplement. Review on 6/11/19 of client #6's physician's orders dated 3/29/19 revealed an order for Gavilax 17mg by mouth with 8 oz of water, juice, soda, coffee or tea and drink once daily for constipation. The client's MAR (Medication Administration Record) noted the Gavilax should be given at 7:00am. Interview on 6/11/19 with the HM confirmed client #6 should have received the Gavilax during his morning med pass.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by:	W 382		

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W 382	Continued From page 17 Based on observations, record review and interviews, the facility failed to ensure all drugs were kept locked except when being administered. The finding is: Drugs and biologicals were not kept locked. During observations of medication administration in the home on 6/10/19 at 5:13pm, 5:24pm, 5:29pm and 5:35pm, Staff D exited the medication room, leaving the medication cabinet unlocked and/or the doors wide open. During these times, medications were accessible to everyone in the home. During observations of medication administration in the home on 6/11/19 at 6:20am and 6:37am, Staff E exited the medication room, leaving the doors to the medication cabinet wide open and medications accessible to everyone in the home. Interview on 6/10/19 and 6/11/19 with Staff D and Staff E revealed they had been trained to keep the medication cabinet locked when leaving the room. Review of guidelines for medication administration located in the office/med room of the home revealed, "Medication closet is to be kept locked at all times." Interview on 6/11/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed the medications should be locked if the med tech leaves the room while dispensing medications.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)	W 383		

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W 383	Continued From page 18 Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the medication closet. The finding is: Keys to the medication cabinet were accessible to unauthorized persons. During observations of medication administration in the home on 6/10/19 at 5:13pm, 5:24pm, 5:29pm and 5:35pm, Staff D exited the medication room, leaving the keys to the medication cabinet on a counter top and accessible to everyone in the home. During observations of medication administration in the home on 6/11/19 at 6:20am and 6:37am, Staff E exited the medication room, leaving the keys to the medication room on a counter top and accessible to everyone in the home. Interviews on 6/10/19 and 6/11/19 with Staff D and Staff E revealed they had been trained to keep the keys to the medication cabinet in their pocket or on their wrist when leaving the medication room. Interview on 6/11/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) indicated medication technicians have been trained to take the keys to the medication cabinet with them if they need to leave the med room while dispensing	W 383		

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W 383	Continued From page 19 medications.	W 383		