

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

PRINTED: 01/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G284</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/07/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYVIEW RESIDENTIAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>359 FIRETOWER ROAD RICHLANDS, NC 28574</b>		
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E 030	<p>Names and Contact Information CFR(s): 483.475(c)(1)</p> <p>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs.</p>	E 030			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 030	<p>Continued From page 1</p> <p>(v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff.</p>	E 030			

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E 030	Continued From page 2 (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Plan (EP) that included a complete communication plan as evidence by interview and record review. The finding is:  The facility Emergency Plan (EP) did not reflect updated information regarding Management contact information.  Review of the facility's EP on 1/7/20 revealed a general emergency plan that did not contain information updated with current contact names and phone numbers specific to the home. For example, review of the EP revealed information sheets with management staff phone and addresses for individuals who no longer worked for the company.  Interview on 1/6/20 with the Corporate Quality Assurance (QA) consultant confirmed the individuals listed on the management contact list no longer worked for the company.	E 030			
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2)  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124			

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W 124	Continued From page 3  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure one of five audit client's (#3) guardian understood the alternatives to proposed treatments and the possible consequences/alternatives to such refusal of treatment if any. The finding is:  The interdisciplinary team failed to coordinate a meeting with the legal guardian for client #3 to discuss recommended medical procedures and the consequences of refusing these treatments.  During observation in the facility on 1/7/20 between 6-9am client #3 told the residential manager (RM) that she had started her menstrual cycle. Several times client #3 was prompted by the RM to go into the bathroom to start her grooming and self care as part of her morning routine. Client #3 repeatedly told the RM she did not want to change her clothing. At 9:00am client #3 told the RM she was not going to the vocational program.  Review on 1/7/20 of client #3's consultation with the Neuropsychiatrist on 10/29/19 revealed her mood was worsening around the time of her cycle every month and she was refusing to comply with completing activities of daily living around this time of the month . Further notation during this physician's visit notated her legal guardian was not in agreement with starting on her birth control pills. Additional review of this visit noted that client #3 insisted on staying in bed all day during her menstrual cycle and that one occasion she had become combative, refusing to take her	W 124			

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W 124	Continued From page 4 medication, kicked staff and had to be restrained. The recommendations by the Neuropsychiatrist included: Continuing her current medication, talking with her guardian about starting her on birth control and the possibility of starting client #3 on a low dose of Prozac to stabilize her mood.  Review on 1/6/20 revealed client #3's record revealed she has been adjudicated incompetent and that her Grandmother is her legal guardian. Further review of the qualified intellectual disabilities professional (QIDP) notes revealed no documentation of any discussion of the risks versus the benefits of these medications with the legal guardian or interdisciplinary team members.  Interview on 1/7/20 with the Regional Director revealed the QIDP is out on medical leave and there has not been discussion with either the interdisciplinary team or the legal guardian about the risks versus benefits of starting birth control medication and Prozac at the recommendation of the Neuropsychiatrist.	W 124			
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 to address the needs of the clients for whom they were responsible in the areas of : preparing thickened liquids as prescribed, treating	W 189			

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W 189	<p>Continued From page 5</p> <p>clients with dignity and ensuring independence was promoted during medication administration. This affected 3 of 5 sampled clients (#2, #5 #6). The findings include:</p> <p>1. Staff failed to promote independence during medication administration for client #5.</p> <p>During observations of medication administration on 1/7/20 at 8:14am client #5 was seated in a chair in the facility office. Direct Care staff C prepared her medication, crushed and mixed them with applesauce. Staff C then used a plastic spoon and fed client #5 her medications and applesauce.</p> <p>During observations of lunch and supper meals on 1/6/20 and breakfast on 1/7/20 client #5 was observed to use a built up spoon to feed herself using a high sided scoop bowl.</p> <p>Review on 1/7/20 of her individual program plan (IPP) dated 5/10/19 revealed client #5 uses a built up spoon and nose cup for liquids.</p> <p>Review on 1/7/20 of client #5's Adaptive Behavior Inventory (ABI) dated 11/4/19 revealed client #5 is partially independent in eating with a spoon. In addition, in the area of self-administration of medication, client #5 is partially independent in taking her own pills.</p> <p>Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 routinely takes her medication and participates in the administration as directed by staff. In addition, she has a strength of adequate dining skills using adaptive dining equipment.</p>	W 189			

