STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G280	A. BUILDING _____ B. WING _____	05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SECOND AVENUE GROUP HOME	49 SECOND AVENUE SE TAYLORSVILLE, NC 28681

(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
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: Based on observation and interview, the governing body and management failed to exercise general operating direction over the facility by failing to assure the facility van was equipped with appropriate safety equipment for 2 of 2 clients utilizing wheelchairs during transport (#4 and #6). The finding is: Observations conducted on 5/14/19 at 8:20 AM revealed all 6 clients residing in the home were prompted to board the facility van for transportation to the day program. Continued observation revealed clients #1, #2, #3 and #5 were assisted by staff to board the facility van and fasten their seatbelts which included a lap belt with shoulder strap. On-going observations revealed clients #4 and #6 were loaded onto the van in their respective wheelchairs via the wheelchair ramp. Staff were then observed to engage the 4-point tie down hooks to the frame of each wheelchair, however, no lap belts or shoulder straps were utilized for clients #4 or #6. Interview with direct care staff G on 5/14/19 at 8:30 AM revealed no lap belts or shoulder straps were available on the van for the use of clients traveling in wheelchairs. Interview conducted on 5/14/19 with the operations manager revealed the lap belts and shoulder straps for clients in wheelchairs had not been available on the facility's van for at least a	W 104	Shoulder straps will be purchased and placed in van. Staff will be inserviced on utilizing them appropriately. Management will complete observations to ensure being used appropriately RECEIVED JUN - 3 2019 DHSR NH L & C Black Mountain / WRO	7/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nabu Wyatt — TITLE: Program Manager — (X6) DATE: 5/20/19

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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W 104	Continued From page 1 month and possibly for several months. This interview further revealed facility management were aware the lap/shoulder belts for clients transporting in wheelchairs on the van were missing and had unsuccessfully looked into purchasing replacements. There was no documentation available related to the purchase and provision of these safety mechanisms.	W 104	See page 1	
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, record review and interview, the facility failed to provide interventions in sufficient number and frequency to support the achievement of medication self-administration objectives for 3 of 3 clients observed during medication administration (clients #1, #3 and #5). The findings are: A. The facility failed to provide interventions in sufficient number and frequency to support the achievement of medication self-administration objectives for client #1. Observations conducted on 5/14/19 at 7:05 AM revealed client #1 entered the medication	W 249	Staff will be inserviced about training programs ensuring reviewing importance of following all programs as written. Management will complete observations of medication administration to ensure that programming is completed	7/13/19

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W 249	Continued From page 2 administration area and received medications including Proloprim 100 mg.; Vitamin D-3 1000 units, three capsules; multivitamin; Calcium/D 600/400 mg.; Esomeprazole 40 mg.; GNP fiber 0.526 mg.; Glycopyrolate 2 mg.-two tablets; Keppra ER 500 mg.-two tablets; Baclofen 20 mg. and Ensure Plus- 1 carton. Continued observations conducted during the medication administration for client #1 revealed client #1 was not prompted by staff administering medications (Staff D) or provided with the opportunity to participate in self-administration of medications, nor was client #1 prompted or assisted by staff to wash her hands prior to medication administration. Staff D was observed to retrieve client #1's medications from the storage closet, scan the labels, punch out all the medications, mix the medications with applesauce, feed the applesauce containing the medications to client #1 and throw the medication cup into the trash. Review of the record for client #1 revealed an individual support plan (ISP) dated 12/21/18. Review of the 12/21/18 ISP revealed a medication self-administration program objective with a revised implementation date of 4/19 stating client #1 would participate in taking medications with 40% independence for 3 consecutive months. Steps included in this objective documented client #1 should wash hands, scan medication card, take medications and throw cup away. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 5/14/19 revealed client #1's medication self-administration objective should be taught at each opportunity. This interview further verified client #1 should have been prompted and provided the opportunity	W 249	See pg 2	

