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| E 004 | Develop EP Plan, Review and Update Annually CFR(s): 483.475(a)<br><br>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. | E 004 | | |

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 004 | Continued From page 1<br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br><br>.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is:<br><br>Review on 9/19/23 of the facility's emergency preparedness documentation revealed a document which noted that the EPP originally completed in October, 2012 was most recently updated in August, 2019.<br><br>Interview on 9/20/23 with the Program Manager (PM) and the Center Director revealed that the EPP had not been updated since August, 2019. | E 004 | | |
| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>§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), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of | E 037 | | |

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| E 037 | Continued From page 2<br>the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(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.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice | E 037 | | |

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| E 037 | Continued From page 3<br>must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(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.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and | E 037 | | |

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| E 037 | Continued From page 4<br>procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and | E 037 | | |

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| E 037 | Continued From page 5<br>procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must 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, 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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide emergency preparedness training for staff at least every 2 years. The | E 037 | | |

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| E 037 | Continued From page 6<br>finding is,<br><br>Record review on 9/19/23 revealed an emergency preparedness manual. Continued review revealed the emergency preparedness manual contained no training records and no other evidence that staff are being trained on the plan.<br><br>Interview on 9/20/23 with the Program Manager revealed that the direct care staff have not had emergency preparedness training during the last 2 years. | E 037 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>§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).<br><br>*[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]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is | E 039 | | |

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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 [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

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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 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

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| E 039 | Continued From page 9<br>exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or | E 039 | | |

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| E 039 | Continued From page 10<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or | E 039 | | |

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| E 039 | Continued From page 11<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a | E 039 | | |

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| E 039 | Continued From page 12<br>narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(iii) Analyze the ICF/IID's response to and | E 039 | | |

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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, 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

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| E 039 | Continued From page 14<br>documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(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.<br>(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.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, | E 039 | | |

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| E 039 | Continued From page 15<br>and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is:<br><br>Review of the facility EPP manual on 9/19/23 revealed the manual was last updated in August, 2019. Continued review of the EPP manual revealed no evidence of a full-scale community or facility-based training, a mock drill, or a tabletop exercise.<br><br>Interviews with the Program Manager (PM) on 9/20/23 confirmed that the facility has not conducted a full-scale community or facility-based training, mock drill, or a tabletop exercise within the last 2 years as required. | E 039 | | |
| W 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint survey for Intake #NC00205735. The complaint was unsubstantiated and no deficiencies were cited. However, deficiencies were cited as a result of the recertification survey. | W 000 | | |
| W 125 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(3)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility | W 125 | | |

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| W 125 | Continued From page 16<br>failed to ensure client #9 was able to move freely in her environment. The finding is:<br><br>During observations on the blue hall throughout the survey on 9/19/23 to 9/20/23, client #9 was observed to walk around the day room. Each time client #9 stood up and walked, staff repeatedly told her to sit down; At times, would grab her arm and guide her to sit down in a chair.<br><br>Interview on 9/20/23 with the facility administrator confirmed client #9 should be able to move freely around her home, utilizing her walker for that purpose. | W 125 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person Centered Plan (PCP) in the areas of leisure activities. The findings are:<br><br>A. The facility failed to provide an adequate active treatment program to engage all clients during | W 249 | | |

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| W 249 | Continued From page 17<br>large amounts of unstructured time on the Blue Hall. For example:<br><br>Observations on the Blue Hall on 9/19/23 from 4:00pm to 5:12pm, clients and staff were observed sitting at three activity tables in the day room. On each table was a doll house/castle. There were no pieces to the doll houses or castle and staff were observed to manipulate the doll houses and not involve clients. Additional observations during this time revealed several clients sitting in front of the television. At no time during the observation was staff observed to talk to the clients about the program that was on, etc.<br><br>Interview on 9/20/23 with the facility administrator confirmed staff should be engaging clients in various activities at all times, talking to them about what's on television, etc.<br>B. The facility failed to implement training objectives and provide an adequate active treatment program to engage client #8 during large amounts of unstructured time on the Green Hall. For example:<br><br>Afternoon observations on 9/19/23 from 4:00 PM to 6:00 PM revealed client #8 to sit unengaged without activity for 75 of 120 minutes of observation. During the remaining 45 minutes of observation the client was observed to go to the computer room and participate in dinner alone in the staff break room. Continued observations revealed client #8 to spend most of the time in his room sitting in an oversized chair.<br><br>Morning observations on 9/20/23 from 7:00 AM to 9:00 AM revealed client #8 to sit unengaged for 90 of 120 minutes of observation. During the remaining 30 minutes of observation, the client | W 249 | | |

