PRINTED: 08/23/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G039	A. BUILDING Moore B. WING	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER-ADULT RESIDENTIAL	737 CHAPPELL DRIVE RALEIGH, NC 27606

(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 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. *[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.	E 037	Correct: Staff was trained on the Emergency Preparedness Plan in April, 2018. Staff will be retrained on the Emergency Preparedness Plan including but not limited to alternative relocation sites by September 30, 2018. Training will be conducted by Property Management and QM. Prevent: Staff will be trained on the Emergency Preparedness Plan at orientation and annually. Agency QM will implement an annual Emergency Preparedness Training. Monitor: Maintain in-service training sign in sheets and develop a test to be administered at each annual training. How Often: New Hire Orientation and Annually. DHSR-Mental Health SEP 05 2018 Lic. & Cert. Section	10/20/18

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

President + CEO | 9/4/2018

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 037	Continued From page 1 (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 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.	E 037		

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E 037	Continued From page 2 *[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, 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	E 037		

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E 037	Continued From page 3 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 interview and record review, the facility failed to assure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is: Staff had not received adequate training on the emergency plan (EP). Review on 8/20/18, of the facility documents revealed training in-service sheets for direct care staff in regards to their EP plan. Staff interviews (2) on 8/20/18 and 8/21/18 revealed the following: staff were able to provide the procedures regarding fire drills and disaster drills; however, the staff could not provide specific details in regards to their alternative relocation sites if they have to evacuate the facility. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) revealed all staff have been trained on their EP plan and should be aware of the alternative relocation sites.	E 037		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1)	W 111		

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W 111	Continued From page 4 The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to maintain a recording system that accurately reflected the clients' status. The finding is: Client #3's records was not maintained with accurate information. Review on 8/21/18 of client #3's record revealed a psychological evaluation with another clients name on it. This psychological evaluation did not belong to client #3. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) confirmed the client's record contained inaccurate information which belong to another client and should not have been in client #3's record.	W 111	Correct: QDDP removed psychological evaluation from client 3's file and was placed into the correct client file. Prevent: QDDP, QM and supervisory staff will perform medical records audits to ensure client documents are maintained in the appropriate client files. Monitor: Monitoring will take place with monthly Peer Reviews and spot audits by QM. How Often: Monthly Peer Reviews and spot audits.	10/20/18
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, record reviews, and interview, the facility failed to assure client #8 had	W 125		

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W 125	Continued From page 5 the right to freedom of movement in her environment. This affected 1 of 5 audit clients. The finding is: Client #8's wheelchair was locked while in the home. During morning observations in the home on 8/21/18 from approximately 6:30am - 7:14am, client #8 sat in her wheelchair in her bedroom. Further observations revealed client #8 attempting to self-propel her wheelchair out of her bedroom and into the hallway. Additional observations revealed staff entering client #8's bedroom unlocking her wheelchair and moving it back in front of the television and then re-locking her wheelchair. Review on 8/21/18 of client #8's individual program plan (IPP) dated 10/23/17 stated, "...able to maneuver her wheelchair independently." Review on 8/21/18 of client #8's nursing evaluation dated 10/15/17 revealed, "[Client #8] ambulates via wheelchair and is able to independently propel herself in her wheelchair." Review on 8/21/18 of client #8's physical therapy (PT) evaluation dated 10/10/17 indicated, "Guidelines for Wheelchair: Since [Client #8] is able to push her wheelchair for short distances, she should be given this opportunity when she is safe to do so. Her wheelchair wheels should remain unlocked unless she is in an unsafe area or needs to be stationary for a programming activity...Strengths: Ability to propel her w/c short distances on even surfaces." During an interview on 8/21/18, the third shift	W 125	Correct: Staff will be in-serviced on each individual's plan, ambulation goals and guidelines by September 30, 2018. Prevent: Staff will be in-serviced on each individual's plan, ambulation goals and guidelines. Staff will encourage individuals to move freely throughout their environments according to their plan. Staff will not be allowed to lock wheel chairs unless there is a safety concern, repositioning, or refreshing. Monitor: Maintain in-service training sign in sheets. QP and Shift Supervisors will monitor staff daily for one month on all shifts to ensure all individuals are moving freely throughout their environment according to their plan. How Often: In-service by September 30, 2018 and annually and/or when ambulation goals change.	10/20/18