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W 249	Continued From page 3 to participate in the administration of medications as prescribed in the medication self-administration program objective. B. The facility failed to provide interventions in sufficient number and frequency to support the achievement of medication self-administration objectives for client #3. Observations conducted on 5/14/19 at 7:26 AM revealed client #3 entered the medication administration area and received Equalactin chew 625 mg.-two tablets; Potassium chloride 20 meq.; Lexapro 20 mg.; Fibrotherapy 500 mg.; Risperdal 0.5 mg.; Claritan 10 mg.; Furosemide 20 mg.; Synthroid 75 mcg.; Calcium/D 600/400 mg. and Miralax 17 grams. Continued observations conducted during the medication administration for client #3 revealed client #3 was not prompted by Staff D or provided with the opportunity to participate in self-administration medications. Client #3was also not observed to be prompted or assisted by staff to wash his hands prior to medication administration. Staff D was observed to retrieve client #3's medications from the storage closet, scan the labels, punch out all the medications, mix the medications in applesauce, feed the applesauce containing the medications to client #3 and throw the medication cup into the trash. Staff D was further observed to place the Miralax powder 17GM into a lidded cup with a straw containing coffee and milk, which client #3 had brought into the medication area. Review of the record for client #3, conducted on 5/14/19, revealed an ISP dated 7/20/18 which included a medication self-administration program objective with a revised implementation	W 249	see pg 2	

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W 249	Continued From page 4 date of 3/1/18 stating client #3 would participate in taking medication with 75% independence for 3 consecutive months. Steps included in this objective documented client #3 should tap his picture on the QuickMar, state at least two of his medications, tell what the medication is for, scan medication card with the scanner and pop out the pill from the medication card into a medication cup. Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed client #3's medication self-administration objective should be taught at each opportunity. This interview further verified client #3 should have been prompted and provided the opportunity to participate in the administration of medications as prescribed in the medication self-administration program objective. C. The facility failed to provide interventions in sufficient number and frequency to support the achievement of medication self-administration objectives for client #5. Observations conducted on 5/14/19 at 6:50 AM revealed client #5 entered the medication administration area and received Clonazepam 0.25 mg.; NP Century tab.; Calcium/D 600/400 mg.; Synthroid 50 mcg.; Keppra XR 750 mg.; Lexapro 20 mg.; Triliptal 600 mg.; Glyco 2 mg.; Depakote ER 250 mg.-three tablets and Abilify 15 mg.. Continued observations conducted during the medication administration for client #5 revealed client #5 was not prompted by Staff D or provided with the opportunity to participate in self-administration of medications. Client #5 was also not observed to be prompted or assisted by staff to wash/sanitize his hands prior to medication administration. Staff D was observed	W 249	See pg 2	

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W 249	Continued From page 5 to retrieve client #5's medications from the storage closet, scan the labels, punch out all the medications, mix the medications with applesauce, feed the applesauce containing the medications to client #5 and place the medication cup in the trash. Review of the record for client #5, conducted on 5/14/19, revealed an ISP dated 1/28/19 which included a current medication self- administration program objective stating client #5 would take his medications with 50% independence for three consecutive months. Steps included in this objective documented client #5 should take his medication basket out of the storage closet, sanitize his hands, tap picture on the QuickMar, scan medication card with the scanner and pop out medications into the medication cup. Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed client #5's medication self-administration objective should be taught at each opportunity. This interview further verified client #5 should have been prompted and provided the opportunity to participate in the administration of his medications as prescribed in the medication self-administration program objective.	W 249	see pg 7	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide nursing services in accordance	W 331	see pg 7	

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W 331	Continued From page 6 with the needs of 1 of 3 sampled clients (#1), and 2 non-sampled clients (#3 and #5) relative to training staff in appropriate hygiene practices and client participation during medication administration. The findings are: A. The facility failed to provide nursing services in accordance with the needs of client #1. Observations conducted on 5/14/19 at 7:05 AM revealed client #1 entered the medication administration area and received medications including Proloprim 100 mg.; Vitamin D-3 1000 units, three capsules; multivitamin; Calcium/D 600/400 mg.; Esomeprazole 40 mg.; GNP fiber 0.526 mg.; Glycopyrolate 2 mg.-two tablets; Keppra ER 500 mg.-two tablets; Baclofen 20 mg. and Ensure Plus- 1 carton. Continued observations conducted during the medication administration for client #1 revealed staff administering medication (Staff D) did not provide client #1 with information related to the name, purpose or possible side effects of medications received, nor was client #1 offered the opportunity to participate in self-administration of medications. Staff D was observed to wipe client #1's mouth with a tissue, place the tissue in the trash and then retrieve client #1's medications from the storage closet, scan the labels, punch out all the medications into Staff D's hand before placing medications into the medication cup, mix the medications with applesauce, feed the applesauce containing the medications to client #1 and throw the medication cup into the trash. Staff D was further observed to place the Miralax powder 17GM into a lidded cup with a straw containing coffee and milk, which client #3 had brought into the medication area. Staff D was not observed to wash or sanitize their hands or client	W 331	All staff will be inserved about medicatn policies and procedures includy medicatn educatn, appropriate hygiene practices for staff and consumers Management will complete observatns to ensure procedures are being followed	7/13/19

