STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

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E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039	The team will review our Crisis Response protocol and determine if changes need to be made to meet standards. Once the review is complete, the Program Managers will identify facilitators for Table Top drills and inservice those identified on the process. each home will complete an appropriate drill and file in the appropriate drill book. The Program Managers or designees will ensure each drill is completed as necessary. In the future, the Program Manager will monitor monthly to ensure all drills have been completed as scheduled.	8/19/2023

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

Sherry J. Chappell, BA/QP/Program Manager 6/27/2023

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 039	Continued From page 1 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 5 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 6 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 7 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 8 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct exercises to test their emergency preparedness plan at least twice per year. This potentially affected all clients (#1, #2, #3, #4, #5, and #6) living in the home. Review on 6/19/23 of the emergency preparedness plan, dated 1/27/23, revealed that neither a tabletop activity, nor a full-scale, community-based activity could be located. Interview on 6/19/23 with the Program Manager	E 039		

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E 039	Continued From page 9 revealed the facility did a mock drill and completed a hurricane drill. No documentation was located to support a tabletop activity, or a full-scale, community-based activity.	E 039		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) 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 the interdisciplinary team completed preliminary accurate assessments within 30 days after admission. This affected 1 of 2 newly admitted clients (#2). The finding is: Review on 6/19/23 of client #2's individual program plan (IPP) dated 12/30/22 revealed he was admitted to the facility 12/2/2022. Further review of client #2's record revealed no comprehensive functional assessment was obtained within 30 days of admission. Interview on 6/20/23 with the program manager confirmed that the team had not completed a comprehensive functional assessment within 30 days of admission.	W 210	A Community Home Life Assessment will be completed for Client #2. Completion of this assessment will be monitored by the Program Manager. Upon completion all staff will be inserviced on the recommendations of the Assessment. In the future, the Program Manager or designee will monitor completion of all required initial assessments through weekly chart reviews for the initial 30 days following admission.	8/19/2023
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	W 249		

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W 249	Continued From page 10 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 4 of 4 audit clients (#2, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program implementation. The findings are: A. Record review on 6/19/23 of client #2's IPP revealed formal training objectives for loading the dryer, brushing his teeth and cleaning his room. None of the training objectives had an implementation or target date. Further record review on 6/19/23 revealed staff were not training any of the formal objectives. B. During observations in the home on 6/19/23 client #5 assisted with meal prep at dinner and setting the table. Client #5 also folded laundry with staff assistance. Record review on 6/19/23 of client #5's program plan data book revealed formal training objectives for brushing his teeth with a target date of 11/30/20, cleaning his room with a target date of 10/31/19 and ironing his clothes with a target date of 11/31/20. Further record review on 6/19/23 revealed no formal training objectives had been updated since target dates were reached.	W 249	Formal objectives will be updated for all clients. All staff will be inserviced on the new objectives prior to implementation. Program Manager will implement CANC form F2.38, Training Objective Status Tracking, with all Qualified Professionals (QP). Program Manager will monitor completion and implementation of updated formal objectives through weekly chart reviews for 90 days. In the future, The Program Manager will monitor formal goal implementation through quarterly chart reviews.	8/19/2023

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W 249	Continued From page 11	W 249		

C. During observations in the home on 6/19/23 from 4:00pm-5:00pm, client #4 assisted with setting the table at dinner with staff prompting. Client #4 was also noted to participate in a bowling game with peers and staff.

Review on 6/19/23 of client #4's IPP, dated 3/21/23, revealed no formal objective training goals. However, review of client #4's digital training records on 6/19/23 revealed formal training objectives to include toothbrushing, unloading the dishwasher, bathing, money management, and participating in an activity with a target completion date of 12/14/22.

Review on 6/20/23 of the Qualified Intellectual Disabilities Professional (QIDP) Review Notes from Novemeber, 2022-June, 2023 revealed client #4 had regressed in all training objectives.

Further record review on 6/20/23 for client #6 revealed no revisions to objectives were made. In addition, no updated training objectives had been implemented since target dates were reached.

D. During observations in the home on 6/19/23 from 4:00pm-5:00pm, client #6 sat at the dining table alone, looking around and talking aloud to himself. Client #6 briefly sat with peers in the den area during a bowling game.

