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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 Plan (EPP) was updated to include all potential hazards. The finding is: Review on 9/14/22 of the facility's EPP dated 2021 - 2022 revealed processes and procedures to address various natural, man-made, facility and geographic hazards. Additional review of the plan; however, did not indicate any information regarding procedures to address a pandemic/epidemic. Interview on 9/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility's current EPP had not been updated to include emergency procedures for a potential pandemic/epidemic.	E 004		
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:]	E 037		

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E 037	Continued From page 2 (1) Training program. The [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 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	E 037		

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E 037	Continued From page 3	E 037		

procedures are significantly updated, the hospice 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

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E 037	Continued From page 4 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 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	E 037		

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E 037	Continued From page 5 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 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 ensure all staff received intial and	E 037		

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E 037	Continued From page 6 ongoing training on it's Emergency Preparedness Plan (EPP). The finding is: Review on 9/14/22 of the facility's EPP (dated 2021 - 2022) revealed staff had received training on the plan in December '18 and January '20. No current training could be located. Interview on 9/15/22 with the Home Manager (HM) and Qualified Intellectual Disablities Professional (QIDP) confirmed no current EPP training was available for review and the training was last completed on 1/22/20.	E 037		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #4 was afforded consistent opportunities for personal choice and self-management in his home environment. This affected 1 of 5 audit clients. The finding is: During observations in the home throughout the survey on 9/14/22 - 9/15/22, various staff repeatedly verbally prompted client #4 to return to his seat as he stood up and walked throughout the home. The staff stated, "Have a seat, [Client #4]...Where you goin' [Client #4]?...Go sit down, [Client #4]...You can't go into the kitchen..." Additional observations revealed staff physically assisting client #4 by his arm to return to his seat after he stood up and walked a few feet from his chair. Throughout the observations, the client was	W 247		

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W 247	Continued From page 7 not consistently provided alternative activities or personal choice to move freely in his home. Interview on 9/14/22 with Staff C revealed client #4 can go where he wants to go in the home; however, he was afraid the client would have a seizure. Review on 9/15/22 of client #4's Individual Program Plan (IPP) dated 9/22/21 revealed he can make some choices of his daily activities. The plan also identified a need to increase his choice of leisure activities. Interview on 9/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #4's movements in the home should not be limited and he should be allowed the choice to move freely in his home. Additional interview indicated staff should be offering client #4 activities and ask him what he would like to do.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 5 audit	W 249		

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clients (#2, #3 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation and family style dining. The findings are:

A. During 3 of 3 meal preparation observations in the home on 9/14/22 - 9/15/22, various staff performed all cooking tasks without any client involvement. The staff used an electric can opener, prepared a tossed salad, pot pies, chicken nuggets, french fries, green peas, peaches, a pitcher of tea, and bowls of cereal. With the exception of client #2 retrieving cans from the pantry and placing a pan of chicken nuggets in the oven, clients were not assisted or encouraged to participate with cooking tasks.

Interview on 9/14/22 with Staff A revealed client #2 and client #3 will sometimes assist in the kitchen. The staff stated they are "my main help in the kitchen." Additional interview on 9/15/22 with Staff F indicated she does not usually work with clients in the kitchen and would be afraid clients would get burned if they do anything involving the stove.

Review on 9/15/22 of client #2's Adaptive Behavior Inventory (ABI) dated 8/20/21 revealed he can assist with preparing beverages requiring mixing, preparing a sandwich, preparing a salad and identifying meats, breads, cereals, raw foods, kitchen equipment and basic food groups.

Review on 9/15/22 of client #3's IPP dated 5/27/22 revealed she participates with meal preparation and can operate some kitchen appliances. Additional review of the client's ABI

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dated 4/1/22 noted she can assist with using an electric can opener, prepare a salad, prepare beverages requiring mixing, canned foods in the oven, meat dishes, and combination dishes.

Interview on 9/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be assisting clients to participate with cooking tasks based on their individual abilities.

B. During snack observations at the home on 9/14/22 at 4:28pm, Staff C poured drinks for all clients without their participation.

During dinner observations in the home on 9/14/22 at 6:08pm, Staff C placed food on client #3's plate, put ketchup and/or dressing on her food and poured her drinks. Client #3 was not encouraged or assisted to participate with these tasks.

During breakfast observations in the home on 9/15/22 at 7:50am, Staff F prepared six bowls of cereal at the kitchen counter and took several to the table. Clients were not prompted or assisted to serve their own cereal.

Interview on 9/14/22 with Staff C revealed clients can participate with pouring and serving themselves with hand-over-hand assistance.

