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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 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	RHA Health Services will ensure the facility is in compliance with all CMS guidelines as related to Emergency plans and supplies. IDT team will ensure all Emergency Preparedness Plan trainings are done correctly and with all current staff and as new staff are hired. All Drills will be returned and tracked at the main office as well as leaving a copy at the group home. All DSP's and RTL will be in-serviced on Emergency Drill's. Fire drills will be audited monthly in the corporate safety meeting for 3 months. RECEIVED JAN 17 2024 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Program Manager	1/16/24

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

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(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

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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: Th facBased on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially. The finding is: Review on 12/5/23 of the facility's EPP revealed no evidence of initial or biennial training on the EPP. Interview on 12/6/23 with the facility administrator verified that initial and biennial trainings for current staff had not been completed to her knowledge.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039	RHA Health Services will ensure the facility is in compliance with all CMS guidelines as related to Emergency plans and supplies. Program manager, Unit Clerk, RTL, and QP will ensure all Emergency Preparedness Plan trainings are done correctly and with all current staff and as new staff are hired. RHA will ensure that Pinebrook will hold an annual Tabletop training or Full disaster drill as required per CMS guidelines. All Drills will be returned and tracked at the main office as well as leaving a copy at the group home. All DSP's and RTL will be in-serviced on Emergency Drill's. Fire drills will be audited monthly in the corporate safety meeting for 3 months.	

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(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

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

*[For Hospices at 418.113(d):]

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

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or

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

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

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(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

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

(B) A mock disaster drill; or

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

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

*[For PACE at §460.84(d):]

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

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

(B) If the PACE experiences an actual natural or man-made emergency that requires activation of

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

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

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

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

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year.
The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

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

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not

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E 039	Continued From page 12 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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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 exercises to test the emergency preparedness plan (EPP) annually. For example, Review of the facility EPP revealed no evidence of a full-scale or community-based training exercise. Interview with the facility administrator confirmed that there has not been a full-scale or community- based exercise nor a tabletop exercise or mock drill to her knowledge.	E 039		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by:	W 125	RHA Health Services will ensure the facility is in compliance with all CMS guidelines in regard to Employee Training as it relates to clients rights. IDT Team will ensure that all employees have appropriate training required before working directly with clients and ensure training is up to date on an ongoing basis. Administrator/Program manager will Inservice staff on clients rights with an emphasis on freedom of movement. IDT team will ensure compliance by doing 2 interaction assessments a week for 60 days then on an ongoing basis.	

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W 125	Continued From page 14 W125Based on observations and interviews, the facility failed to ensure the rights of 1 of 6 clients (#6) were protected with respect to freedom of movement in their environment. The finding is: During observations in the vocational program and group home throughout the survey on 12/5/23 and 12/6/23, client #6 was observed to attempt to get up and walk around the day placement and the group home. Each time client #6 stood up and walked, staff told him to sit down. At times, staff physically redirected client #6 to sit in a chair or on the couch. Interview on 12/6/23 with the facility administrator and the habilitation specialist confirmed that client #6 should be able to move freely around his environment.	W 125		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the rights of 1 of 6 clients (#3) were protected with respect to privacy during care and treatment. The finding is: During observations in the group home on 12/5/23 staff were observed to move client #3 from his wheelchair to his shower chair inside the client's bedroom while client #3 was completely naked and the bedroom door open. Interview on 12/6/23 with the facility administrator and the habilitation specialist confirmed that client	W 130	RHA Health Services will ensure the facility is in compliance with all CMS guidelines in regard to Employee Training as it relates to clients rights. IDT Team will ensure that all employees have appropriate training required before working directly with clients and ensure training is up to date on an ongoing basis. Administrator/Program manager will Inservice staff on clients rights with an emphasis on Client privacy. IDT team will ensure compliance by doing 2 interaction assessments a week for 60 days then on an ongoing basis.	