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W 125	Continued From page 6 supervisor revealed client #8's wheelchair should be unlocked because she is able to self-propel her wheelchair. Further interview revealed the locking of client #8's wheelchair is "like a restraint" and it might cause a behavior. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) confirmed client #8's wheelchair should have been unlocked, because she has the ability to self-propel her wheelchair.	W 125		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure written procedures to prevent potential neglect. This affected 1 of 5 audit clients (#5). The finding is: Staff did not assure client (#5) were toileted in a timely manner. During afternoon observations in the home on 8/20/18 from approximately 3:55pm - 5:20pm, client #5 was observed walking throughout the building. Client #5's shorts were wet in the front and between his legs. As client #5 continued to walk around the building he was observed walking around and near staff on duty. Additional observations revealed as the time elapsed, client #5's shorts become more soaked and the wet spots were larger in size in the front and back. At	W 149	Correct: Staff will be in-serviced on ensuring all individuals are refreshed at a minimum of every two hours or as needed by September 30, 2018. QP will amend client 5's ISP to include and individual toileting goal to be worked on daily by September 30, 2018. Prevent: Staff will be in-serviced on policies and procedures for refreshing clients every two hours or as needed. Staff will be trained to look for obvious signs of need for refreshment. Monitor: Maintain in-service training sign in sheets. QP and Shift Supervisors will monitor staff and residents for one month on all shifts to ensure all individuals are being refreshed on schedule. Monitoring sheets will be maintained for one month ensuring proper refreshment. Client 5's ISP toileting goal with be run daily and documented accordingly in the medical record. How Often: In-service and ISP update by September 30, 2018.	10/20/18

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W 149	Continued From page 7 approximately 4:46pm, the qualified intellectual disabilities professional (QIDP) escorted client #5 by walking side by side with him from the hallway to were other clients were singing along with the Karaoke machine in the day room. The QIDP assisted client #5 to sit down in a chair. At no time did staff notice the wetness of client #5's shorts, until he sat down at the dining room table at 5:20pm as he was about to begin eating his dinner. During an interview on 8/20/18, staff stated client #5 "is not on a toileting schedule because he wears a diaper." During an interview on 8/21/18, staff revealed how client #5's shorts were observed to be wet and how it was not addressed could be considered neglect. Review on 8/21/18 of client #5's individual program plan (IPP) dated 4/19/18 stated, "[Client #5] follows simple routine commands when provided with appropriate cues...." Review on 8/21/18 of client #5's comprehensive functional assessment dated 4/19/17 revealed client #5 is able to use the toilet with partial physical assistance. During an interview on 8/21/18, the QIDP revealed client #5 does not have a toileting schedule. The QIDP stated client #5 does not indicate when he needs to toilet and he relies on staff when he needs to toilet.	W 149	Correct: Staff will be in-serviced on ensuring all individuals are refreshed at a minimum of every two hours or as needed by September 30, 2018. QP will amend client 5's ISP to include and individual toileting goal to be worked on daily by September 30, 2018. Prevent: Staff will be in-serviced on policies and procedures for refreshing clients every two hours or as needed. Staff will be trained to look for obvious signs of need for refreshment. Monitor: Maintain in-service training sign in sheets. QP and Shift Supervisors will monitor staff and residents for one month on all shifts to ensure all individuals are being refreshed on schedule. Monitoring sheets will be maintained for one month ensuring proper refreshment. Client 5's ISP toileting goal with be run daily and documented accordingly in the medical record. How Often: In-service and ISP update by September 30, 2018	10/20/18
W 209	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(2)	W 209		

