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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is: Review of the facility's EPP on 5/6/25 revealed the plan to be dated 12/7/21. Continued review of the EPP revealed the client specific information to be expired. Interview with the qualified intellectual disabilities professional (QIDP) on 5/7/25 confirmed there is no evidence of an updated EPP. Continued interview with the QIDP confirmed the EPP should be reviewed and/or updated at least biennially.	E 004		
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,	E 037		

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E 037	Continued From page 2 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 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.	E 037		

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E 037	Continued From page 3	E 037		

(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 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

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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 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

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E 037	Continued From page 5	E 037		

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 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

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E 037	Continued From page 6 failed to ensure direct care staff were trained on the facility's Emergency Preparedness Plan (EPP) at least biennially. The finding is: Review of the facility's EPP on 5/6/25 revealed no evidence of initial or biennial staff training. Interview with the qualified intellectual disabilities professional (QIDP) on 5/7/25 confirmed there is no evidence of initial or biennial staff training.	E 037		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure routine repairs and maintenance at the group home were completed in a timely manner. The finding is: Observations throughout the 5/6/25 - 5/7/25 survey revealed repairs needed inside the group home to include holes in wall throughout the home, paint peeling on walls, and mold in the bathroom on the right where the client's bedrooms are located. Continued observations in the bathroom revealed mold to be in the shower, on the ceiling, and along the wall entering the bathroom. Interview on 5/6/25 at the group home with staff A revealed that the staff has been employed for approximately 2 years. Continued interview with staff A revealed that the mold has always been a problem in the bathroom and staff were informed	W 104		

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W 104	Continued From page 7 the bathroom would be remodeled a few years ago. The bathroom has not been remodeled. Interview on 5/7/25 with the qualified intellectual disabilities professional (QIDP) verified the walls needed repair and there was mold in the bathroom. Continued interview with the QIDP revealed that there were work orders completed on 4/29/25; however, there was no timeline on the completion of work.	W 104		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: The facility failed to ensure the personal privacy of 1 of 5 audited clients (#2) in the group home as evidenced by observations and interviews. The finding is: Observations in the group home throughout the survey on 5/6/7 - 5/7/25 revealed that client #2's bedroom window had one window completely frosted and the other window to contain no frost, blind, or any window treatment/coverings. Continued observation did not reveal client #2 to receive privacy while in his bedroom. Interview with staff A on 5/6/25 confirmed that client #2's bedroom window did not provide the client with privacy. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that client #2's window should provide the client with privacy. Continued interview with the QIDP revealed that	W 129		

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W 129	Continued From page 8 client #2 will break his bedroom windows and the frosting may have been missed after replacing a broken window.	W 129		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 5 audited clients (#2, #6) received a continuous active treatment program consisting of needed interventions in the area of dining guidelines and adaptive equipment. The findings are: A. The facility failed to ensure dietary guidelines for client #2. For example: Observations throughout the 5/6-7/25 survey revealed client #2 to follow various staff prompts and instructions, and to participate independently in both the dinner and breakfast meal. Continued observations during the dinner and breakfast meal revealed client #2 to never receive prompts to alternate bites of food with sips of liquid. Review of client #2's record on 5/7/25 revealed a Speech-Language Assessment dated 6/17/24.	W 249		

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Review of the assessment indicated client #2 is on a chopped meats diet consistency with thin liquids; he overfills his oral cavity and lacks proper mastication; he is advised to alternate bites of solids with sips of liquid.

Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 5/7/25 confirmed staff should prompt client #2 to take sips of liquid between bites as he will not always do this on his own. Continued interview with the QIDP and facility nurse confirmed staff are responsible for ensuring client #2 follows his dietary guidelines.

B. The facility failed to ensure adaptive equipment use relative to client #2's eyeglasses. For example:

Observations throughout the 5/6-7/25 survey revealed client #2 to participate in leisure activities, hygiene, meal preparation, mealtime, and medication management. Continued observations throughout the survey revealed client #2 to participate in activities without his eyeglasses. Further observations throughout the survey revealed no staff to prompt client #2 to wear his eyeglasses.

