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{E 020}	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical	{E 020}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{E 020}	Continued From page 1 Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness, which included specific locations where management would relocate clients in the facility in the event of an emergency evacuation. The finding is: Management staff did not have a plan with an outside entity regarding sheltering individuals and staff in the event evacuation of the facility became necessary. Review on 11/7/19 of the facility's emergency preparedness plan dated 6/2019 did not include an agreement with alternate lodging specific to where the clients would evacuate in the event of an emergency. Interviews on 11/7/19 with the qualified intellectual disabilities professional (QIDP) revealed the emergency preparedness plan (EP) was a template to be used as a guide in developing the facility's EP. When asked where clients would be relocated, the qualified intellectual disabilities professional (QIDP) stated a local entity would be used. He stated there was no written agreement or contact person. During an interview on 11/7/19, the QIDP	{E 020}		

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{E 020}	Continued From page 2 acknowledged the plan does not include all of the components outlined in the emergency preparedness plan including an agreement with a local entity that may be used for lodging should the clients need to evacuate from the facility.	{E 020}		
W 000	INITIAL COMMENTS A revisit was conducted on 11/7/19 for all previous deficiencies cited on 9/4/19. Some deficiencies have been corrected, and additional deficiencies were cited.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to provided sufficient direct care staff to manage and supervise clients appropriately in the areas of dining, self help skills and behavioral intervention. This affected 3 of 6 clients (#1, #4 and #6). The findings include: 1. Staff failed to supervise client #4 during dining as described in her individual program plan (IPP). During observations on 11/7/19 at the facility 8:20am client #4 grabbed sausage out of the serving bowl and ate it. There were 2 staff working at the facility. The residential manager	W 186		

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W 186	Continued From page 3	W 186		

(RM) was cooking the remainder of breakfast and the qualified intellectual disabilities professional (QIDP) was giving medications in the office. Client #4 was not redirected. At 8:30am client #4 ate a large piece of uncut pancakes with the fingers of her right hand. She was not cued to use her utensils or cut up her pancakes which had syrup on them.

Review on 11/7/19 of client #4's IPP dated 5/8/19 revealed mealtime guidelines which instructed staff to sit within arms reach of her during all meals. Staff are to ensure she utilizes a small spoon to decrease the amount of food she consumes per bite. Staff are to encourage her to put her spoon down after each bite.

Interview on 11/7/19 with the qualified intellectual disabilities professional (QIDP) revealed these guidelines are current and should be followed. Additional interview revealed the home is currently short staffed by 6 full time positions which has affected staffing in the mornings during mealtimes.

2. Staff were not consistently available to prevent client #6 from stealing food from other clients during mealtimes.

During observations at the facility on 11/7/19 at 8:40am, client #6 reached into client #5's plate and took several pieces of food. The residential manager was assisting client ##3 with her meal and the QIDP was giving medications.

Review on 11/7/19 of client #6's IPP dated 6/26/19 revealed, "Has tendency to steal food, please monitor for food stealing behaviors at mealtimes."

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W 186	Continued From page 4 Interview on 11/7/19 with the QIDP revealed staff should monitor client #6 closely during mealtimes to prevent food stealing behaviors. 3. There were not sufficient trained staff available to assist client #1 with mealtime for over 30 minutes. During observations in the facility on 11/7/19 client #1 who is nonverbal and non ambulatory sat in her wheelchair waiting for assistance from staff during mealtime for over 30 minutes (8:15-8:45am). During this time the residential manager was assisting serving clients breakfast, assisting client #3 with dining. The residential manager was also intervening with client inappropriate behaviors. The QIDP was assisting clients, intervening with client inappropriate behaviors and finishing medication administration. Client #1 sat unable to feed herself from 8:15-8:45am waiting for assistance from staff. Review on 11/7/19 of client #1's IPP dated 6/18/19 revealed she requires assistance feeding herself and total physical assistance in all areas of self help skills. Interview on 11/7/19 with the QIDP revealed client #1 requires total assistance with dining. 4. There were not sufficient trained staff available to assist client #4 with her shower on 11/7/19 when she indicated she wanted to bathe. During observations on 11/7/19 client #4 was prompted to get up in her bedroom at 6:20am. She was in 2 piece pajamas and grabbed her	W 186		

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grooming kit . The residential manager told her she would have to wait until the qualified intellectual disabilities professional (QIDP) arrived to get her shower because she had to monitor the other clients. She put her grooming kit down and walked to the living room and curled up on the living room couch until 6:55am when the QIDP arrived. At 7:05am the residential manager verbally cued her to follow her to the bathroom to get her shower.

