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E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to develop a Shelter in Place Policy in their Emergency Preparedness Plan (EPP). The finding is: Review on 2/2/23 of the facility's EPP dated	E 022		

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

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E 022	Continued From page 1 1/23/23 revealed it did not have a policy to direct staff when to shelter in place during an emergency. Interview on 2/2/23 with the Regional Director revealed she did not know the policy was required and it has not been developed.	E 022		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure each client received a continuous active treatment program consisted of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of personal grooming and supervision. This affected 2 of 4 audit clients (#3 and #4). The findings are: A. During morning observations in the home on 2/2/23 from 7:30am until 8:45am, Staff H supervised client #3 at breakfast. Client #3 demonstrated right hand tremors when lifting a cup of orange juice to take sips of beverage. The juice was observed by Staff H to spill on client #3's shirt and light gray knit pants. After breakfast	W 249		

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W 249	Continued From page 2	W 249		

Staff H took client #3 to the bathroom to brush his teeth; client #3 returned wearing the same clothes. At 8:15am, Staff H was observed taking a wet cloth and wiping the stains off client #3's shirt before putting a jacket on him. At 8:35am, Staff H brought client #3 outside to board the van for a community outing. Client #3's gray knit pants had large oval stains on the inner thighs of his pants. Client #3 was boarded on the van and fastened in his seat.

Review on 2/1/23 of client #3's IPP dated 12/15/22 revealed that he needed assistance from staff for dressing and personal grooming.

Interview on 2/2/23 with Staff H revealed that he was uncertain what he should have done about client #3's stained pants. Staff H acknowledged that he tried to wipe the stain off the shirt.

Interview on 2/2/23 with Staff M revealed that after client #3 sat on the van, she noticed that his pants were soiled and made sure his pants were changed before going on the outing.

Interview on 2/2/23 with the Regional Director revealed that staff should make sure all clients were appropriately dressed before they go out of the house.

B. During morning observations in the home on 2/2/23 from 7:45am until 7:59am, client #4 was observed sweeping and mopping the dining room floor after breakfast with various staff in and out of the dining room/kitchen/hallway areas. At 8:00am, client #4 was observed left alone in the kitchen, with no staff in the vicinity. Client #4 stood over the trash can and had removed four slices of toast, placing them on counter that were

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W 249	Continued From page 3 discarded after breakfast. Client #4 held a fast food restaurant bag, that he dug out the trash. In his right hand, client #4 held several packs of sugar. In his mouth, client #4 was still chewing unknown contents. Client #4 was aware that he was being observed by the surveyor and dropped the contents, and then went into the food pantry, closing the door behind him. At 8:02am, Staff I entered the back door in the kitchen. Review on 2/2/23 of client #4's psychological evaluation dated 8/17/22 revealed client #4 took food or beverages that he has not chose as part of his snack and/or is part of the menu for the day. Client #4 took items that do not belong to him and will take them from the pantry, kitchen or peers. An additional review of client #4's Behavior Support Plan dated 8/17/22 revealed staff should always be aware of his whereabouts. Interview on 2/2/23 with Staff I revealed that Staff M was assigned to client #4. Interview on 2/2/23 with Staff M revealed she was unaware that client #4 was in the kitchen alone because she had taken client #2 to the bathroom. Interview on 2/2/23 with the Regional Director revealed client #4 had a history of taking food from the pantry and hoarding food in his room. Staff are assigned to him and along with client #2 and he needed to be monitored. The Regional Director stated if his assigned staff had to leave the room, staff are expected to notify other staff to watch client #3 in their absence.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 4 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 document review and interview, the facility failed to ensure a restrictive programs were only conducted with the written informed consent of both legal guardians. This affected 1 of 4 audit clients (#5). The finding is: Review on 2/2/23 of client #5's BSP dated 8/7/22 revealed an objective to exhibit 7 or fewer challenging behaviors per month. Client #5 took Risperidone medication to help manage these challenging behaviors. The BSP had only one signature of the female legal guardian, who signed on 3/15/22. Interview on 2/2/23 with the Regional Director revealed that client #5 had two legal guardians and they failed to get written consent from both legal guardians.	W 263		
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 document review and interview, the facility failed to conduct quarterly fire drills per shift, under varying times and conditions. The finding is: Review on 2/2/23 of the the facility fire drills from February 2022 until January 2023, revealed they were not recording the times of the fire drills. 2/14/22 no time recorded for 2nd shift	W 441		

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W 441	Continued From page 5 3/24/22 no time recorded for unknown shift 4/16/22 no time recorded for 1st shift 5/24/22 no time recorded for 2nd shift 6/22/22 no time recorded for 3rd shift 8/10/22 no time recorded for 3rd shift 11/16/22 no time recorded for unknown shift 12/13/22 no time recorded for 3rd shift 1/13/23 no time recorded for 1st shift Interview on 2/2/23 with the Resident Director revealed that last year they modified their fire drill report form to make it accessible online and omitted the time of the drill.	W 441		
W 508	COVID-19 Vaccination of Facility Staff 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	W 508		

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W 508	Continued From page 6 (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 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	W 508		

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W 508	Continued From page 7 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 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	W 508		

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W 508	Continued From page 8 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 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 observations, record review and interviews, the facility failed to implement their COVID-19 Vaccination Policy. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The findings are: A. During afternoon observations in the home on 2/1/23 from 3:00pm to 6:00pm, Staff I and Staff G were observed working closely with all clients in the home during active treatment and meal preparation. Review on 2/2/23 of the facility's list of staff vaccination status revealed Staff I had only received one dose of the Moderna vaccine on 11/15/22 and Staff G never submitted evidence of vaccine or a request for religious exemption. B. During observations at the day program on	W 508		

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2/2/23 from 1:30pm to 2:00pm, Nurse A was observed wearing a cloth face mask over her nose and mouth.

Review on 2/2/23 of the facility's exempted staff revealed Nurse A was approved for a religious exemption for the COVID-19 vaccine on 12/1/21.

Review on 2/2/23 of the facility's COVID-19 Vaccination Program revealed:
No later than 12/5/21 all staff must present proof of having received the one dose COVID-19 vaccine or the first dose of a multi-dose COVID-19 vaccine unless a vaccine exemption or temporary delay as recommended by the Center for Disease Control (CDC) has been approved. By no later than 1/4/22, all staff receiving multi-dose COVID-19 vaccine also must present proof of having received all doses. Staff who fail to submit sufficient proof of vaccinations and who are not approved an exemption or temporary delay as recommended by CDC will be unable to commence or continue providing services to Intermediate Care Facilities (ICF)...Approved exemptions-comply with universal infection control, wear N95 mask and may undergone periodic COVID-19 testing.

An additional review on 2/2/23 of staff revealed there were no evidence of vaccinations or exemptions for the Occupational Therapist (OT), Physical Therapist (PT), or both maintenance staff. The Behavioral Specialist who had monthly contact with the group home, had submitted a religious exemption on 2/1/23.

Interview with the Regional Director on 2/2/23 revealed the facility's human resource department handles the collection of all vaccine

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W 508	Continued From page 10 documentation and she was unaware of Staff G and Staff I's status until today. The Regional Director on 2/2/23 revealed the facility furnished disposable face masks and N95 masks for exempted staff. Nurse A was present during the interview, but offered no explanation for wearing a cloth face mask.	W 508		