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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		

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 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 provide and maintain documentation of annual staff training on the Emergency Preparedness Plan (EPP). The finding is: A review of the facility's EPP on 2/21/24 revealed no documentation of the annual staff training. Continued review revealed the last training was conducted on 10/15/20. Interview on 2/21/24 with the facility program manager confirmed that the facility had not conducted an updated EPP training for direct care staff since 10/15/20.	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	E 039		

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E 039	Continued From page 5 §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 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.	E 039		

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E 039	Continued From page 6 *[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 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	E 039		

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E 039	Continued From page 7 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. *[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,	E 039		

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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):]
(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

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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 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

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E 039	Continued From page 10 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 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	E 039		

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E 039	Continued From page 11 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. (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	E 039		

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E 039	Continued From page 12 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 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.	E 039		

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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 2/21/24 of the facility's EPP revealed no evidence of an updated full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise. Continued review revealed a table top drill conducted on 1/15/20. Interview on 2/21/24 with the facility program manager confirmed the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise since 1/15/20.	E 039		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 227		

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W 227	Continued From page 14 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 reviews, and interview, the facility failed to ensure the behavior support plan (BSP) for client #1 included specific objectives directed to an identified need to refrain from picking paint and plaster off of walls. The finding is: Observations in the home between 4:00 PM on 2/20/24 and 9:15 AM on 2/21/24 revealed client #1 several times to lie on the floor against the walls and cabinets or squat next to the wall separating the kitchen and living room. Continued observation revealed client #1 to flick the walls and cabinets with his fingers while he was lying on the floor or squatting. Further observation revealed areas on the kitchen wall and the wall in client #1's bedroom in which client #1 had picked off the paint and the plaster. Subsequent observations revealed pieces of wall plaster lying on the floor in the area where client #1 had just been picking at the wall. Additional observation revealed staff to ignore client #1's behaviors and to not offer him any alternative activities to redirect him to a more appropriate situation. Review of records on 2/21/24 revealed a BSP for client #1 dated 5/1/23 which lists client #1's target behaviors as refusal, self-stimulatory behaviors, self-injurious behaviors, and grabbing others. Continued review revealed that the BSP contains no information about the observed behavior of flicking or picking paint and plaster off of walls, even though staff had documented this behavior	W 227		

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W 227	Continued From page 15 at least as far back as November, 2023. Further review of the record revealed a person-centered plan (PCP) dated 2/13/24 which states, "Watch for items on the ground, client #1 will pick up unsanitary items off the ground and place them in his mouth. Client #1 was diagnosed with PICA in December, 2018." Interview with the behavior specialist (BS) confirmed that client #1 picks and flicks the walls and that this causes portions of the walls to fall off. Continued interview with the BS confirmed the PICA diagnosis for client #1. The BS also confirmed that client #1 has a need to refrain from the picking behavior for his health and safety and that no such plan is presently in place.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#3, and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Person Centered Plan (PCP). The findings are:	W 249		

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W 249	Continued From page 16 A. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #3. For example: During observations throughout the survey on 2/20/24 from 4:00 PM until 5:30 PM and on 2/22/24 from 6:30AM until 9:15 AM, client #3 was observed to sit in a recliner in the living room unengaged. At no point during the observations was client #3 prompted to do anything other than shower, take medications and eat dinner meal on 2/20/24. On 2/21/24 client was observed to participate in medication administration and breakfast meal. Review on 2/21/24 of client #3's record revealed a person centered plan (PCP) dated 8/22/23. Continued review revealed training objectives in the areas of brushing with a mouth swab, walking, handwashing, bib toleration, lift spoon, and sign the word "more". Interview on 2/21/24 with the interim qualified intellectual developmental professional (QIDP) confirmed that client #3's goal are current and staff should engage him in training objectives as written. B. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #6. For example: During observations throughout the survey on 2/20/24 from 4:00 PM until 5:30 PM and on 2/22/24 from 6:30AM until 9:15 AM, client #6 was observed to sit at a chair in his room unengaged. At no point during the observations was client #6	W 249		