Review of client #6's IPP, dated 9/15/22, revealed no formal objective training goals. However, review of client #6's digital training records on

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W 249	Continued From page 12 6/19/23 revealed formal training objectives to include unloading the dishwasher with a target date of 3/3/23 and participating in a community event with a target completion date of 6/3/23. Further record review on 6/20/23 for client #6 revealed no updated training objectives had been implemented since target dates expired. Interview on 6/19/23 with the site supervisor revealed no updated objectives were implemented for clients #2, #4, #5, and #6. The site supervisor stated planning the objectives would be the responsibility of the Qualified Intellectual Disabilities Professional (QIDP). Interview on 6/19/23 with the QIDP revealed the facility is moving towards a digital format for recording data and goals were being placed in this system. When asked to locate goals within the digital system for clients #2, #4, #5, and #6, the QIDP stated the dates must have been entered incorrectly and there were no goals. The QIDP stated that clients should have goals toward independence with ongoing training opportunities. Interview on 6/20/23 with the Program Manager revealed there should have been updated training objectives to meet their needs, and objectives should be revised if clients regressed.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 4 of 4 audit clients (#2, #4, #5 and #6). The findings are: A. Review on 6/19/23 of client #2's record revealed a formal training program for loading the dryer with data to be collected 2 times per week, brushing his teeth with data to be collected each time the skill is used and cleaning his bedroom with data to be collected on 2nd shift. Review on 6/19/23 of client #2's program plan data revealed no data has been documented on any training programs. B. Review on 6/19//23 of client #5's program plan data book revealed a formal training program for brushing his teeth with data to be collected daily, ironing his clothes with data to be collected 1 time per week and cleaning his bedroom with data to be taken on Saturday. Review on 6/19/23 of client #5's program plan data revealed no data has been documented on any training programs. C. Review on 6/19/23 of client #4's digital training records revealed formal training objectives to include toothbrushing, unloading the dishwasher, bathing, money management, and participating in an activity with the targeted completion date of	W 252	Upon completion of updated formal objectives, all staff will be inserviced on how to implement each program and the documentation requirements for each program. Completion of data will be monitored by the Site Supervisor five times per week; the Area Supervisor twice a week; the QP once a week; the Program Manager every other week for 90 days. In the future, the Site Supervisor, Area Supervisor, QP and Program Manager will ensure documentation is completed as scheduled through weekly documentation reviews.	8/19/2023

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W 252	Continued From page 14 12/14/22. No training data could be located. Review on 6/19/23 of client #4's program plan data book revealed no data had been documented on any training programs. D. Review on 6/19/23 of client #6's digital training records revealed a formal training objective to include unloading the dishwasher with a target completion date of 3/3/23 and participating in a community event with a target date of 6/3/23. No training data could be located. Review on 6/19/23 of client #6's program plan data book revealed no data has been documented on any training programs Interview on 6/19/23 with staff A revealed goal documentation was kept in data books. Staff A stated "if goals and data are not in the book, it does not exist." Interview on 6/19/23 with staff B revealed staff "use to do specific training data but not now". Staff B stated that data is recorded in the digital training record on the computer when a client "does something, such as take out the trash" by staff writing a comment. Interview on 6/19/23 with the site supervisor revealed staff should record data in either the program plan data books or in the digital training record. However, the site supervisor stated only a few staff can access the digital format at this time. The site supervisor stated that she could not locate any data for clients #2, #4, #5, and #6. Interview on 6/19/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the	W 252		

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W 252	Continued From page 15 facility is moving towards a digital format for recording data. The QIDP acknowledge no data could be located in the digital training data format for clients #2, #4, #5, and #6. The QIDP stated the dates must have been entered incorrectly and resulted in no goals or data. The QIDP stated that clients should have goals toward independence with ongoing training opportunities with staff recording training data. Interview on 6/20/23 with the Program Manager revealed all clients should have data recorded for objective training to track progress.	W 252		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 audit clients (#4 and #6) objectives were reviewed and/or revised as needed, including when the target date had passed. The findings are: C. Review on 6/19/23 of client #4's IPP, dated 3/21/23, revealed no formal objective training goals. However, review of client #4's digital training records on 6/19/23 revealed formal training objectives for skills in toothbrushing, unloading the dishwasher, bathing, money management, and participating in an activity for targeted completion by 12/14/22.	W 255	All client's Individual Support Plans will be revised to reflect changes to the formal objectives. The Program Manager will Inservice the QP on updating The ISP as necessary. The Program Manager will monitor to ensure the revisions are completed through weekly chart reviews for 90 days. In the future, the Program Manager or designee will Monitor to ensure all Individual Support Plans are updated as needed through quarterly chart reviews.	8/19/2023

