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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), §485.542(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, REHs at §485.542, 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		

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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

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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.

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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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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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(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

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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 (EP) at least yearly. This potentially affected all clients (#1, #2, #3, #4, #5, and #6) living in the home.

Review on 8/21/23 of the facility's EP revealed there was no tabletop exercise for this year or the previous year.

Interview on 8/21/23 with the facility qualified intellectual disabilities professional (QIDP)

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E 039	Continued From page 9 revealed she was certain a tabletop exercise had been completed. However, further interview revealed on 8/22/23 that a written tabletop exercise could not be located for this year or the previous year.	E 039		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to complete repairs in the facility and maintenance outside in the yard. This affected 4 of 6 clients in the facility (#1, #2, #3 and #6). The findings are: A. Observation on 8/21/23 of the front, side and back yards revealed the grass was over the client's knees. Several inside dining room chairs were seated in the yard. During observations from 9:30am-12:45pm clients #1, #2, #3, and #6 were noted to sit or walk in the side yard with staff A and staff G. Interview on 8/21/23 with the residential manager (RM) revealed the maintenance staff usually mows the yard, however the maintenance staff had not been to the home in the past 2 weeks. Further interview revealed she had been told the maintenance staff would be at the home soon to mow the yard. B. Observation on 8/21/23 at 9:30am of the front foyer of the inside of the home revealed paint peeling around the ceiling and the skylights	W 104		

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W 104	Continued From page 10 around the front of the home. Interview on 8/22/23 with the RM revealed this had been reported to management and she had been told a work order had been completed. Further interview revealed a work order for this repair could not be located. Interview on 8/22/23 with the qualified intellectual disabilities professional (QIDP) revealed she was aware of the issues regarding the yard needing maintenance and the front inside of the home requiring painting. She stated these issues would be addressed.	W 104		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 4 audit clients (#6) received an nutritional assessment. The finding is: Observation on 8/21/23 of clients diets posted in the kitchen listed client #6's diet as bite size pieces. During dinner observation at 5:00pm, direct care staff E cut clients meatballs into bite size pieces. Review on 8/23/23 of client #6's record revealed there was no nutritional assessment. Interview on 8/23/23 direct care staff B verified that client #6's diet "food should be bite size pieces".	W 217		

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W 217	Continued From page 11 Interview on 8/23/23, the Qualified Intellectual Developmental Professional (QIDP) revealed client #6's nutritional assessment "should have been in the chart."	W 217		
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: Based on observations, record review and interview, the facility failed to ensure 1 of 4 audit clients (#1) individual program plan (IPP) included specific objectives to address her needs identified in the comprehensive functional assessment (CFA). The finding is: Review on 8/21/23 of client #1's IPP dated 2/14/23 revealed she had the following needs identified in her IPP: Improve toothbrushing, improve flossing, decrease inappropriate behavior, improve communication skills, improve prevocational skills, improve community living skills and improve daily living skills. Further review of client #1's IPP revealed two training objectives: a formal objective to improve toothbrushing and a behavioral support program (BSP) to reduce non-compliance, self-injurious behavior, decrease aggression, decrease PICA and decrease spitting behaviors. Interview on 8/21/23 with the qualified intellectual disabilities professional (QIDP) revealed client #1 has a formal objective to improve toothbrushing and a behavior support program to decrease inappropriate behaviors. Further interview	W 227		

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W 227	Continued From page 12 confirmed no additional formal training has been developed to address client #1's daily living, self care and community living needs as identified in her IPP.	W 227		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations and record review, the facility failed to ensure 1 of 4 audit clients (#6) individual program plan (IPP) included information to support client #6 towards personal independence specifically during dining. The finding is: Observation on 8/21/23 at 5:00pm direct care staff E cut client #6's meatballs into bite size pieces with no assistance from client #6. Staff E also stood beside client #6 and instructed him to slow down and put his hands in his lap before taking another bite of food. Further observation on 8/22/23 at 7:30am direct care staff C cut client #6 sausage into bite size pieces with no assistance from client #6. The Residential Manager (RM) instructed client #6 to slow down and put his hands in his lap before taking another bite of his food. Review on 8/22/23 of client #6's individual program plan (IPP) dated 10/20/22 revealed no mealtime guidelines listed to support client #6. Review on 8/23/23 of client #6's adaptive behavior inventory (ABI) dated 9/20/22 revealed	W 240		

