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W 136	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(11) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure opportunity and documentation relative to community integration for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). For example: Observation in the group home on 8/19/19 revealed a ratio of 3 staff to 6 clients. Further observation revealed the qualified intellectual disabilities professional (QIDP) to inform staff A, B and survey staff that the current afternoon outing planned for clients #1, #5 and #6 was canceled due to staff shortage. Review of internal documentation of community outings for all clients in the group home revealed: (0) outings documented for 2/2019, (1) community outing in 3/2019, (4) community outings in 4/2019 related to a van ride, volunteer opportunities, the airport and church, (5) community outings in 5/2019, (2) community outings in 6/2019 related to church and bible study, (0) outings documented for 7/2019 and (3) community outings in 8/2019 related to church and 1 movie outing. It should be noted client #6 was documented to participate in 3 community outings over the review period of 2/2019-8/2019. Review of records for all clients revealed current individual habilitation plans that indicated clients #1, #2, #3, #4, #5 and #6 should be provided	W 136		

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

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W 136	Continued From page 1 plenty of opportunity for community integration, which is important to the physical and emotional well-being of each client and provides exposure to a variety of social settings and sensory stimulation. Interview with the QIDP on 8/20/19 revealed outings are often canceled due to a shortage of staff. The QIDP further verified the group home did not have a calendar of pre-planned activities for clients in the group home. Additional interview with the QIDP revealed each time staff take clients on an outing they are to document the outing in the internal activity book although staff were not documenting all outings. Subsequent interview with the QIDP verified staff training had not been conducted to address the need for documentation of all outings for clients in the group home.	W 136		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in completing documentation relative to incident reports in the group home for 6 of 6 clients (#1, #2, #3, #4, #5 and #6.) The finding is: Review of incident reporting for the facility from 1/2019 through 8/2019 revealed no incident reports for 1/2019-5/2019. Incident reports were	W 189		

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W 189	Continued From page 2 reviewed for 6/2019, 7/2019 and 8/2019. Interview with QIDP confirmed she was unaware incident reports for the group home were not in the internal record book for incident reports during 1/2019-5/2019. The QIDP subsequently verified incident reports for 1/2019-5/2019 were unavailable for review and it was unknown if staff had completed incident reporting for the months of unavailable reports.	W 189		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) were provided opportunities for choice and self management relative to meal preparation and beverage options. The finding is: Observation in the group home on 8/19/19 at 4:45 PM revealed all clients to be engaged in various art and leisure activities. Further observation revealed all dinner items for the dinner meal to be prepared and on the stove with chicken nuggets in the oven. Observation at 5:20 PM revealed staff B to fix all client plates in the kitchen, cut all items to diet size appropriateness for all clients and to serve each client their individual plate at the dining table. Interview with the QIDP at 5:00 PM on 8/19/19 revealed the home manager had prepared all dinner items before clients returned home from their vocational program.	W 247		

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Observation in the group home on 8/20/19 at 7:00 AM revealed client #1 to enter the medication room for morning medications and clients #2, #3, #4 and #5 to engage in various leisure activities in the living room. Continued observation revealed staff C to prepare the breakfast meal in the kitchen with no client assistance. Staff C was observed to access strawberries from the refrigerator, make cream of wheat on the stove adding an unmeasured amount of sugar, and to scramble egg whites that were placed into a large serving bowl. Staff C was further observed to cut up the strawberries and place the fruit slices into a large serving bowl and to place the prepared hot cereal from the stove into a serving bowl. Subsequent observation revealed staff C to pour milk into a pitcher and place on the dining table. Observation of the breakfast menu for 8/20/19 revealed the meal to consist of: (1) serving of fruit, 1 c. Cream of Wheat, (2) egg whites scrambled and beverage options of water, coffee or 2% milk.

Observation at 7:20 AM revealed client's #1, #2, #3, #4 and #5 to participate in the morning meal with serving bowls placed on the table by staff. All clients were observed to drink milk with client's #1 and #4 to have a muscle powder supplement added to their milk. At no time during the breakfast observation was coffee or water offered to any client.

