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	34G058	A. BUILDING _____ B. WING _____	08/05/2025

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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

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 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 (EP) plan was reviewed and/or updated as needed. The finding is: Review on 8/4/25 of the facility's EP plan revealed no evidence of a recent review and/or update. Additional review of the plan did not include any information regarding one newly admitted client. Further review of the EP plan did not include recent changes in management staff. Interview on 8/5/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the Business Manager is responsible for updating the EP plan. The QIDP acknowledged the plan should be updated as needed with current client and staff information.	E 004		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1 was afforded privacy during toileting. This affected 1 of 5 audit clients. The finding is:	W 130		

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W 130	Continued From page 2 During evening observations in the home on 8/4/25 at 3:45pm, client #1 entered the hall bathroom and began urinating in the toilet with the door wide open. At this time, Staff C stood outside of the opened door and watched the client in the bathroom. Client #1 was not afforded privacy while using the bathroom. Immediate interview with Staff C revealed he does not close the door while client #1 uses the toilet because he has behaviors and will sit on the toilet and start straining. Review on 8/5/25 of client #1's Individual Program Plan (IPP) dated 3/12/25 revealed he is continent of his bowel and bladder. Additional review of the IPP indicated Privacy Guidelines (dated 1/25/10). The guidelines noted, "Staff will ensure that the bathroom door is closed each time [Client #1] goes to the bathroom by giving him a verbal prompt to close the door." Further review of the client's Adaptive Behavior Inventory (ABI) last updated 3/3/25 noted partial independence with closing the bathroom door for privacy. Interview on 8/5/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should ensure the bathroom door is closed to ensure client #1's privacy while toileting.	W 130		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with 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	W 340		

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W 340	Continued From page 3 health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure staff were sufficiently trained regarding appropriate health measures related to blood sugar checks. The finding is: During observations of medication administration on 8/5/25 at 8:50am, the Medication Technician (MT2) gathered materials to take client #2's blood sugar level. During the procedure, the MT used two different lancets to pierce the client's skin in an effort to obtain blood. Once finished with the lancets, the MT threw them into a nearby trash can. Closer observation of the medication closet revealed a sharps container inside. Immediate interview with the MT2 revealed she routinely throws used lancets in the trash. Review on 8/5/25 of training materials for blood sugar checks revealed, "Dispose of your lancets in a sharps container." Interview on 8/5/25 with Nurse A confirmed MT's have been trained to dispose of their used lancets in the sharps container located in the medication closet.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all	W 368		

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W 368	Continued From page 4 medications were administered in accordance with physician's orders. This affected 1 of 2 clients (#1) observed receiving medications. The finding is: During observations of medication administration in the home on 8/5/25 at 7:47am, client #1 ingested Inderal 120mg along with seven other medications. The client's blood pressure and pulse were not taken before or after he ingested his medications. Review on 8/5/25 of client #1's physician's orders dated 7/11/25 revealed an order for Inderal 120mg, take 1 capsule by mouth every morning at 8:00am. The order further noted, "Check blood pressure and pulse before giving call nursing and hold if blood pressure less than 90/60 or pulse less than 60." Interview on 8/5/25 with Nurse B confirmed client #1's physician's orders for Inderal should have been followed as written.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications are administered without error. This affected 2 of 2 clients (#1 and #2) observed receiving medications. The findings are: A. During observations of medication administration in the home on 8/5/25 at 7:47am,	W 369		

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W 369	Continued From page 5	W 369		

the Medication Technician (MT2) dispensed an undetermined amount of liquid Lactulose in a white unmarked paper medicine cup. The Lactulose was not measured. Client #1 ingested the Lactulose along with seven other medications.

Immediate interview with the MT2 revealed no marked medicine cups were available in the home. When asked how she knows how much Lactulose client #1 received, the MT used her fingers to identify the area of the unmarked cup she normally measures for his medicine.

Review on 8/5/25 of client #1's physician's orders dated 7/11/25 revealed an order for Lactulose 10mg/15ml by mouth every morning for constipation at 8:00am.

Interview on 8/5/25 with Nurse B confirmed plastic marked medicine cups should be used for proper measurement of liquids and the white unmarked paper medicine cups should not be used.

B. During observations of medication administration in the home on 8/5/25 at 8:19am, client #2 ingested Metformin, Abilify, Vitamin D3 and Linzess. The client also received Alphagan .1% eye drops in both eyes. No other medications were administered.

Review on 8/5/25 of client #1's physician's orders dated 7/11/25 revealed an order for Miralax 17gms to be mixed in 8oz of liquid by mouth twice daily for constipation at 8:00am and 8:00pm.

Interview on 8/5/25 with Nurse B confirmed client #2 should have received Miralax during the

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W 369	Continued From page 6 morning med pass.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review and interview, the facility failed to ensure all drugs remained locked except when being administered. The findings are: During evening observations in the home on 8/4/25 at 4:09pm, the Medication Technician (MT1) left the medication closet door and the door leading into the medication room wide open as he left the area to retrieve a client. During this time, the drug storage closet was unlocked and accessible to anyone in the home. During morning observations in the home on 8/5/25 at 8:28am and 8:41am, the Medication Technician (MT2) left the medication closet door wide open as she left the area on two separate occasions to obtain latex gloves. During this time, the client #2 remained in the room while the drug storage closet was unlocked and drugs were accessible. Immediate interview with the MT1 revealed he became a medication technician about a month ago and he was trained that the medication closet and the door leading into the medication room should be kept locked. Interview on 8/5/25 with the MT2 indicated the medication closet should be "locked at all times"	W 382		

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W 382	Continued From page 7 and this was a part of their training. Review on 8/5/25 of the facility's medication administration observation form noted the medication technician should be observed to lock "the med closet door when leaving the area at any time." Interview on 8/5/25 with the Nurse A confirmed the drug storage area should be locked if the MT leaves the room during medication administration.	W 382		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure each client received their modified diets as indicated. This affected 1 of 5 audit clients (#5). The finding is: During lunch observations at the day program on 8/4/25 at 11:30am, client #5 consumed a ground chicken salad sandwich. Additional observations in the home during dinner at 4:45pm, the client consumed his spaghetti with meat sauce and green beans at a ground consistency while his biscuit was cut up into bite size pieces. During further observations in the home at breakfast on 8/5/25 at 9:01am, client #5 consumed a whole slice of toast. Interview on 8/5/25 with Staff A revealed client #5	W 460		

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W 460	Continued From page 8 receives a 1/2 to 1 inch consistency for his foods. Review on 8/5/25 of client #5's Individual Program Plan (IPP) dated 2/21/25 and a diet list posted in the kitchen (dated 1/27/25) revealed has food consistency should be 1/2 to 1 inch pieces. Interview on 8/5/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 should consume his food in 1/2 to 1 inch pieces.	W 460		