Interview on 11/7/19 with the residential manager revealed she was the only staff working with 6 clients from around 6am until the QIDP arrived on 11/7/19.

W 249 PROGRAM IMPLEMENTATION W 249

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 reviews and interviews, the facility failed to ensure 3 of 6 audit clients (#2, #4, #6) received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plans (IPP) for these clients in the areas of family style dining and implementation of behavioral support programs

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(BSP)'s. The findings include:

1. Staff failed to redirect client #2 to use her utensils during dining on 11/7/19.

During observations of breakfast on 11/7/19 at 8:20am client #2 repeatedly picked up pieces of pancakes and sausage covered with syrup with her fingers. She was not redirected by the residential manager (RM)who was assisting client #3 with dining nor was she redirected by the qualified intellectual disabilities professional (QIDP) who was assisting another client at the dining room table.

Review on 11/7/19 of client #2's community home life assessment dated 1/11/18 revealed she is independent in using all utensils during dining.

Interview on 11/7/19 revealed client #2 is independent in using her utensils but need some cueing during dining to consistently use utensils.

2. Staff failed to supervise client #4 during dining as described in her individual program plan (IPP).

During observations on 11/7/19 at the facility 8:20am client #4 grabbed sausage out of the serving bowl and ate it. There were 2 staff working at the facility. The residential manager (RM) was cooking the remainder of breakfast and the qualified intellectual disabilities professional (QIDP) was giving medications in the office. At 8:30am, client #4 ate a large piece of uncut pancakes with the fingers of her right hand. She was not cued to use her utensils or cut up her pancakes which had syrup on them.

Review on 11/7/19 of client #4's IPP dated 5/8/19

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W 249	Continued From page 7 revealed mealtime guidelines which instructed staff to sit within arms reach of her during all meals. Staff are to ensure she utilizes a small spoon to decrease the amount of food she consumes per bite. Staff are to encourage her to put her spoon down after each bite. Interview on 11/7/19 with the qualified intellectual disabilities professional (QIDP) revealed these guidelines are current and should be followed. Additional interview revealed the home is currently short staffed by 6 full time positions which has affected staffing in the mornings during mealtimes. 3. Staff were not consistently available to prevent client #6 from stealing food from other clients during mealtimes. During observations at the facility on 11/7/19 at 8:40am, client #6 reached into client #5's plate and took several pieces of food. The residential manager (RM) was assisting client #3 with her meal and the QIDP was giving medications. Review on 11/7/19 of client #6's IPP dated 6/26/19 revealed, "Has tendency to steal food, please monitor for food stealing behaviors at mealtimes." Interview on 11/7/19 with the QIDP revealed staff should monitor client #6 closely during mealtimes to prevent food stealing behaviors.	W 249		
{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	{W 257}		

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{W 257}	Continued From page 8 professional and revised as necessary, including, but not limited to situations in which the client is 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 1 of 3 audit clients (#1). The finding is: Client #1's team failed to revise her behavior support program (BSP). Review on 11/7/19 of client #1's individual program plan (IPP) dated 6/18/19 revealed she has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19 revealed a BSP dated 6/13/18 to address these target behaviors. Review of her behavioral data for the past 6 months indicated that client #1 had not exhibited any episodes of physical aggression. Review on 11/7/19 of a note by the qualified intellectual disabilities professional (QIDP) for client #1's progress summaries dated 7/2019 revealed a note indicating that client #1's BSP needed to be revised. Interview on 11/7/19 with the QIDP confirmed there has been no episodes of physical aggression by client #1 in several months. Further interview revealed he has contacted the Psychologist several times to to request revisions	{W 257}		