Review of the records for clients #1, #2, #3, #4 and #5 on 8/20/19 revealed all clients had a current individual habilitation plan and a daily living skills assessment completed within the past year. Review of the daily living skills assessment for all five clients indicated they were at least partially independent with multiple areas related

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W 247	Continued From page 4 to meal preparation tasks. Additional record review for client #2 on 8/20/19 revealed the IHP to document client #2 likes coffee in the morning. Interview with the qualified intellectual disabilities professional (QIDP) on 8/20/19 confirmed clients #1, #2, #3, #4, #5 and #6 are all capable of participating with meal preparation tasks with at least partial independence. The QIDP also confirmed that the clients should have been offered the opportunity of choice and self management by assisting with dinner preparation on 8/19/19 and breakfast meal preparation on 8/20/19. The QIDP further confirmed beverage options on the breakfast menu should have been offered to all clients.	W 247		
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, review of records and interviews the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 6 of 6 clients. The findings are: A. The facility failed to ensure ambulation	W 249		

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guidelines and a communication objective for client #2 were implemented as prescribed. For example:

1. The facility failed to ensure ambulation guidelines for client #2.

Observation of client #2 at the vocational program on 8/19/19 at 1:55 PM revealed the client to return from the bathroom to an activity table in the classroom. Client #2 was observed to ambulate with staff assistance in a wheelchair. Further observation revealed client #2 to transfer from his wheelchair to a chair at the activity table using a two hand supported transition by staff. Staff was observed to stand in front of the client and hold both hands of the client while client #2 ambulated to the chair. Observation during the 8/19-20/19 survey did not reveal client #2 to wear a gait belt.

Review of records for client #2 on 8/20/19 revealed an individual habilitation plan (IHP) dated 5/5/19. Review of the IHP revealed a physical therapy (PT) evaluation dated 4/12/19. Review of the PT evaluation revealed a recommendation for an exercise regimen that included: 1) Moving sit to stand 10 times with upper extremity support. 2) Standing with 2 hands support (with walker or caregiver) 15 seconds to 1 minute. 3) Walking progressive distance starting with support from a walker. Contact guard assist from a caregiver is recommended. A gait belt is recommended.

A review of internal incident reports on 8/20/19 revealed on 6/26/19 client #2 had a fall while transitioning from a chair at the table to his wheelchair. Further review of the 6/26/19 incident report revealed client #2 to sustain a scrape on

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his back as a result of the fall. Additional review of records for client #2 revealed no guidelines to support staff with continuity in supporting client #2 with ambulation or transitions.

Interview with the facility nurse and qualified intellectual disabilities professional (QIDP) verified client #2 did not have guidelines to support ambulation or transitions. Further interview with the facility nurse and QIDP verified an in-service with staff had not been conducted relative to supporting client #2 with ambulation or transitions from his wheelchair. Interview with the QIDP further revealed client #2 had incurred one fall since admission in 4/2019. Subsequent interview with the facility nurse and QIDP verified client #2 did not have a furnished gait belt as recommended for transitions.

2. The facility failed to ensure a communication objective for client #2 was implemented as prescribed.

Observations throughout the 8/19-20/2019 survey revealed client #2 to participate in various activities to include an art activity with paint, meal participation, leisure activity (playing checkers with staff, watching television, holding hand held objects such as blocks), medication administration and loading the van for transport. During all observations, client #2 was verbally prompted regarding all transitions. At no time during observations were staff observed to use physical objects to support communication relative to a activity or schedule transition.

Review of records for client #2 on 8/20/19 revealed an individual habilitation plan dated 5/5/19. Review of the IHP revealed a

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communication objective relative to transitions implemented 5/2019. Further review of the communication objective revealed given specific visual prompts paired with objects to hold along with a physical escort to the corresponding area (med cup, toothbrush, spoon), client #2 will transition to specific tasks/activities. Further review of records for client #2 revealed a communication evaluation dated 5/10/19. Review of the 5/2019 communication evaluation revealed the need for programming for client #2 to increase receptive and expressive language skills.

Interview with the qualified intellectual disabilities professional (QIDP) verified client #2's communication objective relative to transitions remained current and staff should have utilized physical prompts to support the client with transitions.

B. The facility failed to ensure ambulation guidelines relative to a gait belt for client #4. For example:

Observation of client #4 throughout the 8/19-20/19 survey revealed the client to ambulate with a walker. Observation of client #4 on 8/19/19 at the group home during afternoon observations revealed client #4 to also wear a gait belt underneath his shirt. Observation of client #4 on 8/20/19 in the group home during morning observations revealed the client to wear a gait belt on the outside of his clothing. Continued observations during ambulation of client #4 throughout the 8/19-20/19 survey revealed at various times staff held client #4's gait belt while the client ambulated while at other times staff stood close to client #4 without holding

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the gait belt.

