Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 01G011	**(X3) Date Survey Completed** 07/13/2023
Name of Provider or Supplier Rainbow Omega, Inc,	**Street Address, City, State** 202 Hope Drive, Eastaboga, AL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	K3 Building: 0101 K6 Plan Approval: 2006 K7 Survey Under: 2012 Existing K8 ICF/IID Small Generator: One Diesel, Katolight 125 kW (installed 2007, with remote maual stop station) FACP: Simplex 4010 (installed 2007) Locking Devices: 15 Second Delayed Egress (all doors except kitchen exterior door) Smoke Detection: Corridor Beds: 16 Census:16 Type of Structure: 2006 one story unprotected wood frame, Type V(000). The facility has a complete automatic sprinkler system with a sprinkler pit. The facility is surveyed under impractical to evacuate. During a routine recertification survey conducted on this date, the facility was found to be not in compliance with 42 CFR 483.475 Emergency Preparedness for LTC facilities, as observed by the LS Surveyors while accompanied by facility personnel.
K0000	K3 Building: 0101

	K6 Plan Approval: 2006 K7 Survey Under: 2012 Existing K8 ICF/IID Small Generator: One Diesel, Katolight 125 kW (installed 2007, with remote maual stop station) FACP: Simplex 4010 (installed 2007) Locking Devices: 15 Second Delayed Egress (all doors except kitchen exterior door) Smoke Detection: Corridor Beds: 16 Census:16 Type of Structure: 2006 one story unprotected wood frame, Type V(000). The facility has a complete automatic sprinkler system with a sprinkler pit. The facility is surveyed under impractical to evacuate. During a routine recertification survey conducted on this date, the requirements of 42 CFR, Subpart 483.470 were NOT MET as evidenced by the following deficiencies of the 2012 NFPA 101 Life Safety Code (LSC), the 2012 NFPA 99 Health Care Facilities Code and the standards referenced by these codes, as observed by the LS Surveyors while accompanied by the facility maintenance personnel.
W0000	A Recertification Survey was conducted at Davis / Orman Intermediate Care Facility from 07/12/2023 - 07/13/2023. The facility is in substantial compliance respective to applicable Condition of Participation (CoP) under 42 CFR 483, Subpart I with the following standard-level deficiencies cited.
E0015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 460.84(b)(1), 482.15(b)(1), 483.73(b)(1), 483.475(b)(1), 485.542(b)(1), 485.625(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 every 2 years [annually for LTC facilities]. At a 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. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on review of documentation, the facility failed to provide subsistence needs policies and procedures per the requirements of: 42 CFR 483.475(b)(1) This deficiency affects all of the emergency preparedness plan. Findings include: During a tour of the facility, the facility failed to provide a contract or MOU for a back-up emergency generator, if the facility's emergency generator were to stop working. How would the facility provide subsistence needs for residents and staff: A member of maintenance staff and administrative staff were present when this deficiency was identified. Based on review of documentation, the facility failed to provide subsistence needs policies and procedures per the requirements of: 42 CFR 483.475(b)(1) This deficiency affects all of the emergency preparedness plan. Findings include: During a tour of the facility, the facility failed to provide a contract or MOU for a back-up emergency generator, if the facility's emergency generator were to stop working. How would the facility provide subsistence needs for residents and staff: A member of maintenance staff and administrative staff were present when this deficiency was identified.
KS353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings

	and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on review of documentation and observation, the facility failed to maintain the automatic sprinkler system per the requirements of: 2012 NFPA 101, 33.3.3.5.1, and 9.7.5 2011 NFPA 25, 7.2, 7.3, 7.4, and Table 7.1.1.2 This deficiency affects 1 private fire hydrant. Findings include: Based on review of documentation and observation, the facility failed to provide documentation on inspecting, testing, and maintaining the private fire hydrant within the past 12 months. A member of the maintenance staff was present when this deficiency was identified.
KS511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on review of documentation, the facility failed to maintain the testing of the

