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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 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		

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

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E 018	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	E 018		

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E 018	Continued From page 2 failed to develop a system to track clients and staff in the event, their emergency preparedness (EP) plan had to be implemented. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 7/2/24 of the facility's EP plan dated 5/16/24 revealed there were no details for the clients residing in the home and current staff. Interview on 7/2/24 with the Home Manager (HM) revealed most of the direct care professionals working in the home, were recently hired. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the EP plan lacked information on the clients in the home. The QIDP revealed staff used a computer program where the information could be retrieved, however, she acknowledged there was no reference to review electronic records within the EP plan.	E 018		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the	E 030		

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E 030	Continued From page 3 following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		

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E 030	Continued From page 4 (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a system to identify clients and guardians in their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:	E 030		

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E 030	Continued From page 5 Review on 7/2/24 of the facility's EP plan dated 5/16/24 revealed there were no details that listed the names of all clients and the contact information of their guardians. Interview on 7/2/24 with the Home Manager (HM) revealed most of the direct care professionals working in the home, were recently hired. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the EP plan lacked information on the clients and their guardians. The QIDP revealed staff used a computer program where the information could be retrieved, however, she acknowledged there was no reference to review electronic records within the EP plan.	E 030		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the	E 036		

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emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient

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E 036	Continued From page 7 orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency medical records storage system, as part of their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 7/2/24 of the facility's EP plan dated 5/16/24 revealed there were no details that listed the clients' medical diagnoses, physician's orders and medications to be dispensed during an emergency. Interview on 7/2/24 with the Home Manager (HM) revealed most of the direct care professionals working in the home were recently hired. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the EP plan lacked information on the clients' medical conditions and physician's orders. The QIDP revealed staff used a computer program where the information could be retrieved, however, she acknowledged there was no reference to review electronic records within the EP plan.	E 036		
E 037	EP Training Program CFR(s): 483.475(d)(1)	E 037		

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E 037	Continued From page 8 §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. (ii) Demonstrate staff knowledge of emergency	E 037		

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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 policies and procedures to all new and existing

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E 037	Continued From page 10 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. (ii) Provide emergency preparedness training at	E 037		

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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.

*[For CMHCs at §485.920(d):] (1) Training. The

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E 037	Continued From page 12 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure new staff received emergency preparedness (EP) plan training upon hire. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Record review on 7/2/24 of the facility's EP plan training dated 5/16/24 revealed there was no evidence of the five new staff (Staff A, Staff C, Staff E, Staff F and Staff G working in the home, receiving their initial EP plan training. Interview on 7/2/24 with the Home Manager and the Supervisor revealed they had new staff in the home with less than 30 days experience. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the home had experienced turnover with staffing over the year and both the Home Manager and most of the staff were new in their roles. The QIDP revealed they hoped to get back on track now that vacancies have been filled.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2)	E 039		

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E 039	Continued From page 13 §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 a facilitator and includes a group discussion using	E 039		

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E 039	Continued From page 14 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 a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 15 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. *[For PRFTs at §441.184(d), Hospitals at	E 039		

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E 039	Continued From page 16 §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):] (2) Testing. The PACE organization must conduct	E 039		

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E 039	Continued From page 17 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 test the emergency plan at least twice per year,	E 039		

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E 039	Continued From page 18 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 is community-based; or	E 039		

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E 039	Continued From page 19 (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. (B) If the HHA experiences an actual natural	E 039		

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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 questions designed to challenge an emergency

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E 039	Continued From page 21 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 interview, the facility failed to conduct a table top exercise and/or disaster drills to test their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 7/2/24 of the facility's EP dated 5/16/24 revealed the facility had a pandemic policy and had recently implemented it when several staff and clients developed COVID-19 in May 2024. There was no evidence of disaster drills or a table top exercise.	E 039		

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E 039	Continued From page 22 Interview on 7/2/24 with the Home Manager and the Supervisor revealed they were recently promoted to their positions and were not involved in conducting exercises or drills for the home. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she did not have any evidence of a table top or disaster drills were conducted.	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, record review and interview, the facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services regarding assisting with meal preparation and medication administration; encouragement for family style dining opportunities at meals and clearing dishes. The findings are: A. Observation in the home on 7/1/24 at 4:08pm, Staff B was in the kitchen with client #4 who sat in a wheelchair at the counter. During the	W 249		

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preparation, clients #1 and #2 came to the kitchen, sat down in chairs and watched Staff B cooked. Staff B was observed to remove food from the cabinets and refrigerator before using a can opener to open a can of corn and empty it in a pot on the stove. Staff B placed all garbage in the trash can, removed a baking sheet from a bottom cabinet and took aluminum foil out of cabinet to line the baking sheet. Clients #1, #2 or #4 were not encouraged to participate in the meal preparation.

