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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(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. 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 every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. 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. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC 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	E 004		

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

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . 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 as needed. The finding is: Review on 4/25/22 of the facility's EP plan (last reviewed August 2018) revealed the plan included information not specific to the facility but referenced the corporation. Interview on 4/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he could not be sure if the EP plan had been updated since August 2018. Further interview confirmed the corporation had assumed ownership of the facility in December 2021 however had not updated the EP to reflect current changes in the facility.	E 004		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop	E 006		

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E 006	Continued From page 2	E 006		

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 Hospices at §418.113(a):] Emergency 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.

*[For LTC facilities at §483.73(a):] 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.

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E 006	Continued From page 3 *[For ICF/IIDs at §483.475(a):] 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. This STANDARD is not met as evidenced by: Based on record 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. The finding is: Review on 4/25/22 of the facility's current EP plan dated August 2018 revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 4/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no EP risk assessment had been completed utilizing an all-hazards approach.	E 006		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3),	E 032		

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E 032	Continued From page 4 §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Emergency Preparedness Plan (EP) plan included an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: Review on 4/25/22 of the facility's EP plan dated August 2018 there was no communication plan included in the facility's EP. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) revealed the facility did not have currently have back up cellphones, chargers, computers for email communication or battery operated radios.	E 032		

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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure staff coverage to provide appropriate supervision of clients and environmental cleanliness. The findings are: A. Interview on 4/26/22 with staff F revealed staff D had contacted her 4/25/22 to let her know staff C had left the facility on 4/25/22 around 7:30pm before her shift ended at 11pm without notifying the qualified intellectual disabilities professional (QIDP). This unexpected departure by staff C left staff D with all 4 clients from 7:30pm until around 9:00pm. Staff F stated that staff C has left her shift without authorization on several prior occasions. Interview on 4/26/22 with staff D revealed staff C left the facility on 4/25/22 around 7:30pm and did not get back until 9:00pm. Staff D confirmed she was left with all four clients from 7:30pm until 9:00pm. Further interview revealed staff C was supposed administer medications to all four clients at 8pm. Staff D stated staff C prepared all of the medications for clients #1, #2, #3 and #4 put the medication cups on the table in the office area around 9:30pm. Additional interview confirmed staff C took the client's medications to their bedrooms, in some cases waking the clients to take their medications. Interview on 4/26/22 with the QIDP revealed he was not contacted by staff C or staff D on 4/25/22	W 104		

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W 104	Continued From page 6 regarding the gap in staff coverage on second shift. Additional interview confirmed management has arranged the staffing schedule for 2 staff to be on duty at all times because of aggression, food stealing and property destruction by clients #2 and #4 who require direct supervision. Additional interview with the QIDP revealed staff C violated company policy by leaving her shift without authorization and administering medications outside the medication window for 8pm without authorization from the facility Nurse. B. Observations on 4/25/22 of the facility revealed several repairs that needed to be completed. Observations revealed the following: -A hole was noted in the wall of the kitchen and a broken chair was sitting against the kitchen wall. -The back ramp and wooden walkway outside the side door leading to the driveway was composed of loose boards and several nails sticking up through the planks. -There was a broken arm chair sitting outside the back door in the yard. - The grass in the front, side and backyard was long and up to the surveyor's knees. Interview on 4/26/22 with the qualified intellectual disabilities (QIDP) supervisor and QIDP confirmed maintenance needed to address the building and yard repairs.	W 104		
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:	W 227		

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Based on observation, record review and interviews, the facility failed to ensure client #2's individual program plan (IPP) included objectives to address knife, napkin use and medication administration. This affected 3 of 3 audit clients (#1, #2 and #3). The findings are:

A. During observations of supper on 4/25/22 client #2 at 5:35pm, revealed client #2 scooping large pieces of lasagna and salad into her mouth without any redirection from staff C and staff D who were working with the clients. Client #2 had a knife, fork and spoon at her placesetting but she was not assisted to use her knife to cut up her food into smaller pieces. Client #2 scooped food into her cheeks until she could not put any additional food into her mouth. Staff C and staff D did not redirect her. Client #2 had a napkin at her placesetting but was not verbally cued to use her napkin. As client #2 finished her meal, she had lasagna and salad on her face as she left the dining room table to take her plates, cups and silverware to the kitchen.

