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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID 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: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency	E 006		

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 006	Continued From page 1	E 006		

Plan. The Hospice 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:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
This STANDARD is not met as evidenced by:
Based on policy review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment utilizing an all-hazards approach. This had the potential to affect all clients. The finding is:

The facility did not have an EP plan based upon risk assessments.

Review on 3/10/20 of the the facility's current EP plan revised on 12/31/19, revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach.

Interview on 3/10/20 with the Habilitation Specialist (HS) revealed that any additional information not contained in the EP manual presented most likely was kept at the corporate office.

Interview on 3/10/20 with the Qualified Intellectual Disabilities Professional (QIDP) identified that she could not locate a risk assessment for the group

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E 006	Continued From page 2 home that identified specifics hazards.	E 006		
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. *[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	E 015		

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E 015	Continued From page 3 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 observation, policy review and staff interviews, the facility failed to ensure emergency provisions for subsistence needs for staff and clients included adequate food and water as identified in the emergency preparedness (EP) plan. This potentially affected all clients residing in the home. The finding is: Adequate emergency food and water were not available. During observations in the home from 3/10/20 to 3/11/20, the facility's portable container for emergency food supplies remained empty. In the facility cabinets was a large selection of canned vegetables, boxes of dry pasta and sauces, that required a heat source to prepare. In addition there was an inadequate supply of ready to eat foods in the cabinet which included: several opened containers of dry cereal, boxes of chips and crackers, 1 six pack of applesauce, 1 four pack of pudding, and 1 jar of peanut butter. Review on 3/11/20 of the facility's EP plan revised on 12/31/19, did not have specific information on	E 015		

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E 015	Continued From page 4 emergency food storage policy or identify a rotation schedule to ensure the food's freshness. Interview on 3/10/20 with the Habilitation Specialist (HS) revealed that it was the responsibility of the Home Manager (HM) to stock the emergency supplies. The HS acknowledged that she was supposed to check monthly to ensure that there were adequate supplies. Interview on 3/11/20 with the Home Manager (HM) revealed that in January '20, the nutritionist visited the home and found expired food in the emergency supplies container. The nutritionist had the former HM discard all expired food. The HM commented that she thought the emergency food supplies were supposed to be check annually. Currently, she stated that they had a 24 pack of water and a few gallons of water on hand for clients and staff. The HS did not have an explanation for why the food had not been replenished since she took over as HM a month ago.	E 015		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) (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 every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place	E 022		

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E 022	Continued From page 5 for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop policy and procedures for sheltering in place in their emergency preparedness (EP) plan. This potentially affected all clients residing in the home. The finding is: The facility's EP plan only focused on evacuation. Review on 3/10/20 of the facility's EP plan revised on 12/31/19 did not include language for situations that would call for the clients and staff to shelter in place. Interview on 3/10/20 with the Habilitation Specialist (HS) and Qualified Intellectual Disabilities Professional (QIDP) revealed that their EP policy had not addressed provisions and instruction for staff in the event of an emergency that required them to shelter in place, for an undetermined period of time. The HS suggested that if anyone in their household was suspected of having an infectious disease, she would seek medical guidance from the hospital, in the event a quarantine was necessary.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7)	E 025		

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E 025	Continued From page 6 [(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 every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by:	E 025		

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E 025	Continued From page 7 Based on interviews and review of the facility's emergency preparedness (EP) plan, the facility failed to document pre-arranged accomodations for clients in the event services could not be delivered in the home. This potentially affected all clients in the home. The finding is: The facility failed to list emergency accomodations in their EP plan. Review on 3/10/20 of the facility's EP plan revised on 12/31/19 revealed that there was no listing of accomodations or agreements for emergency purposes. Interview on 3/10/20 with the Habilitation Specialist (HS) revealed that the facility had an arrangement with a hotel in the county, but she did not have a copy of the agreement. The HS stated that the Qualified Intellectual Disabilities Professional (QIDP) had a copy of the hotel arrangements. Interview on 3/10/20 with the QIDP revealed that the facility had used a local hotel in the past for the group homes. The QIDP could not locate a copy of the agreement when reviewing the EP plan files.	E 025		
E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 8 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 every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and 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. (iii) Provide emergency preparedness training at least every 2 years. (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. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 9 *[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 every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility 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 all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[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	E 037		