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W 130		W 130		
	Continued From page 15 #3 should be given privacy during care and treatment.			
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure sufficient direct care staff were available to manage and supervise 6 of 6 clients in the home (#1, #2, #3, #4, #5 a #6) in accordance with their individual program plans. The finding is: Observations in the group home on 12/6/23 at 6:30 AM revealed Staff A to be on duty and supervising all 6 clients in the home (#1, #2, #3, #4, #5, and #6). Continued observation revealed that client #3 was awake and lying in his bed. Further observation revealed that Staff B arrived to the group home at 7:50 AM and Staff A left the group home at 7:53 AM. Subsequent observations revealed that Staff B began passing medications at 7:54 AM, at which point Staff B was in the medication room with client #6 and surveyor with the door closed and no other staff present in the home. Additional observations revealed that the alarm on client #2's bedroom door alerted at 8:07 AM, while Staff B was still in the medication room and no other staff were present. At that time, Staff B	W 186	RHA Health Services will ensure the facility is in compliance with all CMS guidelines in regard to appropriate staffing levels. IDT team will ensure appropriate levels of staffing at all times. Staffing coordinator has been put in place to ensure that client staff ratio is met per state guidelines. Administrator will review schedule weekly to ensure compliance for 60 days.	

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W 186	Continued From page 16 opened the medication room door, but did not go out of the room or see client #2, and directed client #2 to return to his bedroom. Review of records for client #2 revealed a person-centered plan (PCP) dated 4/11/23 which indicates that he requires line of sight supervision due to a history of absconding behavior. Continued review of records revealed current physical therapy evaluations for client #3 and client #4 which indicated they require 2-peson or mechanical transfers and are dependent on staff for all activities of daily living. Interview with the facility administrator confirmed the group home was not within the appropriate staff to client ratio based on identified needs of the facility between 6:30 AM and 8:18 AM on 12/6/23.	W 186		
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 clients received a continuous active treatment program consisting of needed interventions and services	W 249	RHA Health Services will ensure the facility is in compliance with all CMS guidelines. RHA will audit Pinebrook's PCP's within 60 days and update them as needed to bring them back into compliance. RHA will audit the PCP's on an ongoing basis through our biannual review process and again with our annual QA review.	

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W 249		W 249		

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as identified in the Person-Centered Plan (PCP) for 4 of 6 clients (#2, #3, and #6) relative to implementing training objectives and providing adaptive equipment. The findings are:

A. The facility failed to provide prescribed adaptive equipment necessary to maintain client #2's safety. For example:

Observations in the group home and vocational center on 12/5/23 and 12/6/23 revealed client #1 to be without the Angel Watch device which alerts staff whenever client #2 leaves a supervised area. Further observation revealed client #2 to leave the group home alone 1t 5:33 PM on 12/5/23 to take out the trash and to leave the vocational center alone at approximately 12:45 PM on 12/6/23, again to take items to the trash.

Record review on 12/5/23 revealed a person-centered plan (PCP) dated 4/11/23 for client #2 which describes a history of client #2 absconding from various caregivers and displaying opportunistic behaviors in order to avoid detection. Continued record review revealed that the PCP calls for the use of a watch device which monitors client #2's movements and notifies staff when he has left an area of supervision. The PCP states that this device is to be worn by client #2 during all waking hours.

Interview with the facility administrator confirmed that client #2's PCP is current, and that staff should ensure that client #2 is wearing the Angel Watch device for his safety during all waking hours.

B. The facility failed to provide meaningful activities or implement training objectives for

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client #3 during large amounts of unstructured leisure time. For example:

Observations in the group home on 12/5/23 revealed client #3 to be seated in his wheelchair which was parked in the living room facing the television. Continued observation revealed client #1 to remain in that situation from 4:30 PM until 6:11 PM, except for a 22-minute period when staff wheeled him to the dining room where he ate dinner. Further observation revealed staff had minimal interaction with client #3 during that same period and did not offer him any of his preferred items or activities. Additional observation revealed that client #3 is unable to propel his wheelchair independently and depends on staff for all needs.