Interview on 9/15/22 with Staff F indicated she normally does not assist with breakfast; however, the staff acknowledged clients can assist with serving themselves.

Review on 9/15/22 of client #2's IPP dated 9/26/21 noted he participates in family style dining given assistance. Additional review of the client's

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W 249	Continued From page 10 ABI dated 8/20/21 revealed he can pour from a small pitcher and serve himself from a bowl/platter given assistance. Review on 9/15/22 of client #3's IPP dated 5/27/21 revealed she participates with family style dining. Additional review of the client's ABI indicated she can pour from a small pitcher with assistance and serve herself from a bowl/platter independently. Interview on 9/15/22 with the Home Manager (HM) indicated clients should be assisted to participate with family style dining tasks at all meals.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all data relative to the accomplishment of specified objectives was documented in measurable terms. This affected 1 of 5 audit clients (#1). The finding is: During evening observations in the home on 9/14/22 from 4:00pm - 6:00pm, client #1 exhibited numerous aggressive behaviors including the following:	W 252		

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W 252	Continued From page 11 4:15pm - Client #1 hit another client in the head 4:48pm - Client #1 pushed another client to the ground 5:50pm - Client #1 hit another client on her leg 5:58pm - Client #1 hit another client on her leg Review on 9/15/22 of client #1's behavior data sheet revealed no documentation of her aggressive behaviors observed on 9/14/22. Interview on 9/15/22 with Staff F indicated client #1's behavior incidents are documented on her behavior sheet. Additional review of the client's Behavior Intervention Plan (BIP) dated 7/8/21 included objectives to address noncompliance, crying, self-injurious behavior, loud vocalizations, aggression, pica and spitting. The plan defined aggression as "actual or attempted act intended to physically harm another person (i.e. physical assault, but not self-defense), including but not limited to hitting. pushing, kicking, pulling hair, biting)." Further review of the BIP identified instructions for documenting client #1's behaviors on the behavior data sheet including, "...staff will enter a corresponding code for each type of behavior displayed." During an interview on 9/15/22, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #1's behaviors should be documented as indicated.	W 252		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a	W 336		

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W 336	Continued From page 12 review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure each client's health status was assessed at least quarterly. This affected 3 of 5 audit clients (#2, #3 and #6). The findings are: Review on 9/15/22 of client #2, client #3 and client #6's records revealed the last quarterly nursing assessment had been completed in April 2022. No current quarterly nursing assessments could be located. Interview on 9/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed no current quarterly nursing assessments were available for review.	W 336		
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 reviews and interviews, the facility failed to ensure all staff were sufficiently trained on the facility's COVID-19 screening procedures for employees and visitors, COVID-19 procedures for wearing face masks, COVID-19 procedures for staff with approved vaccination exemptions and the appropriate use of gloves. The findings are:	W 340		

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W 340	Continued From page 13 A. Upon arrival to the home on 9/14/22 at 9:30am, two staff working in the home (Staff A and Staff B) were not wearing a face mask or any covering over their nose and mouth. After being questioned by the surveyor, both staff retrieved a face mask and immediately placed in over their nose and mouth. Immediate interview with both staff revealed no face masks were available in the home. Interview on 9/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated staff are still required to wear face masks while working in the home. B. Upon arrival to the home on 9/14/22 at 9:30am, the surveyor's temperature was taken and a clip board documenting the date/time of the visit and the reason for the visit was completed. No questions were asked regarding exposure to COVID-19. Upon arrival to the home on 9/15/22 at 6:30am, the surveyor was asked to complete a clip board documenting the date/time of the visit and the reason for the visit. The surveyor's temperature was not taken and no questions regarding exposure to COVID-19 were asked. During additional morning observations in the home on 9/15/22 from 7:00am - 8:30am, as various staff entered the home for first shift duties, the staff did not take their own temperature and no COVID-19 screening questionnaire was completed. Review on 9/15/22 of the facility's COVID-19 Staff	W 340		

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	34G268	A. BUILDING _____ B. WING _____	09/15/2022