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W 240	Continued From page 13 client #6 uses knife for cutting with partial independence and sometimes self initiates this skill. Further review revealed client #6 eats without eating too fast with partial independence and sometimes self initiated. Interview on 8/22/23 with the qualified intellectual disabilities professional (QIDP) revealed there was not information in client #6's IPP regarding his diet consistency requiring all food to be cut into bite sized pieces. Further interview confirmed client #6 did not have mealtime guidelines in his IPP about prompting him to slow his rate of eating or his level of independence during dining.	W 240		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure training was developed for 2 of 4 sampled clients (#1 and #6) to address self care, daily living and dining needs identified in the individual program plans to promote personal independence. The findings are: A. During observations on 8/23/23 of supper at 5:05pm client #1 was assisted in serving meatballs, rice, corn and pears. As client #1	W 242		

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W 242	Continued From page 14	W 242		

consumed her supper, she was observed to have food around her mouth. There was a napkin at her placesetting but she was not prompted to use a napkin until she had finished her supper and was taking her plates to the kitchen.

During observations on 8/22/23 of breakfast at 7:44am, client #1 was observed to be assisted in serving scrambled eggs, sausage and grits onto her plate. She was observed to have food around her mouth. There was a napkin at her placesetting but she was not prompted to use her napkin.

Interview on 8/22/23 with staff A revealed client #1 needs assistance in being prompted to use her napkin during a meal.

During observations in the home on 8/22/23 at 7:50am, staff A took client #1 to the bathroom after a toileting accident . Staff A shut the door after client #1 went into the bathroom.

Immediate interview on 8/21/23 with staff A regarding client #1's needs in the area of toileting revealed she needs assistance safeguarding privacy during self care and needs staff assistance going to the bathroom frequently, assistance with wiping after toileting, washing her hands and drying her hands.

Review on 8/21/23 of client #1's IPP dated 2/14/23 revealed she had the following needs identified in her IPP: Improve toothbrushing, improve flossing, decrease inappropriate behavior, improve communication skills, improve prevocational skills, improve community living skills and improve daily living skills. Further review of client #1's IPP revealed 2 training

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W 242	Continued From page 15 objectives: a formal objective to improve toothbrushing and a behavioral support program (BSP) to reduce non-compliance, self-injurious behavior, decrease aggression, decrease PICA and decrease spitting behaviors. Interview on 8/21/23 with the qualified intellectual disabilities professional (QIDP) revealed client #1 has a formal objective to improve toothbrushing and a behavior support program to decrease inappropriate behaviors. Further interview confirmed no additional formal training has been developed to address client #1's needs identified in her IPP which self care and daily living. B. Observation on 8/21/23 at 3:00pm client #6 was pouring drink during snack time at the kitchen table. Client #6's fingernails were over the tips of his fingers. Review on 8/22/23 the adaptive behavior inventory dated 9/20/22 revealed client #6 cooperates while being groomed. Trimming nails criteria no independence and never self initiates. Review on 8/21/23 of the daily hygiene checklist for client #6 under the area for nail cutting indicated for August 1-21, 2023 (a minus) for each day in August indicating his fingernails had not been trimmed. Interview on 8/22/23 the residential manager (RM) confirmed client #6 nails were uncut. RM verified the Nurse usually comes to the house and trimmed the clients nails.	W 242		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 16 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to: consistently implement formal training for ensuring the privacy of clients during self care and promote independence during medication administration. This affected 2 of 4 audit clients (#2 and #5). The findings are: A. During morning observations on 8/22/23 at 6:40am staff C took client #5 from her bedroom to the hallway bathroom in a t-shirt and her underwear. Staff C then told client #5 to use the toilet leaving the bathroom door open while client #5 sat on the toilet with her underpants down.. Staff C walked out of the bathroom and to client #5's bedroom to get her grooming items, clothing and walked back into the bathroom. Staff C asked client #5 to get undressed leaving the bathroom door open. As client #5 got into the shower staff C closed the bathroom door. During morning observations on 8/22/23 at 7:20am client #5 walked to her bedroom after the medication pass and pulled off her shirt with the bedroom door open while staff A assisted her in selecting another shirt. At 7:23am, the residential manager came into the bedroom to assist client	W 249		

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#5 and shut the bedroom door.

Record review of client #5's individual program plan (IPP) dated 2/11/23 revealed she has a need to maintain privacy during toileting. Further review of client #5's IPP revealed she has a formal training objective to observe privacy during toileting with 55% independence for 2 review periods.