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W 255	Continued From page 16 Review on 6/20/23 of the QP Review revealed regression in the following areas from November, 2022 - June, 2023: Personal Goal - Regression Money Management - Regression Meal Prep - Regression Personal Hygiene - Regression Toothbrushing - Regression Review on 6/19/23 of client #4's program plan data book revealed no data has been documented on any training programs Review on 6/19/23 of client #4's digital training records revealed no data has been documented on any training programs. D. Review of client #6's IPP, dated 9/15/22, revealed no formal objective training goals. However, review of client #6's digital training records on 6/19/23 revealed formal training objectives for unloading the dishwasher, with a target of 3/3/23, and participating in a community event, with a target date of 6/3/23. No other goals were located. Review on 6/20/23 of the QP review revealed client #6's progress reviewed for four goals from October, 2022 - May, 2023. On 6/6/23, the QP review stated the following progress: Medication Goal - Satisfactory Progress at 90% Bathing Goal - Satisfactory Progress at 80% Money Management Goal - Satisfactory Progress at 65% Laundry Goal - Satisfactory Progress at 92% Review on 6/19/23 of client #6's program plan data book revealed no data has been	W 255		

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W 255	Continued From page 17 documented on any training programs. Review on 6/19/23 of client #6's digital training records revealed no data has been documented on any training programs. Interview on 6/20/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he asked the Site Supervisor how clients were doing to determine progress for client objective training during the conversation. When asked how he gained understanding of specific progress percentages, the QIDP stated he asked the Site Supervisor. Interview on 6/20/23 with the Program Manager revealed data is needed to correctly determine progress in training for clients and revision is needed is progress is not made.	W 255		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the comprehensive functional assessments (CFA) were updated as needed. This affected 1 of 4 audit clients (#5). The finding is: Record review on 6/20/23 revealed no comprehensive functional assessment could be located in client #5's chart. Interview on 6/20/23 with the program manager	W 259	A Community Home Life Assessment will be completed for client #5. The QP will ensure the assessment is completed, reviewed and filed in the record. Once completed, all staff will be inserviced on the recommendations from the assessment. The Program Manager will monitor completion and filing of assessments through weekly chart reviews for 90 days. In the future, the Program Manager or designee will ensure completion of required assessments by completing chart reviews at least quarterly.	8/19/2023

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W 259	Continued From page 18 revealed the CFA should be updated annually. The program manager confirmed that no CFA could be located for client #5.	W 259		
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 record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 4 audit clients (#2 and #5) was reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 6/19/23 of client #2's physician's orders dated 3/20/23 revealed the use of Seroquel daily and Lorazepam as needed for doctor visits. Further review on 6/19/23 of client #2's medication consent revealed no written consent by the HRC. B. Review on 6/19/23 of client #5's Behavior Support Plan (BSP) dated 9/3/22 revealed the use of Abilify, Clonidine, Fluoxetine, Hydroxyzine, Intuniv, Saphris and Olanzapine. Further review of client #5's medication consent form revealed no written consent by the HRC. Interview on 6/20//23 with the program manager revealed no written consent has been obtained for client #2 and #5 by the HRC..	W 262	Human Rights Consent will be obtained for all programs that involve risks to client protection and rights. Upon receipt, consents will be filed in the client's chart by the QP. The Program Manager will inservice the QP on ensuring appropriate consents are obtained prior to starting any new medications. The Program Manager will monitor completion of required consents through weekly chart reviews for 90 days. In the future, the Program Manager or designee will monitor completion of all required consents through chart reviews at least quarterly.	8/19/2023
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 19 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 observation, record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 4 audit clients (#2 and #5). The findings are: A. Review on 6/19/23 of client #2's revealed the client was currently hospitalized and had been hospitalized since 6/13/23. Review of client #2's physician's orders dated 3/20/23 revealed client #2 takes Seroquel 50mg at 7:00am, Seroquel 50mg at 8:00am and Seroquel 100mg at bedtime. Further review revealed no consent had been signed by the guardian for the use of Seroquel. B. During observations of the medication pass in the home on 6/20/23 at 7:23am, client #5 was observed consuming Guafacine ER 1mg, Abilify 10mg, Clonidine 0.1mg, Fluoxetine 40mg, Lybalvi 10mg and Saphris 10mg Review on 6/19/23 of client #5's Behavior Support Plan (BSP) dated 9/23/22 revealed target behaviors consisting physical aggression, inappropriate verbalizations and non-compliance. The BSP included the use of Abilify, Clonidine, Fluoxetine, Hydroxyzine, Intuniv, Olanzapine and Saphris. Further review revealed no consent had been	W 263	Guardian consent will be obtained for all medications being taken by the clients. Upon receipt, consents will be filed in the client's charts. The Program Manager will Inservice the QP on ensuring All consents are obtained Prior to starting new Medications. The Program Manager will monitor completion of required consent Through weekly chart reviews for 90 days. In the future, The Program Manager or designee will monitor completion of all required consents through chart reviews at least quarterly.	8/19/2023

