STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G022	A. BUILDING _____ B. WING _____	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	4123 CONRAD STREET ALEXANDRIA, VA 22312

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/25/18 through 6/27/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Intermediate Care Facilities for Persons with Intellectual Disabilities.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide	E 006		

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

EXECUTIVE DIRECTOR 7/23/18

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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 006		E 006		

Continued From page 1

care.

This STANDARD is not met as evidenced by:
Based on staff interview and facility document review, it was determined that the facility staff failed to develop an emergency preparedness plan based on and including a facility-based and community-based risk assessment, utilizing an all-hazards approach.

The facility staff failed to evidence a facility-based and community-based risk assessment was completed.

The findings include:

On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence a facility-based and community-based risk assessment, utilizing an all-hazards approach. ASM #1 was made aware of this concern.

No further information was obtained prior to exit.

E006 (a)

1. A facility based and community based risk assessment, utilizing an all hazards approach will completed by the Agency Compliance Manager in conjunction with the facility manager and QIDP by July 31st, 2018. This assessment (The Kaiser Permanente Medical Center Hazard and Vulnerability Analysis Tool) will be utilized to amend the facility's Emergency Preparedness Plan based on the hazards that were assessed to have the highest likelihood and impact on the facility and each individual. 8/1/18
2. The risk assessment and Emergency Preparedness Plan will address the risks and needs of all individuals in the facility. Therefore, no other individuals in the facility will be affected by the same deficiency.
3. The risk assessment and subsequent edits to the Emergency Preparedness Plan will be reviewed and updated annually to ensure that this deficiency does not recur.
4. The Home Manager, Project Director and

			Compliance Manager will work together to monitor performance around these solutions quarterly to ensure they are adequate and sustained. They will track emergencies and responses annually and update the plan annually. E006 (2) A. The Emergency Preparedness Plan will address emergency events identified by the facility and community based risk assessment. The Emergency Preparedness Plan will be completed by August 1, 2018. B. The Emergency Preparedness Plan will address concerns for all individuals living in the facility. Therefore, no other individuals in the facility will be affected by the same deficiency in the future. C. The Emergency Preparedness Plan will be reviewed and updated annually to ensure that this deficiency does not recur. D. The QIDP, Home Manager, and Project Director will meet quarterly to review any emergencies and responses and make updates to the Emergency Preparedness Plan. Any changes will be reviewed with the Compliance Manager. The plan will be updated at least annually to address any newly identified risks or needs.	8/1/2019
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007	E007 (a) (3) 1. The facility Emergency Preparedness Plan that addressed the individual population, including individual risk, services the facility has the ability to provide in an emergency and continuity of operations will be completed by 8/1/18. An individual risk assessment that includes each individual's basic information, details on their disability, medical needs, level of functioning and additional vulnerabilities will be conducted by the Home Manager and QIDP, using data from medical records, documentation by staff and additional information. The individual risk assessment for each individual will be completed by 7/31/18. 2. Individual risk assessments will be conducted for each individual in the facility and any future individual who is admitted to the facility. Therefore no additional individuals will be affected	8/1/2018

			by this same deficiency. 3. Through quarterly reviews conducted by the QIDP, Home Manager and Project Director, any changes to an individual's level of function, medical diagnosis, or additional vulnerabilities will be identified and used to update the individual's assessment. These changes will be reflected in an updated Emergency Preparedness Plan. Any change to the services the facility has the ability to provide or the continuity of operations plan will also be reflected in an updated Emergency Preparedness Plan when these changes occur. Therefore this deficiency will not recur. 4. The QIDP, Home Manager and Project Director will meet quarterly to monitor the accuracy of the risk assessments and any updates that need to be made. If changes are made to the individual risk assessments, those changes will also be reflected in the Emergency Preparedness Plan. Barring no mid-year changes, the Risk Assessments and Emergency Preparedness Plan will be reviewed and updated annually in order to sustain this solution.	