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W 189	<p>Continued From page 6</p> <p>Interview on 1/7/20 with the regional director confirmed staff should have encouraged client #5 to use an adaptive spoon to take her medication and applesauce. Further interview revealed direct care staff had been trained on client #5's strengths during medication administration.</p> <p>2. Staff failed to promote dignity to client #2 when communicating her wants and needs.</p> <p>During observations of the medication pass on 1/7/20 at 8am, the surveyor asked client #2 if it was okay to observe the administration of her medications. When client #2 did not initially respond, the surveyor used sign language to communicate with her. Direct care staff C stated, " That is a waste of time, she can't understand that." When sign language was used again, client #2 signed "Yes."</p> <p>Review on 1/6/20 of client #2's individual program plan (IPP) dated 1/28/19 revealed she is non-verbal and will occasionally use sign language to indicate when she has to use the toilet. Further review of her record did not reveal a speech evaluation. Further review of her IPP indicated client #2 uses gestures, some signs (such as toilet) to communicate her wants and needs.</p> <p>Interview on 1/7/20 with the program manager confirmed direct care staff have not had any training in sign language although 3 clients in the facility ( #2, #4, #5) are non-verbal.</p> <p>Interview on 1/7/20 with the regional director confirmed direct care staff C should have treated client #2 with dignity in communicating with her. Further interview confirmed client #2 has good</p>	W 189			

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W 189	<p>Continued From page 7</p> <p>receptive language skills. Additional interview revealed staff have been trained on client rights and how to promote dignity with clients.</p> <p>3. Staff failed to promote dignity to client #6 when communicating with her regarding the needs of client #5.</p> <p>During early morning observations in the facility on 1/7/20 at 6:00am staff A was assisting another client. Client #6 went into the hallway and told staff A that she needed to assist client #5 with putting on her shoes and that client #5 needed assistance tying her shoes. Staff A told client #6 that she needed to, " Stay in her lane and quit trying to do my job." When client #6 observed staff A putting on client #5's shoes and then walking out of the bedroom, she stated " Don't leave her shoes untied, she will fall." Staff A told client #6, "Don't worry about it, I will take care of it later."</p> <p>Review on 1/7/20 of client #5's IPP dated 5/10/19 revealed she uses a walker to assist her with ambulation and that she is a fall risk with fall prevention guidelines.</p> <p>Interview on 1/7/20 with the regional director confirmed that direct care staff A should have responded differently to client #6 who was showing concern for client #5. Further interview confirmed that all precautions should to be taken to prevent falls for client #5. Additional interview revealed direct care staff have been trained on client rights and how to promote dignity with clients.</p>	W 189			
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)	W 210			

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W 210	<p>Continued From page 8</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to assure the interdisciplinary team performed accurate assessment(s) within 30 days after admission. This affected 2 of 2 newly admitted audit clients (#3, #6). The findings include:</p> <p>The interdisciplinary team failed to complete initial evaluations for 2 of 2 newly admitted clients.</p> <p>1. The interdisciplinary team failed to complete initial evaluations for client #6.</p> <p>Review on 1/6/20 of client #6's record revealed she was admitted on 1/9/19. Further review of client #6's record revealed no speech, occupational therapy (OT) or physical therapy (PT) assessments since her admission.</p> <p>Interview on 1/6/20 with the corporate quality assurance consultant revealed the qualified intellectual disabilities professional was out on medical leave and these assessments had not been completed.</p> <p>2. The interdisciplinary team failed to complete initial evaluations for client #3.</p> <p>Review on 1/6/20 of client #3's IPP dated 2/5/19 revealed she was admitted to the facility on</p>	W 210			

