| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| FANJOY HOME #2 | 450 TWIN OAKS ROAD STATESVILLE, NC 28625 |

| (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 |
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| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>§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).<br><br>*[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:]<br>(1) Training program. The [facility] must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(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 | E037<br><br>The Qualified Professional and Safety Chairperson will update the Emergency Preparedness Plan. The Qualified Professional will train all staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan every 6 months to ensure it remains updated and staff are trained. The Program Manager and Safety Chairperson will organize and complete a tabletop exercise. The Safety Chairperson will monitor to ensure tabletop exercises are completed at least on an annual basis. In the future, the Regional Administrator will ensure tabletop exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plan is updated and staff are trained on the current plan and training conducted annually. | 5/25/25 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | DD Regional Administrator 4/1/25 | |

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<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(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.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness | E 037 | | |

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| E 037 | Continued From page 2<br>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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(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<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(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<br>*[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.<br>This STANDARD is not met as evidenced by:<br>Based 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:<br><br>Review of the facility's EPP on 3/25/25 revealed no evidence of initial and biennial staff training on the EPP.<br><br>Interview with the qualified intellectual disability professional on 3/26/25 confirmed there is no evidence of initial and biennial staff training on the EPP. | E 037 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>§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).<br><br>*[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 | E 039<br>Cross reference E 037 | 5/25/25 |

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| E 039 | Continued From page 5<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For Hospices at 418.113(d):] | E 039 | | |

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| E 039 | Continued From page 6<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br><br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or | E 039 | | |

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| E 039 | Continued From page 7<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or | E 039 | | |

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| E 039 | Continued From page 8<br>(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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of | E 039 | | |

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| E 039 | Continued From page 9<br>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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that | E 039 | | |

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| E 039 | Continued From page 10<br>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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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. | E 039 | | |

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| E 039 | Continued From page 11<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(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.<br>(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 | E 039 | | |

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| | 34G081 | A. BUILDING _____ B. WING _____ | 03/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| E 039 | Continued From page 12<br>limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(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.<br>(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<br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct biennial testing of the facility's Emergency Preparedness Plan (EPP). The finding is:<br><br>Review of the facility's EPP on 3/25/25 revealed a table top exercise dated 3/15/24. Continued review revealed no evidence of an additional full-scale community/facility-based exercise.<br><br>Interview with the qualified intellectual disability professional on 3/26/25 confirmed the facility has not conducted a full-scale community/facility-based exercise within the last two years. | E 039 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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 | W 249 | | |

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| W 249 | Continued From page 14<br>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure that 1 of 6 clients (#1) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to mealtime supervision. The finding is:<br><br>Evening observations in the group home on 3/25/25 revealed client #1 to participate in the evening meal which consisted of pepper steak, rice, and collard greens. Further observation revealed client #1 to consume the meal independently. Continued observations revealed that 3 staff were present in the dining room during the evening meal and that the staff were all actively monitoring client #2 and client #5 at the opposite end of the table from client #1. Subsequent observation revealed that client #1 ate his meal in 7 minutes with no prompting by staff to slow his rate of eating, chew his food well, or swallow before taking another bite.<br><br>Morning observations in the group home on 3/26/25 revealed client #1 to participate in the breakfast meal which consisted of turkey bacon, toast and banana. Further observation revealed client #1 to consume the meal independently. Continued observations revealed that no staff were present in the dining room while client #1 ate his breakfast, therefore, no staff prompted client #1 to slow his rate of eating, chew his food | W 249 | W 249<br><br>The Qualified Professional will in-service all staff one diet orders for People Supported. The clinical team will monitor through meal time assessments 2x a week for a period of 30 days and then on a routine basis to ensure diet orders are followed properly. In the future, the Qualified Professional will ensure all staff are trained on diet orders of People Supported. | 5/25/25 |

