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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		

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

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a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using

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a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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

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

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

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

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that

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

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

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared

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questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.
(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:
(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to conduct exercises to test the emergency preparedness plan (EPP) annually. The finding is:

Review of the facility EPP on 4/10/24 revealed no evidence of a full-scale community or facility-based exercise or a tabletop exercise to test the EPP.

Interview with the qualified intellectual disabilities professional (QIDP) on 4/10/24 revealed there

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E 039	Continued From page 9 has not been a full-scale community or facility-based exercise or a tabletop exercise to test the EPP.	E 039		
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, interviews, and record reviews, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in the individual habilitation plan (IHP) for 3 of 5 clients (#1, #3, and #4). The findings are: A. The facility failed to implement client #1's program goal relative to using sign language. For example: Observations in the group home on 4/9/24 at 4:15 PM revealed client #1 to participate in a block activity and staff to ask the client if she would like more blocks. Continued observations at 5:25 PM revealed client #1 to point and make sounds to request more salad and staff put more salad on the client's plate. Further observations at 5:27 PM revealed client #1 pointed at a serving bowl with salad and made sounds. Subsequent	W 249		

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observations revealed staff prompted the client to finish her salad already on her plate. At no time during observations was staff observed to prompt client #1 to use sign language to make her request for "more".

Review of records for client #1 on 4/10/24 revealed an IHP dated 3/19/24. Continued review of the IHP revealed a program goal for client #1 to request "more" using sign language for her request to staff with no more than three verbal prompts.

Interview on 4/10/24 with the qualified intellectual disabilities professional (QIDP) confirmed that client #1's IHP was current. Continued interview with the QIDP confirmed that staff should implement the client's current goals.

B. The facility failed to implement client #3's program goal relative to using a Big Mac. For example:

Observations in the group home on 4/9/24 at 5:06 PM revealed client #3 to participate in the dinner meal. Continued observations at 5:23 PM revealed client #3 to finish the dinner meal and exit the dining area. Further observations revealed client #3 to take her dirty dishes to the kitchen sink. Subsequent observations revealed that at no time was staff observed to provide client #3 with a Big Mac.

Observations in the group home on 4/10/24 at 8:15 AM revealed the home manager (HM) to ask client #3 if she had her morning coffee. Continued observations revealed that HM asked staff C to prepare the client's coffee. Further observations revealed that client #3 received a cup of coffee

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W 249	Continued From page 11 while sitting at the dining room table. Review of records for client #3 on 4/10/24 revealed an IHP dated 12/19/23. Continued review of the IHP revealed a program goal for client #3 to use the Big Mac to indicate "I'm finished" after eating a meal and to use the Big Mac to request "Please" when she would like to make her coffee. Interview on 4/10/24 with the QIDP confirmed that client #3's IHP was current. Continued interview with the QIDP confirmed that staff should implement the client's current goals. C. The facility failed to implement client #4's program relative to using a Big Mac. For example: Observations in the group home on 4/10/24 at 7:06 AM revealed client #4 to participate in the breakfast meal. Continued observations at 7:13 AM revealed client #4 to finish the breakfast meal and staff assisted the client to the kitchen with her dishes. Further observations revealed the client exited the kitchen and went to the bathroom with staff to brush her teeth. Subsequent observations revealed that at no time was staff observed to assist client #4 with her Big Mac. Review of records for client #4 on 4/10/23 revealed an IHP dated 12/7/23. Continued review of the IHP revealed a program goal for client #4 to utilize Big Mac to indicate "I'm finished" after mealtime. Interview on 4/10/24 with the QIDP confirmed that client #4's IHP was current. Continued interview with the QIDP confirmed that staff should	W 249		

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W 249	Continued From page 12 implement the client's current goals.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the system for drug administration failed to ensure all drugs were administered in compliance with physician orders for 4 of 5 clients (#1, #3, #4, and #5). The findings are: A. Observation on 4/10/24 at 7:45 AM revealed client #1 to enter the medication room with staff A. Continued observation revealed staff A to offer medications repeatedly to client #1 and client #1 to refuse the medications. Further observation at 8:05 AM revealed staff A to call staff D to the medication room and request that staff D administer the medications to client #1. Surveyor left the medication room in order to reduce stress on client #1, and subsequent observation revealed staff D to leave the medication room and report that client #1 had taken the meds. Record review on 4/10/24 revealed a physician's order for client #1 dated 2/8/24 which specifies that AM medications are to be administered at 7:00 AM. Interview with staff A, the home manager (HM), and the qualified intellectual disabilities professional (QIDP) on 4/10/24 confirmed that client #1's medication order is current and that all medications are to be administered within one hour of the prescribed administration time.	W 368		

