## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  WENDELL FOSTER'S CAMPUS FOR DEVELOPMENTAL DISABIL  (X4) ID  (X4) ID  (X4) ID  (X5) ID  (X6) ID  (X7) ID  (X8) ID  (X8) ID  (X9) ID  (X9	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
WENDELL FOSTER'S CAMPUS FOR DEVELOPMENTAL DISABILI  (X4) ID  (X4) ID  (X4) ID  (X4) ID  (RAD DEFICIENCY MUST BE PRECEDED BY FULL TAGS  (RAD DEFICIENCY)  W 000  INITIAL COMMENTS  A Recertification Survey and a COVID-19 Focused Infection Control Survey was initiated on 09/21/20 and concluded on 09/23/2020  determined the facility was found to be in compliance with Conditions of Participation with no deficiencies cited. The facility was found to be in compliance with 42 CFR 483.430(e)(2) infection control regulations and has implemented the Centers for Medicare & Medical Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.			18G009	B. WING			09/23/2020	
WENDELL FOSTER'S CAMPUS FOR DEVELOPMENTAL DISABIL   (X4)   ID   SUMMARY STATEMENT OF DEFICIENCISES	NAME OF F	PROVIDER OR SUPPLIER					,	
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  A Recertification Survey and a COVID-19 Focused Infection Control Survey was initiated on 09/21/20 and concluded on 09/23/2020 determined the facility was in compliance with 42 CFR 483.430(e)(2) Infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	WENDELL FOSTER'S CAMPUS FOR DEVELOPMENTAL DISAE							
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Focused Infection Control Survey was inititated on 09/21/20 and concluded on 09/23/2020 determined the facility was in compliance with Conditions of Participation with no deficiencies cited. The facility was found to be in compliance with 42 CFR 483.430(e)(2) infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	W 000	INITIAL COMMENTS		w 000				
	AROBATOR	Focused Infection C 09/21/20 and concli- determined the faci Conditions of Partic cited. The facility with 42 CFR 483.43 regulations and has Medicare & Medica Centers for Disease (CDC) recommende COVID-19.	Control Survey was initiated on uded on 09/23/2020 lity was in compliance with sipation with no deficiencies was found to be in compliance 30(e)(2) infection control is implemented the Centers for id Services (CMS) and is Control and Prevention ed practices to prepare for	ATHER.		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		18G009	B. WING			09/23/2020	
		S FOR DEVELOPMENTAL DISA	BILI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated concluded on 09/23	sed Emergency Preparedness d on 09/21/2020 and 8/2020. The facility was found with 42 CFR 483.73 related					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.