STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BUILDING _____ B. WING _____	R 07/16/2024

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{E 037}	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	{E 037}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{E 037}	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	{E 037}		

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{E 037}	Continued From page 2 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.	{E 037}		

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{E 037}	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	{E 037}		

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{E 037}	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) plan. The finding is: Review on 5/6/24 of the facility's EP manual (4/23) did not include any information regarding training of staff. During an interview on 5/7/24, the management staff confirmed staff have not been trained in regards to the EP plan. A follow up visit was conducted on 7/16/24: During an interview on 7/16/24, the Qualified Intellectual Disabilities Professional (QIDP) stated staff have not been trained in regards to the EP plan.	{E 037}		
{W 000}	INITIAL COMMENTS A revisit was conducted on 7/16/24 for all previous deficiencies cited on 5/7/24. All deficiencies were not corrected and no new non-compliance was found. The facility is not in compliance with all regulations surveyed.	{W 000}		

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{W 189}	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in the documentation of incidents/accidents and medication administration. This affected 2 of 3 audit clients (#3 and #5). The findings are: A. During observations in the home on 5/6/24, client #3 was observed to have a right swollen eye and a right swollen bottom lip. During an interview on 5/6/24, Staff A revealed that on 5/4/24 client #3 had fallen in the home after he spilled some water while walking to the dining from his bedroom. Further interview revealed Staff A did not document the incident because she personally did not witness it. During an interview on 5/6/24, Staff B revealed he had went into client #3's bedroom on 5/4/24 to get him up for dinner. Client #3 had a cup filled with water on his nightstand, which he grabbed and rushed quickly to the kitchen for dinner. Staff B stated that some of the water spilled while client #3 was quickly walking into the dining room and that is when client #3 fell. Additional interview revealed Staff B does not have access to the computer system to write the incident report, so he could not enter it. Staff B also revealed he did not write anything down in the homes' day book, to inform other staff what had happened. During an interview on 5/6/24, Staff D stated staff	{W 189}		

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{W 189}	Continued From page 6	{W 189}		

are to document all incidents in the homes' computer system before the end of their shift.

During an interview on 5/6/24, the Program Manager revealed staff are to document in the homes' computer system all incident/accident reports.

Review on 5/7/24 of the facility's Incident Reporting policy (11/11/13) states. "An incident report will be completed for any event which is not consistent with the routine operation of a program or the routine care of the person served". Further review indicated, "Community Innovations staff with the most knowledge regarding the incident should complete the Internal incident reporting form....".

During an interview on 5/6/24, the facility's nurse stated staff are to document incidents/accidents in the homes' computer system incident form.

B. During observations on 5/6/24 of the electronic Medication Administration Record (MAR), it was revealed there was no documentation in the facility's computer system indicating whether client #5 received his 8pm medications for 5/5/24.

During an interview on 5/6/24, Staff A who was the medication technician on 5/5/24, stated she had been trained on the documentation of the MAR. Further interview revealed Staff A must have forgotten to sign off on the MAR.

During an interview on 5/6/24, the facility's nurse revealed staff have been inserviced on how to document in the MAR.

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{W 189}	Continued From page 7 C. During medication administration in the home on 5/7/24 at 7:27am, client #5 took a medication cup with prescribed mouthwash out of the medication room and shut the door. Further observations revealed Staff C did not go with client #5 when he exited the medication room. During an interview on 5/7/24, Staff C revealed he should have went with client #5 to ensure he used the mouthwash as prescribed. During an interview on 5/7/24, management staff confirmed Staff C should have exited to medication room and observed client #5 using his mouthwash as prescribed. During an interview on 5/7/24, the facility's nurse stated Staff C should have left the medication room and observed client #5 using his mouthwash as prescribed. A follow up visit was conducted on 7/16/24: During an interview on 7/16/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed Regional Management Staff have not been re-trained on how to report incidents according to the company's Incident Reporting Policy.	{W 189}		
{W 248}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by:	{W 248}		

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{W 248}	Continued From page 8 Based on record reviews and interviews, the facility failed to ensure current Individual Program Plan (IPP) were available to all relevant staff. This affected 1 of 3 audit client (#3). The finding is: Record review on 5/6/24 of client #3's record revealed there was no IPP from 2023 available to all relevant staff. During an interview on 5/7/24, the management staff confirmed client #3 did not have a current IPP. A follow up visit was conducted on 7/16/24: During an interview on 7/16/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed the Clinical Supervisor had not monitored all programs and ensured the current IPP's are available for staff reference.	{W 248}		
{W 263}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#3). The finding is: Review on 5/6/24 of client #3's Behavior Support Plan (BSP) revealed there was no signed consent by his legal guardian.	{W 263}		

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{W 263}	Continued From page 9 During an interview on 5/7/24, the management staff confirmed client #3 does not have a signed consent by his legal guardian. A follow up visit was conducted on 7/16/24: During an interview on 7/16/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed the Clinical Director has not reviewed all records and ensured there is a current signed consent for all BSP's.	{W 263}		
{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 review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at least quarterly for each shift. This potentially affected all clients (#1, #2, #3, #4 and #5) residing in the home. The finding is: Review on 5/6/24 of the facility's fire drills revealed there were no fire drills documented in 2024. During an interview on 5/7/24, the management staff confirmed there were no documented fire drills for 2024. A follow up visit was conducted on 7/16/24: During an interview on 7/16/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed the Regional Manager has not reviewed with the team weekly on the importance of	{W 440}		

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{W 440}	Continued From page 10 conducting evacuation drills at least quarterly. Further interview revealed the Clinical Supervisor did not re-inservice the Program Manager regarding the requirements to conduct evacuation drills at least quarterly per shift.	{W 440}		