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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The finding is: The facility's EP plan was not reviewed or updated annually.	E 004		

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

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E 004	Continued From page 1 Review on 7/1/19 of the facility's EP plan revealed no date. Further review of the plan did not include evidence of an annual review or update. Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware if the EP plan had been reviewed or updated.	E 004		
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: *[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	E 039		

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E 039	Continued From page 2 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: (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.	E 039		

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E 039	Continued From page 3 Review on 7/1/19 of the facility's EP plan (no date) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he thought an Emergency Preparedness exercise had been conducted; however, no documentation could be provided.	E 039		
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, 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 #2's Individual Program Plan (IPP) included objectives to address his needs. This affected 1 of 3 audit clients. The finding is: Client #2's IPP did not include objectives to address his self-help and daily living needs. Review on 7/1/19 of client #2's IPP dated 2/6/19 revealed objectives to follow a simple recipe and to state the value of coins. Additional review of the plan indicated under recommendations, "Other programs to be considered in the area of self-help: Drying his body, washing face with	W 227		

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W 227	Continued From page 4 soap, drying face, tie shoe laces and caring for grooming supply basket. In the area of daily living: folding underwear, socks and other items, preparing beverage requiring mixing, use of dishwasher, measuring laundry detergent, use of washer." Further review of the client's Adaptive Behavior Inventory (ABI) dated 1/28/19 indicated needs in the area of self-help (i.e. cleaning, trimming and filing nails) and daily living (i.e. using the washer/dryer, ironing and sewing). Further review of previous objective training revealed client #2 had completed objectives to floss his teeth in 2017 and to apply deodorant in 2018. Review of the IPP did not include current objectives to address client #2's self-help and daily living needs. Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 currently does not have any formal self-help and/or daily living objectives and has not worked on objectives in this area since 2018. The QIDP acknowledged client #2 continues to have needs in this area.	W 227		
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.	W 249		

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W 249	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#2, #6) received a continuous active treatment plan consisting of needed interventions as identified in the Individual Program Plan (IPP) in the areas of cooking and family style dining. The findings are: 1. Client #2 was not actively involved with cooking tasks. During observations of meal preparation in the home on 7/2/19 from 4:40pm - 5:37pm, Staff C performed cooking tasks such as filling a pot with water, cooking frozen broccoli, cooking hamburger meat, preparing two boxes of Hamburger Helper (per box instructions) and placing food into serving bowls. During this time, client #2 reviewed the dinner menu, obtained items used for cooking and items from the pantry, put bread on a pan and set the table. Client #2 was not prompted or assisted to participate with cooking tasks. Interview on 7/1/19 with Staff C revealed client #2 can participate with cooking tasks and has an objective to follow a recipe. Review on 7/2/19 of client #2's IPP dated 2/6/19 revealed an objective to follow a simple recipe (implemented 5/14/18). The objective noted, "[Client #2] really enjoys helping out in the kitchen. This program will increase his cooking skills and to be more independent in his environment." Additional review of the objective's task analysis identified steps to wash his hands, check the menu with staff, collect ingredients, follow recipe on package, put food into serving	W 249		

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W 249	Continued From page 6	W 249		

bowls, store food properly and clean up. Further review of client #2's Adaptive Behavior Inventory (ABI) dated 1/28/19 indicated the client can independently prepare frozen foods in the microwave and vegetables in the oven. The ABI also revealed he required partial assistance to prepare sandwiches, salads, canned foods, meat dishes, fresh vegetables, combination dishes and baked goods.

Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2 "can do pretty much anything once you show him". The QIDP noted the client "can function independently" in the kitchen when given little assistance from staff.

2. Client #6 was not prompted or assisted to participate with family style dining.

During evening observations in the home on 7/1/19 at 5:40pm, Staff C prepared client #6's dinner plate in the kitchen while the client sat in the living room. The client's bread was cut into smaller pieces and the plate was later taken to him as he sat at the dinner table. Client #6 was not prompted or assisted to participate in family style dining tasks.

Interview on 7/1/19 with Staff C revealed the client used to participate in family style dining but they had been told to now prepare his plate in the kitchen and cut up his food at the counter.

Review on 7/2/19 of client #6's ABI dated 3/25/19 revealed he can serve himself from a bowl/platter with partial independence and pass a bowl/platter independently.

