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W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on, interviews, observations and record reviews, the facility failed to provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. This affected 6 of 9 audit clients (#1, #2, #4, #9, #13 and #14). The findings are: 1. Facility failed to provide adequate direct care staff to monitor newly admitted client (#1) on 3rd shift. During a resident interview with client #13 on 9/24/19, she revealed that client #1 pulled on her hair, while she was in her room. An additional interview was conducted with client #13 on 9/25/19 who shared additional details. Last weekend, client #13 was in her room with the door closed, when client #1 opened the door to her room and wheeled himself up to her bed. Client #13 stated that this was late at night, while the clients were sleeping. Client #1 pulled on client #13's hair. She indicated that she tried to protect herself, by jabbing her left elbow toward client #1 making contact. Client #1 responded by grabbing her arm. Staff were not available to intervene, but client #1 left the room on his own. Client #13 shared the following day she reported	W 186		

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

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the incident to staff but did not know if anything was done about it. Client #13 was asked if there had been anymore incidents between her and client #1 and she responded yes. Client #13 stated that client #1 has pulled on her clothes when she came down the hall and now, she was scared of him.

Record review on 9/25/19 revealed an incident report for client #1 recorded on 9/22/19 by staff P. In the report it noted that client #1 had a scratch on his left arm from an incident of an unknown origin.

Interview with staff F on 9/25/19 revealed that on 9/24/19, client #13 reported to her that she was hit by client #1 who came into her bedroom while she was in bed. Staff F did not discuss the incident with management but did ask the other aides if they knew about the incident.

Interview was conducted with staff L on 9/25/19 who acknowledged that client #1 required constant supervision.

Interview was conducted with staff N on 9/25/19 revealed that she had heard from other staff that some clients had complained that client #1 had touched them but she had not witnessed these incidents. She shared that the first few nights after his admission, that he did not sleep and was up on third shift.

Interview with the qualified intellectual disabilities professional (QIDP) on 9/25/19 revealed that she was not familiar with the incident between clients #1 and #13. However, the QIDP shared that she had received an incident report from staff on 9/22/19 after finding a mark on client #1's arm.

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The mark had not been there at the beginning of 3rd shift. She commented that clients having behaviors should be kept away from other clients and that staff should be on the hall and report if clients are wandering.

2. Facility failed to provide adequate direct care staff to monitor newly admitted client (#1) to prevent him from disrupting mealtimes.

During a meal observation on 9/24/19 at 12:12 pm, 8 clients were in the activity room preparing to eat lunch. Client #1, was able to self propel his wheelchair and move about freely without staff's assistance. Client #1 was observed with staff C trying to bite her hand and grab her arms. Client #1 was in close proximity to the table where three other clients sat. Staff A was helping some clients wash their hands for lunch and setting up the table. Staff B entered the room to help get client #8 up from the recliner to walk to the sink. Client #1 got close to client #14, who was already seated at the table and pulled on client #14's left arm. Staff C redirected client #1. At the second table, client #4 was sitting in front of client #'s wheelchair and showed signs of anxiety, as evidence by client #4 leaning heavily over the right side of her wheelchair, as if to avoid making any contact with client #1. Client #1 was still able to put his hands on client #4's gait vest, tugging on in it, when staff C physically intervened.

During dinner observation on 9/24/19 at 6:00 pm, staff H and K were assisting clients with ambulation, transfers, hand washing and scooping contents of meals. There was a staff for each table, with 4 clients seated at each of the two tables. Client #1 had to be fed by the QIDP since he had knocked his food plate on the floor

