STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G231	A. BUILDING _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAWBERRY HOUSE	309 NORTH HOWARD STREET CHADBOURN, NC 28431

(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 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] 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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 7/2/18 of the facility's emergency preparedness (EP) plan (revised 5/21/18) did not include any information regarding alternate means of communication. During an interview on 7/3/18, staff indicated the home does not have an alternate means of communication other than the land line phone. When asked how they would contact someone if	E 032	E 032 the Facility will develop and maintain an emergency preparedness communication plan that compiles with Federal, State ans local laws. QP will In-service all staff members on the revision of the emergency preparedness communication plan. QP will review the plan annually. RECEIVED JUL 30 2018 DHSR-MH Licensure Sect	8/31/18 8/31/18

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

ICF Division Director 7-30-18

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 032	Continued From page 1 the land line was not working, the staff indicated they would likely need to use their personal cell phone. During an interview on 7/3/18, the Qualified Intellectual Disabilities Professional (QIDP) stated in regards to an alternate mean of communication "nothing has been put in place."	E 032		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. "[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] 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, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037	E 037 the Facility will assure each staff will receive training of the emergency preparedness plan and that all training are revised annually. QP and Program Manager will re-inservice all staff members on emergency preparedness plan. Program Manager will in-service all new hires on emergency preparedness plan. QP will in-service facility annually.	8/31/18 8/31/18

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E 037	Continued From page 2 *[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 annually. (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. *[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 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[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	E 037		

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E 037	Continued From page 3 arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (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. *[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 annually. (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. *[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, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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E 037	Continued From page 4 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency 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 annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency prepardness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 7/2/18 of the facility's EP plan (revised 5/21/18) did not include any information regarding training of staff. During an interview on 7/2 - 7/3/18, staff (2) revealed they had received training on conducting monthly drills for fire, tornado, or bomb threat type emergencies; however, the staff could not provide specifics regarding the facility's EP plan.	E 037		

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E 037	Continued From page 5 During an interview on 7/3/18, the Qualified Intellectual Disabilities Professional (QIDP) revealed there was no documentation to indicate if or when staff had been trained on the facility's EP plan.	E 037		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained regarding each client's diet and food/drink consistency. The findings are: 1. Staff were not adequately trained to ensure client #6's appropriate food/drink consistency and aspiration/swallowing guidelines were followed at 3 of 3 meals. During lunch observations in the home on 7/2/18 at 12:24 pm, client #6 consumed macaroni and cheese, green peas and chopped steak. All food items were ground, dry, thick and chunky. The client also consumed liquid which was of a pudding consistency. Client #6 used a spoon to scoop his liquids from his cup. At the lunch meal, client #6 consumed his food quickly and ate approximately 25% of the meal before drinking or prompts to drink. Client #6 periodically coughed while eating. Staff standing next to him provided verbal prompts to drink after the client coughed	W 189	W189 The Facility will assure each staff will receive proper training of diets, drink consistencies, and Aspiration/Swallowing guidelines at each meal. 1. Habilitation Specialist will in-service all staff members on diet, food consistencies, and aspiration guidelines for client #6. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/16/18 8/16/18