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W 210	Continued From page 9 1/5/19. Further review of client #3's record on 1/6/20 revealed no assessments were obtained in the areas of occupational therapy (OT), physical therapy (PT), speech, audiological and dental.	W 210			
W 227	<p>Interview on 1/6/20 with the facility QA consultant revealed that no assessments in the areas of OT, PT, speech, audiological and dental were obtained following client #3's admission to the facility.</p> <p><b>INDIVIDUAL PROGRAM PLAN</b> CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews, the facility failed to consider client #3 for training when the need was identified to address her non-compliance in evacuating from the facility during evacuation drills. This affected 1 of 5 audit clients. The finding is:</p> <p>The interdisciplinary team did not consider client #3 for training to increase her compliance during evacuation drills.</p> <p>Interview on 1/7/20 with third shift staff A revealed fire drills have not been conducted in the middle of third shift as client #3 refuses to comply with being awakened on third shift and becomes very agitated.</p>	W 227			

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W 227	Continued From page 10 Review on 1/7/20 of client #3's record revealed her individual program plan (IPP) was held on 2/5/19. Further review revealed no active treatment programs to increase compliance during evacuation drills in the facility.	W 227			
W 249	Interview on 1/7/20 with the corporate quality assurance consultant confirmed client #3 does not currently have training to address her compliance during facility evacuation drills. <b>PROGRAM IMPLEMENTATION</b> 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 3 of 5 audit clients (#2, #3, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of consistent use of assistive devices, program implementation, and adaptive dining equipment use. The findings include:  1. Client #5's assistive devices were not used.  Observations in the home on 1/7/20 revealed the	W 249			

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W 249	<p>Continued From page 11</p> <p>residential manager walking with client #5 into the bathroom. Client #5 was using a walker. At 7:44am, the residential manager came out of the bathroom and client #5 was still inside. At 7:48am, the residential manager went to the bathroom door and asked client #5 "Are you ready?" The residential manager was observed to say "Sit down." At 7:51am, client #5 and the residential manager exited the bathroom. The only assistive device in the bathroom was a shower chair.</p> <p>Review of client #5's IPP dated 5/10/19 revealed that client #5 utilizes a raised toilet seat to prevent falls and injuries.</p> <p>Review of client #5's record on 1/7/20 revealed a annual medical evaluation dated 4/12/19 which states she remains on strict fall precautions in and out of the home.</p> <p>Additional review of client #5's record on 1/7/20 revealed a physical therapy (PT) evaluation dated 10/17/18. The PT evaluation stated that client #5 is involved in fall precaution and safety guidelines and tips to prevent spinal compression fracture. In addition, she remains a moderate to high risk for falls. The PT evaluation recommends continuing fall prevention and safety guidelines.</p> <p>Interview on 1/7/20 with the residential manager revealed that client #5 is able to be in the bathroom by herself. The residential manager stated that once client #5 is in the bathroom, staff can check on her or be outside around the bathroom door to hear her in case she falls or needs assistance.</p> <p>2. Client #3's psychological recommendations</p>	W 249			

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W 249	<p>Continued From page 12 were not followed up on.</p> <p>Review of client #3's record on 1/6/20 revealed a psychological statement dated 8/22/19 to establish care. In the psychologist plan of care, it is recommended that a rocking chair or swing be placed in the main area of the home as this might be a way for client #3 to be more social while also self soothing.</p> <p>Interview on 1/7/20 with the regional director confirmed that after speaking with the qualified intellectual disabilities professional (QIDP), they were unaware of the recommendation for a rocking chair or swing so this was not followed up on.</p> <p>3. Client #2 was not provided assistance as needed.</p> <p>During observations in the home on 1/7/20 at 7:37am, client #2 was observed to go into the bathroom. At 7:39am, client #2 was heard to flush the toilet and immediately exited the bathroom without washing her hands. At 8:44am, client #2 signed to Staff C and Staff C was observed to say "Well go to the bathroom then," Client #2 went to the bathroom but did not go behind her. At 8:47am, client #2 was heard to flush the toilet and immediately exited the bathroom without washing her hands.</p> <p>Review of client #2's record on 1/7/20 revealed an Adaptive Behavior Inventory (ABI) dated 11/4/19. The ABI revealed that client #2 requires assistance when toileting. She is partially independent in the areas of flushing, handwashing, wiping, etc.</p>	W 249			