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E 007	Continued From page 2 plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop the emergency preparedness plan that included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence the emergency preparedness plan included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. ASM #1was made aware of this concern. No further information was obtained prior to exit.	E 007		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 013	E013(b) 1. A facility based and community based risk assessment, utilizing an all hazards approach will completed by July 31st, 2018. This assessment (The Kaiser Permanente Medical Center Hazard and Vulnerability Analysis Tool) will be utilized to amend the facility's Emergency Preparedness Plan based on the hazards that were assessed to have the highest likelihood and impact on the facility and each individual. The agency Policy and Procedure for Risk Management (Policy #20) will	7/31/18

			be updated by July 31th 2018, so that it encompasses a facility-and-community based risk, utilizing all-hazards approach and a revised communication plan. 2. The assessment, Emergency Preparedness Plan, and Agency Policy and Procedures #20 will be revised and finalized based on all individuals living in the facility and therefore no other individuals will be affected by this deficiency. 3. The risk assessment and Emergency Preparedness Plan will be reviewed and updated annually by the Home Manager, Project Director, and QIDP to ensure ongoing evaluation of all facility-based and community-based risks. Likewise, the agency Policy and Procedures #20 will be reviewed and updated annually by the agency Executive Team. However, should there be a facility, agency, social or environmental change, the risk assessment and subsequently the Emergency Plan and Policy and Procedures will be updated immediately to ensure these deficiencies do not recur. 4. The QIDP, Home Manager and Project Director will meet quarterly to monitor the accuracy of the risk assessments and any updates that need to be made. If changes are made to the individual risk assessments, those changes will also be reflected in the Emergency Preparedness Plan and Policy and Procedures #20, if applicable. Barring no mid-year changes, the Risk Assessments and Emergency Preparedness Plan will be reviewed and updated annually in order to sustain this solution.	

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E 013	Continued From page 3 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's	E 013		

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E 013	Continued From page 4 geographic area. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the policies and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures were developed based on a facility- based and community-based risk assessment and utilizing an all-hazards approach. ASM #1 was made aware of this concern. No further information was obtained prior to exit.	E 013		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a	E 015	E015 (b) 1. The facility Emergency Preparedness Plan will be amended to include policies and procedures on how to provide for subsistence needs including sewage and waste disposal. The procedures will include details regarding the location of all emergency food, water, medical and pharmaceutical supplies. The procedures also will address alternate sources of energy including the use of the onsite generator that will be used to maintain safe temperatures, lighting, and alarm systems working. Fire detection, extinguishing and alarm services as well as sewage and waste disposal will also be addressed in the procedures. Within those procedures will be details about the process for dealing with water and sewage in the event that the public water and sewage system is	8/1/2018

compromised. This includes keeping adequate water available not only for drinking, bathing and food preparation but also for flushing toilets should there be a disruption in water service. Additionally, the agency has an on-going contract with D&B Hauling for solid waste removal should there be a need to have waste removed. The revised Emergency Preparedness Plan will be completed by 8/1/18.

2. The revised Emergency Preparedness Plan will address subsistence needs including sewage and waste disposal that will adequately address the needs of all individuals in the facility as well as staff and/or any volunteers present. No other individuals will be be affected by this deficiency.
3. The Emergency Preparedness Plan including the procedures around maintaining subsistence needs will be reviewed and updated at least annually. As a part of the bi-annual Quality Assurance Review, the food, water and medical supplies are inventoried to ensure there is an adequate amount to withstand an emergency evacuation or shelter in place. The amount of water needed will be increased and included in this review to allow for the emergency flushing of toilets in the event the need arises. Therefore this deficiency will not recur.
4. As a part of the annual review of the Emergency Preparedness Plan, the procedures around maintaining subsistence needs will be closely evaluated to ensure any changes are made. The generator is monitored weekly to ensure it is in working order and it is maintained by an accredited technician annually to ensure its safety and performance. Adequate food, water, and medical supplies are monitored by the Home Manager monthly to ensure no food has expired and water and medical supplies are still adequate. Therefore these solutions will be maintained.

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E 015	Continued From page 5 minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems.	E 015		

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E 015	Continued From page 6 (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the provision of subsistence needs including sewage and waste disposal. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the provision of subsistence needs including sewage and waste disposal. ASM #1 was made aware of this concern. No further information was obtained prior to exit.	E 015		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 022	E022 (b) 1. Using the facility based and community based risk assessment, events that will require Individuals residing at the ICF and DSP's providing services, to Shelter-In-Place have been identified and will be included in the Emergency Plan by August 1, 2018. The policies and procedures will address a means to shelter in place for individuals, staff, and volunteers that align with the facility and community risk assessments. The agency Policy and Procedures #20 will also be amended to include more detailed procedures on sheltering in place as an agency. 2. The Emergency Preparedness Plan will address shelter in place needs and procedures for all individuals in the facility and therefore no other	8/1/18

			individuals will be affected by this deficiency. 3. Shelter in Place Drills that address how to shelter in place, will occur twice a year, with any issues being documented and addressed through a change in the procedures. Procedures will be reviewed and updated annually; therefore the deficient practice will not recur. 4. Drills will be documented by the Home Manager and reviewed by the Home Manager, Project Director and Compliance Manager twice a year to monitor performance of the procedures and ensure adequate solutions are maintained.	

