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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: The governing body and management failed to ensure staff followed a policy regarding cell phone usage during work hours as evidenced by observations and interviews. The finding is: Staff were using their personal cell phone during work hours. During evening observations in the home on 7/8/19 at 5:45pm, Staff A was observed to be on her personal cell phone. Further observations revealed Staff A was standing in the bedroom of a client, while the client was laying in his bed. During an immediate interview, Staff A confirmed they should not be on their personal cell while working. Review on 7/9/19 of the facility's policy Using Mobile Devices in the Workplace dated 10/1/17 stated, "...employees are expected to focus on work and should not...engage in personal use of any personal mobile device in the workplace...." During an interview on 7/8/19, the qualified disabilities professional (QIDP) confirmed staff should not being using their personal cell phones during working hours.	W 104		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)	W 189		

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

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W 189	Continued From page 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 to document target behaviors and documenting in the medication administration record. The findings are: 1. Staff were not effectively trained regarding documenting target behaviors. During observations in the home on 7/8/19 at 5:50pm, client #4 was hitting the side of his head while he was at the dining room table. A staff person redirected him to finish eating; which he did. During an interview on 7/8/19, Staff A revealed she did not know if client #4 had a behavior support plan or not. Further interview revealed she normally works at another home and was working today because she was put on the schedule. During an interview on 7/9/19, the home manager (HM) revealed Staff A has been trained on the behavior support plans of the clients in the home, including client #4. 2. Staff were not effectively trained regarding documenting on the MAR. During observations in the home on 7/9/19 at 7:21am and 7:25am, Staff B signed the MAR	W 189		

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W 189	Continued From page 2 prior to clients #4 and #2 consuming their medications. During an interview on 7/9/19, Staff B confirmed she had signed off on the MAR prior to clients #4 and #2 consuming their medications. Staff B stated she was only trained to check the medications against the MAR three times before the clients consumed their medications. During an interview on 7/9/19, the HM revealed the MAR is to be signed off after the clients consume their medications. During an interview on 7/9/19, the facility's nurse stated the MAR is "absolutely" not suppose to be signed prior to the clients consuming their medications.	W 189		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain a needed visual assessment for 1 newly admitted client (#2) no later than 30 days after admission. The finding is: The facility failed to obtain a visual examination for client #2 in a timely manner.	W 210		

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W 210	Continued From page 3 Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed a visual examination dated 12/3/18. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's visual examination was not completed within 30 days of admission to the facility.	W 210		
W 216	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 newly admitted client (#2) received a physical within 30 days of admission. The finding is: Client #2 did not receive a physical examination within 30 days of admission. Review on 7/8/19 of client #2's record revealed a physical examination dated 10/31/18. Further review revealed client #2 was admitted to the facility on 8/28/18. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's physical examination was not completed within 30 days of admission to the facility.	W 216		
W 217	INDIVIDUAL PROGRAM PLAN	W 217		

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W 217	Continued From page 4 CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 newly admitted client (#2) nutritional assessment was completed within 30 days of admission. The finding is: The facility failed to obtain a nutritional assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review indicated client #2's nutritional assessment was completed on 5/2/19. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's nutritional assessment was not completed within 30 days of admission to the facility.	W 217		
W 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a needed sensorimotor assessment for 1 newly admitted client (#2) within 30 days of admission. The finding is:	W 218		

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W 218	Continued From page 5 The facility failed to obtain an occupational therapy (OT) assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed her OT assessment was completed on 12/4/18. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's OT assessment was not completed within 30 days of admission to the facility.	W 218		
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain in a timely manner a auditory assessment for 1 newly admitted client (#2) within 30 days of admission. The finding is: The facility failed to obtain a auditory assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed there is no record of her initial auditory assessment.	W 221		

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W 221	Continued From page 6 During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's auditory assessment was not completed within 30 days of admission to the facility.	W 221		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#2, #4) received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas appearance, self help and dining guidelines. The findings are: 1. Client #2 was not afforded the opportunity to wear properly fitted clothing. During morning observations in the home on 7/9/19 at 6:35am, client #2 stood up from a chair and her pants were hanging and loose on her hips. Further observations revealed client #2's undergarments were visible to anyone in the home. At 8:38am Staff C had client #2 change her pants. Client #2 came out of her bedroom	W 249		

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W 249	Continued From page 7 wearing a different pair of pants. Upon further observations those pants were hanging and loose on her hips. Additional observations revealed client #2's undergarments were visible to anyone in the home. During an interview on 7/9/19, Staff C revealed a staff person on third shift had told the home manager (HM) how client #2's pants were not fitting her. Review on 7/8/19 of client #2's IPP dated 10/2/18 stated, "[Client 2's] appearance is important to her." During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's pants were banging and loose on her hips. Further interview revealed client #2 does not own belt. 2. Client #2's meal guidelines were not followed. During dinner observations in the home on 7/8/19 client #2 was overstuffing her mouth with food. Further observations revealed as client #2 put more food in her mouth, there was food visible inside of her mouth that she had not swallowed. At no time was client #2 prompted to swallow her food before putting more in her mouth. Review on 7/9/19 of client #2's meal guidelines dated 12/12/18 stated, "...Monitor for packing her mouth...2. Encourage her to chew her foods and to not over-pack her mouth....." During an interview on 7/9/19, the QIDP revealed staff should have prompted client #2 not to overstuff her mouth while she was eating.	W 249		