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

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FORM APPROVED
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W 189	Continued From page 6 briefly. During dinner observations in the home on 7/2/18 at 5:59pm, client #6 consumed baked chicken, green beans, cream corn and chocolate chip muffins. The beans and corn were loose and runny while the chicken was moist and thick with small chunks of meat visible. Client #6's milk was initially nectar thick as he began drinking it from his glass. Towards the end of the meal, the client began using a spoon to scoop his milk from the glass as the milk had thickened to a pudding consistency. As client #6 finished his meal, he began coughing. A staff next to him hit him on his back twice. He continued to cough while leaving the table and removing his dishes from the table. During the meal, the client consumed his food quickly putting large spoonfuls of food in his mouth. A staff next to him gave the client sporadic verbal prompts to "slow down"; however, he was not consistently prompted to drink any liquids between spoonfuls of food. During breakfast observations in the home on 7/3/18 at 7:37am, client #6 consumed Turkey sausage, a waffle, mixed fruit, and oatmeal. The oatmeal was dry and thick while the Turkey sausage was finely chopped and dry. The client also consumed orange juice, milk, prune juice and water. The liquids initially resembled a nectar type consistency as client #6 picked up his glass to drink. Towards the end of the meal, the drinks were thick and pudding like when consumed by the client using a spoon. It should also be noted that the client drank sips of his prune juice as a thin liquid while waiting to serve himself. Throughout the meal, client #6 consumed his food quickly and periodically coughed. Staff C stood next to him and	W 189	1. Habilitation Specialist will inservice all staff members on diet, food consistencies, and aspiration guidelines for client #6. Habilitation Specialist and Program mananger will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 7 encouraged the client to continue coughing and gave verbal prompts to "slow down." During observations of medication administration in the home on 7/3/18 at 7:10am, client #6 consumed his crushed pills in pudding with thin liquid (water). The client immediately coughed after drinking the water. Interviews on 7/3/18 with staff revealed the following regarding client #6's food/drink consistency and mealtime behaviors: Staff C revealed client #6's food goes in the blender for a pureed consistency. The staff indicated his liquids are "thickened ...so he won't get strangled." Additional interview revealed client #6's liquids should be a "pudding" consistency. The staff also indicated the client will cough at times during meals and they usually prompt him to keep coughing to clear his throat. Further interview indicated client #6 "eats fast" and the only mealtime guidelines they follow are to monitor client #6 at meals and tell him to "slow down." Staff A revealed client #6 gets a pureed diet and pudding thick liquids. The staff stated they add his food to a blender and the food "should be smooth". When asked why the client's Turkey sausage was dry and finely chopped, the staff indicated she does not usually add liquid to the client's meats. The staff also revealed oatmeal usually does not get processed in the blender. During the interview, the staff acknowledged client #6's sausage and oatmeal were not a pureed consistency. Review on 7/3/18 of client #6's IPP dated 6/1/18,	W 189	1. Habilitation Specialist will inservice all staff members on diet, food consistencies, and aspiration guidelines for client #6. Habilitation Specialist and Program mananger will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 8 current physician's orders and a diet consistency list posted in the home (dated 7/24/17) revealed he receives a Heart Healthy regular diet, "pureed smooth consistency" with "pudding thick liquids." Additional review of Guidelines for Aspirating and Swallowing dated 7/21/17 revealed, "Diet: Regular diet pureed...Liquids: Pudding thick...Supervision: 100% during meals and snacks." The guidelines noted the following: "1. Sits upright at 90 degree angle 2. Takes a tablespoon amount of food 3. Holds head up 4. Chews food 5. Performs voice check throughout meal, prompt to clear throat and swallow again (clear mouth between bites 6. Check mouth after each swallow to make sure clean 7. Take one sip of liquids at a time. 8. Perform voice check throughout meal, prompt to clear throat and swallow again (clear mouth between sips) 9. Wipes mouth with napkin (as needed) Follow above steps until meal is completed. After feeding: Sweep mouth with swab for any remaining food particles Maintain 90 degree position after feeding for 60 minutes (1 hour)" Additional review of the IPP revealed Rate of Eating Guidelines dated 6/18/14. These guidelines indicated, "[Client #6] has the tendency to eat too fast at times so these guidelines were put in place with the intent to help slow down and improve his rate of eating. Staff will start with a	W 189	1. Habilitation Specialist will inservice all staff members on diet, food consistencies, and aspiration guidelines for client #6. Habilitation Specialist and Program mananger will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 9 verbal cue, "[Client #6] slow down." Give him time to respond. If he does not respond to the first prompt then prompt him again and so on. These guidelines will be followed on all shifts. Staff will ensure that [Client #6] completes the following steps in order for him to eat his meal properly." Further review of the guidelines also noted, "1. Takes small mouthful of food...2. Chews food completely...3. Holds head up...4. Sips liquid...5. Wipes mouth with napkin." Interview on 7/3/18 the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6's current diet includes pureed foods and pudding thick liquids. Additional interview indicated the client's guidelines to address his rate of eating and aspiration/swallowing guidelines were also current and should continue to be followed by staff at meals. During the interview, the QIDP provided documentation which included staff training on client #6's diet, food/drink consistency and the client's guidelines for aspiration/swallowing at meals had been completed in July 2017. Review of the documents indicated staff B had attended the training; however, the document did not indicate staff A, staff C and two other staff working in the home during the survey had been included in the training. During an interview on 7/3/18, the facility's nurse also confirmed client #6 should have his foods pureed smooth and his liquids should be a pudding consistency which would likely make it difficult to drink the liquid from a glass if done properly. Additional interview revealed the client's cough during meals could be an indication that the consistency of his food or drinks was not appropriate. The nurse acknowledged more staff	W 189	1. Habilitation Specialist will inservice all staff members on diet, food consistencies, and aspiration guidelines/ rate of eating for client #6. Habilitation Specialist and Program mananger will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 10 training needed to be done. 2. Staff were not adequately trained to prepare foods/drinks to the appropriate consistency. During dinner preparation observations in the home on on 7/2/18 at 5:40pm, staff B prepared client #6's food using a blender. The staff added an undetermined amount of water to pieces of baked chicken and blended it up in the blender. Once finished, the meat was moist and thick with small pieces of chicken visible. The staff also blended mixed fruit and green beans in the blender with no liquid added. These food items were served with excess liquid noted. During breakfast preparation in the home on 7/3/18 at 7:25am, staff A prepared client #6's waffle and Turkey sausage using a blender. The staff added an undetermined amount of milk and syrup to a single waffle and blended it in the blender. Once finished, the waffle appeared soft and moist when placed in a bowl. The staff then added Turkey sausage to the blender and ground it to a finely chopped consistency. No liquid was added to the sausage in the blender. The meat was served dry and finely chopped. Client #6 also consumed oatmeal for breakfast. The oatmeal was not blended in the blender and appeared chunky, thick and dry when served. During 3 of 3 mealtime observations in the home on 7/2 - 7/3/18, several staff added varying amounts of Thick-It to client #6's liquids. The staff did not consistently measure the amount of Thick-It used to thicken the client's liquids. Client #6 consumed drinks which were of varying consistencies. At times, his drinks were a nectar like consistency which allowed him to drink freely	W 189	W189 The Facility will assure each staff will receive proper training of diets, drink consistencies, and Aspiration/Swallowing guidelines at each meal 2.QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #6. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/16/18 8/16/18