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W 186	Continued From page 3 earlier and in order to closely supervise him. During breakfast observations on 9/25/19 at 8:30 am, staff E, staff F, staff A and the QIDP were washing their hands at the sink in the activity room, with all of their backs turned to the clients. Client #1 was free to roam around in his wheelchair while staff were at the sink. Client #1 was observed to roll his wheelchair over to client #4 and grabbed her on the right side of her face and neck, appearing to pinch her. Client #4 yelled out, getting staff's attention. Staff E promptly went to the dining table and separated client #1 from client #4. Staff E then proceeded to finish passing out equipment for the 2nd table when client #1 rolled over to client #9 and grabbed him by the arm. Client #9 screamed out and staff had to intervene and wheel client #1 to a different area in the activity room. Client #1 became upset, swiping the table, tossing his plate of food on the floor. He then knocked over a wooden chair, while he remained seated in the wheelchair. Client #1 also knocked over a large metal object, that came inches from striking client #2's feet. Client #1 was brought to the dining table with clients #2 and #4 to eat after his food was replaced. Client #2 showed signs of anxiety, sat facing client #1 and was not paying attention to her food. Client #1 who was still agitated, faced client #2 and was trying to kick her legs, when the program director (PD) stepped in between client #1 and #2, causing client #1 to attack PD's hair. The QIDP had to intervene. QIDP had to use one hand to hold client #1's plate of food and use the other hand to feed him in order for him to remain at the table and get fed. Client #2 was moved by staff C and the PD further down to the end of the table, once there was more room at the table. Once client #2 was further away from client #1,	W 186		

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W 186	Continued From page 4 she was able to concentrate on eating. Interview was conducted with staff A on 9/25/19 who stated that due to client's #1's history of aggression, they were expected to keep him away from other clients when he started to act out. Interview was conducted with QIDP on 9/24/19 revealed that client #1 moved into the facility last week after experiencing several failed placements and hospitalizations in the past year. They were currently completing their evaluation. An additional interview with QIDP on 9/25/19 revealed that they were bringing a behavioral specialist to the facility to offer training to their staff on how to work with clients with aggressive behaviors. In the meantime, client #1 was not on a formal 1:1 program but they have recognized that when client #1 tries to attack other clients, staff must immediately move him away or relocated the other clients, in order to protect them. Staff have to provide visual supervision constantly for client #1 and maintain him in their line of sight. Regarding third shift, staff should be on the hall at night to prevent opportunities for wandering.	W 186		
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 observations, record review and interviews, the facility failed to re-assess transfer guidelines for 1 of 9 audit clients (#9), once	W 216		

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mobility skills continued to decline. The findings are:

Client #8 was no longer able to stand and pivot with seated transfers and was dependent on staff.

During a meal observation in the home, on 9/24/19 at 12:40 pm, client #9 had finished lunch and was asked by staff B to transfer from a dining room chair with arms, to his wheelchair, that also had the sides up. Client #9 was unable to straighten his knees and remained in a seated, crouched position. Client #8 would flex his hips, causing his left hip to poke out, and was able to scoot off of the chair, crouching in mid-air, but unable to slide into the wheelchair independently, without risking a fall. Staff B, who stood by, then placed her hand on the back of client #8's waistband and grabbed it to lift his buttock, and shift his body into the wheelchair, that was parallel to the dining room chair.

During a meal observation in the home, on 9/24/19 at 6:45 pm, client #9 needed physical assistance to transfer from his dining arm chair into his wheelchair, that was positioned parallel to the chair. Staff K stood by, as client #9 attempted to slide from one device to the other, remaining in crouched position. Staff K noticed that client #9 was sliding off the chair and asked for assistance. The qualified individual disabilities professional (QIDP) came over to help and held onto client #8's waistband, to help transfer him into the wheelchair.

During a meal observation in the home, on 9/25/19 at 8:50 am, staff E rolled the wheelchair of client #8 to the dining table and parked it in front of his armchair. Client #8 was given verbal

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W 216	Continued From page 6 prompts to transfer into his wheelchair and tried to slide off of the armchair into the wheelchair, but could not pivot independently. Staff E was observed to lift client #8 out of the armchair by his waistband, and transferred him into the wheelchair, providing all of the support for a safe transfer. Record review on 9/25/19 of client #9's revised transfer guidelines, dated 11/22/16, mentioned that client #9 was capable of getting out of his wheelchair independently; however staff should provide assistance by holding onto one of his arms or hands throughout the transfer. Wheelchair is placed at right angle to the surface client #9 is being transferred. An additional review of the individual program plan (IPP) dated 6/24/19 that client #9 was non-ambulatory with spastic quadriplegia. He had contractures with below functional range of motion in the lower extremities secondary to long standing soft tissue tightness. On 6/1/12 it was noted that his skill to transfer independently had deteriorated according to the physical therapist. Client #9 beared weight assuming a crouch posture. During an interview with the QIDP on 9/25/19 she mentioned that she had received reports from staff working third shift that client #9 was able to transfer from his low bed into his wheelchair independently. Last Friday, she had also observed client #9 get into his wheelchair without staff's assistance. The QIDP could not recall if client #9 was able to set up his wheelchair and locked the wheels before independently transferring. During the conversation, the QIDP was asked if the most recent transfer assessment was done in 2016 and she confirmed that it was the most recent assessment done.	W 216		