Review of records for client #4 on 8/20/19 revealed an IHP dated 1/29/19. Further record review for client #4 revealed no guidelines to support staff with continuity in supporting client #4 with ambulation.

Interview with the facility nurse on 8/20/19 revealed staff should always hold client #4's gait belt during ambulation. The facility nurse further verified client #4's gait belt should never be worn under the client's clothing. Subsequent interview with the facility nurse and QIDP verified guidelines specific to the needs of ambulation for client #4 had not been developed and an in-service with staff had not been conducted to address the use of a gait belt for client #4.

C. The facility failed to ensure a communication and meal preparation objective for client #3 were implemented as prescribed. For example:

1. The facility failed to ensure a communication objective for client #3 was implemented as prescribed.

Observation on 8/19/19 of the dinner meal revealed the place setting for client #3 to include a communication switch. Continued observation of the dinner meal revealed client #3 to participate in and complete the dinner meal and attempt to hit the communication device at his place setting that would not work. Client #3 was observed to hit the communication button multiple times until staff A and the QIDP acknowledged the client and indicated "it's ok, we need to put in a new battery".

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Observation on 8/20/19 of the breakfast meal revealed the place setting for client #3 to include a communication switch. Continued observation of the breakfast meal revealed client #3 to participate in and complete the breakfast meal and attempt to hit the communication device at his place setting that would not work, and then begin attempting to hit the communication device of another client until staff A intervened and acknowledged client #3.

Review of records for client #3 on 8/20/19 revealed an IHP dated 3/27/19. Further review of the IHP revealed a communication objective for client #3 to indicate "finished" at snack and meals with a big mack switch implemented 3/2019.

Interview with the QIDP on 8/20/19 verified client #3's communication objective relative to using a big mack switch at meals remains current. Further interview with the QIDP verified the communication device was not working at either meal due to the need for a new battery and the battery should have been replaced to allow for client #3 to run his communication program.

2. The facility failed to ensure a meal prepartation objective for client #3 was implemented as prescribed.

Observation in the group home on 8/19/19 at 4:45 PM revealed all clients to be engaged in various art and leisure activities. Further observation revealed all dinner items for the dinner meal to be prepared and on the stove with chicken nuggets in the oven. Observation at 5:20 PM revealed staff B to fix all client plates in the kitchen, cut all items to diet size appropriateness for all clients and to serve each client their individual plate at

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the dining table. Interview with the QIDP at 5:00 PM on 8/19/19 revealed the home manager had prepared all dinner items before clients returned home from their vocational program.

Review of records for client #3 on 8/20/19 revealed a IHP dated 3/27/19. Review of the IHP for client #3 revealed a meal preparation objective that client #3 will participate in meal preparation 3 times weekly (Mon, Wed, Fri) with staff assistance, implemented 3/2019.

Interview with the QIDP confirmed client #3's meal preparation objective remains current and should have been implemented as written on 8/19/19. Further interview with the QIDP revealed she was unsure why the home manager had prepared the dinner meal before all clients had returned home and the meal should not have been prepared until the residents were home.

D. The facility failed to ensure a table setting objective for client #1 was implemented as prescribed. For example:

Observation in the group home on 8/19/19 at 5:20 PM revealed client #1 to complete an activity at the dining table and to wash his hands for the dinner meal. Further observation revealed client #1 to sit at the dining table until staff served his meal to him from the kitchen at 5:45 PM. Subsequent observation revealed staff A and B to provide each client with cups and their individual plates with dinner items from the kitchen.

Observation in the group home on 8/20/19 at 6:20 AM revealed client #1 to sit in the living room with a magazine, to socialize with various staff and survey members and to look at the television until

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staff A verbally prompted the client to the medication room. Observation at 7:05 AM revealed client #1 to enter the medication room and to exit the medication room to the dining table for breakfast. Client #1 was observed to sit at the dining table until staff C brought serving bowls from the kitchen with breakfast items, at no time was client #1 observed to assist with setting the table for the breakfast meal or prompted by staff to assist with setting the table.