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| W 249 | Continued From page 18<br>was observed to go to the bathroom twice then participate in a breakfast meal in the staff break room. Continued observation did not reveal client #8's 1:1 staff to offer choices in participation of leisure or scheduled activities.<br><br>Review of record for client #8 on 9/20/23 revealed a PCP dated 11-5-22. Continued review of the PCP revealed the client to have training objectives to include walking, vocalizing his activity choice, to attend chosen activity with peers and behavior.<br><br>Interview with the facility administrator and program manager (PM) on 9/20/23 revealed that client #8 training objectives are current, and the client was admitted to the facility in 10/22. Continued interview revealed that the client prefers not to engage in any type of activities, including leisure, refuses to walk, interact with his peers, and complete his personal hygiene. Further interview revealed that the client has recently started walking to the computer room to play on the computer. Subsequent interview revealed that staff should be implementing client #8's active treatment programming throughout the day.<br><br>C. The facility failed to implement training objectives and provide an adequate active treatment program to engage client #1 during large amounts of unstructured time on the Orange Hall. For example:<br><br>Afternoon observations on 9/19/23 from 4:00 PM to 6:00 PM revealed client #1 to lay on a floor mat unengaged without activity for 60 of 120 minutes of observation. Continued observations revealed | W 249 | | |

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staff to walk by the client, call her name then attend to another client. During the remaining 60 minutes of observation the client was observed to spend the rest of the time in her room. At no time during observations did staff offer choices to participate in a leisure or scheduled activity.

Morning observations on 9/20/23 from 7:00 AM to 9:00 AM revealed client #1 to lay in bed during the entire time of observation. Continued observation revealed staff to enter client's room, pull the privacy curtain then exit.

Review of record for client #1 on 9/20/23 revealed a person centered plan (PCP) dated 9-22-22. Continued review of the PCP revealed the client to have training objectives to include tossing a ball, shut door upon request, sign for ball and/or book and behavior.

Interview with the program manager on 9/20/23 revealed that client #1's training objectives are current. Continued interview with the program manager revealed staff should be offering and implementing client #1's active treatment programming throughout the day and helping the client with meaningful activities during afternoon and morning periods of inactivity.

D. The facility failed to implement training objectives and provide an adequate active treatment program for client #5 during unstructured leisure time on the yellow hall. For example:

During afternoon observations on 9/19/23, client #5 was observed to sit at a table in the large day room on the hall from 4:00 pm until 6:18 pm. During this time, the client was not offered any choice of activities nor did any staff attempt to

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engage with the client, except to greet him, inquire about his general well-being, and assist him to eat his dinner at 5:58 pm. Continued observation revealed client #5 to get up from the table at 6:10 pm to throw some trash in the trash can, then return to the same chair.

Record review on 9/19/23 revealed a Person Centered Plan (PCP) for client #5 dated 4/24/23 which lists training objectives including picking up and throwing a ball, using a washcloth, and pointing to a picture of the bathroom when he needs to use it. Continued record review reveals that the client can throw, toss, kick and roll a ball, walk, play basketball and use an electronic tablet.

Interview with the PM on 9/20/23 revealed that client #5's training objectives are current, and that the client should have been given opportunities to engage in meaningful activities during the leisure time.

E. The facility failed to ensure that client #2 received a continuous active treatment plan relative to behavior guidelines. For example:

During observations on 9/19/23, client #10 was observed to engage in self-injurious behavior by hitting herself in the head with her hands and banging her head on the wall of the classroom. Staff told the client to stop hitting her head but did not offer the client a replacement activity such as exercise or walking.

During observations on 9/20/23, client #10 was observed hitting her head with her hands and banging her head on the wall of her bedroom. Staff sat in the doorway of the client's bedroom, preventing the client from walking around outside

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| W 249 | Continued From page 21<br>of her room. Continued observations revealed client to hit her head with her hands on the way to the classroom, then to bang her head on the window in the classroom. Staff again told the client to stop hitting her head but did not offer the client a replacement activity.<br><br>Record review on 9/20/23 revealed a Behavior Support Plan (BSP) dated 1/10/20 which notes a target behavior of "Self-injurious behavior (SIB) - Any behavior that does or could result in injury, especially repetitively striking head with hand/hitting head on objects or other forms of head banging." Continued review of the BSP revealed a preventative procedure for target behaviors which reads, "Throughout the day, when the client is not being worked with on an individual basis, she should be provided with objects to manipulate. The client has a high level of energy and it is important that she be given the opportunity to exercise to release some of this energy. Gross motor activities are activities that may help in releasing some of her energy ...Staff should periodically provide the client with new activities so that she does not lose interest in them.<br><br>Interview with the PM and the facility administrator on 9/20/23 confirmed that client #10's BSP is current and that the staff should have followed the behavior guidelines in response to the client's self-injurious behavior. | W 249 | | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. | W 368 | | |

