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E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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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.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

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

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E 037	Continued From page 4 *[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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially. The finding is: Review on 9/19/23 of the facility's EPP revealed no evidence of initial or biennial training on the EPP. Interview on 9/20/23 with the qualified intellectual disabilities professional (QIDP) confirmed that initial training and biennial training for current staff were not completed regarding the facility's EPP.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(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]:	E 039		

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E 039	Continued From page 5 (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]	E 039		

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E 039	Continued From page 6 (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 7 (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 8 (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of	E 039		

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the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that

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E 039	Continued From page 10 requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, 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

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limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13 *[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 review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is: Review on 9/19/23 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training, mock drill, or a tabletop exercise. Interview on 9/20/23 with the qualified intellectual disabilities professional (QIDP) revealed that in-service training, mock drills or table top exercises could not be found during the survey. Continued interview with the QIDP verified the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training, mock drill, or a tabletop exercise.	E 039		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)	W 210		

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W 210	Continued From page 14 Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure needed assessments for 1 of 6 clients (#6) were completed within 30 days after admission. The finding is: Review on 9/20/23 of client #6's record revealed he was admitted to the facility on 10/6/22. Continued review of client #6's record did not include a current occupational therapy evaluation (OT), physical therapy evaluation (PT), or nutritional evaluation. Interview on 9/20/23 with the qualified intellectual disabilities professional (QIDP) verified that current assessments for client #6 which include OT, PT, and nutritional evaluation were not available during survey for review.	W 210		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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This STANDARD is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in the person-centered plan (PCP) for 1 sampled client (#6) relative to communication book or communication album. The finding is:

Observations during the recertification survey on 9/19/23-9/20/23 revealed client #6 to participate in various activities to include running around outside, place napkins and spoons on table, participate in dinner meal, and to participate in medication administration. Continued observations revealed client to be prompted to sit in the kitchen area while staff prepared the dinner meal and for client #6 to continuously exit the kitchen to invade the space of his housemates. Staff were observed repeatedly to redirect the client back to the kitchen to sit in a chair. At no point during observations on both days did staff offer client #6 his communication book or communication album.

Review of the record on 9/20/23 for client #6 revealed a person-centered plan (PCP) dated 7/17/23. Continued review of the PCP revealed client #6 has the following program goals: laundry, attend to a task for 10 minutes, set place at table, brush teeth, improve in his ability to tolerate his daily routine, and make a choice when presented with picture choices and a question prompt. Further review of the PCP revealed a communication evaluation dated 2/27/23 that indicated client #6 should be provided a picture choice notebook for making choices in his daily routine. Subsequent review of the PCP revealed client #6 should be prompted to

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W 249	Continued From page 16 make a choice for snack and leisure with the trainer presenting the communication book. Interview with the qualified intellectual disabilities professional (QIDP) on 9/20/23 revealed that staff should have provided client #6 with a communication picture book to assist with making choices and improveing independence. Continued interview with the QIDP verified that all of client #6's goals are current.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 6 of 6 clients (#1, #2, #3, #4, #5, and #6). The finding is: Observations throughout the recertification survey from 9/19/23-9/20/23 revealed a keypad lock on the laundry/office room door. Continued observation revealed that staff had to enter a code into the keypad to allow entry for clients to complete laundry chores. Review of records on 9/20/23 for clients #1, #2, #3, #4, #5, and #6 revealed no guardian approval or Human Rights Committee consents for keypad lock on laundry room door. Interview on 9/20/23 with the residential manager (RM) confirmed that a keypad lock on the laundry	W 263		

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W 263	Continued From page 17 door was installed because the office shares space with the laundry area and items needed to be secured. Interview on 9/20/23 with the qualified intellectual disabilities professional (QIDP) confirmed that there are no guardians approval in place or Human Rights Committee consents for the clients at Oakdale Group Home.	W 263		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 6 clients (#4) observed during medication administration. The finding is: Observation in the group home on 9/20/23 at 7:34 AM revealed staff A to complete a blood pressure check for client #4 with a reading of 158/110 and for staff to notify nursing of results. Continued observation revealed staff A to confirm from nursing to administer client #4's medications. Further observation revealed staff A to pour a capful of Miralax and pour it into the glass of water client #4 was holding. Subsequent observations revealed staff A to punch all morning medications into a medicine cup and client #4 was observed to take all medications whole with water containing Miralax. Review of records for client #4 on 9/20/23 revealed physician orders dated 7/20/23. Review of the 7/20/23 physician orders revealed medications to administer at 8:00 AM to be	W 369		