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W 209	Continued From page 8 Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure client #4 was afforded the opportunity to participate in the development of her individual program plan (IPP). This affected 1 of 5 audit clients. The finding is: Client #4 did not attend her annual IPP meeting. Review on 8/20/18 of client #4's record revealed review of the client's IPP meeting attendance list and signature sheet revealed client #4 had not attended her planning meeting. Further review of the IPP revealed the client's guardian had also not attended the meeting. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) confirmed neither client #4 or her guardian had attended her annual IPP meeting. Further interview revealed the IPP was not discussed with either client #4 or her guardian.	W 209	Correct: Client's ISP was updated to include information on why client and guardian did not participate in the plan meeting. As best practice, individuals generally attend their ISP meetings. Guardian was able to provide feedback and contribute to client's ISP; however, had a conflict and could not attend the meeting. A copy of the ISP and supporting documentation were discussed with and mailed to the guardian. Prevent: QP will give adequate notice of dates of ISP Meetings allowing for adequate participation from guardians and natural supports. QP will change date of ISP Meetings if necessary to accommodate schedules if needed. Monitor: QP and Social worker will continue to coordinate ISP meetings. How Often: Annually.	10/20/18
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated	W 242		

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W 242	Continued From page 9 that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, record review and interview the interdisciplinary team failed to assure objective training to meet identified needs relative to toileting were implemented for 1 of 5 audit clients (#5). The finding is: Client #5's interdisciplinary team failed to establish training in the area of toileting to address his personal care needs. During afternoon observations in the home on 8/20/18 from approximately 3:55pm - 5:20pm, client #5 was observed walking throughout the building. Client #5's shorts were wet in the front and between his legs. As client #5 continued to walk around the building he was observed walking around and near staff on duty. Additional observations revealed as the time elapsed, client #5's shorts become more soaked and the wet spots were larger in size in the front and back. At approximately 4:46pm, the qualified intellectual disabilities professional (QIDP) escorted client #5 by walking side by side with him from the hallway to were other clients were singing along with the Karaoke machine in the day room. The QIDP assisted client #5 to sit down in a chair. At no time did staff notice the wetness of client #5's shorts, until he sat down at the dining room table at 5:20pm as he was about to begin eating his dinner. During an interview on 8/20/18, staff stated client #5 "is not on a toileting schedule because he wears a diaper."	W 242	Correct: QP will amend client 5's ISP to include and individual toileting goal to be worked on daily by September 30, 2018. Prevent: Staff will be in-serviced on policies and procedures for refreshing clients every two hours or as needed. Staff will be trained to look for obvious signs of need for refreshment. Monitor: Client 5's ISP toileting goal with be run daily and documented accordingly in the medical record. How Often: In-service and ISP update by September 30, 2018.	10/20/18

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W 242	Continued From page 10 Review on 8/21/18 of client #5's individual program plan (IPP) dated 4/19/18 stated, "[Client #5] follows simple routine commands when provided with appropriate cues...." Further review revealed there was not any objective training considered for client #5 to make him more independent in this area. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) revealed client #5 had a toileting schedule in the past, but it was unsuccessful and it was discontinued. The QIDP confirmed client #5 does not have any training to address his toileting needs.	W 242		
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 observation, interviews and record reviews, the facility failed to assure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of program implementation, serving self and adaptive spoon use during medication	W 249	Correct: Staff will be in-serviced on each individual's meal time plan by September 30, 2018. Staff will be instructed to follow meal plan as written at all times unless there is a change in functioning requiring a change in plan. Nurses will be in-serviced on adaptive equipment goals for self-administration of medication. Staff will be in-serviced on redirecting Client 5 on personal space boundaries and redirect as needed from others personal space when not occupied and/or on a visit. Client 1's mealtime plan will be updated to include use of both hands for feeding by OT. Prevent: Staff will be in-serviced on each individual's meal time plan. Staff will encourage individuals to assist with meal time activities including feeding themselves, serving themselves, drinking and eating independently, use of adaptive equipment according to their individual abilities and ISP goals.	10/20/18

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	34G039	A. BUILDING Moore B. WING	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER-ADULT RESIDENTIAL	737 CHAPPELL DRIVE RALEIGH, NC 27608