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E 022	Continued From page 7 (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for sheltering in place that aligned with a facility risk assessment. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation of how the policies and procedures for sheltering in place are aligned with a facility risk assessment. ASM #1 was made aware of this concern. No further information was obtained prior to exit.	E 022		
E 024	Policies/Procedures-Volunteers and Staffing	E 024	E024 (b.6) 1. The facility Emergency Preparedness Plan will be updated using the facility based and community based risk assessment and will include procedures for the use of volunteers in the event of an emergency. The Emergency Plan will be updated by August 1, 2018. The policies and procedures will address a means to provide emergency staffing and other supports through the use of volunteers. The agency Policy and Procedures #20 will also be amended to include more detailed procedures on utilizing volunteers as an agency in the event of an emergency. 2. The Emergency Preparedness Plan	8/1/18

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			will identify the use and role of volunteers in the event of an emergency for all individuals in the facility. It will utilize the individual risk assessment to determine the best use of volunteers for each individual. Therefore, no other individuals will be affected by this deficiency. 3. A policy and procedure for utilizing volunteers in emergency situations will be developed and included in both the Agency Policy and Procedures #20 and the Facility's Emergency Preparedness Plan. It will identify best practices and processes for using volunteers at this facility with the specific individuals who live there. Volunteers will be provided with the documents and included in semi-annual drills to ensure they are aware of their roles and responsibilities. Both documents will be reviewed and updated annually to ensure this deficiency does not recur. 4. The Home Manager, QIDP and Project Director will maintain contact with potential volunteers and monitor the effectiveness of using volunteers during the bi-annual drills. Amendments will be made to the policies and procedures based on monitoring to ensure these solutions are maintained.	

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E 024		E 024		
	Continued From page 8 CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers in the emergency plan. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM			8/1/2018

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E 024	Continued From page 9 (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the use of volunteers in the emergency plan. ASM #1 was made aware of this concern. No further information was obtained prior to exit.	E 024		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff	E 026		

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E 026		E 026	E026 (b.8)	
	Continued From page 10 failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. ASM #1 was made aware of this concern. No further information was obtained prior to exit.		1. The Facility's Emergency Preparedness Plan will be updated to include a process for providing care and treatment at alternate care sites should the need arise under an 1135 Waiver. This plan will include procedures that delineates staff's role in providing care and services to the Individuals at the ICF at an alternate facility, with whom it has established a connection with and able to support the needs of the Individuals. 2. The Emergency Preparedness Plan will include processes that ensure the safety of all individuals in the home in the event of an 1135 Waiver or other emergency situation that requires the relocation of individuals to another facility. Therefore, no other individuals will be affected by this deficiency. 3. CLA previously identified the ARC of Frederick County as a potential partner in which we could relocate individuals in the event we needed to provide supports at an alternate location beyond a 50 mile radius of our current location. We will develop a formal procedure and agreement with the ARC of Frederick County and continue to conduct annual drills to ensure this deficiency does not recur. 4. The QIDP, Home Manager, and Project Director will maintain an agreement with the ARC of Frederick County (or develop an additional partner in which to maintain an agreement) and conduct annual drills in which feedback will be obtained. The Emergency Preparedness Plan will be updated annually and will reflect any changes found to be necessary during the annual drill or as a result in any other changes. This will ensure these solutions are maintained.	8/1/18

E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on staff interview and facility document	E 035	E035 (c.8) 1. An Emergency Preparedness Communication Plan that complies with Federal, State and Local laws will be developed by August 1, 2018 and updated annually. The plan will include a method for sharing information with the individuals and their families/guardians. The plan will be shared with the individuals and families/guardians by August 9, 2018. 2. The Communication Plan will address communication policies, procedures and strategies that will address the needs of all individuals in the facility and therefore no other individuals will be affected by this deficiency. 3. The Emergency Preparedness Plan, including the communication plan will be reviewed and updated annually by the Home Manager and Project Director. The updated Plan will be provided to the individuals and families/guardians for their feedback annually, ensuring that this deficiency does not recur. 4. The effectiveness of the communication plan will be monitored throughout the year as a part of routine drills, including the monthly fire drills, bi-annual shelter in place drills, and annual 1135 Waiverevacuation drill. Any changes will be made as needed based on the success or challenges uncovered during those drills. The Emergency Preparedness Plan, including the communication plan will be updated at least annually or as the need arises to ensure these solutions are sustained.	8/1/18

