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W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure each client had the right to be treated with dignity regarding their toileting needs and the right to written informed consent from both legal guardians. This affected 2 of 6 audit clients (#5, #15). The findings are: 1. Client #5 did not have the right to dignity/privacy regarding his toileting needs. During observations in the home throughout the survey on 6/11 - 6/12/18, client #5 was seated in his wheelchair with a large bath towel positioned underneath him. The towel was visible to anyone in the area. Staff interviews (2) on 6/11 - 6/12/18 revealed client #5 "sweats and pees a lot" or "drinks a lot" so the towel was in place to keep his wheelchair seat cover from getting wet. Additional interview indicated they have to "wash the cover" on the seat most of the time. Review on 6/12/18 of client #5's individual program plan (IPP) dated 2/15/18 revealed, "He continues to wear attends with occasional accidents. The team agreed to continue service 13S, Toileting schedule which places him on a two hour toileting regimen to help decrease the number of accidents." Additional review of the	W 125		

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

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W 125	Continued From page 1 client's Toileting Schedule guidelines (13-S) indicated, "...Staff will assist [Client #5] with using the bathroom every 2 hours. Staff will notify the Program Director if there is an increase of toileting accidents..." Interview on 6/12/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #5 has replacement wheelchair covers to be used as needed. Additional interview indicated staff should be following the client's toileting schedule and bath towels should not be used over the seat of his wheelchair. 2. Co-guardians for client #15 did not provide written informed consent for a restrictive behavior program. Review on 6/12/18 of client #15's record revealed guardianship papers dated 10/23/02 which identified two guardians. Additional review of the record indicated written informed consent for the client's restrictive behavior program was obtained from only one of the two co-guardians on 1/29/18. Interview on 6/12/18 with the QIDP confirmed client #15 has two guardians and both should have provided written informed consent for his restrictive program.	W 125		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by:	W 192		

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Based on observations, record reviews, and interviews, the facility failed to ensure all staff were sufficiently trained to intitiate/complete facility incident reports and ensure clients receive necessary medical assessment/treatment. This affected 1 of 6 audit clients (#14). The finding is:

Staff were not adequately trained to ensure appropriate medical care and complete necessary facility documents for client #14's injury.

During morning observations in the living area of the home on 6/12/18 at 8:15am, a client ran over to client #14 and bit her on the top of her head. Client #14 screamed, rubbed the top of her head and stated, "He bit me on my head." A staff immediately escorted the aggressive client out of the area.

Interview on 6/12/18 at 9:30am with the facility's on-duty nurse revealed she had not been made aware of any clients being in need of medical assessment or treatment so far that morning. Additional interview indicated a medication technician (MT) was also available in the home for simple medical assessments. The nurse further stated that staff should immediately seek the nurse or MT when clients are injured and also complete incident reports for all client injuries as soon as they occur.

Review on 6/12/18 of the facility's incident reporting policy revealed, "All incidents that are inconsistent with the routine operation of a service or care that are likely to lead to adverse effects must be documented and reported, as defined by DHHS...Staff will discuss with nursing staff to determine if treatment is required."

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W 192	Continued From page 3 Staff interview on 6/12/18 revealed if a client receives an injury, they document it on an incident report and notify the nurse and Program Manager. The staff added an MT can also give first aid to clients, if necessary. Interview on 6/12/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the incident involving client #14 should have been reported to the nurse immediately and an incident report should have been completed in a timely manner.	W 192		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure a pattern of interactions between staff and clients supported the implementation of the individual program plan (IPP). This affected 3 of 6 audit clients (#5, #14, #15). The findings are: 1. Client #15's Behavior Intervention Program (BIP) was not implemented as written.	W 249		

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During morning observations in the home on 6/12/18 at 8:15am, client #15 became agitated, began yelling, jumping up/down and ran over to another client and bit them on the top of the head. A staff immediately intervened and escorted client #15 out of the area and to his bedroom.

Staff interview on 6/12/18 revealed they had taken client #15 to his bedroom to calm down.

Review on 6/12/18 of client #15's BIP dated 11/30/17 revealed an objective to reduce his frequency of defined disruptive behavior episodes to 190 or fewer for 10 out of 12 months. The objective addressed target behaviors of aggression, self-injurious behavior and property abuse Additional review of the plan noted, "...exhibits emerging agitation, (yelling, hand flapping, jumping, running, etc.), staff or to direct [Client #15] to area that is at a safe distance away from the other members. He should not be directed to his bedroom as a location for the purpose of de-escalating his agitation."

Interview on 6/12/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the BIP was current and should have been implemented as written.

2. Client #5's mealtime guidelines were not implemented as written.

During dinner observations in the home on 6/11/18 at 6:10pm, client #5 began eating his pasta salad with his fingers. The client quickly consumed two drinks at the meal. Although his adaptive spoon was in his plate, the client was not prompted to use the spoon.

