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E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on record verification and interview, the facility failed to assure the emergency plan (EP) contained information specific to the needs of clients in the group home. The finding is: Review of the facility EP on 1/16/20 revealed the facility EP to reveal no specifics relative to any client of the group home. Further review of the EP revealed the plan to contain no information to support any client in a manner that was easy for	E 007		

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 007	Continued From page 1 people who may have to work with the clients and not be familiar with them. Interview with the facility qualified intellectual disabilities professional verified client specific information such as communication needs, behavior plans, nutritional assessments or adaptive needs were not included in the current EP.	E 007		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		

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*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on record verification and interview, the facility failed to assure the emergency plan (EP) contained information specific to the subsistence needs of the group home. The finding is:

Observation of the the kitchen pantry of the group home on 1/16/20 revealed a plastic storage bin with various food items. Additional observation of the kitchen pantry revealed a storage of water on a shelf in the pantry.

Review of the facility EP on 1/16/20 revealed no information relative to the subsistence needs of the group home. Interview with staff C on 1/16/20 revealed an emergency supply of food and water was kept in the kitchen pantry of the facility. Further interview with staff C revealed the staff

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E 015	Continued From page 3 was unsure how long the supply of food and water was to sustain the facility during an emergency. Interview with the qualified intellectual disabilities professional (QIDP) verified emergency supplies were not addressed in the EP for the facility. Further interview with the QIDP confirmed the facility EP could benefit from additional specifics relative to emergency supplies such as specified items, location of items and details of delegated items such as the food and water supply.	E 015		
E 036	EP Training and Testing CFR(s): 483.475(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 036		

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policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This STANDARD is not met as evidenced by:
Based on record verification and interview, the facility failed to ensure a system was in place to assure staff were adequately trained on the emergency plan (EP). The finding is:

Review of the facility EP on 1/16/20 revealed no

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E 036	Continued From page 5 information regarding staff training was included in the plan. Interview with staff C on 1/16/20 revealed the staff had not been trained on the EP of the facility. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed the facility had no documentation of formal training to staff regarding the EP. Further interview with the QIDP revealed there is currently no system to train new staff on the EP or assure current staff are trained annually on the information contained in the EP.	E 036		
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 observation, review of records and interview, the team failed to ensure the individual habilitation plan (IHP) for 1 of 3 sampled clients (#4) included training to address needs relative to falling behavior. The finding is: Observation on 1/17/20 at 7:00 AM revealed 3 of 4 clients in the group home to be present in the facility. Interview with staff E on 1/17/20 revealed client #4 was not at the group home due to the need to go to the hospital after a fall during the night. Further interview with staff E revealed client #4 had a behavior with the third shift staff and hit her head in the bathroom. Interview with third shift staff, F, revealed about 2:45 AM on 1/17/20, client #4 became upset about the need	W 227		

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to get up to check her colostomy bag and after going into the bathroom the client fell face forward at the bathroom sink and hit her head. Staff F further revealed EMS was called and the client was transported to the hospital while the facility qualified intellectual disabilities professional met the client at the hospital. Interview with staff E and F revealed client #4 has a history of behavioral falls when the client becomes upset. Observation in the group home at 8:05 AM revealed client #4 to return to the group home with a swollen nasal area and stitches to the forehead.

Review of incident reports for client #4 on 1/17/20 revealed from 8/2019 through the current survey date of 1/17/20, client #4 had 8 documented falls on various shifts with various staff. Further review of incident reports revealed client #4 had sustained no injuries after most falls and needed first aid treatment only for abrasions or redness. Review of incident report dated 8/25/19 revealed client #4 was taken to urgent care after a fall due to an elbow laceration.

Review of records for client #4 on 1/17/20 revealed a behavior support plan (BSP) dated 8/26/20. Further review of the BSP revealed target behaviors of stomping feet, clenching fists, cursing, screaming, hollering, making threats to staff and peers, telling others what to do, hitting staff/peers, hitting walls with her fist, not caring for her colostomy bag appropriately and throwing feces. Subsequent review of the BSP for client #4 revealed no behavior of falls.

Interview with the QIDP on 1/17/20 verified client #4 has had a history of behavioral falls in which the client falls forward after getting upset. The

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W 227	Continued From page 7 QIDP further revealed client #4's fall behavior tends to happen after a directive from staff to do something she doesn't want to do. The facility QIDP additionally verified client #4 has had to have medical treatment after a fall two times that she was aware of (8/25/19 and 1/17/20). Subsequent interview with the QIDP revealed client #4's fall behavior should be in the BSP for the client and she thought that it was. The QIDP verified client #4's BSP should be amended to include fall behavior and a discussion had recently occurred with the facility behaviorist regarding client #4's falls.	W 227		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to furnish and provide teaching relative to eyeglasses for 2 of 3 sampled clients (#1 and #4). The finding is: A. The facility failed to provide teaching relative to eyeglasses for client #1. For example: Observation of client #1 throughout the 1/16-17/20 survey revealed the client to not wear glasses or be prompted by staff to put on glasses.	W 436		

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Review of records for client #1 on 1/17/20 revealed a vision exam dated 8/29/19. Further review of the 8/2019 vision exam revealed a diagnosis of myopia and Presbyopia. Subsequent review of the 8/2019 vision exam revealed prescribed glasses with a recommended follow-up exam in one year.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/17/20 revealed client #1 has prescribed glasses that the client should wear at all times. Further interview with the QIDP revealed client #1 often hides her glasses or loses them due to not wanting to wear them. The QIDP further confirmed client #1 did not have a training program to address wearing eyeglasses or the need to keep up with eyeglasses.

B. The facility failed to furnish eyeglasses for client #4. For example:

Observation of client #4 throughout the 1/16-17/20 survey revealed the client to not wear glasses or be prompted by staff to put on glasses.

Review of facility incident reports on 1/17/20 revealed on 9/6/19 client #4 had a fall and sustained an abrasion to the forehead. Further review of the 9/6/19 incident report revealed client #4's glasses broke with the client's fall. Review of records for client #4 revealed a vision exam dated 1/2/20 that indicated a new prescription for glasses was provided with exam.

Interview with the QIDP verified client #4 currently did not have glasses. The QIDP further verified client #4 had not had glasses furnished since the last pair broke in 9/2019. Additional interview with the QIDP revealed client #4 currently has

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W 436	Continued From page 9 eyeglasses ordered although the glasses had not come in. The QIDP subsequently confirmed client #4 had been without prescribed eyeglasses for 4 months.	W 436		