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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 that 4 of 9 audit clients (#3, #6, #9, #14) received a continuous active treatment program consisting of needed interventions as identified in the Individual Program Plan (IPP) in the areas of meals guidelines and adaptive equipment. The findings are: A. Client #3 hand cushion and hygiene was not afforded. During observations in the home the survey on 9/24-25/19 client #3 sat on her wheelchair with the right hand placed on the chest area with a severe contractor. Further observation revealed the client had no cushion in her hand and the finger nail were long especially the thumb and was jagged. Interview on 9/25/19 with staff C revealed client #3 finger nail should be trimmed short. Review on 9/25/19 of client #3's IPP dated 10/8/18 revealed an occupational therapist (OT)	W 249		

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evaluation dated 10/19/13, "Staff should make sure finger nails are cut short, trimmed and filed so to prevent nails from digging into palm of hand. Finger contracture cushion should then be applied to hand making sure the roll is in the palms of the hand and the finger dividers..."

Interview on 9/25/19 with the program director indicated client #3 finger nails should be short and the cushion should be applied as indicated on the OT evaluation.

B. Client #6 Knee pillow and hand finger splint were not provided as ordered.

During observations in the home throughout the survey on 9/24-25/19 client #6 sat on his wheelchair. Upper and lower extremities were noted to have contracture. No position aid was applied apart from 9/25/19 from 7:30am-8:38am.

Interview on 9/25/19 with staff C revealed client #6 finger splint should be on while awake apart from when he is using his hands.

Review on 9/25/19 of client #6's IPP dated 2/18/19, ":...use abduction pillow between knee to assist with preventing skin breakdown due to spasticity in the knee area.... Finger contracture cushion are to be worn all day expect when (Client #6) is using his hands. cushion to be worn on both hands to provide cushioning separation of fingers."

Interview on 9/25/19 with the program director indicated client #6 knee abduction pillow and finger cushion should be applied as indicated in the IPP.

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W 249	Continued From page 9 C. Client #9 did not receive adequate supervision from staff during mealtimes. During dinner observation in the home on 9/24/19 from 6:00 pm to 6:45 pm, client #9 sat at a table with three other clients. Client #9 was one of the two clients that received a pureed diet. Client #9 was served ice cream in a bowl before his hot meal entree. Client #9 ate the ice cream at a fast pace, using his thumb at one time to scoop the ice cream and also picked up the bowl, to pour some of the melting ice cream into his mouth. Staff K was at the table and reminded client #9 to use his utensils. Most of the ice cream that client #9 attempted to eat, spilled out of his mouth onto his clothing protector because he is unable to close his mouth, while eating. Client #9 then used his spoon to eat pureed chicken and dumplings and mixed vegetable at a fast pace with no prompts to slow down. There was also a great deal of food spillage onto client #9's clothing protector. After client #9 finished eating, he remained at the table and noticed that client #7 got up from the table, leaving contents of his ground textured food in his bowls. Staff K followed client #7 to the sofa in the activity room, which allowed client #9 the opportunity to steal the bowl of food from client #7's place setting. Client #9 began to eat client #7's food. Staff K returned to the table a minute later and noticed that client #9 was eating someone else's food from a bowl. Staff K did not remove the bowl of food away from client #9. Record review of client #9's IPP dated 6/24/19 revealed that he ate at a fast pace and required verbal cues to slow down his eating pace. He also attempted to use his hands to eat on occasion. It	W 249		

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further mentioned that client #9 would take food from the table and remove food from other clients plates. Staff should monitor his closely to ensure he does not take food from his peers. In addition, client #9 had been evaluated on 7/8/29 by the occupational therapy (OT) consultant due to food spillage, related to weight loss. It was noted during the OT's observation that client #9 would feed himself, had tongue protrusion, drooling which liquefied the pureed food and had head flexion, which made most of the food fall out of his mouth. The OT recommended that staff feed client #9 parts of his meal, if after 3-5 minutes of self feed, client #9 had 50% or more of food spillage. The meal guidelines were revised by the program director (PD) and staff were inserviced, which was reflected on an inservice sheet with dates of discussion ranging from 6/25/19 to 7/12/19 by the habilitation aide staff.