Immediate interview with staff D on 4/25/22 revealed client #2 does not have training to use her knife, utensils or napkin but she feels with consistent training she could learn to use her utensils and napkin consistently.

During observations of breakfast on 4/26/22 at 6:15am, client #2 was observed to pick up a pancake with syrup and a patty of sausage with her hands without using her utensils. Client #2 had a fork, spoon and knife at her placesetting. Staff A and staff E did not redirect her to cut up her pancake or her patty sausage using a knife and fork. Client #2 licked the pancake syrup from her hands without using her napkin.

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W 227	Continued From page 8 Interview on 4/26/22 with staff E revealed he did not think client #2 has current training to use her utensils or napkin at the dining room table while dining. Review on 4/26/22 of client #2's adult skills assessment dated 4/8/22 revealed she is independent using a fork but needs assistance using a napkin. The skills assessment did not provide information regarding using a knife and cutting up her food. Interview on 4/26/22 with the qualified intellectual disabilities professional (QIDP) revealed client #2 does not have current training on using a napkin or fork and knife. B. During observation of supper on 4/25/22 at 5:35pm, client #1 had a plateguard attached to his plate, Client #1 was observed to put large pieces of lasagna into his mouth. Staff C and staff D did not redirect him. Client #1 had a knife, fork and spoon at his placesetting but he was not assisted to use his knife to cut up his food into smaller pieces. During observation of breakfast on 4/26/22 at 6:15am, client #1 had a plate guard attached to his plate. Client #1 picked up his pancake and sausage with his fingers without cutting up his food into smaller pieces. Review on 5/26/22 of client #1's adult skills assessment dated 4/19/22 revealed he scored (2) indicating he is not independent using his table utensils. Interview on 4/26/22 with the QIDP revealed	W 227		

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W 227	Continued From page 9 client #1 does not have training identified to learn to use his dining utensils independently. C. During observations of medication administration on 4/26/22 at 8:35am client #3 was administered Citalopram, Clonazepam, Hydrochlorothiazide (HCTZ) and staff F applied Ammonium Lactate lotion to her right arm. Staff F and client #3 hand over hand punched her pills into the medication administration cup. Staff F poured her water into her cup. Client #3, who has a hearing impairment and wears a hearing amplification device, was not told what pills she was receiving or why she receives them. During observations of the breakfast meal at 6:15am client #3 was observed to pour her own beverages from a pitcher at the dining room table. Immediate interview with staff F revealed she thought with training client #3 was capable of learning what the names and purposes of some of her medications. Review of client #3's individual program plan (IPP) dated 10/4/21 revealed objectives to comb her hair independently, identify letters independently, make a cracker sandwich with 100% accuracy and her behavior support program. There was no training identified in the area of medication administration. Interview on 4/26/22 with the QIDP confirmed client #3 currently does not have training identified in the area of medication administration.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 10 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 3 audit clients (#1, #2 and #3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of objective training, choice making and leisure. The findings are: A. During observations in the facility from 9:30am-11:00am staff A and staff B monitored clients #1, #2 and #3 in the facility. The television was on in the living room and clients #1, #2 and #3 sat on the living room couches without being offered training on their formal objectives or being provided choices of leisure activities. Review on 4/25/22 of client #1's IPP dated 10/8/21 revealed he has identified objectives to turn off the light independently, learn to unhook his pants and learn to walk up the stairs independently and a behavior support program (BSP) to address non-compliance, aggression, public masturbation and food stealing. Review on 4/25/22 of client #2's IPP dated	W 249		

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9/30/21 revealed she has objectives identified to put placemats on the table, fold clothing in a drawer, wash her hands independently and a BSP to address food stealing, non-compliance, physical aggression, loud vocalizations and self-wetting.