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During breakfast observations in the home on 6/12/18 at 8:20am, client #5 consumed his cereal using his fingers while scooping with his spoon on only one occasion. After the client reached for one of four drinks at his place setting, a staff removed the drink and prompted him to "finish eating first". Client #5 consumed his drinks very quickly, without taking sips and at the end of the meal.

Staff interview on 6/12/18 revealed client #5 likes to drink a lot at meals. When asked if they follow any specific guidelines at meals, the staff stated, "No".

Review on 6/12/18 of client #5's IPP dated 2/15/18 revealed he uses a built-up handle spoon at meals. The plan noted the client "is capable of feeding himself with minimal staff assistance". Additional review of the client's mealtime guidelines (14-S) revised 1/31/11 indicated, "...Staff will make sure that [Client #5] has all adaptive equipment and is using it correctly... Staff will monitor and cue him as needed to slow his liquid consumption. Cue him to take frequent sips spaced evenly throughout the meal..."

Interview on 6/12/18 with the QIDP revealed client #5 should have been prompted to use his adaptive spoon and his mealtime guidelines were current and should have been followed.

3. Client #13's mealtime guidelines were not implemented as written.

During lunch and dinner observations in the home on 6/11 - 6/12/18 at 12:23pm and 6:00pm, staff fed client #13 using a built-up handle spoon without prompting him to participate with feeding

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himself. Additional observations at breakfast on 6/12/18 at 8:20am, client #13 fed himself using a built-up handle spoon until 8:43pm when staff began feeding him.

Staff interview on 6/12/18 revealed client #13 can feed himself at meals; however, staff will feed him if he "starts making a mess".

Review on 6/12/18 of client #13's IPP dated 11/2/17 revealed mealtime guidelines (6-S) last revised 4/22/10. Additional review of the guidelines noted, "Staff should allow [Client #13] to feed himself during all meals...If [Client #13] seems to display trouble feeding himself such as excess spillage or misuse of utensils, staff should assist him with hand over hand manipulation."

Interview with the QIDP on 6/12/18 confirmed client #13 should be feeding himself at meals and his mealtime guidelines were current and should be followed as written.

4. Client #5's cervical neck collar was not utilized as indicated.

During observations in the home throughout the survey on 6/11 - 6/12/18, client #5 did not wear a cervical neck collar. The neck collar was observed hanging from the handle bar of his wheelchair throughout the observations.

Staff interview on 6/12/18 revealed client #5 has a cervical neck collar which is used "for support" of his neck. The staff indicated the collar would be applied after meals and other specific times during the day.

Review on 6/12/18 of client #5's IPP dated

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W 249	Continued From page 7 2/15/18 revealed cervical collar application guidelines (43-S) dated 4/9/18. The guidelines noted, "Apply collar 4x daily for 30 minute intervals. Approximate wearing schedule should include mid morning between breakfast and lunch time, mid-afternoon between lunch and dinner and finally wearing period will be at his dinner meal." Additional review of the documentation sheet noted wear times of "9:30 - 10:00am...Lunch time...3:00 - 3:30...Dinner time". Interview on 6/12/18 with the QIDP confirmed the cervical collar should be used during meals and the current guidelines should be followed as written.	W 249		
W 252	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 observations, record review and interviews, the facility failed to ensure data was collected in accordance with individual program plan (IPP) objectives. This affected 2 of 6 audit clients (#5, #15). The findings are: 1. Client #15's behavior incident was not documented. During morning observations in the home on 6/12/18 at 7:41 am, client #15 grabbed a staff by her wrists and hit the staff on the head. During	W 252		

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additional observations at 8:13 am, the client hit two different staff in the living area of the home. Further observations in the home at 8:15am, client #15 ran across the room and bit another client on the top of the head causing the client to scream out loud.

Review on 6/12/18 of client #15's Behavior Intervention Program (dated 11/30/17) revealed an objective to reduce his frequency of defined disruptive behavior episodes to 190 or fewer for 10 out of 12 months. The plan noted, "...If he exhibits a target behavior, place the letter that corresponds with the behavior. If he exhibits more than one target behavior during a 30-minute interval, place each letter in the particular period. If he exhibits the same target behavior more than once during a 30-minute observation period, circle the particular letter that had been placed in the observation period indicating that multiple displays have occurred."

Additional review on 6/12/18 at 9:15am of client #15's objective training book (located in different living area of the home) revealed no documentation of any behavior incidents for the morning of 6/12/18.

Staff interview on 6/12/18 revealed documentation occurs as they are working and not at the end of the shift. The staff indicated some clients have goals with specific times identified for documentation.

Interview on 6/12/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be documenting behavior incidents as they occur.