Interview with the PD on 9/25/19 revealed that staff should prompt client #9 to slow down when eating.

Interview with the executive director (ED) on 9/25/19 revealed that once staff realized that client #9 stole someone else's food, they should redirect him and get the food especially if it is not the right texture.

D. Staff failed to follow client #14's the meal guidelines.

During lunch observation in the home on 9/24/19 at 12:00 pm, client #14 was served pureed beefaroni, pureed peas, 2 full 8 ounce glasses of beverage, then 2 small containers of lemon pudding. Client #14 hurriedly drunk the contents in the glasses and showed no interest in eating

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W 249	Continued From page 11 the hot food. Client #14 started to feed himself the pudding and was observed to cough at times, while eating. The only verbal prompt that client #14 received was to wipe his mouth. During dinner observation in the home on 9/24/19 at 6:00 pm, client #14 was served pureed chicken and dumplings, pureed mixed vegetables and vanilla ice cream. Client #14 had also received an 8 ounce glass of water and pink lemonade with his meal. He drunk the water all at once, with no verbal prompt from staff to slow down; coughing was observed from client #14. He had already eating his ice cream and fed himself the chicken entree with more coughing noticed during the meal. Client #14 proceeded to get a 2nd bowl of ice cream, which was melting and was observed coughing; then he started to eat his pureed vegetables. During breakfast observation in the home on 9/25/19 at 8:30 am, client #14 had drunk the 8 ounce glass of milk and was feeding himself pureed waffles and sausage, with coughing noted. There were no prompts from staff for client #14 to slow down eating and drinking. Record review on 9/25/19 revealed that an oral motor dining assessment was conducted on 2/10/18 for client #14 indicated that he had some reflux issues due to him eating and drinking fast. Staff should cue him to slow his rate of eating and drinking. During the assessment it was noted that he coughed 3 x which caused from client #14 eating too fast and overfilling his spoon. He also drunk his fluids all at once until the glass was empty which caused him to cough twice. The OT recommended that staff monitor client #14 at meals and cue him to slow down when drinking	W 249		

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W 249	Continued From page 12 and eating as needed. A method that staff can use to slow down his rate of drinking was not giving him a full glass at one time but give him a half of a glass of liquid. Once he drunk the half a glass, give him another half a glass until he drunk the required liquids for that meal. This would minimize coughing and reduce the risk of reflux from liquids. Interview with staff E on 9/25/19 revealed that he noticed that client #14 coughed at meals when he overstuffed his mouth with food. Staff E was unaware of any fluid guidelines at meals. Interview with the PD on 9/25/19 revealed that staff should prompt client #14 to slow down when eating. Interview with the QIDP on 9/25/19 revealed that she had observed client #14 cough at meals. She mentioned that he should get a half of a cup at meals, then more fluids should be poured.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a physician's orders were followed as written for 1 of 4 audit clients (#2). The finding is: Physician's orders were not followed as indicated for client #2.	W 368		

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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 368	Continued From page 13 During observations of medication administration in the home on 9/24/19 at 7:28pm, the med tech (MT) poured unspecified amount of Keppra into a medication cup. It was more than 7.5ml but less than 10ml into medication cup. Review on 9/24/19 of client #2's physician's orders dated 1/2/19 revealed an order for, "Keppra 100mg/ml: take 8ml by mouth twice daily." Interview on 9/24/19 with the medication technician revealed, client #2 gets Keppra and it is measured with medication cup. She said she poured a little more than 7.5ml to estimate 8ml. Further interview on 9/25/18 with facility's nurse confirmed the client takes Keppra 8ml, which is measured with a syringe. She further confirmed the physician's order was not followed.	W 368		
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 observation, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 4 audit clients (#4). The finding is: Client #4 was not given a full dose of Lactulose. During observation of medication administration	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G047	A. BUILDING _____ B. WING _____	09/25/2019