Review of records for client #1 on 8/20/19 revealed an IHP dated 1/25/19. Review of client #1's IHP revealed a training objective relative to setting the table during meal time implemented 1/2019. Further review of the table setting objective revealed client #1 will participate in setting the table during meal time with staff assistance with no more than 3 verbal prompts. Subsequent review of client #1's IHP revealed with encouragement, client #1 can participate in a wide array of domestic activities around the house.

Interview with the QIDP on 8/20/19 revealed client #1's table setting goal remains current and should have been implemented with each meal opportunity.

E. The facility failed to ensure a oral hygiene objective for client #1, #2, #4, #5 and #6 was implemented as prescribed. For example:

Observations in the group home on 8/20/19 at 7:15 AM revealed client #1, #2, #4 and #5 to participate in the morning meal, take dishes to the kitchen after completing their individual meals, participate in medication management

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upon verbal prompting by staff A and to engage in leisure activity in the living room (magazines, TV, hand held blocks) while waiting to leave for the vocational site. Observation at 8:10 AM revealed client #6 to enter the dining area and to have breakfast, take dishes to the kitchen after completing the morning meal, collect trash in the group home with staff support and to enter the medication room for morning medications before loading the van at 8:45 AM for transport to the vocational site. At no time after the breakfast meal were staff observed to prompt any client to conduct any hygiene activity to include toothbrushing before loading the facility van for transport.

Review of records on 8/20/19 for clients #1, #2, #4, #5 and #6 revealed:

Review of records for client #1 revealed an IHP dated 1/25/19. Review of the IHP revealed an oral hygiene goal implemented on 1/25/19. Further review of the 1/25/19 oral hygiene objective revealed that client #1 will brush his teeth in the AM/PM for 60 seconds.

Review of records for client #2 revealed an IHP dated 5/22/19. Review of the IHP revealed an oral hygiene goal implemented 5/22/19. Review of the 5/22/19 oral hygiene objective revealed client #2 will brush his teeth in the AM/PM for 60 seconds with hand over hand assistance.

Review of records for client #4 revealed an IHP dated 1/29/19. Review of the IHP revealed an oral hygiene goal implemented on 1/29/19. Review of the 1/29/19 oral hygiene revealed client #4 will brush his teeth in the AM/PM for 60 seconds.

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W 249	Continued From page 13 Review of records for client #5 revealed an IHP dated 7/19/19. Review of the IHP revealed an oral hygiene goal implemented on 7/19/19. Review of the 7/19/19 oral hygiene objective revealed client #5 will brush his teeth in the AM/PM for 60 seconds. Review of records for client #6 revealed an IHP dated 11/15/18. Review of the IHP revealed a oral hygiene goal implemented 11/15/18. Review of the 11/15/18 oral hygiene objective revealed client #6 will brush his teeth in the AM/PM for 60 seconds. Interview with the QIDP on 8/20/19 revealed the oral hygiene objectives for clients #1, #2, #4, #5 and #6 remain current. Further interview with the QIDP confirmed the most appropriate time for all clients to conduct toothbrushing is after meals.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, nursing services failed to ensure staff were trained to assure adequate hygiene related to client handwashing for 5 of 6 clients (#1, #2, #3, #4 and #5) . The findings are:	W 340		

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	34G184	A. BUILDING _____ B. WING _____	08/20/2019

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A. The team failed to assure client hygiene related to handwashing during medication administration for client #1. For example:

Observations in the group home on 8/20/19 at 7:00 AM revealed client #1 to enter the medication room for his morning medication pass. Observation during the medication administration for client #1 revealed the client to punch medications from a bubble pack into a medication cup, add applesauce to medications with staff assistance and to take all medications independently. Subsequent observation revealed that at no time before, during or after the medication administration for client #1 did staff A prompt the client to wash his hands.

Interview with the qualified intellectual disabilities profession (QIDP) on 8/20/19 confirmed that client #1 should have been prompted by staff to wash his hands before his medication pass to ensure adequate hygiene.

B. Staff failed to assure handwashing before the breakfast meal for clients #1, #2, #3, #4 and #5. For example:

Observation in the group home on 8/20/19 at 6:45 AM revealed clients #1, #2, #3, #4 and #5 to sit in the living room engaged in various leisure activities to include watching television and looking at magazines. Observation at 7:05 AM revealed client #1 to go to the medication room for morning medication administration after prompting by staff A. Subsequent observation revealed clients #3 and #4 to set placemats, bowls, utensils and cups at the table. At no time was it observed for staff to prompt client #3 or #4 to wash their hands before setting the table.