Further review on 4/25/22 of client #2's BSP revealed should be provided, "ongoing activities, vocational opportunities and community outings. Encourage her to engage in leisure time in structured, stimulating activities."

Review on 4/25/22 of client #3's IPP dated 10/4/21 revealed formal objectives to comb her hair independently, identify letters independently, make a cracker sandwich with 100% accuracy and her BSP to address non-compliance and attention seeking behaviors.

Interview on 4/25/22 with staff A and B revealed not having a facility van for the home and having to share a van with the other facility makes it difficult to plan community outings. Additional interview revealed there are limited leisure supplies and clients #1, #2 and #3 have not expressed an interest in the activities that are available.

Observation on 4/25/22 of the leisure materials available revealed 2 puzzles and a "Simon Says" electronic game.

Interview on 4/25/22 with the facility qualified intellectual disabilities professional (QIDP) revealed there are leisure materials and activities that clients #1, #2 and #3 can utilize at the vocational program. Further interview confirmed that additional leisure materials appropriate for

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W 249	Continued From page 12 the client's interests need to be purchased for the facility.	W 249		
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 observation, record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 3 audit clients (#1 and #3). The findings are: A. Review on 4/25/22 of client #1's behavior support program (BSP) dated 3/6/17 revealed has an objective statement to decrease episodes of inappropriate behavior to 15 or less a month for 4 consecutive months. His target behaviors were listed as: non-compliance, aggression, self-injurious behavior, public masturbation and food stealing. Further review of this program revealed it incorporates the use of Fluoxetine and Quetiapine Fumarate. Review of the consent for this program revealed the written informed consent from client #1's legal guardian was signed on 10/8/20. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) confirmed the corporation that assumed ownership of the facility assumed responsibility in December 2021. Further interview confirmed the corporation was in the process of updating all BSP consents for the clients. Additional interview confirmed that	W 263		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 13 client #1's BSP consent had not been updated since 10/8/20. B. Review on 4/25/22 of client #3's record revealed she has a BSP dated 3/4/17 that addresses non-compliance and attention seeking behaviors that incorporates the use of Citalopram, Clonazepam and Trazedone. A recent informed written consent for this program could not be located. During observations on 4/25/22 the guardian representative from a county Department of Social Services that is client #3's legal guardian visited the facility and visited with client #3 at 4:10pm. However, the QIDP had just left the facility a few minutes earlier and was not there to obtain client #3's written informed consent. Interview on 4/26/22 with the QIDP revealed he could not locate recent written informed consent for client #3's BSP and he had intended to get the updated written informed consent for client #3 when the guardian representative visited on 4/25/22, however he was unable accomplish this. Further interview confirmed the corporation that assumed ownership of the facility assumed responsibility in December 2021. Further interview confirmed the corporation was in the process of updating all BSP consents for the clients.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on records review and interviews, the	W 331		

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	34G239	A. BUILDING _____ B. WING _____	04/26/2022

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W 331	Continued From page 14 facility failed to provide nursing services in accordance with the needs of 3 of 3 audit clients (#1, #2 and #3) relative to ensuring authenticated physician orders were available. The finding is: Review on 4/25/22 of quarterly physician orders revealed for clients #1, #2 and #3 these orders were not signed by the physician. Further review revealed there were not signed physician orders since June 2021. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) revealed authenticated physician orders for clients #1, #2 and #3 could not be located. Further interview revealed the physician orders were taken to the physician's office and have not been completed for filing in the client's charts. Additional interview revealed nursing had not followed up on obtaining the physician orders.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure nursing staff sufficiently trained direct care staff regarding appropriate nursing practices and protocols. This potentially affected 4 of 4 clients (#1, #2, #3 and #4). The finding is: During observations in the facility on 4/25/22 from	W 340		