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E 035	Continued From page 11 review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan with individuals and/or their families or representatives. The findings include: On 6/26/18 at 1:05 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) #1 (the compliance manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency with individuals and/or their families or representatives. ASM #1 was made aware of this concern. No further information was obtained prior to exit.	E 035		
W 000	INITIAL COMMENTS An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 6/25/18 through 6/27/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow. The census in this four bed facility was three at the time of the survey. The survey sample consisted of two current individual reviews,	W 000		

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W 000	Continued From page 12 (Individuals #1 and #2).	W 000		

W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interview, residential record review and facility document review, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor individuals' active treatment programs for two of two individuals in the survey sample, Individuals #1 and #2. 1. The QIDP failed to develop PCP (person centered plan) outcomes to support Individual # 1's progress toward independence. 2. The QIDP failed to develop PCP outcomes to support Individual # 2's progress toward independence. The findings include: 1. The QIDP failed to develop PCP outcomes to support Individual # 1's progress toward independence. Individual #1's placement date was June 2000 (the face sheet did not document the exact date). Individual #1's diagnoses included but were not limited to moderate intellectual disability, urine retention and depression. Review of Individual #1's PCP with a start date of 9/1/17 revealed the following:	W 159	W159 1. The QIDP will work with the Home Manager, Project Director, DSP staff and the individuals to continue to assess any skill building outcomes that may further support the individual's progress towards independence. An assessment of the current plans, including obtaining feedback from the individuals and guardians, will be conducted to determine which of the current outcomes are still relevant and which could be developed into skill building outcomes, and if there are other skill building outcomes that may be appropriate. From that feedback and assessment, new person centered plans will be developed and provided to the individuals and guardians for additional feedback. After revisions are finalized, the person centered plans will be submitted to the individuals and/or guardians for signature and returned by August 9, 2018. 2. This assessment, feedback and revision will take place for all of the individuals in the facility. Therefore no other individuals will be affected by this deficiency. 3. In the future a greater emphasis will be placed on outcome development that will support each individual's progress towards independence. Goals that can enhance individual skills will be a greater focus for each individual's plans and ensuring that this deficiency does not recur. 4. Each individual's progress on their goals and outcomes will be evaluated regularly by the QIDP, Home Manager and Project Director and fully assessed each quarter. From these assessments it will be determined whether individuals are making progress towards independence with current supports in place. Challenges will be addressed with the individual, guardians, family members and support team members to find appropriate solutions and to ensure they are sustained.	8/09/18

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Continued From page 13

"Outcome #3- Money Management Skills
List the actions/supports needed: (Name of Individual #1) wants (sic) budget his money for activities in the community.
Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) has a Representative Payee, who pay (sic) his bills and gives him a monthly allowance. (Name of Individual #1) understands that he needs money to purchase the things he wants, and would like to learn how to budget his money to make simple purchases from stores and restaurants in the community. Meet with (name of Individual #1) twice a week to review his petty cask (sic) and budget for activities in the community. Review the different currency denomination with (name of Individual #1). If he choose (sic) to go to 7-Eleven or eat out at a restaurant support him with figuring out how much money he will need including tax...
Outcome #6- Medication Management
List the actions/supports needed: It is important for (name of Individual #1) to take his medications as prescribed by his doctors with staff support daily.
Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) needs to take all his medications daily as prescribed by his doctor in order to remain medically stable. Staff reminds (name of Individual #1) when it is time to take him medication. Staff prompts (name of Individual #1) to get a glass of water to take his medications. Staff identifies the names and purpose of each medication before administering it to (name of Individual #1). Staff initials (name of Individual #1's) MAR (medication