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W 189	Continued From page 11 from his glass. Other times, the client's drink was a pudding like consistency which required him to use a spoon to consume his drink. During one observation on 7/3/18, client #6 was given water without Thick-it added. Interview on 7/2/18 with staff B revealed client #6 is on a pureed diet and they always blend his food in the blender. Interview on 7/3/18 with staff A indicated they generally do not add liquid to client #6's meats and his oatmeal is not added to the blender before serving. Additional interview revealed they add Thick-it to his drinks. The staff referred to a list of each client's diet posted in the kitchen which identified pudding thick liquids for client #6. Review on 7/3/18 of a menu book located on the kitchen counter in the home revealed instructions "To Puree Food." The instructions noted, "Use a food processor or blender to puree all foods...Some foods can be blended without added liquid (e.g. drained, canned or soft-cooked)...Most other foods require added liquid...Gravy, sauces or broth...Adjust the thickness as needed. Add extra liquid if the product is too thick. If the product separates out, add more food or thicken with a commercial thickening agent." Further review on 7/2/18 of a document taped to the dining room table entitled, "Thick-it Mixing Chart Instant Food Thicker" revealed guidelines for the amount of Thick-it to be used when preparing liquids for nectar, honey and pudding consistencies. The document also noted amounts of Thick-it which could be added to certain fruits, vegetables and meats to obtain a	W 189		

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W 189	Continued From page 12 mashed potato consistency. Interview on 7/3/18 with the facility's nurse confirmed client #6's foods and drinks should be prepared a specific way to obtain the pureed consistency. Additional interview indicated his meats should have water or broth added and some foods may need to be reheated and additional liquid added if dryness is noted. Further interview revealed client #6 should have his foods pureed smooth and his liquids should be a pudding consistency which would likely make it difficult to drink the liquid from a glass if done properly. The nurse acknowledged staff need to be retrained on the food/drink consistencies for the home. 3. Staff were not adequately trained to ensure client #3's food/drink consistency was followed. a. During breakfast observations in the home on 7/3/18, client #3 consumed 2 whole Turkey sausage links. Further observations revealed the sausage links where 2 inches in length. At no time was client #3 prompted to cut his food. Further observations indicated a knife was at client #3's place setting. During an interview on 7/3/18, staff C revealed client #3's sausage should have been cut by staff. Review on 7/3/18 of client #3's IPP dated 6/6/18 stated, "On 7/19/17 [Client #3] had a appt with Speech Therapist at CRHS for a Clinical Swallow Assessment & Modified Barium Swallow Study. Dental soft diet with chopped meats...was ordered." Additional review of client #3's physician orders signed 5/16/18 revealed, "Bite size consistency." Review of client #3's medical	W 189	3. A. Habilitation Specialist will in-service all staff members on diet and food consistencies for client #3. Habilitation Specialist will create a goal to assist client #3 with cutting his food. Habilitation Specialist will in-service staff to ensure food is cut to the proper consistency. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 13 evaluation dated 6/6/18 stated, "...Dental soft diet with finely - chopped meats...," Further review of client #3's nutritional evaluation dated 10/10/17 indicated his diet is "finely chopped...." During an interview on 7/3/18, the facility's nurse confirmed client #3's current diet should have been followed by staff. b. During 3 of 3 meal observations in the home, client #3's liquids had an inconsistent amount of powdered Thick-it scooped into his liquids and then stirred by staff. During an interview on 7/3/18, staff C reported they were never trained on how much Thick-it should be scooped into client #3's cups of liquid. Further interview revealed staff C was not aware of the consistency in which client #3's liquids should be served. Review on 7/3/18 of client #3's IPP dated 6/6/18 stated, "On 7/19/17 [Client #3] had a appt with Speech Therapist at CRHS for a Clinical Swallow Assessment & Modified Barium Swallow Study...honey thick liquids was ordered." Review of client #3's nutritional evaluation dated 10/10/17 indicated, "Diet:...honey thick liquids...." During an interview on 7/3/18, the facility's nurse reported client #3's current diet should have been followed by staff. c. During medication administration observation in the home on 7/3/18 at 9:05am, client #3 consumed 5 pills with thin (regular) water. At no time was Thick-it added to his water. Immediately after being interviewed by the surveyor, the medication technician gave client #3	W 189	B.QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #3. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly. C. QP and Nurse will in-service all staff by demonstrating correct measurements for thick-it. Nurse and Program Manager will monitor med pass weekly. QP will monitor monthly.	8/16/18 8/16/18