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W 331	Continued From page 7 #1's hands prior to or during the medication administration process. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Continued interview with staff D revealed the staff to state no further training related to medication administration had been provided by the facility since the initial training. This interview further revealed staff D works on third shift and does not administer medications on a regular basis. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 5/14/19 at 10:00 AM revealed staff administering medications are expected to wash/sanitize their hands and prompt each client to wash/sanitize their hands prior to participating in medication administration. Continued interview with the QIDP revealed staff are expected to wash thier hands any time during the medication administration process the hands come into contact with a possible contaminate. Further interview with the QIDP revealed staff should assist each client to punch their medications directly from the medication card into the medication cup without touching the medication. Subsequent interview with the QIDP verified staff should provide each client with information regarding the name, purpose and possible side effects of their medications and provide each client with the opportunity to participate in the medication administration process. The facility nurse was not available for interview. B. The facility failed to provide nursing services	W 331	see pg 7	

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W 331	Continued From page 8 in accordance with the needs of client #3. Observations conducted on 5/14/19 at 7:26 AM revealed client #3 entered the medication administration area and received Equalactin chew 625 mg.-two tablets; Potassium chloride 20 meq.; Lexapro 20 mg.; Fibrotherapy 500 mg.; Risperdal 0.5 mg.; Claritan 10 mg.; Furosemide 20 mg.; Synthroid 75 mcg.; Calcium/D 600/400 mg. and Miralax 17 grams. Continued observations conducted during the medication administration for client #3 revealed staff D did not provide client #3 with information related to the name, purpose or possible side effects of medications received, nor was client #3 offered the opportunity to participate in self-administration of medications. Staff D was observed to retrieve client #3's medications from the storage closet, scan the labels, punch out all the medications into staff D's hand before placing medications into the medication cup, mix the medications with applesauce, feed the applesauce containing the medications to client #3 and throw the medication cup into the trash. Staff D was not observed to wash or sanitize their hands or client #3's hands prior to or during the medication administration process. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Staff D further stated no additional training related to medication administration had been provided by the facility since the initial training. This interview subsequently revealed staff D works on third shift and does not administer medications on a regular basis.	W 331	See pg 7	

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W 331	Continued From page 9 Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed staff administering medications are expected to wash/sanitize their hands and prompt each client to wash/sanitize their hands prior to participating in medication administration. Continued interview with the QIDP revealed staff should assist each client to punch their medications directly from the medication card into the medication cup without touching the medication. On-going interview with the QIDP verified staff should provide each client with information regarding the name, purpose and possible side effects of their medications and provide each client with the opportunity to participate in the medication administration process. The facility nurse was not available for interview. C. The facility failed to provide nursing services in accordance with the needs of client #5. Observations conducted on 5/14/19 at 6:50 AM revealed client #5 entered the medication administration area and received Clonazepam 0.25 mg.; NP Century tab.; Calcium/D 600/400 mg.; Synthroid 50 mcg.; Keppra XR 750 mg.; Lexapro 20 mg.; Triliptal 600 mg.; Glyco 2 mg.; Depakote ER 250 mg.-three tablets and Abilify 15 mg.. Continued observations conducted during the medication administration for client #5 revealed staff D did not provide client #5 with information related to the name, purpose or possible side effects of medications received. Further observation revealed client #5 was not offered the opportunity to participate in self-administration of medications. Staff D was observed to retrieve client #5's medications from the storage closet, scan the labels, punch out all the medications into staff D's hand before placing	W 331	See pg 7	

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W 331	Continued From page 10 medications into the medication cup, mix the medications with applesauce, feed the applesauce containing the medications to client #5 and throw the medication cup into the trash. Staff D was not observed to wash or sanitize their hands or client #5's hands prior to or during the medication administration process. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Continued interview with staff D revealed no further training related to medication administration had been provided by the facility since the initial training. This interview subsequently revealed staff D works on third shift and does not administer medications on a regular basis. Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed staff administering medications are expected to wash/sanitize their hands and prompt each client to wash/sanitize their hands prior to participating in medication administration. Continued interview with the QIDP revealed staff should assist each client to punch their medications directly from the medication card into the medication cup without touching the medication. On-going interview with the QIDP verified staff should provide each client with information regarding the name, purpose and possible side effects of their medications and provide each client with the opportunity to participate in the medication administration process. The facility nurse was not available for interview.	W 331	See pg 7	
W 371	DRUG ADMINISTRATION	W 371		