Observation in the group home on 12/6/23 from 6:30 AM until 8:50 AM revealed client #3 to be in his bed awake and drinking from a baby bottle. At 8:50 AM, staff used a 2-person lift to move client #2 from his bed to his wheelchair, then placed client #3 in the living room in front of the television, where he remained until 9:15 AM. Client #3 then ate his breakfast in the dining room before staff returned him to the living room in front of the television until the end of the observation at 9:30 AM. Further observation revealed staff had minimal interaction with client #3 during that same period and did not offer him any of his preferred items or activities.

Record review on 12/5/23 revealed a PCP for client #3 dated 7/31/23 which indicates that client #3 enjoys tablet games, music, board games, and interactive learning toys. Continued record review revealed a specific training objective to say the names of shapes and colors with the use

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W 249		W 249		

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flashcards.

Interview with the facility administrator confirmed that client #3's PCP is current, and that staff should assist client #3 to access his preferred items and activities and should consistently train client #3's goals and objectives.

C. The facility failed to provide meaningful activities or implement training objectives for client #6 during large amounts of unstructured leisure time. For example:

Observations in the group home on 12/5/23 revealed client #6 to be seated in the living room facing the television which was playing a movie. Continued observation revealed client #6 to remain in that situation from 4:30 PM until 5:00 PM, when he ate his dinner in the dining room. Immediately after finishing his meal, client #6 was directed to sit on the couch and was not allowed to go to his bedroom. Further observation revealed client #6 to repeatedly get up from the couch and staff to repeatedly direct client #5 to sit back down until 5:55 PM, when client #6 went to take a shower. Subsequent observation revealed that when client #5 returned from the shower at 6:08 PM, he was again directed to sit on the couch and remained there until the end of observations at 6:30 PM.

Observations in the group home on 12/5/23 revealed client #6 to be out of bed and dressed at 7:56 AM, and to be directed by staff to sit in a specific chair and wait to be called into the medication room. Continued observation revealed client #6 to be seated in the living room at the direction of staff from 8:18 AM until the end of morning observations at 9:30 AM, except for 10

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W 249		W 249		

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minutes during which he ate breakfast in the dining room. Further observations revealed that every time client #6 attempted to get up from the couch, staff redirected him to sit back down. On one occasion, client #6 went to the kitchen and requested coffee and was, again, told to sit down and wait for it. Additional observations revealed that no staff used a visual schedule with client #6 at any time during the observation period, nor was one visible in the group home.

Record review on 12/5/23 revealed a PCP for client #6 dated 11/15/23 which includes goals of thoroughly washing hands after toileting, participating in oral hygiene with staff assist, participating in community outings twice per month, hanging up to 5 shirts in his closet, making his bed, and making his morning coffee with staff assist. The PCP further states, "Staff should routinely structure client #6's day, via a series of pictures displayed on a board. Staff should use the prompt, 'check your schedule,' to assist client #6 through his daily routine. Seek to incorporate preferred leisure activities and items into daily routine, as part of the schedule."

Interview with Staff A on 12/5/23 revealed that client #6 communicates with staff mostly by pointing and that there is no visual communication tool available in the home at this time.

Interview with the facility administrator confirmed that client #6's PCP is current. Continued interview confirmed that staff should assist client #6 to use a visual schedule as part of his daily routine and that they should offer client #6 opportunities for meaningful engagement with preferred leisure activities and items, and train