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

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FORM APPROVED
OMB NO. 0938-0391

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W 189	Continued From page 14 a second glass of thin (regular) water. During an immediate interview, the medication technician confirmed client #3 should have drank his water with Thick-it added. During an interview on 7/3/18, the facility's nurse revealed Thick-it should have been added to client #3's water.	W 189		
	4. Staff were not adequately trained to ensure client #5's food consistency was followed.		4. QP and Habilitation Specialist will in-service staff on the correct portion size for client #5.	8/16/18
	a. During lunch observations in the home on 7/2/18, client #5's meat was cut into bite size pieces. Further observations revealed during the meal, client #5 vomited up a clear liquid while taking a sip of water. Client #5 coughed throughout the meal. During dinner observations in the home on 7/2/18, client #5's chicken was cut into bite size pieces. Further observations revealed client #5 coughed throughout the meal.			
	Review on 7/3/18 of client #5's IPP dated 6/1/18 stated, "On 7/27/17, [Client #5] had a appt with Speech Therapy Dept at CRHS for a Clinic Swallowing Assessment & MBSS....Dental Soft diet with finely chopped meats...with aspiration precautions was recommeneded." Review of client #5's physician orders signed 5/16/18 revealed his diet consistency is finely chopped. Additional review of client #5's nutritional evaluation dated 4/7/17 indicated, "...finely chopped texture all foods." During an interview on 7/3/18, the facility's nurse confirmed client #5's current diet order should		A. Habilitation Specialist will demonstrate the correct portion size for client #5. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/16/18

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W 189	Continued From page 15 have been followed by staff.	W 189		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive Behavior Support Plans (BSP) for 2 of 4 audit clients (#5 and #6) were reviewed and monitored by the specially constituted committee, designated as the Human Rights Committee. The findings are: The restrictive BSP's for client #5 and client #6 were not consistently reviewed/monitored by the HRC. Review on 7/2/18 of client #6's record revealed a behavior plan dated 4/11/18 to address non-compliance behaviors. The plan included the use of Tegretol and Valium. Additional review of client #5's BSP dated 4/11/18 incorporated the use of Risperdal. Additional review of the facility's HRC minutes for meetings held on 3/30/17, 7/17/17, 10/25/17, and 4/10/18 revealed client #6's behavior plan had only been reviewed during the 7/17/17 meeting. The minutes did not include any review of client #5's BSP. Interview on 7/3/18 with the Qualified Intellectual	W 262	W 262 The Facility will assure that the BSP's for client #5 and client #6 is reviewed and monitored by the Human Rights Committee.	8/31/18

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W 262	Continued From page 16 Disabilities Professional (QIDP) revealed the HRC selects clients "randomly" for review at their meetings. The QIDP confirmed client #5 and client #6 have not had their restrictive behavior plans consistently monitored by the HRC for the identified dates.	W 262	QP will ensure client#5 and client #6 BSP's is reviewed by the Human Rights Committee annually.	8/31/18
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive behavior support plan was only conducted with the written informed consent of all legal guardians. This affected 2 of 4 audit clients (#5, #6). The findings are: 1. Written informed consent was not obtained for client #5's restrictive Behavior Support Plan (BSP). Review on 7/3/18 of client #5's BSP dated 4/11/18 revealed his plan incorporated the use of Risperdal. Additional review of the record did not include written informed consent from the guardian for the BSP. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the consent paperwork had been sent to the guardian; however, it had not been returned as of the date of the survey.	W 263	1. QP will ensure that client #5 BSP consent is signed by the guardian. QP will monitor monthly.	8/31/18

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W 263	Continued From page 17 2. Written informed consent was not obtained for client #6's restrictive BSP. Review on 7/3/18 of client #6's BSP dated 4/11/18 revealed an objective to exhibit 1 or fewer challenging behaviors per month for 12 consecutive months. The plan incorporated the use of Tegretol and Valium. Additional review of the record did not include written informed consent from the guardian for the BSP. Interview on 7/3/18 with the QIDP revealed the consent paperwork had been sent to the guardian; however, it had not been returned as of the date of the survey.	W 263	2. QP will ensure that client #6 BSP consent is signed by the guardian. QP will monitor monthly.	8/31/18
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. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure medications were administered without error for 1 of 4 clients (#6) observed during the administration of medications. The finding is: Client #6's Systande .6% was not administered as indicated. During medication administration observations in the home on 7/3/18 at 7:10am, client #6 consumed 15 pills. Client #6 did not receive any other medications.	W 369	W369 The facility will ensure that all drugs will be self administered without error for client #6. Nurse will monitor weekly. QP will monitor monthly.	8/31/18