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W 249	Continued From page 11 administration. This affected 3 of 5 audit clients (#1, #3 and #5). The findings are: 1. Staff were not positioned on client #1's left side to encourage and promote independence as per her individual program plan (IPP). During observation of the lunch and dinner meal in the home on 8/20/18, staff were seated on client #1's right side and client #1 was encouraged to use her right hand. Review on 8/220/18 of client #1's IPP dated 10/10/17 revealed, "Since [Client #1] is left handed, she grasps the spoon with her left hand and staff should always sit to the left." During an interview on 8/21/18, staff stated they sat on client #1's right side as they assisted client #1 during her meals. Further interview revealed client #1 is ambidextrous and they do not have to sit on a particular side. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) confirmed client #1's IPP should have been followed and staff should have been positioned on client #1's left side. 2. Client #3 was not consistently afforded the opportunity to serve herself during meals. During observations of the lunch meal in the home on 8/20/18, staff served client #3 her meals and poured her beverages. The staff did not offer nor encourage client #3 to assist with any of these tasks. During observations of the dinner meal in the	W 249	Nursing will be in-serviced on the self-administration of medication goals for each client. Monitor: Maintain in-service training sign in sheets. QP and Shift Supervisors will monitor meal times 3 times per week for one month, ensuring all meal plans are followed as written. How Often: In-service by September 30, 2018 and annually and/or when abilities and goals change.	

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W 249	Continued From page 12 home on 8/20/18, staff served client #3 her meals and poured her beverages. When client #3 indicated to staff she wanted more of the Squash and Zucchini Medley, the staff obtained the serving dish and placed more onto client #3's plate. The staff did not offer nor encourage client #3 to assist with any of these tasks. Review on 8/21/18 of client #3's comprehensive functional assessment dated 7/1/18 revealed, "6. Can serve self an appropriate serving size from a large container using utensil...8. Can pour...liquid from pitcher to glass or cup Physical Assistance." During an interview on 8/21/18, the QIDP confirmed client #3's assessment was current and should have been followed. 3. Client #1 was not consistently afforded the opportunity to use her adaptive spoon to assist with her medication administration. During observations on 8/20/18 of client #1's medication administration pass at 5:05pm, staff obtained his medication basket, obtained the pill packets, spooned out vanilla pudding from a container, sprinkled the crushed pill into the pudding and spoon fed it to client #1 from the medication cup while using a small bowled disposable spoon. Client #1 was not offered or encouraged to assist feeding herself during this process. Client #1 was given apple juice to drink using her adaptive cup. Client #1's adaptive cup was the only adaptive item provided for use during this medication administration observation. Review on 6/11/12 of client #1's IPP dated 10/10/17 revealed, "[Client #1] is able to...drink independently...assist with feeding herself."	W 249		

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W 249	Continued From page 13 Further review revealed, "[Client #1] requires a...built up handle spoon, and a cup with a lid..." During an interview on 8/20/18, the medication administration staff stated, "Yes," this is the way she normally assists the clients' during their medication administration. Further interview revealed client #1 uses an adaptive cup and spoon and her adaptive spoon was not used. During an interview on 8/21/18, the QIDP confirmed the client's adaptive utensils should be used during their medication administrations. She further stated the clients' should be encouraged to participate to best of their abilities during their medication administration. 3. Client #5 was not prompted to observe the privacy of others. During observations throughout the survey on 8/20 - 21/18, client #5 was observed entering the bedrooms of other clients'. Further observations revealed client #5 looking out the windows in the bedrooms or watching televisions. At various times when client #5 entered the bedrooms, the other clients might be in the room or he was alone in the bedrooms. Client #5 was observed on 8/20/18 at 4:53pm standing in another clients' bedroom; a staff person walked into the room saw him, but did not redirect him to exit, while she walked out the of the room. On 8/21/18, at 6:56am, while client #5 was observed standing in another clients' bedroom a staff person walked by, looked in and kept on walking down the	W 249		