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{W 257}	Continued From page 9 to client #1's BSP since the follow up survey on 9/4/19, however this has not been completed.	{W 257}		
{W 262}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plan (BSP) for 1 of 3 audit clients (#5) was reviewed and monitored by the human rights committee (HRC). The finding is: Management staff failed to have the human rights committee review a restrictive behavior plan for client #5. Review on 11/7/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program addresses the following target behaviors: non-compliance, physical aggression and inappropriate verbalizations. Further review revealed this program incorporates the use of Paroxetine 20 mg., Alprazolam 2 mg. (for physician appointments) and Abilify 2 mg daily and the use of a crisis dose of Abilify 2 mg. for agitation. Additional review of this program revealed the guardian signed written informed consent on 10/8/18. There was no written consent from the HRC for the BSP in client#5's BSP.	{W 262}		

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{W 262}	Continued From page 10 Interview on 11/7/19 with the qualified intellectual disabilities professional (QIDP) confirmed the HRC is mandated to review any programs that contain restrictions, including the use of psychotropic medications. Further interview confirmed there was not consent from the HRC for client #5's BSP dated 9/26/17. Additional interview revealed he has contacted the Psychologist by phone on 10/22/19 however client #5 still does not have HRC consent.	{W 262}		
{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 verified by interview, the facility failed to assure the behavior support plan (BSP) for 2 of 3 sampled clients (#1,#3) were conducted only with the written informed consent of the guardians for these clients. The findings include: 1. Client #1's interdisciplinary team failed to obtain written informed consent for her BSP. Review on 11/7/19 of client #1's record revealed she has been adjudicated incompetent and appointed a Guardian of the Person to act on her behalf. Review of the IPP revealed client #1 has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19	{W 263}		

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{W 263}	Continued From page 11	{W 263}		

revealed a BSP dated 6/13/18 to address these target behaviors. Further review of the BSP revealed no written informed consent from client #1's legal guardian.

Interview on 11/7/19 with the qualified intellectual disabilities professional (QIDP) confirmed that all behavior support programs (BSP)'s that incorporate restrictions which include the use of psychotropic medications must have written informed consent from the legal guardian for the person they support. Additional interview confirmed he had obtained verbal consent on 8/14/18 for client #1's BSP dated 6/13/18 but that he had not followed up with the legal guardian to obtain written informed consent.

2. Client #3's interdisciplinary team failed to obtain written consent for her BSP.

Review on 11/7/19 of client #3's record revealed she has a legal Guardian of the Person to act on her behalf. Review of her BSP dated 1/11/18 revealed she has target behaviors of physical aggression, non-compliance and elopement. Further review of this program revealed she takes Seroquel 100 mg. (1/2 tablet by mouth am, 1 tablet by mouth pm) and Seroquel 300 mg. (take 1 tablet by mouth at bedtime). Additional review revealed North Carolina Interventions (NCI), the use of a limited control walk and a therapeutic wrap in this program.

Review on 11/7/19 of the informed consent for client #3's BSP revealed it was signed by the guardian on 2/10/18 and would expire on 1/11/19.

Interview on 11/7/19 with the QIDP revealed there was not an updated written consent for client #3's

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{W 263}	Continued From page 12 BSP.	{W 263}		
{W 316}	DRUG USAGE CFR(s): 483.450(e)(4)(ii) Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: The facility failed to show evidence medication to control inappropriate behaviors for 1 of 3 sampled clients (#5) had attempted to be reduced within the year or documentation showing the client is on the lowest effective dosage as evidenced by interview and review of records. The finding is: Client #5's team failed to review the use of her crisis medication to determine if it was still needed. Review on 11/7/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program was to target the inappropriate behaviors of Non-Compliance, Physical Aggression and Inappropriate verbalizations. The program included the use of psychotropic medications to include Abilify 2 mg. daily, Paroxetine 20mg. and Alprazolam 2 mg. The program also included a crisis dose of Abilify 2mg. as needed anxiety and agitation. Review on 11/7/19 of client #5's recent physician orders dated 6/26/19 revealed no recent use of this crisis dose of Abilify 2mg. as needed anxiety and agitation. Interview on 11/7/19 with the qualified intellectual disabilities professional (QIDP) revealed client #5	{W 316}		

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{W 316}	Continued From page 13 has not required the use of the crisis dose of Abilify 2mg. in over 6 months. Further interview confirmed the team has not discussed with the Physician the continued need for this crisis dose of Abilify 2mg. for client #5.	{W 316}		