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W 369	Continued From page 18 Review on 7/3/18 of client #6's physician's orders signed 5/16/18 indicated, "Systande .6% at 8am, 2pm and 8pm." During an interview on 7/3/18, the facility's nurse confirmed client #6 should have received his eye drops. The nurse revealed client #6's orders for his eye drops is currently for three times a day.	W 369	W369 The facility will ensure that all drugs will be self administered without error for client #6. Nurse will monitor weekly. QP will monitor monthly.	8/31/18
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure client #6 was taught to administer his own medications as appropriate. This affected 1 of 4 audit clients. The finding is: Client #6 was not encouraged to assist with the administration of his medications to his full potential. During observations of medication administration in the home on 7/3/18 at 7:10am, staff fed client #6 his medications in pudding without prompting him to participate with this task. Staff interview on 7/2/18 revealed client #6 was spoon fed his medications, because he will "get	W 371	W371 The facility will ensure that client #6 will actively participate in medication administration. Habilitation Specialist will develop a medication goal and in-service staff, Habiliation Specialist will monitor weekly. Nurses will monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 371	Continued From page 19 the meds all over himself." Review on 7/3/18 of client #6's IPP dated 6/1/18 revealed he "eats independently". Interview on 7/3/18 with the facility's nurse confirmed client #6 can feed himself but will sometimes refuse his medications. The nurse; however, acknowledged the client should have been given the opportunity to feed himself during medication administration.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all drugs and biologicals remained locked. The finding is: The medications were left unsecured and unsupervised by the medication technician. During morning medication administration in the home on 7/3/18 at 8:40am, the medication technician exited the medication room while escorting a client back into the living room. Further observations revealed a box of eye drops and nose spray where left out on the table. Additional observations revealed the medication closet was left open. The surveyor was left alone in the medication room, where the closet is located, for 2 minutes.	W 382	W382 The facility will ensure all drugs and biologicals are locked safely during medication administration. Nurse will in-service all staff on proper way to secure the medication when leaving the medication room while medications are being administered. Nurse will monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 382	Continued From page 20 During an immediate interview, the medication technician confirmed the medications should not have been left out unattended. The medication technician indicated she had training to ensure that all medications are to be kept locked up, except when being administered. During an interview on 7/3/18, the facility nurse confirmed the door to medication closet should have been locked and all medications should be kept locked up, except when being administered. The staff also revealed all staff have been trained in the procedure of keeping the medication closet door locked.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure only authorized persons have access to the keys to the medication closet. This potentially affected all clients in the home. The finding is: The key to the medication closet was left assessable. During morning medication administration in the home on 7/3/18 at 8:40am, the medication technician exited the medication room while escorting a client back into the living room. Further observations revealed the medication closet doors where open and the key was left in the lock. The surveyor was left alone in the	W 383	W383 The facility will ensure that the medication closet is locked and medication technician will always have possession of the medication keys. Nurse will in-service all staff on proper techniques to use while administering medication. Nurses and Program Manager will monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 383	Continued From page 21 medication room, where the closet is located, for 2 minutes. During an immediate interview, the medication technician confirmed the key to the medication closet should not have been left in the lock. Further interview revealed the key should be kept on the mediation technician at all times. During an interview on 7/3/18, the facility's nurse confirmed the key should not have been left in the lock and should be kept on the medication technician at all times. Further interview revealed all staff have been trained.	W 383		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment specifically eyeglasses was furnished for 1 of 4 audit clients (#1). The finding is: Client #1's was not prompted to wear her eyeglassess. During observations in the home on 7/2/18 from 11:45 until 1:30pm and 3:40pm until 6:47pm,	W 436	W436 Habilitation Specialist will formulate a guideline and in-service all staff members on client #1's eyeglasses guidelines. Habilitation Specialist will observe and monitor weekly. QP will monitor monthly.	8/31/18

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W 436	Continued From page 22 client #1 was sewing a potholder and looking at magazines. At no time was client #1 prompted or assisted to wear eyeglasses. During morning observations in the home on 7/3/18 from 6:28am until 9:25am, client #1 wore eyeglasses. Further observations revealed client #1 was sewing a potholder. During an interview on 7/3/18, staff stated, "[Client #1] wears her glasses when she's sewing or doing a puzzle." Further interview revealed she wears her eyeglasses because "she can't see." When asked where client #1 keeps her eyeglasses, the staff stated, "In her bag on the back of her wheelchair." Additional interview revealed client #1 will ask to wear her eyeglasses. Review on 7/3/18 of client #1's IPP dated 10/17/17 revealed there was no guidelines for staff regarding the wearing of her eyeglasses. During an interview on 7/3/18, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's IPP did not contain any guidelines in regards to how staff are to prompt client #1 to wear her eyeglasses.	W 436		
W 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: ensure each client received	W 459	W459 The facility will ensure the specific dietetic services requirements are met for each client.	8/31/18

