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E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §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	E 039		

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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 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

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a narrated, clinically-relevant emergency 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.

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §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):]	E 039		

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(2) Testing. The PACE organization must conduct 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

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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:
(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

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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 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.

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(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.

(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

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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.
(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 reviews and interviews, the facility failed to show evidence of exercises to verify testing of the emergency preparedness plan (EPP). The findings are:

A. The facility failed to show evidence of full-scale community/facility-based exercises, mock drill, or tabletop exercises to verify testing of the EPP. This affected all clients residing in Rayside B. For example:

Review of facility documentation on 11/18/25

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revealed an EPP dated 10/20/25. Further review of the facility's EPP did not reveal evidence of a mock drill, tabletop exercise, or full-scale community-based exercise to test the facility's EPP.

Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed that evidence of a tabletop exercise, mock drill, or full-scale exercise could not be found during the survey. Further interview with the QIDP revealed a live event was discussed, however, the documentation could not be found.

B. The facility failed to show evidence of full-scale community/facility-based exercises, mock drill, or tabletop exercises to verify testing of the EPP. This affected clients residing in Rayside A. For example:

Review of facility documentation on 11/18/25 revealed an EPP dated 4/25/25. Further review of the facility's EPP did not reveal evidence of a mock drill, tabletop exercise, or full-scale community-based exercise to test the facility's EPP.

Interview with the interim QIDP on 11/18/25 revealed that evidence of a tabletop exercise, mock drill, or full-scale exercise could not be found during the survey. Further interview with the interim QIDP revealed a live event was discussed, however, the documentation was not available during the survey. Continued interview with the interim QIDP verified that staff and management should complete all emergency preparedness exercises to test the EPP as required.

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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: Based on observations and interview, the facility failed to ensure clients have a right to personal privacy for 2 of 5 audited clients (#2 and #3) during personal care and medication administration. This affected clients residing in Rayside A. The findings are: A. The facility failed to respect the privacy of client #2 during personal care. For example: Observations on 11/18/25 at 8:30AM revealed client #2 to lay in her bed while staff prepare the client for personal care. Further observations at 8:46AM revealed staff to transition client #2 to the hoyer lift with her bedroom door remaining open. Continued observations at 9:18AM revealed staff to again transition client #2 to her bed with no clothes on with the client's rear end exposed which could be seen from the hallway. Subsequent observations at 9:30AM revealed staff to again provide personal care to client #2 and change her adult briefs with the door remaining open and rear end exposed no clothes on as various staff and management came in and out of the facility. At no point during the observations did staff close the bedroom door to ensure client #2 received privacy during personal care. Interview with the facility nurse and interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff have been	W 129		

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trained to respect the privacy of clients during personal care.

B. The facility failed to ensure privacy for client #2 and #3 during medication administration. For example:

Observations on 11/18/25 at 7:50AM revealed the medication technician to prepare client #3's medications for administration. Further observations at 7:54AM revealed the medication technician to administer medications in her room while client #2 remained in the room. Continued observations also revealed client #3 to receive her medications with the bedroom door remaining open which could be seen from the hallway by other staff and clients.

Observations on 11/18/25 at 8:15AM revealed staff to prepare medication administration for client #2. Further observations at 8:20AM revealed the medication technician to administer medications to client #2 in the bedroom as client #3 remained in the room. Continued observations revealed the residential team lead (RTL) to enter the bedroom and share with the medication technician that medications should be administered in the medication room. Observations did not reveal medication technician to ensure the privacy of client #2 during medication administration.