Review of her adaptive behavior inventory (ABI) dated 1/10/23 revealed she needs assistance during toileting/self care to maintain privacy.

Interview on 8/22/23 with the RM revealed client #5 requires direct care staff to assist her with privacy during toileting and self care tasks by giving her verbal reminders and assisting her with shutting bedroom and bathroom doors for privacy.

Interview on 8/21/23 with the qualified intellectual disabilities professional (QIDP) revealed client #5's IPP and objectives are current.

B. During observation of the medication administration pass on 8/22/23 for client #5 at 7:15am staff A poured client #5s water into a cup in the sink in the office before she administered the following medications: Lorazepam, Invega, Quetiapine, Divalproex, Clonidine and a Daily Vitamin.

Review on 8/21/23 of client #5's adaptive behavior inventory dated 1/10/23 under medication administration revealed client #5 can pour water into a cup.

C. During observation of the medication

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W 249	Continued From page 18 administration pass at 7:40am, client #2 received the following medications: Risperidone and Vitamin D. Staff A poured her water into a cup from the sink in the office without client #2's assistance. Review on 8/22/23 of client #2's adaptive behavior inventory dated 4/13/23 under medication administration indicated client #2 can pour water into a cup with assistance from staff. Interview on 8/22/23 with the RM revealed both clients #2 and #5 can pour their water into a cup during the medication administration pass.	W 249		
W 254	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on record review and interview the qualified intellectual disabilities professional (QIDP) and psychologist failed to review the written training programs for 3 of 4 audit clients (#1, #2 and #5). The findings are: A. Review on 8/21/23 of client #1's individual program plan (IPP) dated 2/14/23 revealed she has a need to decrease inappropriate behavior. Her target behaviors are listed as physical aggression, non-compliance, self-injury, crying, loud vocalizations, PICA and spitting behaviors. Further review of the IPP revealed a behavior support program (BSP) dated 2/8/23 to address these target behaviors which incorporates the use of Quetiapine, Lorazepam, Clonazepam and Asenapine.	W 254		

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W 254	Continued From page 19 Review on 8/21/23 of the progress summaries for client #1's BSP revealed no notes from the psychologist since implementation of the BSP on 2/14/23. B. Review on 8/21/23 of client #5's IPP dated 2/11/23 revealed she has a need to increase her appropriate behaviors. Further review of the IPP revealed a BSP dated 2/11/23 to address the target behaviors of: profanity, self wetting, severe disruptive behavior and decrease begging for food. This BSP incorporates the use of Clonidine, Ativan, Lorazepam, Quetiapine, Depakote and Ativan for physician appointments. Review on 8/21/23 of the progress summaries for client #5's BSP revealed no notes from the psychologist since implementation of the BSP on 2/11/23. C. Review on 8/21/23 of client #2's IPP dated 5/13/23 revealed she will decrease the frequency of defined behaviors. Her target behaviors are listed as physical aggression, inappropriate touching and inappropriate profanity. Further review of the IPP revealed a BSP dated 2/3/23 to address these target behaviors incorporates the use of Risperidone. Review on 8/21/23 of the progress summaries for client #2's BSP revealed no notes from the psychologist since 3/4/23. Interview on 8/22/23 with the QIDP confirmed she could not produce any progress summaries for clients #1, #2 and #5 BSP's from the psychologist since February 2023.	W 254		

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W 331	Continued From page 20	W 331		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on records review and interviews, the facility failed to provide nursing services in accordance with the needs of 3 of 4 audit clients (#1, #2 and #5) relative to ensuring authenticated physician orders were available. The finding is: Review of clients #1, #2 and #5's physician orders for the periods of 12/1/22-3/31/23 and 4/1/23-6/30/23 revealed the physician orders sent from the pharmacy had not been reviewed by the physician and had not been authenticated with his signature. Further review revealed there were not current authenticated physician orders for 7/1/23-9/30/23 for clients #1, #2 and #5. Interview with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) on 8/22/23 revealed the previous physician orders for 12/1/22- 3/31/23 and 4/1/23-6/30/23 had not been reviewed by the physician and authenticated with his signature. Further interview revealed there were not current authenticated physician orders for 7/1/23-9/30/23 for clients #1, #2 and #5. Additional interview revealed it is Nursing services responsibility to review and have these orders authenticated by the physician.	W 331		