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E 037	Continued From page 10 and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (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. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the	E 037		

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E 037	Continued From page 11 CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The 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 every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to document emergency preparedness (EP) plan training for staff. This potentially affected all clients. The finding is: Staff did not receive EP plan training as required. Review on 3/10/20 of the facility's EP plan revealed that there were no evidence of EP training for all staff. There was one document, dated 1/22/20 titled Emergency Evacuations with an attached flyer on cooking safety. There were six participants which included four non-management staff. Further, the names of the facility's newest employees were not documented as receiving EP plan training sheet. Interview on 3/10/20 with the Habilitation Specialist (HS) revealed that the facility did not provide any training for any new staff; plus no table top or full scale EP exercises were conducted. Interview on 3/11/20 with the Qualified Intellectual	E 037		

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E 037	Continued From page 12 Disabilities Professional (QIDP) revealed that she recalled someone trained staff in their homes on EP plan. The QIDP acknowledged that she did not have documentation of the training.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that	E 039		

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E 039	Continued From page 13 is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that	E 039		

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E 039	Continued From page 14 is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and	E 039		

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E 039	Continued From page 15 maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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	E 039		

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E 039	Continued From page 16 maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all	E 039		

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E 039	Continued From page 17 drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 18 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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 interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their emergency preparedness (EP) plan were conducted. This potentially affected all clients in the home. The findings is: The facility's EP plan did not include completion of facility/community-based or tabletop exercises. Review on 3/10/20 of the facility's EP plan revised on 12/31/19, did not include a full-scale community-based or tabletop exercise. Interview on 3/11/20 with the Home Manager (HM) revealed that she has been in her role for a month and had not conducted any training exercises on the EP full-scale community-based	E 039		

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E 039	Continued From page 19 or tabletop exercises. Interview on 3/11/20 with the Habilitation Specialist (HS) revealed that she could not recall doing any full-scale community based exercise for the EP training.	E 039		
W 000	INITIAL COMMENTS A complaint investigation was conducted during the recertification survey for intakes #NC00160528 and #NC00160659. One deficiency was cited as a result of the complaint.	W 000		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure outside services were coordinated in order to meet the needs of clients. This affected 2 of 3 audit clients (#1, #5). The findings are: A. The potential use of a pain medication was not coordinated with client #5's school. During an interview on 3/10/20, client #5's teacher revealed the use of a pain medication to be used at school was discussed at the client's Individual Education Plan (IEP) meeting. The teacher felt having a pain medication available to be administered at school during her menstrual cycle would be helpful during the client's behavior episodes since she may be expressing pain.	W 120		

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W 120	Continued From page 20 Additional interview indicated she was not sure what happened after the IEP but no pain medication was ever provided from the facility. Interview via phone on 3/11/20 with the school's nurse confirmed pain medication for client #5 had been discussed. Additional interview indicated per her nurse's notes dated 1/10/20, a request for a physician's order for the pain medication had been sent home in the client's book bag; however, there had been no response from the facility since then. Review on 3/11/20 of client #5's record revealed an E-prescription dated 12/4/19 for Acetaminophen 325mg, two tablets by mouth 4 times daily "PRN pain," Interview on 3/11/20 with the Habilitation Specialist (HS) and Home Manager (HM) revealed they were not aware of a discussion regarding pain medication at school or request for an order being sent to the home. Interview via cell phone on 3/11/20 with the facility's nurse revealed client #5 has a prn order for Tylenol and she indicated the guardian felt the client was already on too many medications and some of her other medications could be addressing pain already. Interview via phone on 3/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she had attended client #5's IEP meeting; however, she did not recall a discussion about pain medication being available at school for client #5.	W 120		

