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	49G030	A. BUILDING _____ B. WING _____	04/28/2022

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E 000	Initial Comments The unannounced Emergency Preparedness survey was conducted on 04/26/22 through 04/28/28. Corrections are required for compliance with 42 CFR Part 483, requirement for Long Term facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this	E 036		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/25/2022

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section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This STANDARD is not met as evidenced by:
Based on review of the Emergency Preparedness plan, staff interview, the facility staff failed to have documentation of the facility's written training and testing program.

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E 036	Continued From page 2 The findings included: During an interview on 04/27/22 at 12:58 P.M. with the Residential Service Director and the Residential Program Manager they were asked for documentation of the Emergency Preparedness Plan written training and testing program. Four staff names were provided to the facility staff for documentation of Emergency Preparedness training and testing program. The Residential Service Director and the Residential Program Manager were not able to provide documentation for the four named staff's Emergency Preparedness training and testing program.	E 036		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 3 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,

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personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This STANDARD is not met as evidenced by:
Based on review of the Emergency Preparedness, staff interview, the facility staff failed to have documentation of the facility's written training Emergency Preparedness training program.

The findings included:

During an interview on 04/27/22 at 12:43 P.M. with the Residential Services Director and the Residential Program Manager they were asked

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E 037	Continued From page 7 for documentation of the Emergency Preparedness Plan written training program. Four staff names were provided to the facility staff for documentation of Emergency Preparedness training program. The facility staff were not able to provide documentation of Emergency Preparedness training The Residential Services Director stated the facility had not conducted a written Emergency Preparedness training program.	E 037		
W 000	INITIAL COMMENTS The unannounced Fundamental Medicaid re-certification survey was conducted 04/26/22 through 04/28/22. The facility was not in compliance with corrections are required for compliance with 42 CFR Part 483 requirements for Intermediate Care Facilities for Individuals with Disabilities (ICF/IID). The census in this 4 bed facility was 3 at the time of the survey. The survey sample consisted of 2 current Individual records (Individual #1 through #2) and one closed (Resident #3).	W 000		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews the facility staff failed to ensure 1 resident (Resident #3) in the survey sample of 3 retained the use of his personal possessions.	W 137		

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W 137	Continued From page 8 The findings included: Resident #3 was admitted to the facility on 09/09/16 with diagnoses which included severe intellectual disabilities, anemia, dementia with behavioral disturbance. Resident #3 was discharged from the facility on 04/08/22. Resident #3 was hospitalized on 5/2021 diagnosed with bilateral broken hips. Resident #3 has not participated in services for the past 11 months due to being hospitalized and in rehab center. A review of the personal fund account for Resident #3 indicated an expenditure on 07/20/20 for $431.98. The purchase was for a power recliner chair. During the environmental task and resident room check, the recliner chair was observed not to be in Resident #3's bedroom. Upon questioning of the Residential Program Manager, she stated the recliner chair was in Resident #2's bedroom. The Residential Program Manager was asked to unlock the bedroom door of Resident #2. The recliner chair was observed in the bedroom of Resident #2. The Residential Program Manager was asked why was the recliner chair in Resident #2's bedroom. The Residential Program Manager stated, the Authorized Representative of Resident #3 had given verbal approval of the recliner chair to be donated to Resident #2. The Residential Program Manager was asked for documentation that approval had been given for the facility to give Resident #3's personal recliner chair to Resident #2. The Residential Program Manager stated, she did not have documentation to support the approval of Resident #2 taking possession of Resident #3 recliner chair.	W 137		

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W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to revise as appropriate Behavioral Support Plans for two residents (Resident #1 and #2) in the survey sample of three residents. The findings included: 1. Resident #1 was admitted to the facility 10/11/16 with diagnoses which included moderate intellectual disabilities, major depression, cachexia, prediabetes, vascular implants, anxiety, hypertension, and chronic kidney disease stage 3. The facility staff failed to revise Resident #1's Behavior Support Plan. Resident #1 most recent Level of Function assessment was conducted 09/17/21. Resident #1 was identified as requiring dependency in the areas of Health Status, Behavior and Community Living Skills. Resident #1's Behavior Support Plan was dated 05/23/18. The Plan included Target Behavior's of Making inappropriate statements to other individuals, telling other individuals what to do, shouting at others, cursing at others, touching staff and other individuals inappropriately, cursing at others. Resident #1 Behavior Support Plan included the use of psychotropic medications.	W 260		

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Resident #1 Behavior Support Plan included behaviors monitored at the day support program.

During an interview at 1:55 PM on 04/27/22 with the Residential Support Director she was asked if Resident #1 had an updated or revised Behavioral Support Program since 5/23/18. The Residential Support Director stated, there was not a revised Behavior Support Program and the Consultant Psychologist who developed the program was no longer employed with the agency as of December, 2021.

The Residential Support Director was asked when did the new Consultant Psychologist began employment. The Resident Support Director stated, end of February or first part of March of 2022. The Residential Support Director was asked if the newly hired Consultant Psychologist developed or revise the Behavior Support Plan for Resident #1, and she stated, No.

2. Resident #2 was admitted to the facility on 09/16/15 with diagnoses which included severe intellectual disabilities, autistic disorder.

Resident #2 most recent Level of Function assessment was conducted 09/17/21. Resident #2 was identified as requiring dependency in the areas of Health Status, Communication, Personal/Self Care, Behavior and Community Living Skills.

Resident #2's Behavior Support Plan was dated 09/07/21. The Plan included Target Behavior's of striking his head against walls or objects. 2. Aggression towards others. Resident #2 has a Physician's order for a padded helmet to protect him from self injury.

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W 260	Continued From page 11 Resident #2's Behavior Support Plan included the use of psychotropic medications. Resident #2's Behavior Support Plan included behaviors monitored at the day support program. During an interview at 1:55 PM on 04/27/22 with the Residential Support Director she was asked if Resident #2 had an updated or revised Behavioral Support Program since the Consultant Psychologist who developed the program was no longer employed with the agency as of December, 2021. The Residential Support Director was asked when did the new Consultant Psychologist began employment. The Resident Support Director stated, end of February first of March 2022. The Residential Support Director was asked if the newly hired Consultant Psychologist develop or revise the Behavior Support Plan for Resident #2, and she stated, No.	W 260		