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W 371	Continued From page 11 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 observation, record review and interview, the system for drug administration failed to assure 3 of 3 clients (#1, #3 and #5) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to the name, purpose and side-effects of medications administered. The findings are: A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration or provided teaching related to the name, purpose and side-effects of medications administered. Observations conducted on 5/14/19 at 7:05 AM revealed client #1 entered the medication administration area and received medications including Proloprim 100 mg.; Vitamin D-3 1000 units, three capsules; multivitamin; Calcium/D 600/400 mg.; Esomeprazole 40 mg.; GNP fiber 0.526 mg.; Glycopyrolate 2 mg.-two tablets; Keppra ER 500 mg.-two tablets; Baclofen 20 mg. and Ensure Plus- 1 carton. Continued observations conducted during the medication administration for client #1 revealed staff administering medication (staff D) did not provide	W 371	staff will be retrained on drug administration including follow written training programs, education bery provided to consumers about medications and purpose side effects that consumers are involved in administery. Management will complete observations to ensure processes are bery followed	7/13/19

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W 371	Continued From page 12 client #1 with information related to the name, purpose or possible side effects of medications received, nor was client #1 offered the opportunity to participate in self-administration of medications. Staff D was observed to retrieve client #1's medications from the storage closet, scan the labels, punch out all the medications, mix the medications with applesauce, feed the applesauce containing the medications to client #1 and throw the medication cup into the trash. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Further interview with staff D revealed no further training related to medication administration had been provided by the facility since the initial training. This interview subsequently revealed staff D works on third shift and does not administer medications on a regular basis. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 5/14/19 at 10:00 AM revealed staff administering medications are expected to provide each client with information regarding the name, purpose and possible side effects of their medications and to provide each client with the opportunity to participate in the medication administration process with assistance as needed. B. The system for drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration or provided teaching related to the name, purpose and side-effects of medications administered.	W 371	See pg 12	

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(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
W 371	Continued From page 13 Observations conducted on 5/14/19 at 7:26 AM revealed client #3 entered the medication administration area and received Equalactin chew 625 mg.-two tablets; Potassium chloride 20 meq.; Lexapro 20 mg.; Fibrotherapy 500 mg.; Risperdal 0.5 mg.; Claritan 10 mg.; Furosemide 20 mg.; Synthroid 75 mcg.; Calcium/D 600/400 mg. and Miralax 17 grams. Continued observations conducted during the medication administration for client #3 revealed staff D did not provide client #3 with information related to the name, purpose or possible side effects of medications received, nor was client #3 offered the opportunity to participate in self-administration of medications. Staff D was observed to retrieve client #3's medications from the storage closet, scan the labels, punch out all the medications, mix the medications with applesauce, feed the applesauce containing the medications to client #3 and throw the medication cup into the trash. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Further interview with staff D revealed no further training related to medication administration had been provided by the facility since the initial training. This interview subsequently revealed staff D works on third shift and does not administer medications on a regular basis. Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed staff administering medications are expected to provide each client with information regarding the name, purpose and possible side effects of their medications and to provide each client with the opportunity to	W 371	See pg 12	

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	34G280	A. BUILDING _____ B. WING _____	05/14/2019

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W 371	Continued From page 14 participate in the medication administration process with assistance as needed. C. The system for drug administration failed to assure client #5 was provided the opportunity to participate in medication self-administration or provided teaching related to the name, purpose and side-effects of medications administered. Observations conducted on 5/14/19 at 6:50 AM revealed client #5 entered the medication administration area and received Clonazepam 0.25 mg.; NP Century tab.; Calcium/D 600/400 mg.; Synthroid 50 mcg.; Keppra XR 750 mg.; Lexapro 20 mg.; Triliptal 600 mg.; Glyco 2 mg.; Depakote ER 250 mg.-three tablets and Abilify 15 mg.. Continued observations conducted during the medication administration for client #5 revealed staff D did not provide client #5 with information related to the name, purpose or possible side effects of medications received, nor was client #5 offered the opportunity to participate in self-administration of medications. Staff D was observed to retrieve client #5's medications from the storage closet, scan the labels, punch out all the medications, mix the medications with applesauce, feed the applesauce containing the medications to client #5 and throw the medication cup into the trash. Interview conducted with staff D on 5/14/19 at 7:18 AM revealed staff had been employed by the facility for approximately one year and had received training in medication administration upon hire. Subsequent interview with staff D revealed no further training related to medication administration had been provided by the facility since the initial training. This interview subsequently revealed staff D works on third shift	W 371	see pg 12	