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W 459	Continued From page 23 their modified and specially-prescribed diets (W460); foods were served at an appropriate temperature (473); food was served with the appropriate utensils (475); and menus for food actually served was kept for 30 days (481) The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.	W 459	QP will in-service all staff on each client specific diet QP will update the diet sheet. Program manger will monitor weekly. QP will monitor monthly.	8/31/18
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.460(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 3 of 4 audit clients (#3, #5, #8) received their modified and specially-prescribed diets as indicated. The findings are: 1. Client #6's appropriate food/drink consistency was not followed at 3 of 3 meals. During lunch observations in the home on 7/2/18 at 12:24 pm, client #6 consumed macaroni and cheese, green peas, and chopped steak. The food items were ground, dry, thick and chunky. The client also consumed liquid which was of a pudding consistency. Client #6 used a spoon to scoop his liquids from his cup. At the lunch meal, client #6 consumed his food quickly and ate approximately 25% of the meal before drinking or prompts to drink. Client #6 periodically coughed while eating. Staff standing next to him provided	W 460	W460 The facility will ensure that each client receive a nourishing well-balanced diet including modified and specially-prescribed diets. 1. QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #6. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 460	Continued From page 24 verbal prompts to drink after the client coughed briefly. During dinner observations in the home on 7/2/18 at 5:59pm, client #6 consumed baked chicken, green beans, cream corn and chocolate chip muffins. The beans and corn were loose and runny while the chicken was moist and thick with small chunks of meat visible. Client #6's milk was initially nectar thick as he began drinking it from his glass. Towards the end of the meal, the client began using a spoon to scoop his milk from the glass as the milk had thickened to a pudding consistency. As client #6 finished his meal, he began coughing. A staff next to him hit him on his back twice. He continued to cough while leaving the table and removing his dishes from the table. During the meal, the client consumed his food quickly putting large spoonfuls of food in his mouth. A staff next to him gave the client sporadic verbal prompts to "slow down"; however, he was not consistently prompted to drink any liquids between spoonfuls of food. During breakfast observations in the home on 7/3/18 at 7:37am, client #6 consumed Turkey sausage, a waffle, mixed fruit, and oatmeal. The oatmeal was dry and thick while the Turkey sausage was finely chopped and dry. The client also consumed orange juice, milk, prune juice and water. The liquids initially resembled a nectar type consistency as client #6 picked up his glass to drink. Towards the end of the meal, the drinks were thick and pudding like when consumed by the client using a spoon. It should also be noted that the client drank sips of his prune juice as a thin liquid while waiting to serve himself. Throughout the meal, client #6 consumed his food quickly and periodically	W 460	W460 Habilitation Specialist will inservice all staff members on diet, food consistencies, and aspiration guidelines for client #6. Habilimtion Specialist and Program mananger will observe and monitor weekly. QP will monitor monthly.	8/31/18

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	34G291	A. BUILDING _____ B. WING _____	07/03/2018

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W 460	Continued From page 25 coughed. Staff C stood next to him and encouraged the client to continue coughing and gave verbal prompts to "slow down." During observations of medication administration in the home on 7/3/18 at 7:10am, client #6 consumed his crushed pills in pudding with thin liquid (water). The client immediately coughed after drinking the water. Interviews on 7/3/18 with staff revealed the following regarding client #6's food/drink consistency: Staff C revealed client #6's food goes in the blender for a pureed consistency. The staff indicated his liquids are "thickened ...so he won't get strangled." Additional interview revealed client #6's liquids should be a "pudding" consistency. The staff also indicated the client will cough at times during meals and they usually prompt him to keep coughing to clear his throat. Staff A revealed client #6 gets a pureed diet and pudding thick liquids. The staff stated they add his food to a blender and the food "should be smooth." When asked why the client's turkey sausage was dry and finely chopped, the staff indicated she does not usually add liquid to the client's meats. The staff also revealed oatmeal usually does not get processed in the blender. During the interview, the staff acknowledged client #6's sausage and oatmeal were not a pureed consistency. Review on 7/3/18 of client #6's IPP dated 6/1/18 revealed, "...On 7-19-17, [Client #6] had an appt at CRHS Speech Therapy Dept for a swallowing assessment & MBSS. They recommended NPO	W 460	W460 QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #6. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/31/18

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W 460	Continued From page 26	W 460		

status due to the increased risk of aspiration. On 7-20-17, a STAT interdisciplinary team meeting was held to discuss the dysphasia & aspiration risk. The speech therapist recommendation was discussed, along with the consequences of Implementing it. The team decided to continue allowing [Client #6] to consume a pureed diet with pudding thick liquids. 100% supervision is needed with all meals & snacks..."

Additional review on 7/3/18 of client #6's IPP and current physician's orders and a diet consistency list posted in the home (dated 7/24/17) revealed he receives a Heart Healthy regular diet, "pureed smooth consistency" with "pudding thick liquids."

Interview on 7/3/18 the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6's current diet includes pureed foods and pudding thick liquids.

During an interview on 7/3/18, the facility's nurse also confirmed client #6 should have his foods pureed smooth and his liquids should be a pudding consistency which would likely make it difficult to drink the liquid from a glass if done properly. Additional interview revealed the client's cough during meals could be an indication that the consistency of his food or drinks was not appropriate.