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W 249	Continued From page 7 Interview on 7/2/19 with the QIDP confirmed client #6 can participate with family style dining tasks given assistance and staff should have offered him the opportunity.	W 249		
W 255	PROGRAM MONITORING & CHANGE 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 the Individual Program Plan (IPP) was reviewed and revised after 2 of 3 audit clients (#2, #4) had completed objectives. The findings are: 1. Client #2's IPP was not revised after he had completed an objective. Review on 7/1/19 of client #2's IPP dated 2/6/19 revealed an objective to follow a simple recipe with gestural prompting 85% of the time for 3 consecutive review periods (7 steps/implemented 5/14/18). Additional review of the objective's progress notes from June '18 - May '19 indicated the client had completed steps 1 - 7 with verbal prompts and/or independently while scoring 100% completion over 6 reviews and 95% on one review. A note dated 5/23/19 revealed, "...[Client #2] is currently 100% verbal prompting and independent on step 7. He has exceeded criteria..." Interview on 7/2/19 with the former Habilitation	W 255		

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W 255	Continued From page 8 Specialist (HS) confirmed the objective had been completed; however, training continued. 2. Client #4's IPP was not revised after she had completed an objective. Review on 7/1/19 of client #4's IPP dated 7/5/18 revealed an objective to slow her rate of eating with no more than one verbal prompt 85% of the time for 2 consecutive review periods (6 steps/implemented 2/26/18). Additional review of the objective's progress notes from January '19 - May '19 revealed the client had moved to step 6 on 1/31/19 and had since achieved 90% completion on 2/26/19 and 3/27/19. However, based on the 5/23/19 progress note, training continued. Interview on 7/2/19 with the former HS confirmed the objective had been completed; however, training continued.	W 255		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to address client #6's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is: A technique to address client #6's inappropriate	W 288		

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regurgitation/rumination behavior was not included in an active treatment plan.

During observations after lunch at the day program on 7/1/19 at 11:29am and after breakfast in the home on 7/2/19 at 8:38am, Staff A obtained a jar of peanut butter and gave client #6 a large spoonful.

Interview on 7/1/19 and 7/2/19 with Staff A revealed they have been directed to give client #6 a teaspoon of peanut butter after each meal because he will throw his food up everywhere if he does not get it. The staff indicated the peanut butter was used to keep his food down and prevent him from bringing it back up. The staff indicated this behavior has gotten worse over recent months.

Review on 7/2/19 of client #6's Individual Program Plan (IPP) dated 4/4/19 revealed,"He does have a history of GERD & rumination and is currently on Reglan 10mg two times daily." Additional review of the plan indicated a Behavior Support Plan (BSP) dated 2/26/19 to address unsafe eating behaviors and physical aggression. The BSP did not identify regurgitation/rumination as a target behavior or the use of peanut butter to address this behavior.

Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) and the Behaviorist confirmed client #6 used to have a formal BSP which incorporated the use of peanut butter to address his rumination behavior. However, the program was discontinued after the behavior stopped several years ago. Additional interview indicated this behavior had returned about 6 months ago which is why staff began

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W 288	Continued From page 10 using the peanut butter again. Further interview confirmed the use of peanut butter to address client #6's rumination was not included in a formal active treatment plan.	W 288		
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 review and interview, the facility failed to ensure all drugs were administered without error. This effected 1 of 3 clients observed to receive medications (#6). The finding is: Client #6 did not receive his medications as ordered. During morning observations of medication administration in the home on 7/2/19 at 7:34am, client #6 ingested 10ml of Enulose 10gm/15 and 5ml of Reglan 5mg/5ml. During this administration, Staff E verbally confirmed the amount of liquid in the medication cup for each medication dispensed. Review on 7/2/19 of client #6's physician's orders dated 4/18/19 noted Enulose 10gm/15 with 15ml to be given by mouth twice a day for constipation at 8am and 8pm. The orders also indicated Reglan 5mg/5ml with 10ml to be given by mouth three times a day at 8am, 4pm and 8pm. Interview on 7/2/19 with the Nurse Manager	W 369		

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W 369	Continued From page 11 confirmed client #6's physician's orders were current and should have been followed as indicated.	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: Based on observations, record review and interviews, the facility failed to ensure all drugs were kept locked except when being prepared for administration. The finding is: Drugs were not kept locked except during administration. During observations of medication administration in the home on 7/2/19 from 7:34am - 7:55am, the door to the medication room was kept propped open with a rug positioned underneath the bottom of the door frame. During this time, Staff E walked out of the area at 7:50am and 7:55am, leaving the wide door open and individual medication cabinets inside the room unlocked. Interview on 7/2/19 with Staff E revealed they usually do not leave the door to the medication room opened; however, they "got busy" this morning. Additional interview indicated the staff routinely unlocks the individual medication cabinets at the beginning of the med pass and leaves the room to retrieve clients. Review on 7/2/19 of the facility's Storage of	W 382		

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W 382	Continued From page 12 Medications policy (revised February 2016) noted, "Compartments containing medications are locked when not in use...(Compartments include, but are not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes.)..." Interview on 7/2/19 with the Nurse Manager indicated medication technicians are trained to "never" leave the door to the medication room unlocked with medications unattended.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. The finding is: Facility fire drills were not conducted at varying times. Review on 7/1/19 of facility fire drill reports for June 2018 - June 2019 revealed fire drills were conducted on third shift (11pm - 7am) at 12:09am, 12:32am, 1:08am, and 1:30am and on second shift (3pm - 11pm) at 3:35pm, 4:12pm, 4:24pm, and 4:35pm. The fire drills were not conducted at varying times and conditions for second and third shifts. Interview on 7/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be conducting fire drills at various times throughout the shift.	W 441		

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