B. Observation in the home on 7/1/24 at 5:10pm, client #1 brought dirty dishes to the table and placed them in the sink. Staff D took the dirty plate, rinsed it off and loaded it in the dishwasher for client #1.

C. Observation in the home on 7/1/24 between 4:50pm and 5:15pm, Staff B and Staff F brought cups with milk and water to the table to serve to each client. There were no pitchers present on the table, to give clients the opportunity to pour their own drinks or to pass the pitcher to others.

D. Observation in the home on 7/2/24 between 7:30am to 7:55am, Staff F poured cups of water for clients #2, #3 and #5 who were getting medications.

Record review on 7/2/24 of client #3's Direct Support Evaluation (DSE) from 5/9/23 revealed he was independent with eating and drinking.

Record review on 7/2/24 of client #4's DSE from 5/9/23 revealed client #4 had the ability to serve himself food with limited to no assistance from staff; and could drink with no assistance.

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W 249	Continued From page 24 Interview on 7/2/24 with the Home Manager (HM) revealed staff had a "bad habit of serving clients" and clients should be able to participate. The HM acknowledged client #1 liked to help prepare meals and client #4 could assist with hand over hand participation. The HM also revealed the clients should be given the opportunity to pour their drinks and to load the dishwasher. Interview on 7/2/24 with the qualified intellectual disabilities professional (QIDP) revealed there has been a turnover with staffing the home manager four times and that it affected their assessments not being done. The QIDP acknowledged the clients should participate with meal preparation and family style dining, when possible. The QIDP revealed the facility has small beverage pitchers to assist the clients with pouring. The QIDP revealed she was not aware of client #4 having trouble with scooping his food, however, the directions for placement should be followed, to assist with independent feeding.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure staff maintained positive interactions with clients. This affected 2 of 6 audit clients (#1 and #6). The findings are: A. During dinner observations in the home on 7/1/24 at 5:00pm, client #6 received baked fish with tomato sauce, sweet potatoes, corn and a	W 268		

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W 268	Continued From page 25 pasta salad for dinner. Staff B noticed client #6 was not eating his fish. Staff B was observed saying to client #6, "I cooked what's on the menu. If you do not like it, that's on you." B. During morning observations in the home on 7/2/24 at 8:39am, the clients and staff had assembled in the living getting ready to leave for the day program. Client #1 was conversing with Staff A about working on a lawn crew. Staff A was overheard saying to client #1, "You cannot work on a lawn mower, you do not have a brain." Client #1 responded to Staff A, "Why you pick on me?". Record review on 7/2/24 of Minutes from the facility's Team Meeting on 3/6/24 revealed the Home Manager (HM) discussing with staff, their values "we care about people" and "we build relationships." Staff B had recently completed training on "Our Values" on 6/5/24. Interview on 7/2/24 with the HM revealed there were new staff working in the home, however, Staff B was on of the training lead for direct support professionals. The HM revealed all staff have to take orientation and receive training on client rights, where dignity and normalization are promoted. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed all new staff must receive training during orientation and it was not acceptable to talk to clients in the matter that was observed.	W 268		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with	W 340		

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W 340	Continued From page 26	W 340		

other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.
This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure staff were trained to afford each client privacy while administering medications; and that staff were trained to prepare medications in the presence of the client. This affected 3 of 6 of audited clients (#2, #3 and #6). The findings are:

A. Observations in the home on 7/1/24 at 3:05pm revealed Staff A prepared a cup of medications for client #2 who was not present in the medication room. Staff A left the home and went to the porch, where client #2 sat and gave him medications to ingest.

An additional observation in the home on 7/2/24 at 7:51am, revealed client #2 using his rollator walker to head to the kitchen, after getting up. Staff F wanted client #2 to come into the room to take his medication, however Staff A commented to Staff F client #2 needed to put on clothes and he was taking him to the bathroom. Staff F prepared medication, without client #2 being present, went to the bathroom and opened the door, without knocking, while client #2 sat on the toilet nude. The door to the bathroom was not closed while client #2 ingested his medication.