2. Client #6 did not receive prune juice as recommended.

During snack observations in the home on 7/2/18 at 3:47pm, client #6 consumed a pudding cup and Kool-aid. The client was not offered prune juice.

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W 460	Continued From page 27 Review 7/2/18 of a dietary list (dated 7/24/17) posted in the home revealed client #6 should consume prune juice at breakfast and "4p snack." Additional review of the client's IPP dated 6/1/18 also indicated prune juice should be consumed at his 4:00pm snack. Staff interview on 7/3/18 revealed the client's diets posted in the home should be followed. Interview on 7/3/18 with the QIDP confirmed client #6 should have received prune juice at snack time. 3. Client #3's food/drink consistency was not followed. a. During breakfast observations in the home on 7/3/18, client #3 consumed 2 whole Turkey sausage links. Further observations revealed the sausage links where 2 inches in length. At no time was client #3 prompted to cut his food. Further observations indicated a knife was at client #3's place setting. During an interview on 7/3/18, staff C revealed client #3's sausage should have been cut by staff. Review on 7/3/18 of client #3's Ipp dated 6/6/18 stated, "On 7/19/17 [Client #3] had a appt with Speech Therapist at CRHS for a Clinical Swallow Assessment & Modified Barium Swallow Study. Dental soft diet with chopped meats...was ordered." Additional review of client #3's physician orders signed 5/16/18 revealed, "Bite size consistency." Review of client #3's medical evaluation dated 6/6/18 stated, "...Dental soft diet with finely - chopped meats...." Further review of client #3's nutritional evaluation dated 10/10/17	W 460	3. A. Habilitation Specialist will in-service all staff members on diet and food consistencies for client #3. Habiliitation Specialist will create a goal to assist client #3 with cutting his food. Habilitation Specialist will in-service staff to ensure food is cut to the proper consistency. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/31/18

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W 460	Continued From page 28 indicated his diet is "finely chopped...." During an interview on 7/3/18, the facility's nurse confirmed client #3's current diet should have been followed by staff. b. During 3 of 3 meal observations in the home, client #3's liquids had an inconsistent amount of powdered Thick-It scooped into his liquids and then stirred by staff. During an interview on 7/3/18, staff C reported they were never trained on how much Thick-It should be scooped into client #3's cups of liquid. Further interview revealed staff C was not aware of the consistency in which client #3's liquids should be served. Review on 7/3/18 of client #3's IPP dated 6/8/18 stated, "on 7/19/17 [Client #3] had an appt with Speech Therapist at CRHS for a Clinical Swallow Assessment & Modified Barium Swallow Study...honey thick liquids was ordered." Review of client #3's nutritional evaluation dated 10/10/17 indicated, "Diet:...honey thick liquids...." During an interview on 7/3/18, the facility's nurse reported client #3's current diet should have been followed by staff. c. During medication administration observation in the home on 7/3/18 at 9:05am, client #3 consumed 5 pills with thin (regular) water. At no time was Thick-It added to his water. Immediately after being interviewed by the surveyor, the medication technician gave client #3 a second glass of thin (regular) water. During an immediate interview, the medication	W 460	B.QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #3. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly. C. QP and Nurse will in-service all staff by demonstrating correct measurements for thick-it and when thick it should be administered. Nurse and Program Manager will monitor med pass weekly. QP will monitor monthly.	8/31/18

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W 460	Continued From page 29 technician confirmed client #3 should have drank his water with Thick-It added. During an interview on 7/3/18, the facility's nurse revealed Thick-It should have been added to client #3's water. 4. Client #5's food consistency was not followed. a. During lunch observations in the home on 7/2/18, client #5's meat was cut into bite size pieces. Further observations revealed during the meal, client #5 vomited up a clear liquid while taking a sip of water. Client #5 coughed throughout the meal. During dinner observations in the home on 7/2/18, client #5's chicken was cut into bite size pieces. Further observations revealed client #5 coughed throughout the meal. Review on 7/3/18 of client #5's IPP dated 6/1/18 stated, "On 7/27/17, [Client #5] had an appt with Speech Therapy Dept at CRHS for a Clinic Swallowing Assessment & MBSS....Dental Soft diet with finely chopped meats...with aspiration precautions was recommended." Review of client #5's physician orders signed 5/16/18 revealed his diet consistency is finely chopped. Additional review of client #5's nutritional evaluation dated 4/7/17 indicated, "...finely chopped texture all foods." During an interview on 7/3/18, the facility's nurse confirmed client #5's current diet order should have been followed by staff.	W 460	4. QP and Habilitation Specialist will in-service staff on the correct portion size for client #5. A. Habilitation Specialist will demonstrate the correct portion size for client #5. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly.	8/31/18 8/31/18
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii)	W 473		