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W 120	Continued From page 21 B. Facility did not ensure that client #1's school received medication and current individual program plan (IPP). During record review on 3/11/20, of client #1's Allergy and Anaphylaxis Emergency Plan dated 2/24/20, identified allergy to tree nuts, grapes, celery, green pea, green pepper, green bean, sesame seed. To treat the allergy, the doctor prescribed the use of an Epinephrine Auto Injector (EPI pen) and Benadryl liquid, 3 teaspoons by mouth. An additional review on 3/11/20 of client #1's IPP dated 3/1/20 revealed that the school staff were not in attendance. Interview on 3/10/20 with client #1's teacher revealed, that client #1 had a reaction to a food allergy last month at school which required that EMS be called. An EPI pen was administered and further allergy testing was coordinated by the facility. The teacher indicated that the school was still waiting for the facility to provide the liquid allergy medication for client #1. The teacher also indicated that she also did not receive the current IPP from the facility. Interview on 3/11/20 with client #1's school nurse revealed that the facility did not furnish the liquid allergy medication after dropping off the food allergy list and EPI pen last month. Interview on 3/11/20 with the Home Manager (HM) revealed that the school has not received the liquid allergy medication. The HM had made a request to the corporate office to place the medication on the supply list since it was an item not furnished by their pharmacy. The HM was still	W 120		

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W 120	Continued From page 22 waiting for the corporate office to purchase the medication. Interview on 3/11/20 with the Habilitation Specialist (HS) revealed that the IPP was held on a Sunday and the school staff were not present. The HS indicated that she was out last week and had not sent the current IPP to the school.	W 120		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were able to demonstrate skills needed to implement interventions necessary to manage inappropriate behaviors for 2 of 3 audit clients (#1, #5). The findings are: A. Client #5's Behavior Intervention Plan (BSP) was not implemented as written. Throughout observations in the home during the survey on 3/10 - 3/11/20, staff were not observed to provide reinforcements for client #5's appropriate behaviors even though the client frequently sat quietly while completing tasks and complied with prompts from staff for various tasks. During dinner observations in the home on 3/10/20 at 6:40pm, client #5 pointed to the bowl of macaroni and cheese and stated, "More	W 193		

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macaroni and cheese". Staff C told the client to finish eating the food on her plate. The client was also told to remember her diet. Client #5 returned to eating her food. At 6:43pm, client #5 again asked for macaroni and cheese. The Home Manager (HM) stated, "Fruits and vegetables." Client #5 began to whine. After a few seconds, she turned over a glass of milk onto the table. The client was told to calm down. Client #5 then began to spit. Staff stated, "No spitting." Client #5 continued to spit and turned over another glass and began swearing repeatedly. Staff C and the HM then physically removed client #5 from the table and walked her to her bedroom.

Interview on 3/10/20 with Staff C revealed she has worked at the home for about a week and had a couple of days of training. She indicated she has had training on all behavior plans but has only had to implement one of the plans since starting this job. Additional interview revealed when client #5 has a behavior she should be given five minutes to calm down in her bedroom and then provided with an activity.

Review on 3/11/20 of client #5's BSP dated 1/6/20 revealed objectives to decrease the frequency of non-compliance, running away from staff, food stealing, profanity, explosive behaviors, spitting, and self-injurious behavior for 10 out of 12 months. The plan noted, "[Client #5] will be reinforced for every task completed with an identified reinforcers. Provide [Client #5] with social praise at least every thirty minutes in the absence of the target behaviors. Give her a great deal of attention when she is exhibiting appropriate behaviors to encourage continued compliance as this will help her learn how to gain attention through a socially appropriate means

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W 193	Continued From page 24 other than through inappropriate means...Allow for choices and decision-making whenever possible: Before a problem develops..." Further review of the BSP identified under spitting behaviors, "If [Client #5] appears to be getting ready to spit, staff will then tell her to swallow and redirect to an activity. If she spits, have her clean up the area with a cleaning solution using graduated guidance (least interaction necessary)...If she continues to spit, staff will say, '[Client #5] No Spitting' and then have her clean up the area." For profanity the plan noted staff should call the client's name "in a firm tone and ask her not to use such language..." Interview on 3/11/20 with the HM revealed several new staff were working in the home. Additional interview indicated most staff have been doing hands-on training as behaviors occur. She stated staff have read over each client's behavior plan. B. Client #1's BSP was not implemented as written. During morning observations in the home on 3/11/20 at 6:00am, staff were not observed to provide positive reinforcements for appropriate behaviors, although the client completed tasks such as setting the table and placing food items on the table for breakfast. During additional morning observations in the home on 3/11/20 from 6:10am - 6:23am, client #1 started arguments and caused disturbances with at least two other clients in the home. He refused to allow one client to sit on the couch, called other client's names, and threatened to fight another client. During this time, he was told to calm down	W 193		