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W 340	Continued From page 14 Vaccination Policy (Effective 2/10/22, Revised 5/20/22) revealed, "All staff, trainees, contact staff and volunteers must have temperature taken upon entering facility and each staff change of shift must have temperature taken upon entering facility prior to having contact with clients. Temperatures will be documented on a spread sheet and maintained at facility..." Additional review of documents provided revealed a COVID-19 Screening form. The form noted, "...the COVID-19 Screening form must be completed upon arrival of any employees at [Provider's name] facilities effective August 31, 2021." The form included nine question regarding COVID-19 symptoms, contact with COVID positive individuals, travel within the US, and other questions regarding potential exposure to COVID-19. Interview on 9/14/22 with Staff C revealed it's protocol to take the temperature of visitors prior to entering the home. Interview on 9/15/22 with the Home Manager (HM) and QIDP indicated staff and visitors should be screened prior to entering the home. Additional interview indicated each person's temperature should be taken and COVID-19 screening questions should be asked (as noted on the screening form). C. During observations in the home throughout the survey on 9/14/22 - 9/15/22, Staff G wore a disposable face mask covering her nose and mouth. The mask was identical to face masks being worn by other staff working in the home. Staff G did not wear any other type of face mask or a face shield.	W 340		

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W 340	Continued From page 15 Review on 9/15/22 of the facility's COVID-19 Staff Vaccination Policy (Effective 2/10/22, Revised 5/20/22) revealed, "Those who are still unvaccinated, but have turned in their exemption rather it be religious or medical to the COVID-19 vaccine will be subject to additional precautions to mitigate the transmission and spread of COVID-19, which includes:...Properly wear a NOISH approved N95 mask or equivalent or higher-level respirator for source control, covering nose and mouth, regardless of whether they are providing direct care to or otherwise interacting with clients, Properly wear a Clear Face Shield, along with an approved face mask, that covers entire face during the entire shift whether providing direct or otherwise interacting with clients..." Interview on 9/15/22 with Staff G indicated she was not fully vaccinated against COVID-19 and has an approved exemption. The staff confirmed she should be wearing a different mask from vaccinated staff as well as a face shield. Interview on 9/15/22 with the QIDP confirmed unvaccinated staff should be following the policy as written. D. During observations in the home throughout the survey on 9/14/22 - 9/15/22, several staff consistently wore latex gloves or food handling gloves while performing various tasks. For example, staff were noted wearing gloves while interacting with clients during leisure activities, folding clothes, cooking, meal/snack times, and outdoor activities. Interview with Staff A indicated they should be wearing gloves "all the time" when working in the	W 340		

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W 340	Continued From page 16 home. Additional interview with Staff B revealed wearing gloves was a habit and she had not been trained to wear them all the time. Review on 9/15/22 of the facility's Bloodborne Pathogen Training (no date) explaining the use of Personal Protective Equipment (PPE) such as gloves used to "protect a person from exposure" to potentially infectious bodily fluids (i.e. blood, saliva, vomit, urine, semen or vaginal secretions, skin tissue cell cultures and any other bodily fluid). Additional review of the training did not indicate gloves should be used for any other purpose. Interview on 9/15/22 with the QIDP confirmed staff have not been trained to wear gloves for any other purpose other than what is included in the training.	W 340		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 5 audit clients (#6) received a comprehensive dental examination at least annually. The finding is: Review on 9/15/22 of client #6's record revealed his last comprehensive dental examination was completed on 12/7/20. Additional review of the client's Individual Program Plan (IPP) dated 10/20/21 noted a recommendation for a dental "recall in one year."	W 352		

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W 352	Continued From page 17 Interview on 9/15/22 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) indicated they thought client #6 had received a dental examination since 12/7/20; however, after calling the dental office, the HM confirmed the client had not been seen by the dentist in 21 months.	W 352		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 audit clients (#6) observed receiving medications. The finding is: During morning observations of medication administration in the home on 9/15/22 at 8:41am, client #6 ingested Lorazepam, Clonidine, Zoloft, Keppra, Calcium Carbonate, Risperdal and Depakote. No other medications were ingested. Review on 9/15/22 of client #6's physician's orders (dated 7/1/22 - 9/30/22) revealed an order for Calcium Antacid chewable tab, take one by mouth every day, 8:00am. Interview on 9/15/22 with the Medication Technician (MT), also the Home Manager, confirmed client #6 did not ingest Calcium Antacid during the medication pass.	W 369		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 441		

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W 441	Continued From page 18 and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at varied times and conditions. The finding is: Review on 9/14/22 of the facility's fire drill reports for first shift (8a - 4p), second shift (4p - 12a) and third shift (12a - 8a) revealed the drills were not conducted at various times during each shift. The reports indicated the following drills: First shift 10/28/21 - 9:00am 01/25/22 - 10:06am 04/28/22 - 10:00am 07/28/22 - 9:00am Second shift 08/30/21 - 6:00pm 11/26/21 - 6:00pm 02/23/22 - 6:30pm 06/28/22 - 6:00pm Third shift 09/28/21 - 3:00am 12/23/21 - 3:00am 03/28/21 - 3:00am During an interview on 9/15/22, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the fire drills should be conducted at various times during each shift.	W 441		