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W 473	Continued From page 30 Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure foods were served at an appropriate temperature. This affected all clients residing in the home. The finding is: Food items were not served at an appropriate temperature. During breakfast observations in the home on 7/3/18 at 7:25am, staff removed waffles from the oven and placed one in the blender with cold milk added. The waffle was blended and served to client #6 at 7:39am. The temperature of the food was not taken. Additional breakfast observations revealed milk was removed from the refrigerator at 7:12am and poured into pitchers. The milk remained on the kitchen counter and then the dining room table until 7:45am, when clients began serving themselves the milk. Review of a note posted on a kitchen cabinet in the home (no date) revealed, "Hot food should be heated to a temperature of 140 degrees...Check temperature with thermometer before serving. Should be at least 110 degrees...Cold foods should remain at a temperature of 40 degrees until served...Food should be served within 15 minutes of leaving refrigeration or heating device...If longer than 15 minutes, reheat hot foods..." During an interview on 7/3/18, staff acknowledged adding cold milk to the waffles	W 473	W473 The facility will ensure all meal are served at appropriate temperatures. Staff will be in-service on meal preparation and how to check temperatures of food. Program manager and Habilitation Specialist will monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 473	Continued From page 31 lowered the temperature. The staff also referred to a note posted on a kitchen cabinet regarding food temperatures. Additional interview indicated a temperature gauge would be used to take food temperatures; however, the staff could not locate one in the kitchen. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be ensuring foods are served at appropriate temperatures as indicated including foods of altered consistencies.	W 473		
W 475	MEAL SERVICES CFR(s): 483.460(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, document reviews and interviews, the facility failed to ensure food was served with appropriate adaptive eating equipment. This affected 2 of 4 audit clients (#5, #6). The findings are: 1. Information to support the use of a clothing protector and dycem mat at meals was not included in client #6's program plan. During lunch and dinner observations in the home on 7/2/18 at 12:30pm and 5:59pm, client #6 used a dycem mat under his plate at both meals. During breakfast observations in the home on 7/3/18 at 7:37am, client #6 did not consume his food with a dycem mat positioned under his plate. During additional observations of all meals in the home on 7/2 - 7/3/18, staff placed a large thin	W 475	W475 The facility will ensure all food is served with appropriate utensils. 1. Staff will be in-service on the proper use of adaptive equipment in following client #6 IPP.	8/31/18 8/31/18

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W 475	Continued From page 32 cloth around client #6's neck and tucked the cloth in the collar of his shirt. The client periodically removed the cloth, while staff replaced the cloth. Staff interview on 7/3/18 revealed the cloths are used as clothing protectors for all of the clients in the home. Review on 7/3/18 of client #6's record did not reveal any information regarding the use of a clothing protector or dycem mat at meals. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed all adaptive equipment should be identified on the client's diet sheet. The QIDP acknowledged the information should also be included in client #6's record. 2. Information to address client #5's the usage of a dycem mat and clothing protector was not included in his program plan. a. During lunch observations in the home on 7/2/18, client #5's plate had a dycem mat underneath it. During dinner and breakfast observations in the home on 7/3/18, a dycem mat was not underneath client #5's plate. During lunch and dinner observations in the home on 7/2/18, client #5 had a large over-sized napkin tucked into his shirt collar by staff prior to him eating. During breakfast observations in the home on 7/3/18, client #5 had the upper portion of a large over-sized napkin around his neck while the lower portion was placed underneath his plate while he consumed his meal.	W 475	2. QP will review IPP and in-service staff on correct usage of a dinner napkin. Program manager will monitor weekly. QP will monitor monthly.	8/31/18

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W 475	Continued From page 33 During an interview on 7/3/18, staff revealed client #5's napkin should not have been placed underneath his plate. Further interview staff stated client #5 used the napkin to protect his clothes from when food spills while he is eating. Review on 7/3/18 of client #5's record dated 6/1/18 revealed there was no information for staff regarding the usage of a dycem mat or clothing protector. During an interview on 7/3/18, the QIDP confirmed client #5's record did not contain any information in regards to how staff are to use a dycem mat or clothing protector with him during meals.	W 475		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a record of foods actually served was kept. The finding is: Food substitutions were not documented. Dinner observations in the home on 7/2/18 at 5:59pm revealed clients were served baked chicken, green beans, cream style corn, and chocolate chip muffins. Review of the dinner menu noted barbeque chicken, steamed cabbage, creamed corn, Angel food cake and dinner rolls. Staff interview on 7/2/18 confirmed food	W 481	W481 The facility will ensure all food substitutions are documented. Program manager will in-service staff on the proper way to document a food substitutions. Program manager will monitor weekly. QP will monitor monthly.	8/31/18 8/31/18

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W 481	Continued From page 34 substitutions were made for items at the dinner meal. Breakfast observations in the home on 7/3/18 at 7:37am revealed clients were served oatmeal, turkey sausage, fruit cups and waffles. Review of the breakfast menu noted oatmeal, turkey bacon, and assorted fruit, English muffins. Staff interview on 7/3/18 confirmed food substitutions were made for items at the breakfast meal. Additional interview indicated they have not been told to document food substitutions. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff should be documenting any substitutions made at meals.	W 481		