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W 249	Continued From page 17 prompted to do anything other than go to the bathroom and eat dinner meal on 2/20/24. On 2/21/24 client was observed to take a shower, participate in medication administration and breakfast meal. Review on 2/21/24 of client #6's record revealed a person centered plan (PCP) dated 4/19/23. Continued review revealed training objectives in the areas of hand washing, mouth swab, flush toilet, communication by choices, time on task, bring dirty shirt protector to the laundry room and pull-out chair from under the table before mealtime. Interview on 2/21/24 with the interim QIDP confirmed that client #6 should have been prompted and engaged in training objectives as written.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The finding is: Observations throughout the recertification survey period from 2/20/24 - 2/21/24 revealed locked sharps, locks on refrigerator door, keypad on	W 262		

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W 262	Continued From page 18 pantry door and exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Review of client records on 2/21/24 for clients #1, #2, #3, #4, #5 and #6 revealed expired signed consents ranging until 9/21/21 from HRC relative to locked sharps, refrigerator, pantry and exterior door alarms. Interview with the facility program manager (PM) on 2/21/24 revealed that updated signed consent forms could not be located during the survey. Continued interview with the interim qualified intellectual developmental professional (QIDP) verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		
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, #6). The finding is: Observations throughout the recertification survey period from 2/20/24 - 2/21/24 revealed locked sharps, locks on the refrigerator door, keypad on the pantry door and exterior door alarms to chime as staff, clients and surveyors entered and exited the group home.	W 263		

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W 263	Continued From page 19 Review of client records on 2/21/24 for clients #1, #2, #3, #4, #5 and #6 revealed expired signed consents ranging from 9/20/21 through 12/9/22 from the legal guardians relative to locked sharps, refrigerator, pantry and exterior door alarms. Interview with the facility program manager on 2/21/24 revealed that updated signed consent forms could not be located during the survey. Continued interview with the interim qualified intellectual developmental professional (QIDP) verified HRC limitation consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		
W 419	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iii) The facility must provide each client with bedding appropriate to the weather and climate. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide 1 of 6 clients (client #1) with bedding appropriate to weather and climate. The finding is: Observations in the group home on 2/20/24 revealed client #1's bed to consist of a custom platform and a plastic-covered mattress. Continued observation revealed the presence of a blanket and pillow on the bed, but no sheets. Further observations in the group home at 6:30 AM on 2/21/24 revealed client #1 lying on his plastic mattress with a blanket and pillow next to the bed on the floor and no sheets. Record review revealed a person-centered plan	W 419		

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W 419	Continued From page 20 (PCP) for client #1 dated 2/13/24 which contains no approved restrictions with respect to bedding and no indications of any safety hazards which those items may present for client #1. Interview with the residential team leader (RTL) on 2/21/24 revealed that staff do not provide sheets for client #1's bed because the sheets present a safety hazard for client #1, namely, that he will put them in his mouth. Interview with the interim qualified intellectual disability professional (QIDP) on 2/21/24 confirmed that there is no restriction on client #1's use of appropriate bedding and that all appropriate bedding should be provided to client #1, including sheets.	W 419		
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, 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 interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 2 of 3 sampled clients (#3 and #4). The findings are: A. Afternoon observations in the group home on 2/20/24 from 4:00 PM - 5:30 PM revealed client #3 to sit in a recliner in the living room wearing a gait belt around her waist. Continued observation revealed client #3 to transfer from the recliner to a wheelchair with the assistance of one staff.	W 436		

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Further observation revealed client #3 to transfer back to the recliner, then to the wheelchair again, and finally to a dining room chair with one staff assisting with the gait belt. At no time during the observation was client #3 offered a shoulder harness and none was observed in the home.