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W 159	Continued From page 14 administration record) chart to confirm his medications were administered... Outcome #9- Personal hygiene and grooming List the actions/supports needed: It is important for (name of Individual #1) to maintain good personal hygiene and appearance at all times. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) will attend to his personal grooming with staff support daily. Staff prompts (name of Individual #1) to get ready to take his shower and attend to his grooming needs. (Name of Individual #1) collects items he needs to attend to his personal hygiene; body wash, shaver, washcloth and towel. Staff provides verbal, modeling and physical cues as (name of Individual #1) takes his shower and attends to his grooming needs. Staff prompts (name of Individual #1) to put on clean weather appropriate clothing. Staff redirects/prompts (name of Individual #1) to change his clothing as needed when they are soiled with food..." None of the above outcomes was documented as measurable skill building activity outcomes to promote independence. On 6/27/18 at 9:03 a.m., an interview was conducted with ASM (administrative staff member) #3 (the house manager). ASM #3 was asked to describe the purpose of the person-centered plan. ASM #3 stated the person centered plan addresses the needs of the individuals depending on their individual needs and the goal is to make individuals more independent. ASM #3 stated skill building activity outcomes address areas where the individuals need the most help and have to be measurable so the individuals' progress can be measured.	W 159		

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W 159	Continued From page 15 When asked the purpose of skill building activity outcomes, ASM #3 stated they are implemented to help individuals develop skills. When asked how staff determines which outcomes should be skill building activity outcomes, ASM #3 stated a meeting that involves all staff is held and the staff discusses individuals' strengths, weaknesses and goals. When asked to describe the QIDP's role in relation to the PCP, ASM #3 stated the QIDP's job is to write the plan, make sure it is implemented daily and follow up with staff. ASM #3 was asked to review Individual #1's person centered plan. ASM #3 confirmed outcome #3 (Money Management Skills) was not a skill building activity outcome. ASM #3 stated the outcome could be developed as a skill building activity outcome and the QIDP (Qualified Intellectual Disabilities Professional) was working on the plan. ASM #3 stated Individual #1 understands money and looks forward to having his money management ledger. ASM #3 was asked to review outcome #6 (Medication Management). ASM #3 was asked if this outcome could be developed as a skill building activity outcome. ASM #3 stated the outcome could be developed as a skill building activity outcome and Individual #1 could be taught to recite his medications. ASM #3 was asked to review outcome #9 (Personal hygiene and grooming). ASM #3 was asked if this outcome could be developed as a skill building activity outcome. ASM #3 stated, "It could be. He has a lot of potential." ASM #3 stated that every now and then staff asks Individual #1 if he wants to hold his shaving razor and the individual states, "No. I want you to shave me." ASM #3 stated that over time, Individual #1 could learn to shave himself and this could be incorporated into his plan.	W 159		

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W 159	Continued From page 16 The QIDP was not available for interview during the survey. On 6/27/18 at 10:28 a.m., ASM #2 (the project director) was asked to provide a policy regarding the QIDP role. ASM #2 stated she only had a job description. The job description documented, "Implements or ensures the implementation of the particular requirements of the ISP (individual service plan [person centered plan]) on a daily basis. In the ICF (Intermediate Care Facility), ensures compliance with all pertinent federal regulations applicable to community ICFs." On 6/27/18 at 10:50 a.m., ASM #2 was made aware of the above concern. No further information was presented prior to exit. 2. The QIDP failed to develop PCP outcomes to support Individual # 2's progress toward independence. Individual #2's placement date was 11/2/05. Individual #2's diagnoses included but were not limited to intellectual disabilities, seizure disorder and seasonal allergies. Review of Individual #2's PCP with a start date of 9/1/17 revealed the following: "Outcome #2- Participates in activities in the community he enjoys List the actions/supports needed: (Name of Individual #2 wants to engage in activities he enjoys in the community. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found:	W 159		

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W 159	Continued From page 17 (Name of Individual #2) likes eating out at a restaurant once a week with his housemates and staff. He also enjoys going for van rides and attending other social events in the community. DSP (Direct Support Staff) meets with (name of Individual #2) and reminds him he is going out for lunch/dinner at a restaurant during the weekend. Allow (name of Individual #2) to choose a restaurant he will like to visit. Review (name of Individual #2) petty cash to ensure he has enough money to eat at the restaurant he chooses. Use this as an opportunity to review different currency denomination with him. Encourage him to identify the different current denomination. At the restaurant, staff assists (name of Individual #2) with choosing a healthy meal (a low salt/high calorie meal) and a regular soda. Whenever possible staff will encourage (name of Individual #2) to incorporate fruits and vegetable into his meal. Meet with (name of Individual #2) weekly to discuss/review activities in the community that might be of interest to him. Discuss details of what each activity will entail. Allow him to select an activity he wants to engage in. Ensure (name of Individual #2) is appropriately dressed for the activity. Once a week (name of Individual #2) visits his local 7-Eleven to practice his purchasing skills. Encourage (name of Individual #2) to get his regular soda and pay for it at the cashier register. Remind him to count his change, if change is given and take his receipt. Provide verbal praise to (name of Individual #2) for selecting an activity and his active participation. It is important to remind (name of Individual #2) to refrain from touching everyone he sees at the store; refrain from hogging (sic) everyone he sees at the store... Outcome #4- Completes household task as assigned	W 159		