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W 369	Continued From page 18 Carbamazepin Tab 200MG (2 tablets), Citalopram Tab 20MG (1 & ½ tablets), Clonidine Tab 0.1MG, Hydrochlorothiazide Tab 25MG, Lorazepam Tab 0.5MG, Metoclopram Tab 5MG, Omega-3 Fish Cap 1000MG, Pantoprazole Tab 40MG, PEG3350 Powder- 510G (Miralax), Potassium Chloride Cap 10MEQ ER, Propranolol Tab 20MG, Vitamin D3 2000 IU (50MCG) Cap, Levothyroxin Tab 50MCG take 1 tablet by mouth daily for Hypothyroidism and take 30 minutes before breakfast or other medications. During the medication administration, staff A was observed to administer all medications for client #4 after breakfast which includes the medication Levothyroxin Tab 50 MCG that should have been administered 30 minutes before breakfast and other medications. Interview with the facility nurse on 9/20/23 verified the 7/20/23 physician orders for client #4 to be current. Continued interview with the facility nurse revealed that staff should administer medications to all clients as prescribed.	W 369		
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 observation, record review and interviews, the system for drug administration failed to assure 1 of 6 clients (#4) observed during medication administration were provided the opportunity to participate in medication	W 371		

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W 371	Continued From page 19 self-administration or provided teaching related to name, purpose and side effects of medication administered. The finding is: Observation in the group home 9/20/23 at 7:34 AM revealed staff A to prepare medications for administering for client #4 by pouring a capful of Miralax into the client's cup of water and punching medications into the medicine cup. Continued observation revealed staff A to hand client #4 the medicine cup, the client to take all medications with water containing Miralax and to exit the medication area. Client #4 was not observed to participate with medication administration beyond taking medications from staff A and drinking water containing Miralax. Review of records on 9/20/23 for client #4 revealed a person-centered plan (PCP) dated 1/17/23. Continued review of record revealed an adaptive behavior assessment dated 8/2/2019 that revealed client #4 punches pills from card with total independence and performs task thoroughly without assistance. Interview with the facility nurse on 9/20/22 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that client #4 can punch his own medications from the medication card independently.	W 371		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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,	W 436		

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and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:
Based on observation, record review and interview the facility failed to provide adaptive equipment for 2 of 6 clients (#5 and #6). The findings are:

A. The facility failed to provide adaptive equipment for client #5. For example:

Afternoon observation in the group home on 9/19/23 at 5:10 PM revealed client #5 to prepare for the dinner meal with staff assistance. The dinner meal consisted of the following: rice and ground beef. Continued observation revealed staff to provide client #5 with a shirt protector, divided dish, napkin, two cups, spoon, fork, and knife. Further observation at 5:18 PM revealed client #5 to finish eating the dinner meal. At no point during the observation period did staff offer client #5 his non-skid mat.

Review of record on 9/20/23 for client #5 revealed a person-centered plan (PCP) dated 4/16/23. Review of PCP revealed adaptive equipment to include high sided dish and non-skid mat. Continued review of record revealed an occupational therapy evaluation (OT) dated 1/23/23 that states the client continues to require a high sided divided plate and non-skid mat.

Interview with the qualified intellectual disabilities professional (QIDP) verified the PCP dated 4/16/23 for client #5 was current. Continued interview with the QIDP verified that staff should be using client #5's adaptive equipment as prescribed.

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W 436	Continued From page 21 B. The facility failed to provide adaptive equipment for client #6. For example: Afternoon observation in the group home on 9/19/23 at 5:10 PM revealed client #6 to prepare for the dinner meal. The dinner meal consisted of the following: taco shells, ground beef, lettuce, tomatoes, rice, and peaches. Continued observation revealed staff to provide client #5 with a divided dish, napkin, two cups, spoon, fork, knife, and a shirt protector. Further observation at 5:26 PM revealed client #6 to finish eating the dinner meal. At no point during the observation period did staff offer client #6 his maroon spoon. Additionally, client #6 was observed to cough a couple of times during the dinner meal. Review of record on 9/20/23 for client #6 revealed a PCP dated 7/17/23. Review of the PCP revealed adaptive equipment should be used for meals; however not specified. Continue review of record revealed an OT assessment dated 8/19/20 that recommended the following: adaptive equipment at mealtime to include inner lip plate or high sided dish, maroon spoon, and straw to limit gulping. Interview with the QIDP on 9/20/23 verified the PCP dated 7/17/23 for client #6 was current. Continued interview with the QIDP verified that staff should be using client #6's adaptive equipment as prescribed.	W 436		