	emergency generator per the requirements of: 2012 NFPA 101, 33.2.5.1, 9.1.2, and 9.1.3.1 2010 NFPA 110, 8.3.7.1, and 8.3.8 This deficiency affects 1 of 1 generators. Findings include: During a tour of the facility, the facility failed to provide documentation of the following: 1. Monthly conductance testing on the facility's emergency generator's maintenance-free battery for the past 12 months 2. A fuel quality test was performed within the past twelve months using tests approved by ASTM standards. A member of the maintenance staff was present when this deficiency was identified.
W0252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on facility document review, clinical record reviews, and interviews, the facility failed to document 3 (Clients #1, #2, and #3) of 3 sampled clients' active treatment objectives data per the required frequency of the clients' plans. This failure resulted in three clients not having the required amount of data to assess their progress accurately. Findings included: A review of a facility document titled, "Job Title: ICF/IID [Intermediate Care Facilities for Individuals with Intellectual Disabilities] Resident Aide," dated 04/20 /2021, indicated, "Works closely with and takes direction from the "on duty" ICF/IID LPN [Licensed Practical Nurse] (Team Lead) regarding all aspects of ICF/IID resident care and nursing support." The document further indicated, "Completes documentation for CPAs [Care Program Approaches], IPPs [Individual Program Plans] or BSPs [Behavior Support Plans], and prepares reports, as required by licensing and certifying agencies and ROI [release of information] policy." A review of Client #1's "Data Collection Monthly- Individual Summary Sheet," for April 2023, May 2023, and June 2023, revealed the client had an Individual Support Plan for "Independent Living," "Healthcare Management - Physical Exercise," and "Money Management." Per the documents, the staff were directed to document the client's progress in meeting the established goals three times a week for "Independent Living," two times a week for "Healthcare Management - Physical Exercise," and one time a week for "Money Management." Documentation revealed data was not

collected at the frequency set in the objective for April 2023, May 2023, and June 2023.

A review of Client #2's "Data Collection Monthly- Individual Summary Sheet," for April 2023, May 2023, and June 2023, revealed the client had an Individual Support Plan for "Money Management," "Social/Communication," and "Health Education." Per the documents, the staff were directed to document the client's progress in meeting the established goals one time a week for "Money Management," two times a week for "Social/Communication," and three times a week for "Health Education." Documentation revealed data was not collected at the frequency set in the objective for April 2023, May 2023, and June 2023.

A review of Client #3's "Data Collection Monthly- Individual Summary Sheet," for April 2023, May 2023, and June 2023, revealed the client had an Individual Support Plan for "Sensory," "Stimulation," and "Community Safety." Per the documents, the staff were directed to document the client's progress in meeting the established goals two times a week for Sensory, Stimulation, and Community Safety. Documentation revealed data was not collected at the frequency set in the objective for April 2023, May 2023, and June 2023.

During an interview on 07/13/2023 at 2:32 PM, the Qualified Intellectual Disability Professional (QIDP) stated it was the responsibility of the QIDP to ensure the client's active treatment was provided. Per the QIDP, the collection of the active treatment data was important in the active treatment of the clients as it helped the QIDP assess the clients' progress in their treatment. The QIDP acknowledged the facility failed to ensure active treatment objective data was collected per the required frequency of the clients' plans for Clients #1, #2, and #3.

During an interview on 07/13/2023 at 2:49 PM, the Program Director stated that upper management was aware resident aides were not documenting data as written on the client's Data Collection Monthly- Individual Summary Sheet. According to the Program Director, the resident aides were observed conducting the clients' active treatment objectives; however, the staff had been trying to figure out how to improve the resident aides' documentation. The Program Director explained, the facility understood the importance of the collection of data as it helped the facility track the client's progress." The Program Director acknowledged the facility failed to ensure active treatment objective data was collected per the required frequency of the clients' plans for Clients #1, #2, and #3.