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| W 249 | Continued From page 15<br>well, or swallow before taking another bite.<br><br>Review of records revealed a Person-Centered Plan (PCP) dated 1/17/25 which states, "Diet is Heart Healthy, ½" consistency meats, 1" consistency all other foods. 1:1 monitoring while eating, encourage him to chew and swallow well before taking the next bite."<br><br>Interview with the qualified intellectual disabilities professional (QIDP) confirmed that client #1's PCP is current and that staff should have provided 1:1 supervision of client #1 and prompted him to slow his rate of eating. | W 249 | | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 client (#3) observed during medication administration. The finding is:<br><br>During observations in the home on 3/26/25 at 6:30 am, client #3 was observed to participate in the morning medication administration. Among the medications administered at that time was Mupirocin 2% cream. Further observation revealed staff to apply the Mupirocin cream to client #3's left and right big toes without using peroxide or any other agent to cleanse the area prior to applying the cream.<br><br>Review of records for client #3 revealed a | W 368 | W 368<br><br>The nurse will in-service all staff on proper medication passes when applying topicals and following doctor's orders. The clinical team will monitor through medication pass assessments 2x a week for a period of 30 days and then on a routine basis to ensure medication passes are completed per policy. In the future, the nurse will ensure all staff are trained on proper medication passes. | 5/25/25 |

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| W 368 | Continued From page 16<br>physician's order which states that the Mupirocin cream should be applied to the client's right big toe and that the area should first be cleansed with peroxide.<br><br>Interview with the facility nurse on 3/26/25 confirmed that the physician's order is current and that staff should have cleaned the right big toe before applying the Mupirocin cream and that the cream should not have been applied to the left big toe. | W 368 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure adaptive equipment for 1 of 6 clients (#5) was furnished and maintained in good repair. The finding is:<br><br>Observations during the 3/25/25 through 3/26/25 survey revealed client #5 to engage in a variety of activities, including running, skipping, swinging and jumping. Further observations revealed client #5 to hit his head and his leg with his hands. Continued observation revealed client #5 to wear a soft protective helmet, but no protective equipment on his hands or arms.<br><br>Review of records on 3/26/25 revealed a Person-Centered Plan (PCP) for client #5 dated 7/24/24 which lists client #5's adaptive equipment | W 436 | W 436<br><br>The Behavior Analyst will purchase soft mitts and in-service all staff on the use for Client #5. The clinical team will monitor through interaction assessments 2x a week for a period of 30 days and then on a routine basis to ensure the BSP is followed. In the future, the behavior analyst will ensure all staff are trained on BSPs. | 5/25/25 |

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| W 436 | Continued From page 17<br>as soft helmet, soft mitts, high sided divided dish, shirt protector and small spoon. Continued record review revealed a Behavior Support Plan dated 9/26/24 which indicates that the soft mitts should be offered whenever client #5 begins to hit his head or legs or otherwise attempts self-injury.<br><br>Interview with the Home Manager (HM) on 3/25/25 revealed that she has been in the home for approximately 6 months and had not seen any soft mitts for client #5. Interview with the qualified intellectual disabilities professional (QIDP) revealed that the PCP and BSP are current and that the facility should have made soft mitts available for client #5 in the event he engages in self-injurious behavior. | W 436 | | |
| W 440 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1)<br><br>at least quarterly for each shift of personnel.<br>This STANDARD is not met as evidenced by:<br>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:<br><br>A review of the facility fire drill reports on 3/25/25 revealed March, 2024 and March 2025, the facility conducted 6 fire drills and that, of those, 3 drills occurred on first shift, 2 drills occurred on second shift and 1 drill occurred on third shift.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) confirmed fire drills should have been conducted quarterly for each shift of personnel. | W 440 | W 440<br><br>The Safety Chairperson will in-service the RTL on completing fire drills as scheduled. The Safety Chairperson will monitor fire drill completion through monthly safety meetings. In the future, the Safety Chairperson will ensure all managers are trained on the fire drill policy. | 5/25/25 |