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W 249	Continued From page 14 hallway. At 7:32am on 8/21/18, client #5 was observed standing in another clients' bedroom; a staff person walked by, looked in and continued walking by the door. During an interview on 8/2018, staff stated, "There is nothing that states [Client #5] can't be in the room of another client." Review on 8/21/18 of client #5's IPP dated 4/19/18 indicated, "Staff report although he knows where his own room is, he enjoys walking into other areas, based on observations that when they approach him to redirect him from another resident's room, he turns to leave immediately." Review on 8/21/18 of client #5's psychological evaluation dated 3/28/18 revealed, "...Since [Client #5] will sometimes enter other clients' bedrooms...staff should continue to redirect [Client #5] out of those places...[Client #5] does not appear to understand the concept of ownership or private property." During an interview on 8/21/18, the QIDP confirmed client #5 should be redirected to exit the bedrooms of other clients'.	W 249		
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, interviews and record review, the facility failed to assure all medications	W 369		

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W 369	Continued From page 15 were administered without error for 1 of 5 audit clients (#8). The finding is: Client #8's Miralax laxative was administered with an undetermined amount of a Boost supplement and a Boost supplement was administered at the wrong time. During observations of the medication administration pass on 8/21/18 at 8:34am, the nurse measured 17grams of Miralax using the measuring device from the container and added the Miralax to the undetermined amount of Boost supplement. Client #8 ingested the Miralax and an undetermined amount of Boost Breeze. The remainder of the Boost Breeze supplement was taken to client #8 to drink along with her meal. The nurse left the Boost Breeze supplement with staff at the dining table to presumably be administered to client #8 by the staff. Review on 8/21/18 of client #8's physician's orders dated 6/1/2018 revealed, "MIRALAX POWDER MIX 1 CAPFUL (17 GRAMS) IN 4OZ OF BEVERAGE OF CHOICE & TAKE BY MOUTH EVERY DAY 8AM...BOOST BREEZE JUICE: GIVE 1 CARTON BEFORE BREAKFAST W/MEDICATIONS...." During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) confirmed the physician's orders should be followed. During an interview on 8/21/18, the nurse confirmed client #8's physician's orders were correct and they should have been followed. Further interview confirmed client #8's beverage should have been measured as per the	W 369	Correct: Nurses will be in-serviced on properly measuring all medications and fluids/liquids associated with medication passing before they are given by September 30, 2018. Nursing will ensure that entire dose of medication is consumed. Prevent: Nurses will be in-serviced on properly measuring all medications and fluids/liquids associated with medication passing before they are given by September 30, 2018. Monitor: Nursing Supervisor will monitor the administration of medication and supplements 3 times per week for one month to ensure compliance with proper measuring and administration. How Often: In-service by September 30, 2018. Routine medication administration monitoring by DON.	10/20/18

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W 369	Continued From page 16 Physician's orders. Additional interview revealed normally the Boost supplement is added to the Miralax and the remaining Boost is administered to client #8 during her breakfast.	W 369		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interviews the facility failed to assure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This affected all clients residing in the home. The finding is: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During afternoon observations in the home on 8/20/18 from approximately 3:55pm - 5:20pm, client #5 was observed walking throughout the building. Client #5's shorts were wet in the front and between his legs. At approximately 4:46pm, the qualified intellectual disabilities professional (QIDP) escorted client #5 by walking side by side with him from the hallway to were other clients were singing along with the Karaoke machine in the day room. The QIDP assisted client #5 to sit down in a chair. Client #5 sat in the chair for one minute and twenty seconds. At no time was the chair in which client #5 sat down in was sanitized. During an interview on 8/20/18, staff revealed the	W 454	Correct: Staff and Nurses will participate in a refresher in-service on infection control and providing for a sanitary environment by September 30, 2018. In-Service will be conducted by DON on our Safety/Sanitation: Blood borne Pathogens Exposure Control/Universal Precautions Policy. Staff and Nurses will be in-serviced on disinfecting contaminated areas immediately to promote overall safety and well-being. Prevent: Follow TLC Safety/Sanitation Policy. Monitor: QP and supervisory staff will monitor daily to ensure proper infection control is being utilized. How Often: In-service by September 30, 2018.	10/20/18

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W 454	Continued From page 17 chair should have been sanitized after client #5 sat down on it. During an interview on 8/21/18, the qualified intellectual disabilities professional (QIDP) revealed there was not a policy regarding how to clean an area after it has been contaminated. The QIDP confirmed the chair in which client #5 sat down in should have been sanitized with "Quat" the facility's sanitizer.	W 454		