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and asked if he wanted to go to his room. Client #1 ignored the prompts from staff.

During observations in the home on 3/11/20 at 7:00am, client #1 was unengaged while waiting for his bus to come. He went to the activity room door stating he wanted to go inside. Staff E blocked the door while telling him it was not time to go into the activity room yet. He continued to state he wanted to go in the room while attempting to go around the staff blocking the door. The staff repeatedly told him he could not go into the area. After several minutes of arguing back and forth with Staff E, the Habilitation Specialist (HS) told Staff E client #1 could go into the activity room if he wanted to. At 7:06am, client #1 went into the activity room and began using the computer.

During further observations in the home on 3/11/20 at 7:28am, client #1 began to use profanity while listening to music on the computer. Staff D called his name and went into the activity room to check on him briefly. A few minutes later, he used profanity again, the HS called his name and told him if he swears again he will need to come out of the activity room.

During observations in the home on 3/11/20 at 7:40am, client #1 had been on the computer listening to music for approximately 35 minutes. Staff E entered the room and told him he needed to take turns and allow another client to use the computer while the other client stood waiting. Client #1 became upset and screamed, "No!" The staff continued to remind client #1 about taking turns, being nice and sharing. Client #1 was then told to go to his room by the HS as she sat at a table in an adjacent room. He screamed, "No,

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W 193	Continued From page 26 I'm not going to my room...who gonna make me...I'm not getting up!" The client continued to sit at the computer. At 7:50am, when the HM entered the area and began prompting the client to go to his room in a firm voice, client #1 complied and went to his bedroom. Interview on 3/11/20 with Staff E revealed she has worked at the home for approximately 3 weeks. The staff indicated she had received training on each client's BSP by the HM and HS. Review on 3/11/20 of client #1's BSP dated 2/26/20 revealed objectives to decrease the frequency of defined non-compliance, physical aggression, tantrum behavior, lying, profanity, running from staff and stealing food for 10 out of 12 consecutive months. The BSP noted, "...provide [Client #1] with a variety of structured leisure and recreational activities while at the residence. When not actively engaged in obvious skill building habilitation goals, provide him the opportunity and encourage him to engage, during leisure time, in a structured and stimulating activity." Additionally, the plan noted, "[Client #1] will be reinforced for every task completed with an identified reinforcer. Provide [Client #1] with social praise at least every thirty minutes in the absence of the target behaviors. Identified reinforcers are as follows: social praise, water games, preferred edibles and walks." The plan also indicated, "...Do not give undo attention when applying an intervention. When [Client #1] is displaying inappropriate behavior, be sure to give him the least amount of attention necessary. Speak in a friendly positive manner. He responds poorly to changes in his environment, rules or when things don't go the	W 193		

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	34G272	A. BUILDING _____ B. WING _____	C 03/11/2020

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W 193	Continued From page 27 way he expects them to. (He has difficulty handling disappointment). Be consistent and follow through with what you tell him...Focus on positive things he does. Allow for choices and decision-making whenever possible. Before a problem develops, provide clear opportunities rather than required participation whenever possible...to the degree possible, give him what he wants but do not reward demanding or otherwise inappropriate behaviors." Further review of the BSP under non-compliance indicated, "Staff will give [Client #1] an instruction. If he does not comply within one (1) minute, staff will repeat the instruction. If he does not comply after one (1) additional minute, wait five minutes,...during the 5 minute time span, talk to him and attempt to focus his attention on the request making it sound fun/seem fun. You may entice compliance by reminding him of the reinforcer he will earn upon completion of the activity." For profanity, the plan revealed, "Staff will say [Client #1] in a firm tone and ask him not to use such language. If he does not immediately stop, escort him away from others (His Room) for 5 minutes of calm. Then engage his attention to another activity.' Interview on 3/11/20 with the HM revealed several new staff were working in the home. Additional interview indicated most staff have been doing hands-on training as behaviors occur. She stated staff have read over each client's behavior plan.	W 193		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan	W 252		

