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	34G284	A. BUILDING _____ B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW RESIDENTIAL	**359 FIRETOWER ROAD RICHLANDS, NC 28574**

(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 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 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.	E 037		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[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	E 037		

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E 037	Continued From page 2	E 037		

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 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.

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E 037	Continued From page 3 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the 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	E 037		

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E 037	Continued From page 4 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 preparedness (EP) pan. The finding is: Review on 10/18/22 of the facility's EP manual (12/9/20) did not include any information regarding training of staff. During an interview on 10/18/22, the Program Manager (PM) confirmed there were no information included in the EP concerning training of the staff. During an interview on 10/18/22, the Regional Manager (RM) confirmed there were no information included in the EP concerning training of the staff.	E 037		
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). *[For ASCs at §416.54, CORFs at §485.68, OPO,	E 039		

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E 039	Continued From page 5 "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 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

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E 039	Continued From page 6 [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 care directly. The hospice must conduct exercises to test the emergency plan twice per	E 039		

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E 039	Continued From page 7 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: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 8 (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 (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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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
(A) When a community-based exercise is not accessible, conduct an annual individual,

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E 039	Continued From page 10 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 the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale	E 039		

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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 emergency event.
(ii) Conduct an additional exercise every 2 years,

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E 039	Continued From page 12 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. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and	E 039		

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E 039	Continued From page 13 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 a second full scale evacuation, mock drill or an annual tabletop activity was conducted and included in the facility's Emergency Preparedness Plan (EP). The finding is: Review on 10/18/22 of the facility's' EP Plan revealed there was no annual tabletop conducted. Further review indicated there was no documentation about a tabletop conducted for 2021 or 2022. During an interview on 10/18/22, the Program Manager (PM) and Regional Director confirmed an annual tabletop activity was not conducted.	E 039		
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v)	W 224		

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	34G284	A. BUILDING _____ B. WING _____	10/18/2022

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W 224	Continued From page 14 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 reviews and interviews, the facility failed to ensure the Adaptive Behavior Inventory (ABI) were updated annually. This affected 3 of 6 audit clients (#1, #3 and #5). The findings are: A. Review on 10/17/22 of client #1's ABI was last completed in 2019. Further review revealed there was no updated ABI for client #1. B. Review on 10/17/22 of client #3's ABI was last completed in 2019. Additional review revealed there was no updated ABI for client #3. C. Review on 10/17/22 of client #5's ABI was last completed in 2019. Further review revealed there was no updated ABI for client #5. During an interview on 10/18/22, the Program Manager confirmed the ABI's for clients #1, #3 and #5 have not been updated.	W 224		
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.	W 249		

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W 249	Continued From page 15	W 249		

This STANDARD is not met as evidenced by:
Based on the observations, record reviews and interviews, the facility failed to ensure 2 of 6 audit clients (#1 and #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 family style dining. The findings are:

A. During lunch observations at the day program on 10/17/22 at 11:56am, Staff A was observed putting clients #1 and #3 sandwiches on their plates. At no time were clients #1 and #3 prompted to place their own sandwiches on their plates.

B. During dinner observations in the home on 10/17/22 at 6:13pm, Staff B scooped out the chicken and noodles on clients #1 and #3 plates. At no time were clients #1 and #3 prompted to scoop their ow food on their plates.

During an interview on 10/17/22, Staff B stated clients #1 and #3 are supposed to serve themselves their own food. Further interview revealed Staff B was in a rush and she likes to be on time for dinner for the clients.

Review on 10/17/22 of client #1's IPP dated 4/9/22 stated, "He participates in family style dining. Nutritional evaluation recommends continuing opportunities for family style dining ...."

Review on 10/17/22 of client #3's Adaptive Behavior Inventory (ABI) dated 2019 revealed, she has total independence with serving self from a bowl/platter and passing bowls/platters.

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W 249	Continued From page 16 During an interview on 10/18/22, the Program Manager (PM) reported clients #1 and #3 can participate in family style dining and should have been given the opportunity. During an interview on 10/18/22, the Regional Director revealed clients #1 and #3 should have been given the opportunity to participate in family style dining.	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 1 of 6 audit clients (#6) behavior data was documented. The finding is: During evening observations in the home on 10/17/22 at 5:03pm client #6 was yelling and screaming about how she was not going to eat her dinner. Further observations revealed client #6 was screaming and yelling while in her bedroom. Client #6 was observed yelling and screaming at staff from 6:41pm until 6:50pm, while attempting to go out the back and side doors; staff was able to redirect her into her bedroom. Review on 10/18/22 of client #6's behavior data	W 252		

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W 252	Continued From page 17 sheet revealed the last documentation was written on 10/4/22. Review on 10/18/22 of client #6's Behavior Support Plan (BSP) dated 1/7/22 stated, "DESCRIPTION OF TARGET BEHAVIORS ...SEVERE DISRUPTIVE BEHAVIOR, ATTEMPTING TO GO AWOL ...." Additional review revealed, "DOCUMENTATION: All episodes of CHALLENGING BEHAVIOR will be documented on the "Behavior Intervention Data Sheets" in the BEHAVIOR NOTEBOOK ...." During an interview on 10/18/22, both the Program Manager (PM) and Regional Director (RD) stated the behaviors which client #6 displayed should have been documented on her behavior data sheet.	W 252		
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 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 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. Review on 10/17/22 of client #1's Behavior Support Plan (BSP) dated 1/10/22 revealed he consumes the following medication: Nitrous Oxide.; which is being used for behaviors. Further review revealed written informed consent had not been obtained by the legal guardian.	W 263		

