STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING _____ B. WING _____	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(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
E 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		

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

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E 030	Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an Emergency Preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. This potentially affected clients #1, #2, #3, #4, #5, #5, and #6. The finding is: Review on 10/3/22 of the facility's EP plan did not include any information on the clients who reside in the home. Further review revealed the EP Plan did not include any information about the direct care staff who worked in the home. During an interview on 10/3/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the EP plan should have included both the information about the clients and the direct care staff.	E 030		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54,	E 036		

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E 036	Continued From page 3 Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at	E 036		

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E 036	Continued From page 4 least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to develop a Emergency Preparedness (EP) training and testing program. This potentially affected clients #1, #2, #3, #4, #5, #5, and #6. The finding is: Review on 10/3/22 of facility's EP manual did not include any information on training or testing of the facility's staff. During an interview on 10/3/22, the director stated there was no formal written test for the staff pertaining to the facilty's EP Plan.	E 036		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	E 039		

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E 039	Continued From page 5 *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and 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 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 6 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 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	E 039		

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E 039	Continued From page 7 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 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:	E 039		

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E 039	Continued From page 8 (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 maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 9 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE 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 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 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE'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	E 039		

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E 039	Continued From page 10 (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 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	E 039		

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E 039	Continued From page 11 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. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the	E 039		

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E 039	Continued From page 12 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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[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.	E 039		

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E 039	Continued From page 13 (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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI'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 clients #1, #2, #3, #4, #5, and #6. The finding is: Review on 10/3/22 of the facility's EP plan, did not include a full-scale community-based or tabletop exercise for 2022, which included all staff working in the home. During an interview on 10/4/22, the director confirmed there was no table top exercise which included all the staff working in the home.	E 039		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12)	W 137		

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	34G255	A. BUILDING _____ B. WING _____	10/04/2022

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W 137	Continued From page 14 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 2 of 5 audit clients (#1 and #5) had the right to retain personal possessions. The findings are: A. During medication administration in the home on 10/4/22 at 7:12am, client #5 was given his eyeglasses. Further observations revealed the Qualified Intellectual Disabilites Professional (QIDP) had removed them from a desk drawer. Review on 10/3/22 of client #5's Individual Program Plan IPP (no date) revealed there was no information in regards to a training objective in regards to the care of his eyeglasses. B. During medication administration in the home on 10/4/22 at 7:18am, client #1 was given his eyeglasses. Further observations revealed the QIDP had removed them from a desk drawer. Review on 10/3/22 of client #1's IPP dated March 2021 revealed there was no information in regards to a training objective in regards to the care of his eyeglasses. During an interview on 10/4/22, the QIDP stated both client #1 and #5 will break their eyeglasses and that is the reason they are kept locked in the medication room. The QIDP also mentioned none of the clients in the home know how to use the key to unlock the door to the medication room.	W 137		

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W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 5 audit clients (#1, #3 and #6) Community/Home/Life Skills Assessments had been done. The finding are: A. Review on 10/3/22 of client #1's Individual Program Plan (IPP) dated 3/2021 revealed he was admitted to the facility on 11/15/10. Further review revealed client #1 does not have a Life Skills Assessment. B. Review on 10/3/22 of client #3's IPP dated 8/3/22 revealed he was admitted to the facility on 9/27/97. Further review revealed client #3 does not have a Life Skills Assessment. C. Review on 10/3/22 of client #6's IPP dated 6/23/22 revealed he was admitted to the facility on 5/29/19. Further review revealed client #6 does not have a Life Skills Assessment. During an interview on 10/3/22, the Qualified Intellectual Disabilites Professional (QIDP) confirmed clients #1, #3 and #6 do not have a Life Skills Assessment.	W 213		
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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W 227	Continued From page 16 Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 audit clients (#1 and #5) Individual Program Plans (IPP's) included specific information to address the caring of their eyeglasses. The findings are: A. During observations in the home throughout the survey on 10/3 - 4/22, client #1 was observed not wearing his eyeglasses. At no time was client #1 prompted to wear his eyeglasses. Review on 10/3/22 of client #1's IPP dated March 2021 revealed there was no information in regards to a training objective in regards to the care of his eyeglasses. B. During observations in the home throughout the survey on 10/3 - 4/22, client #5 was observed not wearing his eyeglasses. At no time was client #5 prompted to wear his eyeglasses. Review on 10/3/22 of client #5's IPP (no date) revealed there was no information in regards to a training objective in regards to the care of his eyeglasses. During an interview on 10/3/22, the Qualified Intellectual Disabilites Professional (QIDP) revealed both clients #2 and #5 eyeglasses are broken and have been broken for some time. The QIDP stated neither client #2 or #5 has had an objective to the address the caring of their eyeglasses.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 17 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 clients (#1, #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 area of family style dining. The findings are: A. During dinner observations in the home on 10/3/22 beginning at 5:17pm, client #1's dinner was put on his plate by Staff B. At no time was client #1 prompted to put his own food on his plate. Review on 10/3/22 of client #1's IPP dated March 2021 did not have any information pertaining to his skill level with family style dining. B. During dinner observations in the home on 10/3/22 beginning at 5:17pm, client #3's dinner was put on his plate by Staff B. Client #3 was never prompted to put his own food on his plate. Review on 10/3/22 of client #3's IPP dated 8/3/22 did not have any information pertaining to his skill level with family style dining. C. During dinner observations in the home on 10/3/22 beginning at 5:17pm, client #6's dinner	W 249		