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W 159		W 159		
	Continued From page 18 List the actions/supports needed: It is important for (name of Individual #2) to participate in household tasks to help care for his home and develop independent living skills. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: Completing home living tasks is not what (name of Individual #2) likes to do. He requires verbal cues, modeling/gestural and physical prompts to attend to home living task daily. Develop a daily task schedule so that household tasks are completed by (name of Individual #2) and his housemates daily. Prompt (name of Individual #2) to check the task schedule daily so that he knows what task he is assigned for the day. Prompt and encourage (name of Individual #2) to clean after himself after each meal, bring his dishes to the kitchen, rinse them off and load them into the dishwasher. Provide verbal praise to (name of Individual #2) for his active participation..." None of the above outcomes was documented as measurable skill building activity outcomes to promote independence. On 6/27/18 at 9:03 a.m., an interview was conducted with ASM (administrative staff member) #3 (the house manager). ASM #3 was asked to describe the purpose of the person-centered plan. ASM #3 stated the person centered plan addresses the needs of the individuals depending on their individual needs and the goal is to make individuals more independent. ASM #3 stated skill building activity outcomes address areas where the individuals need the most help and have to be measurable so the individuals' progress can be measured.			

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W 159	Continued From page 19 When asked the purpose of skill building activity outcomes, ASM #3 stated they are implemented to help individuals develop skills. When asked how staff determines which outcomes should be skill building activity outcomes, ASM #3 stated a meeting that involves all staff is held and the staff discusses individuals' strengths, weaknesses and goals. When asked to describe the QIDP's role in relation to the PCP, ASM #3 stated the QIDP's job is to write the plan, make sure it is implemented daily and follow up with staff. ASM #3 was asked to review Individual #1's person centered plan. ASM #3 was asked to review Individual #2's person centered plan. ASM #3 confirmed outcome #2 (participation in community activities) was not a skill building activity outcome but could be. ASM #3 stated Individual #2 loves going out into the community. ASM #3 was asked to review outcome #4 (household tasks). ASM #3 was asked if outcome #4 could be developed as a skill building activity outcome. ASM #3 stated Individual #2 has a limited attention span but does simple tasks such as setting the table and taking the trash out. When asked if it was possible to incorporate short household tasks as a skill building activity outcome, ASM #3 stated it was. The QIDP was not available for interview during the survey. On 6/27/18 at 10:50 a.m., ASM #2 was made aware of the above concern. No further information was presented prior to exit.	W 159		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i)	W 240		

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W 240		W 240	W240-	8/10/18
	Continued From page 20 The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on staff interview, residential record review and facility document review, it was determined that the facility staff failed to develop PCPs (Person Center Plans) to support individuals' move toward independence for two of two individuals in the survey sample, Individuals #1 and #2. 1. The facility staff failed to develop PCP outcomes to support Individual # 1's progress toward independence. 2. The facility staff failed to develop PCP outcomes to support Individual # 2's progress toward independence. The findings include: 1. The facility staff failed to develop PCP outcomes to support Individual # 1's progress toward independence. Individual #1's placement date was June 2000 (the face sheet did not document the exact date). Individual #1's diagnoses included but were not limited to moderate intellectual disability, urine retention and depression. Review of Individual #1's PCP with a start date of 9/1/17 revealed the following: "Outcome #3- Money Management Skills List the actions/supports needed: (Name of Individual #1) wants (sic) budget his money for		1. The facility staff will work with the QIDP, Home Manager, Project Director, and the individuals to continue to assess any skill building outcomes that may further support the individual's progress towards independence. An assessment of the current plans, including obtaining feedback from the individuals and guardians, will be conducted to determine which of the current outcomes are still relevant and which could be developed into skill building outcomes, and if there are other skill building outcomes that may be appropriate. From that feedback and assessment, new person centered plans will be developed and provided to the individuals and guardians for additional feedback. After revisions are finalized the person centered plans will be submitted to the individuals and/or guardians for signature and returned by August 9, 2018. 2. This assessment, feedback and revision will take place for all of the individuals in the facility. Therefore no other individuals will be affected by this deficiency. 3. In the future a greater emphasis will be placed on outcome development that will support each individual's progress towards independence. Goals that can enhance individual skills will be a greater focus for each individual's person centered plan and ensuring that this deficiency does not recur. 4. Each individual's progress on their goals and outcomes will be evaluated regularly by the QIDP, Home Manager and Project Director and fully assessed each quarter. From these assessments it will be determined whether individuals are making progress towards independence with current supports in place. Challenges will be addressed with the individual, guardians, family members and support team members to find appropriate solutions and to ensure they are sustained.	

