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	34G125	A. BUILDING _____ B. WING _____	08/23/2022

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E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(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 facilities]. 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	E 025		

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

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E 025	Continued From page 1 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: Based on interview and review of the facility's Emergency Preparedness Manual (EP), the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) in the home. The findings is: Review on 8/23/22 of the facility's 2022 EP revealed there was no listing of accommodations or agreements for housing for emergency purposes. During an interview on 8/23/22 with the Qualified Intellectual Disabilities Professional (QIDP), she acknowledged that the EP did not list any specific location as an option to relocate clients.	E 025		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(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	E 037		

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E 037	Continued From page 2 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) 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	E 037		

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E 037	Continued From page 3 must conduct training on the updated policies and procedures. *[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 PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and	E 037		

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E 037	Continued From page 4 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 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	E 037		

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E 037	Continued From page 5 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 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 document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency	E 037		

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E 037	Continued From page 6 prepardness (EP) plan. The finding is: Review on 8/23/22 of the facility's EP manual (2022) did not include any information regarding training of staff. During an interview on 8/23/22, the Qualified Intellecutual Disabilities Professional (QIDP) confirmed there was no information included in the EP concerning training of the staff.	E 037		
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Adaptive Behavior Inventory (ABI) was completed. This affected 2 of 3 audit clients (#1 and #3). The findings are: A. Review on 8/22/22 of client #1's record revealed the ABI was not completed. Additional review revealed client #1 was admitted to the facility on 9/8/14. B. Review on 8/22/22 of client #3's record revealed the ABI was not completed. Additional review revealed client #3 was admitted to the facility on 4/11/17. During an interview on 8/23/22, the Habilitation Specialist (HS) confirmed the ABI's were not completed for clients #1 and #3.	W 224		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 7 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 1 of 3 audit clients (#3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of adaptive dining equipment. The finding is: During morning observations at the day program on 8/22/23 at 10:49am, client #3 was observed drinking from a paper cup. Further observations revealed client #3 drinking a soda from the can. Client #3 was observed drinking from a water bottle at 12:27pm. At 5:27pm, client #3 was observed drinking from a regular cup. At no time was client #3 prompted to use his mug with lid. Review on 8/22/22 of client #3's IPP dated 1/5/22 stated, "Adaptive Equipment...Mug with lid...." Additional review indicated the mug with the lid is suppose to be used every time client #3 takes a drink. During an interview on 8/23/22, the Habilitation Specialist (HS) stated client #3 uses a mug with a lid when he is drinking his liquids. Further	W 249		

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W 249	Continued From page 8 interview revealed client #3 uses the mug with the lid due to the fact that he drinks very rapidly.	W 249		
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 and interview, nursing services failed to ensure that staff were sufficiently trained in the taking the temperature of visitors in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During evening observations at the home on 8/22/22 at 4:30pm, a staff person opened the door to the home and greeted the surveyor. Further observations revealed surveyors' temperature was not taken. During an interview on 8/23/22, the Home Manager (HM) reported any visitors who enter the home must have their temperature taken. During an interview on 8/23/22, the Qualified Intellectual Disabilities Professional (QIDP) stated the surveyors' temperatures should have been taken.	W 340		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by:	W 441		

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W 441	Continued From page 9 Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 8/23/22 of the facility's fire drills revealed there where no fire drills conducted in November and December 2021 and January, February, March, April and July 2022. During an interview on 8/23/22, the Qualified Intellectual Disabilites Professional (QIDP) confirmed the fire drills where missing fire drills for November and December 2021 and January, February, March, April and July 2022.	W 441		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The findings are: A. During morning observations at the day program on 8/22/22 at 11:03am, 11:45am and 12:19pm, client #1 was observed picking up food from the floor and eating it. At no time was client #1 prompted not to eat food off the floor.	W 454		

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W 454	Continued From page 10 During an interview on 8/23/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #1 should have been redirected not to eat food off the floor. B. During afternoon observations at the day program on 8/22/22 at 12:33pm, a client put his hand into the plate of another client while the client was eating. Further observations revealed the fingers of the client touched the bottom and sides of the plate; as well as his food. As the client grabbed the food with his bare hand and put the food into his mouth, some of the food fell on the table. Additional observations revealed the staff put the food that fell on the table put that food back into the clients' plate. Further observations revealed the client continued to eat his food. During an interview on 8/23/22, the QIDP stated the clients' plate with the food should have been removed and staff should have ensured the client received another meal.	W 454		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure three clients' diets were provided as prescribed. This affected 3 of 3 audit clients (#1, #3 and #4). The findings are:	W 460		

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W 460	Continued From page 11 A. During morning observations at the day program from 11:00am through 12:22pm, client #1 was observed eating a variety of chips and snack cakes. At no time was client #1's snacks modified. Review on 8/22/22 of client #1's Individual Program Plan (IPP) dated 3/1/22 stated,"diet 1/4 inch consistency." Review on 8/22/22 of client #1's nutritional assessment dated 2/10/22 indicated, "1/4 inch." During an interview on 8/23/22, the Habilitation Specialist (HS) revealed client #1's food should be 1/4 consistency. Further interview indicated client #1 had a swallowing assessment in the past and it was recommended that his food be modified to be 1/4 inch, due to his eating at a rapid pace. B. During morning observations at the day program at 11:17am, client #3 was observed eating a bag of chips. At no time was client #3's snack modified. Review on 8/22/22 of client #3's IPP dated 1/5/22 stated,"[Client #3] is on a Regular Ground consistency diet due to high risk for choking." Review on 8/22/22 of client #3's nutritional assessment dated 12/16/21 stated, "...all foods should be modified to a ground consistency." During an interview on 8/23/22, the facility's nurse reported client #3's diet is ground. Further interview revealed client #3's food is ground consistency due to the fact he is a choking risk for eating to fast.	W 460		

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W 460	Continued From page 12 C. During morning observations at the day program at 11:12am and 11:26am, client #4 was observed eating two bags of chips. At no time was client #4's snack modified. Review on 8/22/22 of client #4's IPP dated 1/19/21 stated,"Current diet is a regular consistency diet cut into 1/4 pieces...." During an interview on 8/23/22, the HS revealed client #4's food should be 1/4 consistency. Further interview indicated client #4 had a swallowing assessment in the past and it was recommended that his food be modified to be 1/4 inch, due to his eating at a rapid pace.	W 460		