Morning observations in the group home on 2/21/24 from 6:00 AM to 9:15 AM revealed client #3 to emerge from her bedroom in a wheelchair, then transfer to the living room recliner with the assistance of one staff using a gait belt. Continued observation revealed client #3 to transfer back to the wheelchair to move to the medication room, then back to the recliner. Further observation revealed client #3 to transfer to the wheelchair to move to the dining room. All transfers were completed by one staff using the gait belt. At no time during the observation was client #3 offered a shoulder harness and none was observed in the home.

Review of records for client #3 revealed a physical therapy (PT) evaluation dated 3/24/23 which states, "Client #3 continues to require assistance for transfers and ambulation (contact guard assist +2 with shoulder harness and 1 hand assistance).

Interview with the facility nurse on 2/21/24 confirmed that the 3/24/23 PT evaluation is the most current evaluation and that staff should be using a 2-person assist and a shoulder harness for transfers and ambulation.

B. Afternoon observations in the group home on 2/20/24 from 4:00 PM- 5:30 PM revealed client #4 to participate in various activities such as listening to music, watching tv, coloring activities and

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W 436	Continued From page 22 participate in the dinner meal. At no point during the observation period was client #4 prompted to wear her eyeglasses. Morning observations in the group home on 2/21/24 from 6:00 AM to 9:15 AM revealed client #4 to participate in various activities such as a coloring activity, medication administration, prepare her lunch, participate in breakfast meal and clean up. At no point during the observation period was client #4 prompted to wear her eyeglasses. Review of record for client #4 on 2/21/24 revealed a person centered plan (PCP) dated 2/15/24. Continued review revealed eyeglasses listed as an adaptive equipment to be worn daily. Further review revealed an eye exam consult dated 6/14/23. Subsequent review revealed client #4 to require eyeglasses and a new prescription provided. Interview with the facility nurse on 2/21/24 revealed client #4 wears eyeglasses daily. Continued interview revealed client #4 to state she only wears her eyeglasses at the group home and prefers not to wear them at the day program. Further interview with the facility nurse verified client #4 needs to wear her glasses daily as prescribed.	W 436		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that 2 of 6 clients (#2 and #4) were provided with	W 475		

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appropriate utensils to allow each client to eat as independently as possible. The findings are:

Afternoon observations in the group home on 2/20/24 at 5:15 PM revealed all clients to sit at the dining table to prepare for the dinner meal. The dinner meal consisted of the following: hamburger patties, gravy, mashed potatoes and mustard greens. Continued observations revealed staff to provide clients #2 and #4 with a fork only as they participated in the dinner meal. Subsequent observations revealed all clients to consume dinner utilizing the utensil provided with no concerns. At no point during the observation period were clients #2 and #4 offered a full place setting of a fork, knife and spoon during the dinner meal.

Morning observations on 2/21/24 at 8:10 AM revealed all clients to sit at the dining table to prepare for the breakfast meal. The breakfast meal consisted of the following: french toast sticks, sausage links, juice and milk. Continued observations revealed staff to provide clients #2 and #4 with only a fork as the clients participated in the breakfast meal.

Review of client #2's record revealed an adaptive behavioral inventory (ABI) dated 10/17/23. Continued review revealed in Subdomain 1-3 Eating: total independence with eating when using a spoon and fork with minimal spillage. Further review revealed partial independence with using a knife for cutting. Subsequent review revealed an (occupational therapy) OT eval dated 1/4/24 which indicates client #2 utilizes a spoon, fork and knife.

Review of client #4's record revealed an ABI

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W 475	Continued From page 24 dated 1/21/23. Continued review revealed in Subdomain 1-3 Eating: total independence with eating when using a spoon and fork with minimal spillage. Further review revealed total independence with using a knife for cutting. Interview with the interim qualified intellectual disabilities professional (QIDP) on 2/21/24 revealed clients should have been offered a full place setting including a fork, knife and spoon during all meals. Continued interview with the QIDP verified that all clients should be provided a full place setting to promote independence during mealtimes.	W 475		