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W 371	Continued From page 15 and does not administer medications on a regular basis. Interview conducted with the QIDP on 5/14/19 at 10:00 AM revealed staff administering medications are expected to provide each client with information regarding the name, purpose and possible side effects of their medications and provide each client with the opportunity to participate in the medication administration process with assistance as needed.	W 371	See pg 12	
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure food was served in a form consistent with the developmental level for 1 non-sampled client (#3). The finding is: Observations conducted on 5/13/19 at 5:20 PM revealed client #3 was sitting in the dining area working on a craft project with staff at which time he accessed a whole, unpeeled apple which he ate independently. Staff was observed to ask client #3 if he wanted the apple peeled and client #3 was observed to decline. Continued observation during the supper meal on 5/13/19 at 5:50 PM revealed client #3 was assisted by staff to serve himself casserole, tossed salad and a whole biscuit, which he ate in two bites. Further observations conducted on the morning of 5/14/19 revealed client #3 accessed 3 tangerines	W 474	Staff will be inserved on all consumers diets, and different consistentcies that should be utilized. Management will complete observations to ensure diets are followed and consumed in appropriate consistency.	7/3/19

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W 474	Continued From page 16 and placed them in his pockets. Staff was then observed to ask client #3 how many tangerines he would need during the day at which time he gave one to staff and kept the other two in his pocket as he loaded onto the facility van at 8:20 AM for transportation to the day program. Review of the record for client #3, conducted on 5/14/19, revealed an individual support plan (ISP) dated 7/20/18 which contained a communication evaluation dated 3/18/15 stating client #3 exhibited signs of dysphagia, and recommended a diet of chopped consistency for client #3. Further review of the record for client #3 revealed a physician's order dated 4/12/19 prescribing a low fat, low cholesterol diet of chopped consistency for client #3. Interview conducted with the facility operations manager verified client #3 was currently prescribed a diet of chopped consistency and all food provided to client #3 should be of chopped consistency.	W 474	see pg 16	
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6) were provided with appropriate utensils and adaptive equipment to enable them to eat as independently as possible in accordance with their highest functioning level. The findings are:	W 475	Staff will be inserviced on ensuring a complete place setting is on table for all meal times. Management will complete observations of meal times to ensure procedures are being followed and that staff are prompting consumers to utelize appropriate utensils 7/13/19	

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W 475	Continued From page 17 A. Observations conducted on 5/13/19 at 6:15 PM revealed client #1 was seated at the dining table and was assisted by staff to serve herself the supper meal which consisted of chicken casserole, tossed salad, a biscuit , fruit cup and beverages. Her place setting was observed to consist of a spoon, plate with plate guard and regular cups. Review of the record for client #1, conducted on 5/14/19 revealed an individual support plan (ISP) dated 12/21/18. Review of the 12/21/18 ISP revealed a Community/Home Life Assessment dated 12/21/18 documenting client #1 uses all utensils as needed with a verbal cue, including a spoon and fork. Interview conducted on 5/14/19 with the operations manager verified client #1 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19. B. Observations conducted on 5/13/19 at 6:15 PM revealed client #2 was seated at the dining table and was assisted by staff to serve herself the supper meal which consisted of chicken casserole, tossed salad, a biscuit fruit cup and beverages. Her place setting was observed to consist of a spoon, plate and regular cup. Review of the record for client #2, conducted on 5/14/19, revealed an ISP dated 4/2/19. Review of the 4/2/19 ISP revealed a Community/Home Life Assessment dated 4/4/18 documenting client #2 uses a spoon, fork and knife independently. Interview conducted on 5/14/19 with the operations manager verified client #2 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19.	W 475	See pg 17	