Interview with the facility nurse on 11/18/25 verified staff have been trained to ensure the privacy of clients during medication administration. Interview with the facility nurse and interim QIDP on 11/18/25 verified that medications should be administered in the medication room to ensure privacy during

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W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 5 audited clients (#3) were provided opportunities for choice and self-management during mealtimes in Rayside A. The finding is: Observations on 11/18/25 at 6:55AM revealed staff to provide personal care and get another client dressed (#2) while client #3 remained in her bed. Further observations revealed client #3 to remain in her room from 7:30AM to 10:00AM while staff provided personal care to client #2 in their shared bedroom. Continued observations at 8:20AM revealed staff to enter the kitchen and prepare the breakfast meal. Subsequent observations at 10:00AM revealed staff to transport client #3 to the dining area to prepare for the breakfast meal. Observations did not reveal a staff member to escort client #3 to the dining table for breakfast meal after 100 minutes of unstructured time in her room. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed that staff should have escorted client #3 to the dining room after the breakfast meal was prepared to feed her. Further interview with the interim QIDP verified that client #3 did not have to wait for 100 minutes in order to participate in the breakfast meal. Continued interview with the	W 247		

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W 247	Continued From page 13 interim QIDP verified it was not a requirement for client #3 to wait until client #2 was dressed in order for the two clients to eat breakfast together.	W 247		
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 continuous active treatment programs were implemented as identified in person centered plans (PCP's) for 2 of 5 audited clients (#4 and #6) in Rayside B. The findings are: A. The facility failed to ensure program and training objectives were implemented as required for client #4. For example: Observations throughout the recertification survey from 11/17/25 to 11/18/25 revealed client #4 to participate in medication administration, converse with staff and other peers, participate in dinner and breakfast meals, take dishes to the sink (dinner meal), and watch her favorite tv show "Martin" in the livingroom. Continued observations did not reveal staff to prompt client #4 to review her visual schedule or follow her gum schedule.	W 249		

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W 249	Continued From page 14 Review of the record for client #4 on 11/18/25 revealed a PCP dated 2/20/25 with six program and service objectives. Continued review of the training objectives for client #4 included the following: 1) Dancing with Music Videos; 2) Music Step; 3) Community Integration; 4) Gum Schedule; 5)Visual Schedule and 6) Calendar Step. Further review of the training objectives for the visual schedule revealed, client #4 will follow her visual schedule daily. Subsequent review of the gum schedule revealed client #4 will be offered by staff gum pieces every two hours beginning at 8am. Interview with the agency's habilitation specialist (HS) on 11/18/25 revealed that client #4 training objectives are current. Continued interview with the HS confirmed staff should review client #4's visual schedule with her throughout the day. Further interview with the HS also confirmed client #4 should be offered a piece of gum every two hours as outlined in her training objective. B. The facility failed to ensure program and training objectives were implemented as required for client #6. For example: Observations throughout the recertification survey from 11/17/25 to 11/18/25 revealed client #6 to engage with a musical instrument in hand, attempt communication with staff and other peers, participate in dinner and breakfast meals, participate in medication administration and display a few targeted behaviors in the morning. Continued observations did not reveal staff to prompt or offer client #6 to pour her drinks during meals.	W 249		

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W 249	Continued From page 15 Review of the record for client #6 on 11/18/25 revealed a PCP dated 8/14/25 with six program and service objectives. Continued review of the training objectives for client #6 included the following: 1) Shampoo Hair; 2) Toileting Schedule; 3) Time on Task; 4) Exercise For 30 Minutes; 5)Verbalize Colors and 6) Pour Drink. Further review of the training objectives for the visual schedule revealed client #6 will pour her drinks during meals. Interview with the HS on 11/18/25 revealed that client #6 training objectives are current. Further interview with the HS confirmed clients should receive training objectives as outlined in their PCP's and staff should provide and encourage participation in order to determine progress towards training and behavior objectives.	W 249		
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 reviews and interviews, the facility failed to assure all drugs were administered without error for 2 of 5 audited clients (#3 and #5). The findings are: A. The facility failed to assure drugs were administered without error for client #3 residing in Rayside A. For example: Observations on 11/18/25 at 7:45AM revealed the medication technician to enter the medication room to prepare for medication administration for client #3. The following medications were placed	W 369		

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in the cup for administration: Levothyroxine 50 mcg, Vitamin D3 2000IU, Levocarnitine 330mg, Carbamazepine 200mg ER, Polyethylene Glycol 3350, Levetiracetam 250mg, Carbamazepine 300mg ER, Calcium + D Tab 315-500, Certavite Tab, Valproic Acid 20ml, Lactulose Solution 5ml, Acetaminophen (2) 325mg, and Calcitonin Salmon Nasal Spray (1 spray in left nostril). Further observations at 8:08AM revealed staff to administer medications to client #3 in her room.