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W 252	Continued From page 28 objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all data relative to the accomplishment of Individual Program Plan (IPP) objectives was documented. This affected 1 of 3 audit clients (#5). The finding is: Client #5's behavior data was not collected at the school. During a visit to client #5's school on 3/11/20 at 12:25p, administrative staff indicated client #5 was in the cafeteria having a behavior episode which required the intervention of several staff members. Interview on 3/11/20 with client #5's teacher confirmed client #5 was having aggressive behaviors and several staff needed to intervene. Additional interview indicated the client has had an increase in behaviors this school year and this was discussed during her Individual Education Plan (IEP) meeting earlier this year which was attended by the former Home Manager and the Qualified Intellectual Disabilities Professional (QIDP). Review on 3/10/20 of client #5's Behavior Intervention Plan (BIP) dated 1/6/20 revealed objectives to decrease the frequency of non-compliance, running away from staff, food stealing, profanity, explosive behaviors, spitting, and self-injurious behavior for 10 out of 12 months. Additional review of client #5's record,	W 252		

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W 252	Continued From page 29 behavior data sheets and incident reports did not include any behavior data from her school. Interview on 3/11/20 with the Home Manager (HM) indicated she thought they used to collect data from the schools but she was not sure. Additional interview revealed the teacher usually calls to tell them about a behavior episode involving client #5; however, this was not documented. The HM acknowledged collecting client #5's behavior data from the school would be beneficial. Interview via cell phone on 3/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5's behavior data from school would be beneficial information overall for the psychologist to be aware of.	W 252		
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to implement policies and procedures to ensure actions imposed upon clients by staff did not potentially affect the client's quality of life. This affected 1 of 3 audit clients (#3). The finding is: Staff smoked a cigarette within arms reach of client #3. During morning observations in the home on	W 267		

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W 267	Continued From page 30 3/11/20 at 7:52am, Staff D prompted client #3 outside to wait for his school bus. As they both waited at the end of the walkway in front of the home, Staff D began smoking a cigarette. As she stood within arms reach of client #3, the smoke floated near him. The staff continued to smoke in front of the client for approximately 3 - 5 minutes. Interview on 3/11/20 with Staff D revealed she had not been told she could not smoke in front of the clients. The staff stated she thought it was ok since they were outside. Interview on 3/11/20 with the Home Manager (HM) and Habilitation Specialist (HS) revealed staff should not be smoking in front of any clients and all staff have been told this. Interview via cell phone on 3/11/20 with the Qualified Intellectual Disabilities (QIDP) confirmed all staff have been told they cannot smoke in front of clients and they should be smoking in designated areas around the outside of the home. The QIDP stated, "That is not acceptable at all."	W 267		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility did not conduct the appropriate number of fire drills, per quarter. This had the potential to affect all clients. The finding is	W 440		

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W 440	Continued From page 31 Facility did not conduct a fire drill, per shift, each quarter. During record review on 3/10/20 of the facility's fire drill log, it revealed that shifts that the drills were conducted, were incorrectly identified based on the time of day. The collected data stated: 1st shift drills given on 3/18/19 at 1:30 am, 9/10/19 at 5:00 am and 12/5/19 at 4:45 pm. 2nd shift drills was given on 4/22/19 at 3:40 am. Interview on 3/10/20 with Qualified Intellectual Disabilities Professional (QIDP) revealed that 1st shift was between 8:00 am-4:00 pm; 2nd shift between 4:00 pm-12:00 am and 3rd shift between 12:00 am-8:00 am. QIDP indicated that the former Home Manager (HM) was monitoring the fire drills until last month. QIDP also acknowledged that had not been "going behind" the former HM to check the drills schedule.	W 440		