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(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
W 240	Continued From page 21 activities in the community. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) has a Representative Payee, who pay (sic) his bills and gives him a monthly allowance. (Name of Individual #1) understands that he needs money to purchase the things he wants, and would like to learn how to budget his money to make simple purchases from stores and restaurants in the community. Meet with (name of Individual #1) twice a week to review his petty cask (sic) and budget for activities in the community. Review the different currency denomination with (name of Individual #1). If he choose (sic) to go to 7-Eleven or eat out at a restaurant support him with figuring out how much money he will need including tax... Outcome #6- Medication Management List the actions/supports needed: It is important for (name of Individual #1) to take his medications as prescribed by his doctors with staff support daily. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) needs to take all his medications daily as prescribed by his doctor in order to remain medically stable. Staff reminds (name of Individual #1) when it is time to take him medication. Staff prompts (name of Individual #1) to get a glass of water to take his medications. Staff identifies the names and purpose of each medication before administering it to (name of Individual #1). Staff initials (name of Individual #1's) MAR (medication administration record) chart to confirm his medications were administered... Outcome #9- Personal hygiene and grooming	W 240		

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		A. BUILDING _____	

	49G022	B. WING	06/27/2018

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W 240		W 240		

Continued From page 22

List the actions/supports needed: It is important for (name of Individual #1) to maintain good personal hygiene and appearance at all times. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #1) will attend to his personal grooming with staff support daily. Staff prompts (name of Individual #1) to get ready to take his shower and attend to his grooming needs. (Name of Individual #1) collects items he needs to attend to his personal hygiene; body wash, shaver, washcloth and towel. Staff provides verbal, modeling and physical cues as (name of Individual #1) takes his shower and attends to his grooming needs. Staff prompts (name of Individual #1) to put on clean weather appropriate clothing. Staff redirects/prompts (name of Individual #1) to change his clothing as needed when they are soiled with food..."

None of the above outcomes was documented as measurable skill building activity outcomes to promote independence.

On 6/27/18 at 9:03 a.m., an interview was conducted with ASM (administrative staff member) #3 (the house manager). ASM #3 was asked to describe the purpose of the person-centered plan. ASM #3 stated the person centered plan addresses the needs of the individuals depending on their individual needs and the goal is to make individuals more independent. ASM #3 stated skill building activity outcomes address areas where the individuals need the most help and have to be measurable so the individuals' progress can be measured. When asked the purpose of skill building activity outcomes, ASM #3 stated they are implemented

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W 240	Continued From page 23 to help individuals develop skills. When asked how staff determines which outcomes should be skill building activity outcomes, ASM #3 stated a meeting that involves all staff is held and the staff discusses individuals' strengths, weaknesses and goals. ASM #3 was asked to review Individual #1's person centered plan. ASM #3 confirmed outcome #3 (Money Management Skills) was not a skill building activity outcome. ASM #3 stated the outcome could be developed as a skill building activity outcome and the QIDP (Qualified Intellectual Disabilities Professional) was working on the plan. ASM #3 stated Individual #1 understands money and looks forward to having his money management ledger. ASM #3 was asked to review outcome #6 (Medication Management). ASM #3 was asked if this outcome could be developed as a skill building activity outcome. ASM #3 stated the outcome could be developed as a skill building activity outcome and Individual #1 could be taught to recite his medications. ASM #3 was asked to review outcome #9 (Personal hygiene and grooming). ASM #3 was asked if this outcome could be developed as a skill building activity outcome. ASM #3 stated, "It could be. He has a lot of potential." ASM #3 stated that every now and then staff asks Individual #1 if he wants to hold his shaving razor and the individual states, "No. I want you to shave me." ASM #3 stated that over time, Individual #1 could learn to shave himself and this could be incorporated into his plan. On 6/27/18 at 10:28 a.m., ASM #2 (the project director) was asked to provide a policy regarding the development of the person centered plan. The policy titled, "Documentation and Records Management" documented, "It is the policy of	W 240		