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W 340	Continued From page 15 9:22am-12:00pm and 3:20pm-4:00pm staff A and staff B wore blue surgical paper masks while working clients #1, #2, #3 and #4. Both staff A and staff B assisted clients with personal hygiene tasks, preparing lunch and monitoring during this time. Review on 4/25/22 of the facility's policy on COVID-19 dated 2/10/22 revealed, "All staff will either be fully vaccinated or have a exemption letter on file by February 28, 2022 or within 2 weeks of hire". Further review of this policy revealed," The mitigation process to reduce the transmission and spread of COVID-19 for all staff who are not fully vaccinated for COVID-19 are as follows: Identify opportunities to get vaccinated. Properly wear a NIOSH approved N-95, a cloth mask with a PM2.5 insert or equivalent or higher level respirator for source control, covering the nose and mouth, regardless of whether they are providing direct care to or otherwise interacting with clients." Interview on 4/26/22 with the facility qualified intellectual disabilities professional (QIDP) revealed both staff A and staff B have letters of approved religious exemption on file with the facility and are currently unvaccinated. Further interview revealed both staff A and staff B should be wearing a NIOSH approved N-95, a cloth mask with a PM2.5 insert or equivalent or higher level respirator for source control to be in compliance with facility policy.	W 340		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services	W 352		

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W 352	Continued From page 16 include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all audit clients received a comprehensive dental examination at least annually. This affected 2 of 3 audit clients (#2 and #3). The findings are: A. Review on 4/25/22 of client #2's latest dental examination dated 8/7/10/20 revealed she was seen for a dental prophy. There was not documentation in client #2's record of a more recent dental visit. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) revealed he could not locate a dental visit in client #2's record since 7/10/20. Further interview revealed he did not know if nursing had followed up on scheduling an annual dental visit. B. Review on 4/25/22 of client #3's record did not provide documentation of dental visits. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) revealed he could not locate a dental visit in client #3's record. Further interview revealed he did not know if nursing had followed up on scheduling an annual dental visit.	W 352		
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental	W 356		

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W 356	Continued From page 17 health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1 received comprehensive dental treatment services for the maintenance of her dental health. This affected 1 of 3 audit clients (#1). The finding is: Review on 4/25/22 of client #1's dental visits revealed he was seen by the Dentist on 8/2/21 but an exam could not be completed because he was not cooperative. The Dentist documented that client #1 needed to "Be referred to the hospital for a dental cleaning and exam." Further review of client #1's record did not provide any documentation that any dental follow up was completed. Interview on 4/25/22 with the qualified intellectual disabilities professional (QIDP) revealed he could not locate any documentation that a dental follow up appointment had been completed. He also stated he was unsure if Nursing had provided any follow up to get this dental appointment scheduled.	W 356		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan.	W 435		

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W 435	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a variety of leisure supplies for 3 of 3 audit clients (#1, #2 and #3). The finding is: During observations in the facility from 9:30am-11:00am staff A and staff B monitored clients #1, #2 and #3 in the facility. The television was on in the living room and clients #1, #2 and #3 sat on the living room couches without being offered choices of leisure activities. Interview on 4/25/22 with staff A and B revealed not having a facility van for the home and having to share a van with the other facility makes it difficult to plan community outings. Additional interview revealed there are limited leisure supplies and clients #1, #2 and #3 have not expressed an interest in the activities that are available. Observation on 4/25/22 of the leisure materials available revealed 2 puzzles and a "Simon Says" electronic game. Interview on 4/25/22 with the facility qualified intellectual disabilities professional (QIDP) revealed there are leisure materials and activities that clients #1, #2 and #3 can utilize at the vocational program. Further interview confirmed that additional leisure materials appropriate for the client's interests need to be purchased for the facility.	W 435		