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W 369	Continued From page 14 in the home on 9/25/19 at 8:15 am, the nurse poured 30 ml of Lactulose into a clear medicine cup for client #4. The Lactulose was offered after client #4 had finished taking her pills. Client #4 had a paper napkin tucked in the front of her shirt. The nurse held the cup and placed it at client #4's lips, asking her to take a sip. Client #4 sipped on a small amount and immediately spit it out, with the orange colored syrup landing on her napkin. The nurse gave client #4 several verbal prompts to finish her medication and client #4 took 3 more sips, leaving a small amount of residue inside of the medicine cup. The nurse observed that the cup was not empty and asked client #4 to finish the dose and client #4 was heard saying that she did not want it. When the cup was brought to client #4's mouth, client #4 turned her head, causing the rest of the contents to spill on her napkin. Record review on 9/25/19 of client #4's August 2019 physician orders revealed that client #4 should get Lactulose Solution 30 ml each day. An interview on 9/25/19 with the qualified individual disabilities professional (QIDP) revealed that it was a medication error once there was spillage or the client spit it out. The staff should notify either the QIDP or program director (PD) so that the director of nurses could be contacted. The QIDP acknowledged that she was not notified of any medication spillage today.	W 369		
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 15 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 reviews and interviews, the facility failed to assure all adaptive equipments (wheelchair, Cushion and knee pillow) were provided for 2 of 9 audit clients (#3, #6). The findings are: A. Client #3 was not provided with a comfortable wheelchair. During observations in the home on 9/24-25/19, client #3 was not provided a comfortable wheelchair. Further observation revealed staff had to support the clients head with one hand from the right side as they feed her with the other hand. The staff continuously kept trying to reposition her properly without effect. Reviewon 9/24/19 of client #3's individual program plan (IPP) dated 10/8/18 revealed she uses a wheelchair for mobility. Interview with staff D on 9/24/19 revealed client #3's wheelchair been out of order for a while and client needs a constant repositioning of her head. Further interview on 9/25/19 with the program director revealed the chair needed fixing. The head support was installed about 4 months ago but functioned for about 2 months. She further confirmed client #3 was in a need of a chair that can support the client head to provide more comfort. Client #3 hand cushion and hygiene was not afforded.	W 436		

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W 436	Continued From page 16 Interview on 9/25/19 with client #3 revealed her chair was uncomfortable. B. Client #3 Finger cushion was not provided. During observations in the home the survey on 9/24-25/19 client #3 sat on her wheelchair with the right hand placed on the chest area with a severe contractor. Further observation revealed the client had no cushion in her hand and the finger nail were long especially the thumb and was jagged. Interview on 9/25/19 with staff C revealed client #3 finger nail should be trimmed short. Review on 9/25/19 of client #3's IPP dated 10/8/18 revealed an occupational therapist (OT) evaluation dated 10/19/13, "Staff should make sure finger nails are cut short, trimmed and filed so to prevent nails from digging into palm of hand. Finger contracture cushion should then be applied to hand making sure the roll is in the palms of the hand and the finger dividers..." Interview on 9/25/19 with the program director indicated client #3 finger nails should be short and the cushion should be applied as indicated on the OT evaluation. C. Client #6 Knee pillow and hand finger splint were not provided as ordered. During observations in the home throughout the survey on 9/24-25/19 client #6 sat on his wheelchair. Upper and lower extremities were noted to have contracture. No position aid was applied apart from 9/25/19 from 7:30am-8:38am.	W 436		

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W 436	Continued From page 17 Interview on 9/25/19 with staff C revealed client #6 finger splint should be on while awake apart from when he is using his hands. Review on 9/25/19 of client #6's IPP dated 2/18/19, ":...use abduction pillow between knee to assist with preventing skin breakdown due to spasticity in the knee area.... Finger contracture cushion are to be worn all day expect when (Client #6) is using his hands. cushion to be worn on both hands to provide cushioning separation of fingers." Interview on 9/25/19 with the program director indicated client #6 knee abduction pillow and finger cushion should be applied as indicated in the IPP.	W 436		