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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
W 368	Continued From page 13 B. Observation on 4/10/24 at 8:36 AM revealed client #3 to enter the medication room with staff A. Continued observation revealed client #3 to receive medications from staff A and to leave the medication room at 8:41 AM. Record review on 4/10/24 revealed a physician's order for client #3 dated 3/22/24 which specifies that AM medications are to be administered at 7:00 AM. Interview with staff A, HM, and QIDP on 4/10/24 confirmed that client #3's medication order is current and that all medications are to be administered within one hour of the prescribed administration time. C. Observation on 4/10/24 at 9:38 AM revealed client #4 to enter the medication room with staff A. Continued observation revealed staff D to leave the medication room and report that client #4 had taken the meds. Record review on 4/10/24 revealed a physician's order for client #4 dated 2/8/24 which specifies that AM medications are to be administered at 7:00 AM. Interview with staff A, HM, and QIDP on 4/10/24 confirmed that client #4's medication order is current and that all medications are to be administered within one hour of the prescribed administration time. D. Observation on 4/10/24 at 9:16 AM revealed client #5 to enter the medication room with staff A. Continued observation revealed staff D to leave the medication room and report that client	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	04/10/2024

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W 368	Continued From page 14 #5 had taken the meds. Record review on 4/10/24 revealed a physician's order for client #5 dated 9/5/23 which specifies that AM medications are to be administered at 7:00 AM. Interview with staff A, HM, and QIDP on 4/10/24 confirmed that client #5's medication order is current and that all medications are to be administered within one hour of the prescribed administration time. Additional record review revealed a medication administration policy dated 11/13/18 which states, "Medication should always be administered within one (1) hour of the time it is prescribed, since it is essential that a particular level of certain drugs be maintained in the bloodstream.	W 368		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level of 3 of 5 clients (#1, #3, and #4). The findings are: A. The facility failed to ensure appropriate diet consistency for client #1. For example: Observations in the group home on 4/9/24 at 5:07 PM revealed the dinner meal to include hamburger, whole wheat bread, salad, fries, and ensure. Continued observations revealed staff to	W 474		

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W 474	Continued From page 15	W 474		

cut client #1's food consistent to bite size. Further observations revealed client #1 consumed the dinner meal with no further assistance from staff to provide the client with chopped meat.

Review of records for client #1 on 4/10/24 revealed a nutritional evaluation dated 2/15/24. Review of the nutritional evaluation for client #1 indicates that the client is prescribed a healthy heart, chopped meats diet with double portions at all meals.

Interview with the qualified intellectual disabilities professional (QIDP) and home manager (HM) on 4/10/24 confirmed client #1's diet as current. Continued interviews with the QIDP and HM confirmed that staff should ensure clients receive prescribed diets.

B. The facility failed to ensure appropriate diet consistency for client #3. For example:

Observations in the group home on 4/9/24 at 5:06 PM revealed the dinner meal to include hamburger, whole wheat bread, salad, fries, ketchup, and cranberry juice. Continued observations revealed staff to cut client #3's food consistent to bite size. Further observations revealed client #3 to consume the dinner meal with no further assistance to provide the client with a chopped diet.

Review of records for client #3 on 4/10/24 revealed a nutritional evaluation dated 2/15/24. Review of the nutritional evaluation for client #3 indicates that the client is prescribed a heart healthy, chopped diet, with ½ cup of vegetables for the afternoon snack.

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W 474	Continued From page 16 Interview with the QIDP and HM on 4/10/24 confirmed client #3's diet as current. Continued interview with the QIDP and HM confirmed that staff should ensure clients receive prescribed diets. C. The facility failed to ensure appropriate diet consistency for client #4. For example: Observations in the group home on 4/9/24 at 5:04 PM revealed the dinner meal to include hamburger, whole wheat bread, fries, ketchup, and cranberry juice. Continued observations revealed staff to cut client #4's food consistent to bite size. Further observations revealed client #4 to consume the dinner meal with no further assistance to provide the client with a chopped diet. Observations in the group home on 4/10/24 at 6:55 AM revealed the breakfast meal to include grits, diced bananas, a whole biscuit, water, and milk. Continued observations revealed staff to not assist client #4 to provide the client a chopped diet. Further observations at 7:09 AM revealed the client bit her whole biscuit with difficulty swallowing and staff continuously prompting the client to drink water. Review of records for client #4 on 4/10/24 revealed a nutritional evaluation dated 1/2023. Review of the nutritional evaluation for client #4 indicates that the client is prescribed a heart healthy, chopped diet, with double portions at breakfast, lunch, and dinner. Interview with the QIDP and HM on 4/10/24 confirmed client #4's diet as current. Continued interview with the QIDP and HM confirmed that	W 474		

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W 474	Continued From page 17 staff should have provided client #4 with a chopped diet.	W 474		