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W 249	Continued From page 8 3. Client #4's feeding guidelines were not followed. During dinner observations in the home on 7/8/19 client #4 ate his meal sixteen times with his fingers. At no times was client #4 prompted to use his spoon. Review on 7/9/19 of client #4's feeding guidelines dated 8/13/07 revealed, "...4. Provide verbal prompts as needed to encourage [Client #4] to use his spoon and redirect any attempts of inappropriate finger feeding...." During an interview on 7/9/19, the QIDP revealed staff should have prompted client #4 to use his spoon to eat with.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 3 audit clients (#4). The finding is: Data was not collected as indicated for client #4. During morning observations in the home on 7/9/19 at 6:59am, client #4 hit the side of his head	W 252		

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W 252	Continued From page 9 on seven separate occasions while he was in the kitchen. Further observations revealed a third shift staff person was also in the kitchen. Additional observations revealed no data was documented as indicated. Review on 7/9/19 of client #4's behavior support plan (BSP) dated 7/17/19 stated, "Response to Self-Injurious Behavior: Any behavior that could result in harm to self (for example...hitting himself in the face...." Further review revealed, "Documentation...: Episodes of self-injury requiring staff intervention as well as any other behaviors of clinical concern should be documented...." Review on 7/9/18 of policy for documentation procedures dated July 2003 stated, "A Behavior Support Data Sheet will be used to document the occurrence of inappropriate behavioral expression. Such documentation shall include, at a minimum, the date and time of the episode, a description of the behavior...." Further review revealed, "In addition, individual Behavior Support Plans (BSP) may require completion of data forms specific to the target behaviors identified in the plan...." During an interview on 7/9/19 the qualified intellectual disabilities professional (QIDP) confirmed staff should have documented the target behavior of client #4.	W 252		
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,	W 436		

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W 436	Continued From page 10 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 interview, the facility failed to ensure eyeglasses were purchased for client #2. The finding is: Client #2 was not provided with eyeglasses as recommended by the ophthalmologist. Review on 7/8/19 of client #2's visual examination dated 12/3/18 revealed there was a recommendation for "new glasses". During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's eyeglasses have not been purchased as recommended by the ophthalmologist.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on third shift were not conducted at varied times.	W 441		

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W 441	Continued From page 11 Review of fire drill reports on 7/8/19 revealed the following: Two fire drills on third shift at the following times: 1am and 2am Further review revealed there were no other fire drills conducted on third shift for the twelve month time period. During an interview on 7/8/19, the qualified intellectual disabilities professional (QIDP) confirmed there were only two fire drill conducted on third shift for the twelve month period.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(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, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of diet. This affected 2 of 3 audit clients (#2, #5). The findings are: 1. Client #2's diet consistency were not followed. a. During lunch observations at the day program on 7/8/19, client #2 was observed eating a whole ham and cheese sandwich. Further observations revealed client #2 picking up the sandwich and biting undetermined pieces and consuming them. At no time was client #2 prompted to cut her	W 460		

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W 460	Continued From page 12	W 460		

sandwich. Additional observations revealed client #2 did not cough while consuming her meal.

b. During dinner observations in the home on 7/8/19, client #2 was observed eating pieces of beef which were larger than one inch. At no time was client #2 prompted to cut her beef. Additional observations revealed client #2 did not cough while consuming her meal.

Review on 7/8/19 of client #2's IPP dated 10/2/19 revealed her food consistency is 1/2 - 1 inch.

Review on 7/9/19 of client #2's nutritional evaluation dated 5/2/19 stated, "...1/2 - 1 inch consistency...."

Review on 7/9/19 of client #2's choking prevention guidelines (on going) revealed, "Staff follow diet consistencies as ordered by the physician...."

Review on 7/9/19 of client #2's physician's orders dated 6/26/19 - 9/30/19 indicated her diet consistency is 1/2/ to 1 inch.

During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) revealed client #2's sandwich should have been in the correct diet consistency. Further interview revealed staff should have prompted client #2 to cut her beef to to correct consistency.

2. Client #5's diet consistency were not followed.

During lunch observations at the day program on 7/8/19, client #5 was observed eating a whole ham and cheese sandwich. Further observations revealed client #5 picking up the sandwich and

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W 460	Continued From page 13 biting undetermined pieces and consuming them. At no time was client #5 prompted to cut her sandwich. Additional observations revealed client #5 did not cough while consuming her meal. Review on 7/8/19 of client #5's IPP dated 1/3/19 revealed her diet consistency is 1/2 to 1 inch. Review on 7/9/19 of client #5's meal guidelines stated, "...Assist [Client #5] with fading assistance to cut her food into 1/2 to 1 inch pieces. Review on 7/9/19 of client #5's nutritional evaluation dated 9/25/18 revealed her diet consistency is 1/2 to 1 inch. During an interview on 7/9/19, the QIDP revealed client #5's sandwich should have been in the correct diet consistency.	W 460		