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W 252	Continued From page 9 2. Client #5's service goal's were not documented as indicated. Review on 6/12/18 of client #5's IPP dated 2/15/18 revealed service goals for a PT exercise program dated 2/14/18 (42-S) and Cervical Collar Application Guidelines dated 4/9/18 (43-S). The exercise program noted range of motion exercises for both lower extremities and sit to stand exercises. Additional review of the goal indicated, "Staff should document [Client #5's] participation on the monthly exercise program log. The cervical collar guidelines revealed, "Apply collar 4x daily for 30 minute intervals." Further review of the client's objective training book including the service goals indicated the following data collection: PT exercises (42-S) - No June 2018 data collection sheet Cervical Collar (43-S) - missing data on 5/3 - 5/8/18 - missing data on 5/10 - 5/14/18 - missing data on 6/11/18 Staff interview on 6/12/18 indicated documentation occurs as they are working and not at the end of the shift. The staff indicated some clients have goals with specific times identified for documentation. Interview on 6/12/18 with the QIDP confirmed client #5's service goals should be documented as indicated.	W 252		
W 253	PROGRAM DOCUMENTATION	W 253		

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W 253	Continued From page 10 CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the individual program plan (IPP) fully addressed significant events that affected 1 of 6 audit clients (#6) program plan. The finding is: Client #6 received a swallowing evaluation that revealed he aspirates on his current diet consistency. Observations of client #6 during 3 meals revealed he was fed honey thick liquids with a spoon. Review of client #6's record on 6/12/18 revealed an IPP dated 9/13/17. This document revealed he is on a diet with honey thick liquids and uses "nosey cups" and adaptive utensils with built up handles. This was noted on several different pages and included photos of the adaptive dining equipment. Furthermore, the IPP included 16S for mealtime guidelines. The feeding guidelines did not specify how liquids should be given to him. Additional review of a recent modified barium swallow study (MBSS) for client #6 dated 4/18/18 revealed that he is aspirating on honey thick liquids. However, with spoon presentations of the liquid he did not aspirate. The study recommended that responsible parties should be aware of "his risk of aspiration" to make future diet decisions but recommended spoon not cup	W 253		

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W 253	Continued From page 11 sips of honey thick liquids if the diet continues. A more extensive list of possible meal strategies was listed if the responsible parties wanted to "take the risk" of him eating by mouth verses being tube fed. Further review of client of #6's record revealed no documentation of a core team; however, the Qualified Intellectual Disabilities Professional (QIDP) presented a print out of a core team she had saved on her on computer. This print out noted a core team was held on 4/18/18 to discuss the recent results of the MBSS. The QIDP stated the team did discuss risks. However, the documentation did not list the risks of continuing to eat by mouth. While the core team also mentioned they agreed to continue feedings with a spoon instead of a cup. However, there were no addendums to reflect this change on the IPP or in the feeding guidelines. The occupational therapy evaluation also remained unchanged. The IPP included pictures of nosey cups and adaptive built up utensils that should no longer be utilized with client #6 as he should be fed by staff with a spoon. An interview with the QIDP on 6/12/18 confirmed the IPP was not revised to fully reflect the significant finding and related changes.	W 253		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

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W 288	Continued From page 12 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #15's behavior was included in a formal active treatment plan. This affected 1 of 6 audit clients. The finding is: The use of Atarax was not included in client #15's Behavior Intervention Program (BIP). Review on 6/12/18 of client #15's BIP dated 11/30/17 revealed an objective to reduce his frequency of defined disruptive behavior episodes to 190 or fewer for 10 out of 12 months. The plan included the use of Perhenazine, Klonopin, Seroquel, Trazadone, Melatonin, Thioridazine and Valium. Additional review of the client's current physician's orders dated 5/1 - 5/31/18 identified orders for Atarax 25mg tablet, take 1 tablet by mouth 1 hour prior to dental appointment and Atarax 25mg tablet, may take 2nd tablet by mouth prior to appointment if needed. Further review of the record did not include the use of Atarax in a formal active treatment plan. Interview on 6/12/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #15 consumes Atarax prior to dental appointments and the medication should be included in his BIP.	W 288		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 369	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given without error. This affected 1 of 5 clients (#1) observed. The finding is: Client #1 did not receive his medications as ordered. During observations on the morning of 6/12/18 at 6:40am, the nurse began to administer client #1 his medications. He drank 30 ml of Lactulose but then the nurse was called to assess someone who had medical issues. When she returned, client #1 started to take his medications but spit them all out instead. The medications poured also included Calcium Carb, Therems Tablet, Vitamin D3 2000, Zonisamide 100, Tamoxifen 20mg. The nurse tried again later, but client #1 refused the medications. Review of the record on 6/12/18 confirmed the above medications are ordered for 7:00am. The orders were signed by the doctor on 4/27/18. The record did not include strategies for medication refusal. Interview on 6/12/18 with the nurse also confirmed the medications should have been given and stated he had a history of refusal but had not refused in a long time. She also indicated they went to liquid medications in the past when he would refuse.	W 369		