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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, "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	E 039		

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

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E 039	Continued From page 1 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 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	E 039		

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E 039	Continued From page 2 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 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.	E 039		

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E 039	Continued From page 3 *[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 (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):]	E 039		

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E 039	Continued From page 4 (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, 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	E 039		

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E 039	Continued From page 5	E 039		

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, 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

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E 039	Continued From page 6 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 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.	E 039		

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E 039	Continued From page 7 (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, 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	E 039		

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E 039	Continued From page 8 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 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 record reviews and interviews, the facility failed to conduct exercises to test their emergency preparedness plan at least twice per year. This potentially affected all clients (#1, #2, #3, #4, #5, and #6) living in the home. Review on 12/12/22 of the emergency preparedness plan, dated 9/22/20, revealed that neither a tabletop activity, nor a full-scale, community-based activity could be located. Interview on 12/13/22 with the Director revealed	E 039		

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E 039	Continued From page 9 that she was unable to locate either a tabletop activity, or a full-scale, community-based activity.	E 039		
W 000	INITIAL COMMENTS Two complaint surveys was completed on 12/13/22 for intakes #NC00195829 and NC00195921. No deficiencies were cited in relation to the complaint however deficiencies were cited as a result of the recertification.	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client (#5) was afforded dignity regarding the use of washable incontinence pads. This affected 1 of 5 audit clients. The finding is: During observations throughout the survey on 12/12 - 13/22, a washable incontinence pad was seen in a chair which was located in the living room of the home. Further observations revealed the incontinence pad was visible to anyone who entered into the living room. Additional observations revealed client #5 was sitting in the chair where the incontinence pad was located. During an interview on 12/13/22, Staff B did not know why the washable incontinence pad was in the chair, while client #5 was sitting on it. During an interview on 12/13/22, the Director	W 125		

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W 125	Continued From page 10 stated the washable incontinence pad should not be in the chair; nor should client #5 be sitting on it. The Director stated client #5 does have seizures and will have an accident; but staff assist her with cleaning the area where she was sitting.	W 125		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 5 of 5 audit clients (#2, #3, #4, #5 and #6) residing in the home. The finding is: During observations of medication administration in the home on 12/12/22 and 12/13/22, clients #2, #3, #4, and #5 received medications in the common dining area in the presence of others. On 12/12/22 at 5:30pm, clients #2, #3, and #6 were eating dinner in the common dining area. Staff C gave client #3's medications to him at the dining table. On 12/13/22 from 7:15am-7:40am, Staff B gave clients #2, #4, #5, and #6 medications in the common dining area during breakfast. A privacy screen was not used, and clients were not moved to a separate location for medication administration. Interview on 12/12/22 with Staff B revealed that medications could be given either "in back or in the dining room". Interview on 12/13/22 with the Director revealed that medication administration was moved from	W 130		

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W 130	Continued From page 11 the smaller room in back to the larger dining area due to Covid precautions. When asked how client privacy could be ensured in the common area, the Director stated that they chose to be safe and give medications in the dining area.	W 130		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record reviews and interviews with staff, management failed to report an incident to the Health Care Personnel Registry (HCPR) as required. This affected 2 of 5 audit clients (#3 and #6). The finding is: During an interview on 12/12/22, the Director revealed there was an incident with client #1 where she attempted to attack clients #3 and #6. The Director stated the incident happened on 12/8/22. Further interview revealed the Director did not complete a 24 Hour report or summit it to the HCPR.	W 153		
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	W 249		

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W 249	Continued From page 12 plan. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 5 of 6 audit clients (#2, #3, #4, #5, 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 meal preparation. The findings are: During observations of meal preparation in the home on 12/12/22 and 12/13/22, no clients were involved in preparing dinner or breakfast. On 12/12/22 from 4:30pm-5:10pm, Staff D prepared dinner, consisting of ham, collards, wild rice, corn bread, and peaches. At no time were clients prompting to assist with food preparation. On 12/13/22 from 6:00am-6:30am, the Director prepared breakfast consisting of eggs, grits, and toast. At no time were clients involved in food preparation. Interview on 12/13/22 with the Director revealed that client #3 could cook meals and prepare food items. When asked when he participates in food preparation, the Director stated that client #3 was scheduled to make a one dish, baked spaghetti, during the summer and one dish, tuna casserole, during the fall. The Director stated that client #6 could use an electric can opener, pour contents into a pot, and stir items during meal preparation.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs	W 263		

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W 263	Continued From page 13 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 1 of 5 audit clients (#3). The finding is: A. Review on 12/12/22 of client #3's Behavior Improvement Plan (BIP) dated 2/23/22 revealed it was last signed by his guardian on 11/29/19. Further review revealed there was not a current BIP consent signed by his guardian. During an interview on 12/12/22, the Director confirmed there is not a current BIP consent signed by client #3's guardian.	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, document review and interviews, nursing services failed to ensure staff were adequately trained in the wearing of facial masks. The finding is: During observations throughout the survey in the home on 12/12 - 13/22, staff who were working in the home were observed not wearing a facemask. Further observations revealed staff	W 340		

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	34G143	A. BUILDING _____ B. WING _____	C 12/13/2022

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W 340	Continued From page 14 were observed not wearing their facemasks while in the kitchen cooking, administering medications and assisting clients with washing their hands. During an interview on 12/13/22, Staff A stated she knows facemasks are to be worn by staff while they are in the home working. Review on 12/13/22 of the facility's COVID-19 Plan (no date) stated, "[Name of group home] will provide, and ensure that employees wear facemasks, or a higher level of respiratory protection. Facemasks must be worn by employees over the nose and mouth when indoors...." During an interview on 12/13/22, the Director confirmed all staff are to wear facemasks while they are in the home.	W 340		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure training in the area of medication administration for 5 of 5 audit clients (#2, #3, #4, #5, and #6). The findings are: During observations of medication administration in the home on 12/12/22 and 12/13/22, clients #2, #3, #4, #5, and #6 received prepared medications with no active training. On 12/12/22 at 5:30pm,	W 371		

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W 371	Continued From page 15 Client #3 was eating dinner in the dining area. Staff C approached client #3 with a prepared medicine cup and stated, "Here's your meds". Client #3 took the cup and swallowed his medication. On 12/13/22 from 7:15am-7:40am, Staff B approached clients #2, #4, #5, and #6 with prepared cups of medications and stated, "Here are your medications". Clients #2 and #4 were fed medication by Staff B; clients #5 and #6 took their cup and swallowed medication. At no time did staff name or explain medications to clients. Interview on 12/13/22 with the Director revealed that staff should explain medications to clients during medication pass.	W 371		
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/conditions. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 12/12/22 of the fire drill reports dated November 2021 - November 2022 revealed fire drills were conducted between 7:00am and 7:30am for four consecutive months (May - August). Interview on 12/13/22 with the Director revealed that the facility could respond to a drill at any time and on all shifts. The Director stated that the facility has one drill per shift, per quarter.	W 441		
W 508	COVID-19 Vaccination of Facility Staff	W 508		

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W 508	Continued From page 16 CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in	W 508		

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W 508	Continued From page 17 paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	W 508		

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W 508	Continued From page 18 documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the	W 508		

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W 508	Continued From page 19 vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that 100 percent of their staff have been vaccinated or had an approved exemption against COVID-19. The finding is: During review on 12/13/22 of the facility's COVID-19 vaccination information, it was discovered that two staff had not been vaccinated or approved for an exemption. During an interview on 11/8/22, the Director stated there are two staff who did not provide the paperwork for the vaccination for COVID-19 or exemption from the COVID-19 vaccination.	W 508		