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W 249	Continued From page 21 client #6 on his identified objectives and goals.	W 249		
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 ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: A review of the facility fire drill reports on 12/5/23 revealed that between 12/1/22 and 11/3/23, the facility conducted 12 fire drills, but that of those, only one occurred on third shift. All other drills were conducted between 9:00 AM and 4:02 PM. Interview with the facility administrator on 12/6/23 confirmed fire drills should have been conducted quarterly for each shift of personnel.	W 440	RHA Health Services will ensure the facility is in compliance with all CMS guidelines as related to Emergency plans and supplies. IDT Team will ensure all Evacuation Drill trainings are done correctly and with all current staff and as new staff are hired. All Drills will be returned and tracked at the main office as well as leaving a copy at the group home. All DSP's and RTL will be in-serviced on Emergency Drill's. Fire drills will be audited monthly in the corporate safety meeting for 3 months.	
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 interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets of 4 of 6 clients (#2, #3, #5 and #6) during 2 out of 2 meals observed. The findings are: A. The facility failed to ensure the prescribed diet for client #2. For example: Observations in the group home on 12/5/23 at 5:00 PM revealed the dinner meal to be individual	W 474	RHA Health Services will ensure the facility is in compliance with all CMS guidelines. Hab Spec will Inservice appropriate meal time guidelines as it relates to food consistency. IDT team will ensure compliance by doing biweekly meal time assessments for 60 days and on an ongoing basis moving forward.	

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W 474		W 474		

Continued From page 22 chicken pot pie, green beans, and rice pilaf. Continued observations revealed staff to serve a whole pot pie, whole green beans and rice pilaf to client #2, and client #2 to consume all items without staff cutting up or modifying the food in any manner.

Observations on 12/6/23 revealed the breakfast meal to consist of oatmeal, sliced bacon and toast. Continued observations revealed staff to serve oatmeal and whole slices of bacon to client #2, and client #1 to consume all items without staff cutting up or modifying the bacon in any manner.

Record review on 12/5/23 revealed a person-centered plan (PCP) for client #2 dated 4/1/23 stating that client #2 is currently on a regular diet and requires meats to be cut to 1/2" consistency.

Interview with the Facility Administrator confirmed that client #2's pot pie and bacon should have been modified to 1/4" consistency.

B. The facility failed to ensure the prescribed diet for client #3. For example:

Observations of the same dinner meal revealed staff to serve a whole pot pie, whole green beans and rice pilaf to client #3, and client #3 to consume all items without staff cutting up or modifying the food in any manner.

Observations on 12/6/23 of the same breakfast meal revealed staff to serve a whole slice of toast and whole slices of bacon to client #3, and client #3 to consume all items without staff cutting up or modifying the food in any manner.

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Record review on 12/5/23 revealed a person-centered plan (PCP) for client #2 dated 7/31/23 stating that client #3 is currently on a regular diet and requires 1/2" consistency for all foods except finger foods.

Interview with the Facility Administrator confirmed that client #3 should have been provided with a 1/2" consistency diet for all non-finger foods.

C. The facility failed to ensure the prescribed diet for client #5. For example:

Observations of the same dinner meal revealed staff to serve a whole pot pie, whole green beans and rice pilaf to client #5, and client #5 to consume all items without staff cutting up or modifying the food in any manner.

Observations on 12/6/23 of the same breakfast meal revealed staff to serve oatmeal and whole slices of bacon to client #5, and client #5 to consume all items without staff cutting up or modifying the food in any manner.

Record review on 12/5/23 revealed a person-centered plan (PCP) for client #4 dated 5/29/23 stating that client #5 is currently on a heart healthy diet and requires ground consistency for all foods.

Interview with the Facility Administrator confirmed that client #5 should have been provided with a ground consistency diet for all foods.

D. The facility failed to ensure the prescribed diet for client #6. For example:

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W 474	Continued From page 24 Observations of the same dinner meal revealed staff to serve a whole pot pie, whole green beans and rice pilaf to client #6, and client #6 to consume all items without staff cutting up or modifying the food in any manner. Observations on 12/6/23 of the same breakfast meal revealed staff to serve oatmeal and whole slices of bacon to client #6, and client #6 to consume all items without staff cutting up or modifying the food in any manner. Record review on 12/5/23 revealed a person-centered plan (PCP) for client #6 dated 11/15/23 stating that client #6 is currently on a heart healthy diet and requires ¼" consistency for all foods. Interview with the Facility Administrator confirmed that client #6 should have been provided with a ground consistency diet for all foods.	W 474		