B. Observations in the home on 7/2/24 at 7:30am revealed Staff F removed 3 pills from blister packs without client #3 present. Client #3 entered the room at 7:31am and ingested his medications and then received his inhaler and spray for his

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nostril. Staff F did not prompt client #3 to rinse out his mouth after using the inhaler. The door to the medication room was left ajar while the medications were given.

C. Observations in the home on 7/2/24 at 7:55am revealed Staff F preparing medications to give to client #2 with the door left open to the medication room. Client #5, who had just received his medication, returned to the room to "hang out" with Staff F. Client #1 also entered the room to ask Staff F a question.

D. Observations in the home on 7/2/24 at 8:28am, Staff F went to the living room, where client #4 sat with other clients waiting for transportation to work, and sprayed his medication up his nose.

Interview with Staff A on 7/1/24 revealed he takes medication to client #2 instead of asking him to come to the medication because he was not always cooperative.

Interview with Staff F on 7/2/24 revealed he prepared medications without the clients being present because they become inpatient and do not want to wait to pop the pills out of the back. Staff F also revealed client #2 wants to sleep in so he received his medications last. Staff F also revealed because client #2 needs to take his medication 30 minutes before eating breakfast, he takes the medication to him in the bathroom.

Interview with the Home Manager (HM) on 7/2/24 revealed she was trained by the nurse in May 2024 on medication administration practices. During her certification, the home was experiencing COVID-19 and they did not require

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W 340	Continued From page 28 clients to come to the medication room. The HM revealed she trained Staff A on medication administration and gave him clearance to give client #2 his medication outside of the medication room, including the bathroom. Interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed most of the staff working in the home were new and recently certified to pass medications. The QIDP acknowledged when she gave medications in the morning she had each client come to the medication room to take them. The QIDP also revealed clients should have privacy when getting medication and there was no reason to give medications while clients sat on toilet.	W 340		
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 staff interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. This had the potential to affect 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The finding is: Record review on 7/2/24 of the facility's fire drills log from September 2023-March 2024 revealed the following: On 9/18/23 at 10:48pm On 9/28/23 at 6:00pm On 3/21/24 at 4:45am On 3/27/24 at 4:19pm On 3/30/24 at 12:30am Interview on 7/2/24 with Staff A revealed he was	W 440		

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W 440	Continued From page 29 a new employee who started a month ago and has not participated in a fire drill. Interview on 7/2/24 with the Home Manager revealed she started her position in April 2024 and has not conducted fire drills for the home. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they were behind with their fire drills due to turnover of staff in the home.	W 440		
W 454	INFECTION CONTROL CFR(s): 483.470(I)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a sanitary environment in the home. This had the potential to effect 6 of 6 audit clients. The finding is: During observations in the home, during the survey on July 1-2, 2024, there was a noticeable urine odor in the living room, half bathroom and medication room. There were no noticeable stains on the furnishings and none of the clients appeared to be incontinent, creating the odor. Record Review on 7/2/24 of the home's Team Meeting Minutes from 3/6/24 revealed third shift staff were expected to deep clean the common areas, which included mopping up spills. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed when	W 454		

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W 454	Continued From page 30 she works in the home, she wipes down the living room furniture because she had previously detected an odor in the room. The QIDP acknowledged the odors may originate in the carpet.	W 454		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure food was served at the proper temperature for 1 of 6 audit clients (#2). The finding include: During morning observations in the home, on 7/2/24 at 7:30am, Staff A prepared oatmeal, fruit salad and turkey links for breakfast. The clients were coming to the dining table, to eat after getting their medications. An additional observation at 8:00am, revealed client #2's uncovered plate and coffee, placed on the table The side of the coffee mug was touched by the surveyor and it was luke warm temperature. At 7:50am, client #2 began his morning routine; toileted, took his medications, showered and dressed before coming to sit down at the table at 8:55am to eat his breakfast. Staff A did not offer to reheat his food. Client #2 was observed to drink half of his coffee and turkey links. Record review on 7/2/24 of the facility's Safety and Environment of Care Manual revealed proper handling and storage of food products will help to prevent food-borne illness. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff	W 473		

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W 473	Continued From page 31 should keep the food on a heat source until the client is ready to eat.	W 473		