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| W 368 | Continued From page 22<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 client (#11) observed during medication administration. The finding is:<br><br>During observations in the home on 9/20/23, staff was observed to dispense medications for client #11 from a medication cart located in the hallway. The medications dispensed to a paper cup were Dairy Aid, 3000 units 1 tablet; Aspirin, low dose 81 mg, 1 tablet; Levetiracetam 500 mg, 1 tablet; CA Cit / VitD 315-200, 2 tablets; Vit D3 50 mcg, 1 capsule, Linzess 145 mg, 1 capsule. Continued observation revealed the staff to pour all medications, except the Vit. D3, into a small bag and crush them. Staff then poured the crushed medications into a small cup of pudding, then poured the contents of the Vit D3 capsule into the pudding. Further observation revealed staff to administer the medications in the pudding to client #11 by mouth.<br><br>Review on 9/20/23 of client #11's physician's orders dated 12/12/22 revealed an order for Vitamin D3 1000 IU (25 mcg) cap, "TAKE 1 CAPSULE BY MOUTH ONCE EVERY DAY *HOUSE STOCK [Equiv To: PRONUTRIENTS VITAMIN 3] Schedule: DAILY AT 08:00"<br><br>Interview on 9/20/23 with the Director of Nursing for the home confirmed the physician's order was current and that client #11 should have received a dose of 25 mcg of Vit D3 and not 50 mcg. | W 368 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2) | W 436 | | |

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The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure client #3, client #6 and client #9 was taught to use and make informed choices about the use of a hand brace, walker and eyeglasses. This affected 3 of 11 audit clients. The findings are:

A. Client #6 did not utilize his hand brace.

During observations throughout the survey on 9/19/23 to 9/20/23, client #6 was observed sitting in his wheelchair. At no time during the observations was client #6 observed to wear a brace on his right hand.

Review on 9/19/23 of client #6's Individual Program Plan (IPP) dated 2/28/23 revealed client #6 uses a Benik brace on his right hand, worn 12 hours per day to prevent further contracture.

Interview on 9/20/23 with the facility administrator confirmed client #6 should use his brace daily. Further interview revealed the brace to be located in client #6's closet.

B. Client #9 did not utilize a walker.

During observations throughout the survey on 9/19/23 to 9/20/23, client #9 was observed to stand up and walk. At no time during the observations was client #9 utilizing a walker.

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| W 436 | Continued From page 24<br>Review on 9/20/23 of client #9's IPP dated 8/17/23 revealed client #9 ambulates independently with the use of a snug seat crocodile rolling walker.<br><br>Interview on 9/20/23 with the facility administrator confirmed client #9 should use her walker any time she is up ambulating.<br><br>C. Client #3 did not wear eyeglasses.<br><br>During observations throughout the survey on 9/18 - 9/19/23, client #3 did not wear eyeglasses. Client #3 was not prompted or encouraged to wear eyeglasses.<br><br>Interview on 9/19/23 with Staff E revealed she was not sure if client #3 has eyeglasses.<br><br>Review on 9/19/23 of client #3's IPP revealed under adaptive equipment, "Eyeglasses". The plan noted the client is "noncompliant" with wearing his eyeglasses. Additional review of the client's vision examination report dated 9/27/22 indicated, "Myopia...needs to wear eyeglasses...needs to wear RX full time."<br><br>Interview on 9/19/23 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3 had broken his eyeglasses about a month ago and new ones have been ordered. Additional interview confirmed the client has been noncompliant with wearing his glasses; however, no training has been implemented to teach him to wear his eyeglasses appropriately. | W 436 | | |
| W 440 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1) | W 440 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G038 | A. BUILDING _____ B. WING _____ | C 09/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR CREEK | 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227 |

| (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 |
|---|---|---|---|---|
| W 440 | Continued From page 25<br>at least quarterly for each shift of personnel.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. The finding is:<br><br>Review on 9/20/23 of the facility's fire drills for September 2022 to August 2023 revealed the following:<br>- For the blue hall, fire drills were missing for November 2022, February 2023 and April 2023..<br>- For the green hall, fire drills were missing for December 2022, February 2023, April 2023 and July 2023.<br>- For the yellow hall, fire drills were missing for November 2022, January 2023, February 2023, March 2023, April 2023 and July 2023.<br>- For the orange hall, fire drills were missing for October 2022, November 2022, December 2022, January 2023, February 2023 and April 2023.<br><br>Interview on 9/20/23 with the facility administrator confirmed no fire drill reports could be located for the missing months. | W 440 | | |