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W 240	Continued From page 24 (name of company) that clinical records be maintained in compliance with all regulatory standards..." On 6/27/18 at 10:50 a.m., ASM #2 was made aware of the above concern. No further information was presented prior to exit. 2. The facility staff failed to develop PCP outcomes to support Individual # 2's progress toward independence. Individual #2's placement date was 11/2/05. Individual #2's diagnoses included but were not limited to intellectual disabilities, seizure disorder and seasonal allergies. Review of Individual #2's PCP with a start date of 9/1/17 revealed the following: "Outcome #2- Participates in activities in the community he enjoys List the actions/supports needed: (Name of Individual #2 wants to engage in activities he enjoys in the community. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: (Name of Individual #2) likes eating out at a restaurant once a week with his housemates and staff. He also enjoys going for van rides and attending other social events in the community. DSP (Direct Support Staff) meets with (name of Individual #2) and reminds him he is going out for lunch/dinner at a restaurant during the weekend. Allow (name of Individual #2) to choose a restaurant he will like to visit. Review (name of Individual #2) petty cash to ensure he has enough money to eat at the restaurant he chooses. Use	W 240		

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W 240		W 240		
	Continued From page 25 this as an opportunity to review different currency denomination with him. Encourage him to identify the different current denomination. At the restaurant, staff assists (name of Individual #2) with choosing a healthy meal (a low salt/high calorie meal) and a regular soda. Whenever possible staff will encourage (name of Individual #2) to incorporate fruits and vegetable into his meal. Meet with (name of Individual #2) weekly to discuss/review activities in the community that might be of interest to him. Discuss details of what each activity will entail. Allow him to select an activity he wants to engage in. Ensure (name of Individual #2) is appropriately dressed for the activity. Once a week (name of Individual #2) visits his local 7-Eleven to practice his purchasing skills. Encourage (name of Individual #2) to get his regular soda and pay for it at the cashier register. Remind him to count his change, if change is given and take his receipt. Provide verbal praise to (name of Individual #2) for selecting an activity and his active participation. It is important to remind (name of Individual #2) to refrain from touching everyone he sees at the store; refrain from hogging (sic) everyone he sees at the store... Outcome #4- Completes household task as assigned List the actions/supports needed: It is important for (name of Individual #2) to participate in household tasks to help care for his home and develop independent living skills. Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found: Completing home living tasks is not what (name of Individual #2) likes to do. He requires verbal cues, modeling/gestural and physical prompts to attend to home living task daily. Develop a daily			

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W 240		W 240		
	Continued From page 26 task schedule so that household tasks are completed by (name of Individual #2) and his housemates daily. Prompt (name of Individual #2) to check the task schedule daily so that he knows what task he is assigned for the day. Prompt and encourage (name of Individual #2) to clean after himself after each meal, bring his dishes to the kitchen, rinse them off and load them into the dishwasher. Provide verbal praise to (name of Individual #2) for his active participation..." None of the above outcomes was documented as measurable skill building activity outcomes to promote independence. On 6/27/18 at 9:03 a.m., an interview was conducted with ASM (administrative staff member) #3 (the house manager). ASM #3 was asked to describe the purpose of the person-centered plan. ASM #3 stated the person centered plan addresses the needs of the individuals depending on their individual needs and the goal is to make individuals more independent. ASM #3 stated skill building activity outcomes address areas where the individuals need the most help and have to be measurable so the individuals' progress can be measured. When asked the purpose of skill building activity outcomes, ASM #3 stated they are implemented to help individuals develop skills. When asked how staff determines which outcomes should be skill building activity outcomes, ASM #3 stated a meeting that involves all staff is held and the staff discusses individuals' strengths, weaknesses and goals. ASM #3 was asked to review Individual #2's person centered plan. ASM #3 confirmed outcome #2 (participation in community activities) was not a skill building activity outcome but could			

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W 240	Continued From page 27 be. ASM #3 stated Individual #2 loves going out into the community. ASM #3 was asked to review outcome #4 (household tasks). ASM #3 was asked if outcome #4 could be developed as a skill building activity outcome. ASM #3 stated Individual #2 has a limited attention span but does simple tasks such as setting the table and taking the trash out. When asked if it was possible to incorporate short household tasks as a skill building activity outcome, ASM #3 stated it was. On 6/27/18 at 10:50 a.m., ASM #2 was made aware of the above concern. No further information was presented prior to exit.	W 240		