Review of the record for client #3 on 11/18/25 revealed a physician's order dated 10/23/25 which indicated Levothyroxine 50 mcg should be taken on an empty stomach at 6:00AM. Review of the QuickMAR report dated 11/18/25 verified the Levothyroxine 50 mcg for client #3 was administered at 8:08AM.

Interview with the facility nurse on 11/18/25 revealed the medication Levothyroxine 50mcg for client #3 should have been administered at 6:00AM as prescribed. Further interview with the facility nurse verified the physician's order for client #3 was current. Continued interview with the facility nurse revealed medication technician staff should report a late dosage or any problems relative to medications to nursing. Subsequent interview with the facility nurse verified that client #3's medications should be administered as prescribed.

B. The facility failed to assure drugs were administered without error for client #5 residing in Rayside B. For example:

Observations in the group home on 11/17/25 at 4:53PM revealed client #5 to enter the medication room. Further observations revealed the

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W 369	Continued From page 17 residential team lead (RTL) to retrieve client #5's medication bin from the closet, scan the medication Carvedilol 6.25mg (1 tab) blister pack, then dispense into a medication cup. Continued observations revealed the RTL to hand client #5 the medication cup. Subsequent observations revealed client #5 to swallow the medication followed by a cup of water and exit the medication room. Additional observations at 5:00PM revealed client #5 to engage in activities, place serving bowls on the dining table and at 5:55PM participate in the dinner meal. Review of record for client #5 on 11/18/25 revealed a physician's order to include the medication Carvedilol Tab 6.25mg (1 tab), to be taken with meals. Interview with the facility nurse on 11/18/25 revealed client #5's physician order is current. Further interview with the facility nurse revealed client #5's Carvedilol 6.25mg should have been administered with a meal as prescribed.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the system for drug administration failed to assure 4 of 5 audited clients (#2, #3, #4, and #5) observed during medication administration were provided education. The findings are:	W 371		

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W 371	Continued From page 18 A. The facility failed to provide medication education for client #5 during medication administration in Rayside B. For example: During a medication administration observation on 11/17/25 at 4:53PM revealed the residential team lead (RTL) to call client #5 to the medication room to receive medications. Further observations revealed the RTL to retrieve client #5's medication bin from the closet, scan medication carvedilol 6.25mg (1 tab) blister pack, then dispense into a medication cup. Continued observations revealed the RTL to hand client #5 the medication cup. Subsequent observations revealed client #5 to swallow the medication followed by a cup of water, then exit the medication room. Additional observations did not reveal client #5 to receive any education related to name, purpose and side effects of medications administered. Interview with the facility nurse on 11/18/25 revealed staff have been trained to provide education to all clients while administering medication. Continued interview with the facility nurse revealed all clients should be provided some sort of education relative to the medications administered. B. The facility failed to provide medication education for client #4 during medication administration in Rayside B. For example: During a medication administration observation on 11/18/25 at 7:15AM revealed the residential tem lead (RTL) to call client #4 to the medication room to receive medications. Further	W 371		

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observations revealed the RTL to retrieve client #4's medication bin from the closet, scan medication blister packs, then dispense into a medication cup. Continued observations revealed the RTL to crush client #4's medications, open the capsules and empty the sprinkles into the cup. Further observations revealed the RTL to mix the crushed medications with vanilla pudding and feed to client #4. Subsequent observations did not reveal client #4 to receive any education related to name, purpose and side effects of medications administered.