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W 340	Continued From page 15 Observation at 7:20 AM revealed clients #1, #2, #3, #4 and #5 to participate in the morning meal at the dining table with no observation of any client having washed their hands before the breakfast meal. Interview with the facility nurse and the QIDP confirmed all clients should be prompted to wash their hands before each meal. Further interview with the QIDP verified clients are capable of utilizing paper towel dispensers in each bathroom with staff assistance and therefore staff should be assisting clients to also wash their hands rather than only providing prompts.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure a recommended gait belt was furnished for 1 of 3 sampled clients (#2). The finding is: Observation of client #2 at the vocational program on 8/19/19 at 1:55 PM revealed the client to return to an activity table in the classroom from the bathroom. Client #2 was observed to ambulate with staff assistance in a wheelchair. Further observation revealed client #2 to transfer	W 436		

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from his wheelchair to a chair at the activity table using a two hand supported transition by staff. Staff was observed to stand in front of the client and hold both hands of the client while client #2 ambulated to the chair. Observation during the transfer did not reveal client #2 to wear a gait belt.

Observation in the group home throughout the 8/19-20/19 survey revealed client #2 to sit in a wheelchair throughout observations. At no time during observations in the group home was it observed for client #2 to transfer from his wheelchair. Observation of client #2 in his wheelchair did not reveal the client to wear a gait belt.

Review of records for client #2 on 8/20/19 revealed an individual habilitation plan (IHP) dated 5/5/19. Review of the IHP revealed a physical therapy (PT) evaluation dated 4/12/19. Review of the PT evaluation revealed a recommendation for a exercise regimen that included: 1) Moving sit to stand 10 times with upper extremity support. 2) Standing with 2 hands support (with walker or caregiver) 15 seconds to 1 minute. 3) Walking progressive distance starting with support from a walker. Contact guard assist from a caregiver is recommended. A gait belt is recommended.

Interview with the facility nurse on 8/20/19 revealed client #2 should have a gait belt if recommended by the physical therapist. Further interview with the facility nurse revealed she was unaware of the recommendation for client #2 to have a gait belt. Interview with the qualified intellectual disabilities professional further verified a gait belt had never been furnished to client #2 to support ambulation or transitions.

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W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to first shift. The finding is: Review of the facility fire drill reports from 8/18 through 7/19 revealed one 1st shift fire drill conducted on 1/26/19 with 2 staff. Further review of the facility fire drills revealed seven 2nd shift drills and four 3rd shift drills were conducted over the review year. There was no additional evidence to show more than one 1st shift drill was conducted over the review year. Interview with the qualified intellectual disabilities professional (QIDP) verified 1st shift fire drills should have been conducted quarterly over the review year. Further interview with the QIDP revealed it was unknown why there were not additional drills conducted for 1st shift and staff had not run drills according to the internal rotation system for conducting drills.	W 440		
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 review and	W 460		

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interview, the facility failed to provide specifically prescribed diets for 1 of 3 sampled clients (#1). The finding is:

Observation in the group home on 8/19/19 at 5:30 PM revealed client #1 to participate in the dinner meal at the dining table. Continued observation revealed client #1 to be provided a cup of muscle milk prepared by staff A, with his dinner meal. Observation of the muscle milk preparation revealed staff A to mix a powder with milk and serve to client #1.

Observation in the group home on 8/20/19 at 7:20 AM revealed client #1 to participate in the breakfast meal at the dining table. Further observation of the breakfast meal revealed client #1 to have a cup of muscle milk provided by staff A with his meal.

Review of the record for client #1 on 8/20/19 revealed a habilitation plan dated 1/25/19. Continued review of the habilitation plan revealed a nutritional evaluation dated for 6/12/19. Review of the nutritional evaluation indicated a need of weight gain for client #1. Further review of the nutritional evaluation revealed a recommendation for muscle milk to be mixed with 2% milk and ice cream and to be served at bedtime.

Interview with staff A on 8/19/19 and 8/20/19 verified client #1 was drinking muscle milk powder mixed with milk with his dinner and breakfast meal. Interview with the qualified intellectual disabilities professional (QIDP) on 8/20/19 confirmed client #1 should have been served his muscle milk as written and prescribed with 2% milk and ice cream at bedtime.