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W 263	Continued From page 20 signed by the guardian for the use Lybalvi. Interview on 6/20/23 with the program manager revealed no written informed consent had been obtained for the use of Seroquel for client #2 and the use of Lybalvi for client #5. The program manager confirmed the consents should have been obtained by the guardians.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the interdisciplinary team (IDT) developed active treatment programs to use in conjunction with client's psychotropic medications for the reduction and/or elimination of restrictive behavior medications. This affected 1 of 4 audit clients (#2). The finding is: Review on 6/19/23 of client #2's individual program plan (IPP) dated 12/30/22 revealed he was admitted to the facility 12/2/22. Client #2's diagnoses are listed as seizure disorder, hyperlipidemia, aggressive behavior and dysphagia. Review on 6/20/23 of client #2's physician orders dated 3/20/23 revealed he receives Seroquel for psychiatric management. Review on 6/19/23 of client #2's record did not include a formal active treatment program to use	W 312	A Behavior Support Plan will be developed for Client #2. Prior to implementation, all staff will be trained on the BSP. Program Manager will monitor the development and implementation of the BSP through weekly chart reviews for 90 days. In the future, the Program Manager or designee will ensure all necessary active treatment programs are implemented through quarterly chart reviews.	8/19/2023

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W 312	Continued From page 21 in conjunction with his psychotropic medications. Interview on 6/20/23 with the program manager confirmed client #2 does not have a BSP in place at this time.	W 312		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills, per shift, at least quarterly. The finding is: Review on 6/19/23 of the facility's fire drill evacuation reports revealed for the time period of May 2022 through May 2023, no fire drills were conducted for Quarter 1 and Quarter 2 on any shift. Interview on 6/19/23 with the Site Supervisor revealed that the fire drills that were reviewed were the only drills completed to her knowledge. Interview on 6/20/23 with the Program Manager revealed fire drills should be performed on each shift quarterly.	W 440	All staff will be inserviced on completing drills according to the company schedule. Site Supervisor will conduct a drill with each staff to ensure understanding. QP will monitor completion of drills weekly for 90 days. In the future, the Program Manager will review drills monthly to ensure completion according to established company schedule.	8/19/2023
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure variances of times and conditions in scheduled fire drill evacuations. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The finding is:	W 441	All staff will be inserviced on completing drills according to company schedule. QP will monitor completion of drills weekly for 90 days. In the future, the Program Manager will review drills monthly to ensure completion of the drills according to the established schedule.	8/19/2023

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W 441	Continued From page 22 Review on 6/19/23 of fire drills dated 5/1/22 - 5/1/23 revealed the following 2nd shift drills: 8/6/22 1:00pm 9/4/22 1:30pm 2/11/23 1:00pm 3/4/23 1:00pm 3/12/23 1:30pm 4/8/23 1:35pm 5/20/23 12:35pm Further review on 6/19/23 of 3rd shift fire drills revealed three drills occuring between 10:15pm and 10:30pm. Interview on 6/20/23 with the Program Manager revealed fire drills should be conducted at varied time on each shift.	W 441		