Interview with the facility nurse on 11/18/25 revealed staff have been trained to provide education to all clients while administering medications. Continued interview with the facility nurse revealed all clients should be provided some sort of education relative to the medications administered.

C. The facility failed to provide medication education to clients #2 and #3 during medication administration in Rayside A. For example:

Observations on 11/18/25 at 7:50AM revealed the medication technician to pop the medications from a bubble pack and add Ensure to the cup and medications. Further observations reveal the medication technician to enter client #2's room and administer the medication. Continued observations did not reveal the medication technician to provide client #2 with the medication name, usage, and the potential side effects.

Subsequent observations at 8:20AM revealed the medication technician to prepare client #3's medication by popping the pills in a cup and adding applesauce. Additional observations

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W 371	Continued From page 20 revealed the medication technician to walk to enter client #3's bedroom and administer the medication to the client while she sat in bed. Continued observations did not reveal the medication technician to provide client #3 with the medication name, usage, and potential side effects. Interview with the facility nurse on 11/18/25 revealed that the medication technician should have administered the medication to clients with a description of the medication, usage and potential side effects. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff have been trained to provide medication education to clients during medication administration.	W 371		
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 and interviews, the facility failed to assure client medications remained secured except when preparing for medication administration for 2 of 5 audited clients (#2, #3). This affected clients residing in Rayside A. The findings are: A. The facility failed to secure topicals when they are not being administered for client #2. For example: Observations in the facility from	W 382		

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W 382	Continued From page 21 11/17/25-11/18/25 revealed two bottles of topicals on top of client #2's dresser. At no point during the observation did staff remove and secure the topicals in the medication room when they were not being used. Interview with the facility nurse on 11/18/25 verified that prescribed topicals should be locked in the medication cabinet in the medication room when they are not being used. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed staff have been trained to secure medications and topicals in the medication cabinet when they are not being administered. B. The facility failed to secure medications when they are not being administered for clients #2 and #3. For example: Observations in the facility on 11/18/25 at 8:23AM revealed the medication technician and the surveyor to enter the medication room to record and check the medications. Further observation revealed the medication technician to unlock the medication cabinet and remove clients #2 and #3 medication baskets placing them on the desk. Observations also revealed this surveyor to tell the medication technician "please don't leave me in here". Continued observations revealed the medication technician to acknowledge the surveyor's statement by stating "ok, I won't". Subsequent observations at 8:25AM revealed the medication technician to exit the medication area, leaving the medication cabinet unlocked, medication baskets remaining on the desk, and to leave the surveyor in the medication room unattended. Additional observations revealed medication technician to again exit the medication	W 382		

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W 382	Continued From page 22 room at 8:32AM and 8:37AM. Interview with the facility nurse on 11/18/25 verified that medications should not be left unattended and the medication cabinet should be locked when the medications are not being administered. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff have been trained to not leave clients' medications unattended when medications are not being administered.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that clients were provided adaptive equipment and used appropriately as prescribed for 2 of 5 audited clients (#2 and #3) This affected clients residing in Rayside A. The findings are: A. The facility failed to use the gait belt for client #3 as prescribed. For example: Afternoon observations on 11/17/25 from 4:30PM-5:50PM revealed client #3 to sit in the living room area in her recliner. Further observations revealed client #3's gait belt to sit on a side table beside the recliner. Continued	W 436		

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observations at 5:58PM revealed staff A to assist client #3 with getting out of the recliner by holding the client's elbows. Subsequent observations revealed staff A to escort client #3 to the dining room table by holding her hands. Additional observations revealed staff A to position client #3 in a dining room chair by holding onto the client's hands. At no point during the observation did staff use a gait belt to assist client #3 with ambulation as prescribed.