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W 249	Continued From page 18 was put on his plate by Staff B. At no time was client #6 prompted to put his own food on his plate. Review on 10/3/22 of client #6's IPP dated 6/23/22 did not have any information pertaining to his skill level with family style dining. During an interview on 10/3/22, Staff B stated that for the last two years have been putting all the clients' food on their plates due to COVID-19 precautions. During an interview on 10/4/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed family style dining has not been occurring because COVID-19.	W 249		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#2) obtained an annual examination of his vision. The finding is: Review on 10/3/22 of the chart for client #2 revealed his last vision examination occurred on 7/26/19. During an interview on 10/3/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 has not had a vision examination since 7/26/19.	W 323		
W 340	NURSING SERVICES	W 340		

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W 340	Continued From page 19 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 signing of the Medication Administration Record (MAR) and the taking the temperatures of staff in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The findings are: A. During morning observations in the home on 10/4/22 at 7:30am, the Qualified Intellectual Disabilities Professional (QIDP) signed the MAR for Staff A who had actually given the medications to the client. During an interview on 10/4/22, the QIDP stated he should not have signed the MAR for Staff A. Further interview revealed the staff who actually gave the medications to the client should have been the one to sign the MAR. B. During morning observations in the home on 10/4/22 at 8:35am, the QIDP asked Staff C if her temperature was above 100 degrees. Further observations revealed the QIDP did not use the thermometer to actually take Staff C's temperature. Staff C proceeded into the home and began working with the clients. Review on 10/4/22 of the facility's Employee	W 340		

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W 340	Continued From page 20 COVID-19 Screening... dated June 2020 stated, "1. Screen Upon arrival at any RSI home...each employee is screened for potential illness or exposure to COVID-19...." During an interview on 10/4/22, the QIDP revealed he should have used the thermometer to take the temperature of Staff C. The QIDP stated one of the screening process is to take the temperatures of the staff as they enter the home.	W 340		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: During morning observations in the home on 10/3/22 at 10:25am, when the surveyor entered the home the Qualified Intellectual Disabilities Professional (QIDP) took a key ring, with several keys from off of hook which is located right at the front door. The QIDP then proceed to unlock a door to obtain the thermometer which the QIDP used to take the temperature of the surveyor. On 10/4/22, the surveyor observed the door which the QIDP unlocked the previous day is the medication room. During an interview on 10/4/22, the QIDP confirmed the medication key should not have been left unattended. Further interview revealed whoever is the medication technician should have the keys on their person at all times.	W 383		

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W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment, specifically eyeglasses, were furnished for 1 of 5 audit clients (#2). The finding is: During observations in the home on 10/3 - 4/22, client #2 was not observed wearing his eyeglasses. Further observations revealed at no time was client #2 prompted to wear his eyeglasses. Review on 10/3/22 of client #2's annual nursing evaluation dated 8/17/21 stated, "Recommendations: C. Ensure that [client #2's name] is wearing his glasses throughout the day." During an interview on 10/3/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #2's eyeglasses have been broken for over one year.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: 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,	W 441		

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W 441	Continued From page 22 #5 and #6) residing in the home. The finding is: Review on 10/3/22 of the facility's fire drills revealed there where no fire drills conducted in October and November 2021 and February, March, April, July and August 2022. Further review revealed there were no fire drills conducted on third shift. During an interview on 10/3/22, the Qualified Intellectual Disabilites Professional (QIDP) confirmed the fire drills where missing for October and November 2021 and February, March, April, July and August 2022 or any conducted on third shift.	W 441		