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W 475	Continued From page 18 C. Observations conducted on 5/13/19 at 6:15 PM revealed client #3 was seated at the dining table and was assisted by staff to serve himself the supper meal which consisted of chicken casserole, tossed salad, a biscuit, fruit cup and beverages. Client #3's place setting was observed to consist of a spoon, plate with plate guard and a cup with a lid and straw. Continued observation during the supper meal revealed client #3's plate guard was positioned on the top of his plate, facing away from him. Further observations revealed client #3 was utilizing a spoon in his right hand to feed himself, scooping toward the left side of his plate resulting in a large amount of his meal being scooped out of his plate onto the table. Review of the record for client #3, conducted on 5/14/19, revealed an ISP dated 7/20/18. Review of the 7/20/18 ISP revealed a Community/Home Life Assessment documenting client #3 uses a fork and spoon independently. Interview conducted on 5/14/19 with the operations manager verified client #3 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19. This interview further verified client #3's plate guard should have been placed on the left side of his plate to accommodate his scooping toward the left in order to facilitate the client's ability to feed himself with as much independence as possible. D. Observations conducted on 5/13/19 at 6:15 PM revealed client #4 was seated at the dining table and was assisted by staff to serve herself the supper meal which consisted of chicken casserole, tossed salad, a biscuit and beverages.	W 475	See pg 17	

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W 475	Continued From page 19 Client #4's place setting was observed to consist of a dycem mat, large handled curved spoon, scoop dish with plate guard and a handled cup. Review of the record for client #4, conducted on 5/14/19, revealed an ISP dated 7/20/18. Review of the 7/20/18 ISP revealed a Community/Home Life Assessment dated 7/17/18 which documented client #4's eating and table manners were within acceptable range, and further documented client #4 uses a spoon, fork and knife independently. Interview conducted on 5/14/19 with the operations manager verified client #4 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19. E. Observations conducted on 5/13/19 at 6:15 PM revealed client #5 was seated at the dining table and was assisted by staff to serve himself the supper meal which consisted of chicken casserole, tossed salad, a biscuit and beverages. CLient #5's place setting was observed to consist of a spoon, plate with plate guard and regular cups. Review of the record for client #5, conducted on 5/14/19, revealed an ISP dated 1/28/19. Review of the 1/28/19 ISP revealed a Community/Home Life Assessment dated 1/10/18 documenting client #5 uses a spoon and fork independently and uses a knife with physical assistance. Interview conducted on 5/14/19 with the operations manager verified client #5 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19. F. Observations conducted on 5/13/19 at 6:15	W 475	see pg 17	

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W 475	Continued From page 20 PM revealed client #6 was seated at the dining table and was assisted by staff to serve herself the supper meal which consisted of chicken casserole, a biscuit and beverages. Client #6's place setting was observed to consist of a spoon, plate with plate guard and a regular cup. Continued observation during the supper meal revealed the client's plate guard was positioned on the right side of her plate. Subsequent observation revealed client #6 was utilizing her spoon in her right hand, scooping toward the left side of her plate causing a moderate of her meal to be pushed from her plate onto the table. Review of the record for client #6, conducted on 5/14/19, revealed a Community/Home Life Assessment dated 3/13/19. Review of the 3/13/19 assessment revealed client #6 uses a spoon and fork with verbal cues and a knife with physical assistance. Interview conducted on 5/14/19 with the operations manager verified client #6 should have been provided with a place setting consisting of a knife, fork and spoon during the supper meal on 5/13/19. This interview further verified client #6's plate guard should have been placed on the left side of her plate to accommodate her scooping toward the left side of her plate in order to facilitate the client's ability to eat as independently as possible.	W 475	see pg 17	
W 478	MENUS CFR(s): 483.480(c)(1)(ii) Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observation, document review and	W 478	Staff will be inserved on consumer diets and menu as well as importance of Robert it as written. Management will complete meal time observations to ensure menu is being followed	7/3/19

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W 478	Continued From page 21 interview, the facility failed to assure 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6) were offered the variety of foods listed on the menu. The finding is: Observations conducted in the home on the morning of 5/14/19 revealed each client was prompted and assisted by staff to come to the dining area as their morning hygiene, grooming and dressing activities were completed. On-going observations, verified by interview with direct care staff G revealed all 6 clients' breakfast meal consisted of a bowl of instant oatmeal and a beverage. This interview with staff G further revealed this is the usual breakfast served to all clients each morning. Review of the facility's menu located in the kitchen of the home revealed the menu listed breakfast items for 5/14/19. Review of the breakfast items for 5/14/19 revealed the menu to include apple juice, oatmeal, scrambled eggs, biscuits with margarine and jelly, milk and coffee. Interview with the qualified intellectual disabilities professional on 5/14/19 revealed each client should have been offered and provided with all items listed on the menu for their breakfast meal.	W 478	See pg 21	