Morning observations on 11/18/25 at 9:50AM revealed staff to put on client #3's gait belt and transfer the client from her bed to the wheelchair by holding onto her hands. Further observation at 10:19AM revealed staff to transition client #3 from the wheelchair to the dining room table by holding onto the client's hands. At no point during the observation did staff use the gait belt as prescribed.

Review of the record for client #3 on 11/18/25 revealed a physical therapy (PT) assessment dated 8/1/25 which indicated client #3 should wear the gait belt during waking hours with contact guard assistance. Review of the Occupational Therapy (OT) Assessment dated 8/6/25 indicated client #3 "must wear a gait belt or vest for support during mobility. Use wheelchair for longer distances.

Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified that client #3 should wear her gait belt during waking hours with contact guard assistance. Further interview with the interim QIDP verified that staff have been trained to use the gait belt for client #3 during transfers and mobility as prescribed.

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W 436	Continued From page 24 B. The facility failed to use the harness for client #2 as prescribed. For example: Observations throughout the recertification survey from 11/17/25-11/18/25 revealed client #2 to participate in various activities without access to her chest harness. At no point during the observation did staff attach client #2's harness to ensure safety during ambulation. Review of the record for client #2 on 11/18/25 revealed a physician's order dated 9/25/25 and a physical therapy (PT) assessment dated 8/16/25 which indicated client #2 has the following adaptive equipment: safety harness, shower chair, wheelchair with harness, Hoyer lift, bilateral bunny boots, dycem mat, and high sided dish. Further review of the record for client #2 revealed a person centered plan (PCP) dated 8/13/25 indicated the client had been assessed for a new seat and harness. Interview with the interim QIDP on 11/18/25 verified that client #2's physician's order and interventions were current. Further interview with the interim QIDP revealed staff should use client #2's safety harness as prescribed.	W 436		
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 interview, the facility failed to show evidence of quarterly fire drills were conducted with each shift of personnel relative to first, second, and third shift in Rayside B. The finding is:	W 440		

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W 440	Continued From page 25 Review of the facility fire drill reports from 11/24 through 10/25 revealed missing fire drills for 2/25, 3/25, 4/25, 6/25. Further review of the fire drill reports revealed first shift drills conducted on 1/22/25, and 10/7/25; second shift drills conducted on 5/14/25; and third shift drills completed on 7/30/25 and 9/13/25. There was no additional documentation available for conducting the missing fire drills during the review year. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 confirmed facility fire drills should have been conducted quarterly for each shift. Further interview the interim QIDP confirmed that all requested documentation for fire drills conducted 11/24 through 10/25 were provided to the surveyor.	W 440		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to include the timeframes of fire evacuation drills, including the reasoning for evacuation problems during facility evacuation for Rayside A. The finding is: Review of facility documentation on 11/17/25 revealed fire evacuation drill reports covering the last twelve months from 11/2024-10/2025. Further review of fire evacuation drill reports did not include timeframes for the following evacuation drill dates: 1/22/25, 2/5/25, 3/19/25, 5/14/25, 8/17/25, 9/13/25, and 10/7/25.	W 448		

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W 448	Continued From page 26 Review of facility fire evacuation drill reports revealed several fire evacuation drill dates with problems during facility evacuation drills. Further review of facility evacuation drill reports revealed the following dates with areas of concern: 6/5/25 and 11/17/25, "did all people supported evacuate appropriately? No". Review of evacuation drill reports on 5/14/25 and 11/17/25 stated "if a sprinkler system is in the home, is an inspection form onsite dated within 12 months? No". Continued review of facility fire evacuation drills did not reveal reasoning why clients were not evacuated appropriately and why the sprinkler inspection report was not provided within 12 months. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed he was uncertain what problems occurred on the dates of concern according to the fire evacuation drill reports. Further interview with the interim QIDP revealed staff should share fire drill evacuation concerns with management and ensure fire evacuation drills are filled out appropriately. Continued interview with the interim QIDP verified concerns with fire drill evacuation drills should be presented to the facility safety committee for further review.	W 448		