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W 263	Continued From page 18 B. Review on 10/17/22 of client #2's BSP dated 11/16/21 revealed he consumes the following medication: Nitrous Oxide; which is being used for behaviors. Additional review revealed written informed consent had not been obtained by the legal guardian. C. Review on 10/17/22 of client #3's BSP dated 1/10/22 revealed she consumes the following medication: Risperdal. Further review revealed written informed consent had not been obtained by the legal guardian. D. Review on 10/17/22 of client #4's BSP dated 1/7/22 revealed he consumes the following medication: Nitrous Oxide; which is used for behaviors. Further review revealed written informed consent had not been obtained by the legal guardian. E. Review on 10/17/22 of client #5's BSP dated 1/7/22 revealed she consumes the following medications: Risperdal, Lexapro and Lamictal. Further review revealed written informed consent had not been obtained by the legal guardian. F. Review on 10/17/22 of client #6's Behavior Support Plan (BSP) dated 1/7/22 revealed she consumes the following medications: Clonidine, Latuda, Perphenazine and Lorazepam. Further review revealed written informed consent had not been obtained by the legal guardian. During an interview on 10/18/22, the Regional Director (RD) confirmed the BSP consents were not signed by the legal guardians for clients #1,	W 263		

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W 263	Continued From page 19 #2, #3, #4, #5 and #6.	W 263		
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, documentation and interviews, nursing services failed to ensure the temperature of visitors was taken and COVID-19 questionnaire was filled out by staff. This potentially effected all the clients (#1, #2, #3. #4, #5 and #6) residing in the home. The findings are: A.During afternoon observations in the home on 10/17/22 at 4:34pm, when the surveyor entered the home Staff C attempted to take their temperature, but the thermometer was not working and the surveyor was allowed to enter the home. Further observations revealed the surveyor was not asked any questions about their COVID-19 status. During morning observations in the home on 10/18/22 at 6:18am, when the surveyor entered the home Staff D attempted to take their temperature, but the thermometer was not working, and the surveyor was allowed to enter the home. Further observations revealed the surveyor was not asked any questions about their COVID-19 status. The surveyors' temperature was eventually taken at 6:54am.	W 340		

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W 340	Continued From page 20 During an interview on 10/17/22, Staff C stated the batteries in the thermometer needed to be changed. During an interview on 10/18/22, Staff D reported the thermometer was broken. Review on 10/17/22 of a note posted on the wall next to the front door (no date) revealed, "Steps for everyone when they first arrived in the home at any time. 1. Take temperature ...." During an interview on 10/18/22, the Regional Director (RD) stated the surveyors' temperature was supposed to be taken prior to them entering the home. B. During afternoon observations in the home on 10/17/22 at 4:34pm, the surveyor noticed a notebook on a table near the front door. Upon further observations it was determined it was being used as documentation for staff pertaining to their temperature checks and questions about the COVID-19 status. Additional observations revealed the last documentation occurred on 10/14/22. Further observations revealed no staff requested for the surveyor to fill out the form. Review on 10/17/22 of the Staff Health Evaluation Sheet revealed it was last filled out on 10/14/22. During an interview on 10/17/22, Staff C confirmed the last documentation in the notebook concerning temperature checks and COVID-19 questions was last documented on 10/14/22. During an interview on 10/18/22, the Program Manager (PM) stated the Staff Health Evaluation Sheet is supposed to be filled out every day by anyone who enters the home.	W 340		

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W 340	Continued From page 21 During an interview on 10/18/22, the Regional Director (RD) revealed the Staff Health Evaluation Sheet should be filled out by anyone who enters the home.	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: Based on the review of the fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all the clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 10/17/22 of the facility's fire drills revealed the following fire drills: 10/22/21, 10/29/21 and 11/24/21. Further review revealed there were no fire drills held in 2022. During an interview on 10/18/22, the Regional Director (RD) confirmed the only fire drills were conducted on 10/22/21, 10/29/21 and 11/24/21. Further interview revealed there were no fire drills conducted in 2022.	W 441		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 6 audit clients (#6) food was served at the appropriate temperature. The finding is: During morning observations in the home on	W 473		

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W 473	Continued From page 22 10/18/22 at 6:18am, client #6's breakfast was on the dining room table. Further observations revealed client #6's breakfast consisted of oatmeal, two sausage patties and toast. Further observations revealed client #6 began eating at 7:18am. At no time was client #6's breakfast reheated. Review of a note (no date) hanging on the wall in the dining room stated, "once items taken form heat keeping ...devices they must be served to clients within 15 minutes or reheated to 165 degrees, then served ...." During an interview on 10/18/22, the Program Manager (PM) reported client #6's breakfast should have been reheated prior to her eating it. During an interview on 10/18/22, the Regional Director stated client #6's breakfast should have been reheated prior to her eating it.	W 473		