Review of client #2's record on 5/7/25 revealed a person-centered plan (PCP) dated 6/22/22 which indicated he wears glasses daily. Continued review of client #2's record revealed his next vision appointment is scheduled for 5/8/25.

Interview with the QIDP and facility nurse on 5/7/25 confirmed client #2's current eyeglasses prescription. Continued interview with the QIDP and facility nurse confirmed it is the staff's

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W 249	Continued From page 10 responsibility to offer and train client #2 with wearing his eyeglasses. C. The facility failed to ensure adaptive equipment use relative to client #6's eyeglasses. For example: Observations throughout the 5/6-7/25 survey revealed client #6 to participate in leisure activities, hygiene, chores, mealtime, and medication management. Continued observations throughout the survey revealed client #6 to participate in activities without his eyeglasses. Further observations throughout the survey revealed no staff to prompt client #6 to wear his eyeglasses. Review of client #6's record on 5/7/25 revealed a PCP dated 4/16/24 which indicated he wears glasses all day. Continued review of client #6's record revealed his next vision appointment is scheduled for 8/6/25. Interview with the QIDP and facility nurse on 5/7/25 confirmed client #6's current eyeglasses prescription. Continued interview with the QIDP and facility nurse confirmed it is the staff's responsibility to offer and train client #6 with wearing his eyeglasses.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the person-centered plan (PCP)	W 260		

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W 260	Continued From page 11 was revised at least annually for 3 of 5 audited clients (#2, #3, and #6). The findings are: Review of records on 5/7/25 for client #2 revealed a PCP dated 6/22/22. There was no additional documentation provided to show evidence that client #2's PCP meeting had taken place and updated since 6/22/22. Review of records on 5/7/25 for client #3 revealed a PCP dated 3/13/24. There was no additional documentation provided to show evidence that client #3's PCP meeting had taken place and updated since 3/13/24. Review of records on 5/7/25 for client #6 revealed a PCP dated 4/16/24. There was no additional documentation provided to show evidence that client #6's PCP meeting had taken place and updated since 4/16/24. Interview on 5/7/25 with the qualified intellectual disabilities professional (QIDP) confirmed that client #2's, #3's, and #6's PCPs were current. Continued interview with the QIDP revealed that the PCP meetings had not taken place.	W 260		
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 records and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to first, second, and third shift. The finding is: Review of the facility fire drill reports from 6/24	W 440		

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W 440	Continued From page 12 through 5/25 revealed missing fire drills for 9/24, 10/24, 11/24, and 12/24. Further review of the fire drill reports revealed first shift drills conducted on 7/11/24, 1/28/25, and 4/8/25; second shift drills conducted on 8/6/24, 2/11/25, and 5/5/25; and third shift drills completed on 6/11/24 and 3/13/25. There was no additional documentation available about conducting the missing fire drills during the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 5/7/25 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview QIDP confirmed that all requested documentation for fire drills conducted 6/24 through 5/25 were provided to the surveyor.	W 440		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 5 audited clients (#2) received their specially prescribed diet as ordered by the interdisciplinary team. The finding is: Observation in the group home on 5/6/25 revealed the dinner menu and meal to include one baked pork chop, baked potato, tossed salad, pudding, water and juice. Continued observation revealed client #2 to serve himself two pork chops and participate independently in the dinner meal.	W 463		

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W 463	Continued From page 13 Review of client #2's record on 5/7/25 revealed a person-centered plan (PCP) dated 6/22/22 which indicated their diet order as 1800 calorie weight loss diet, whole, ½ inch chopped meats. Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 5/7/25 verified that although client #2's PCP is out of date his diet order is current. Continued interview with the QIDP and facility nurse confirmed staff should supervise client #2 during meal times to ensure he receives his specially prescribed diet.	W 463		