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W 249	<p>Continued From page 13</p> <p>Interview on 1/7/20 with the residential manager revealed that client #2 needs assistance in the bathroom. The residential manager stated that staff should follow client #2 to the bathroom to assist her because she is not thorough with cleaning herself after toileting and needs assistance with washing her hands. The residential manager confirmed that a staff should have followed client #2 to the bathroom.</p> <p>4. Client #3's behavior support plan (BSP) was not implemented.</p> <p>During observations at the day program on 1/6/20 at 12:00pm, client #3 was prompted by staff to get her lunch. Client #3 refused. At 12:07pm, client #3 got up and went to the bathroom. After exiting the bathroom, Staff B asked client #3 if she wanted to sit at the table in the other room by herself to eat her lunch. Client #3 went to the table and sat down. At 12:12pm, Staff B prompted client #3 to get her water and tea for lunch but she refused.</p> <p>During observations in the home on 1/6/20 at 3:48pm, client #3 was prompted by Staff E to get her snack. Client #3 refused.</p> <p>During observations in the home on 1/7/19 at 6:05am, Staff A knocked on client #3's bedroom door, opened the door and turned the light on and prompted her to get up. Client #3 refused. Client #3 got up out of bed, turned the light on and hit her hand on the door. Staff A was observed to say "She's in her mood this morning, I ain't messing with her." At 6:58am, the residential manager was observed in the bedroom with client #3. She was prompting client #3 to put on clothes different from the ones she slept in and</p>	W 249			

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W 249	<p>Continued From page 14</p> <p>wore the previous day. Client #3 was observed to state "I don't want it." The residential manager stated "Ok, but it's clean clothes." Client #3 did not change her clothes.</p> <p>Review on 1/6/20 of client #3's IPP dated 2/5/19 revealed a diagnosis of Intermittent Explosive Disorder. In addition, the IPP stated that client #3 is supported by a BSP for aggression, severe disruptive behaviors, inappropriate toileting and failure to make responsible choices.</p> <p>Review on 1/6/20 of client #3's BSP dated 1/30/19 revealed aggressive behavior is defined as hitting, kicking, biting, spitting, scratching, the use of her upper body or any object as a weapon and threatening behavior. Consequences for aggression include verbal reprimand and exclusionary time out. Failure to make responsible choices is defined as client #3 refusing to comply with reasonable requests from staff. Consequences for failing to make responsible choices includes prompt redirection and prompt guidance. In addition, the BSP stated for behavior prevention techniques, if client #3 appears agitated, she should be prompted to calm down and take a break. Staff should never give demands, but instead offer choices.</p> <p>Interview on 1/7/20 with the residential manager revealed "The psychologist suggested giving client #3 choices, but we ask and then come back 5 minutes or so later and ask again. She just does things on her own time."</p> <p>5. Staff did not use client #5's adaptive spoon during medication administration.</p> <p>During observations of medication administration</p>	W 249			

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

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W 249	<p>Continued From page 15</p> <p>on 1/7/20 at 8:14am client #5 was seated in a chair in the facility office. Direct Care staff C prepared her medication, crushed and mixed them with applesauce. Staff C then used a plastic spoon and fed client #5 her medications and applesauce.</p> <p>During observations of lunch and supper meals on 1/6/20 and breakfast on 1/7/20 client #5 was observed to use a built up spoon to feed herself using a high sided scoop bowl.</p> <p>Review on 1/7/20 of her individual program plan (IPP) dated 5/10/19 revealed client #5 uses a built up spoon and nose cup for liquids.</p> <p>Review on 1/7/20 of client #5's Adaptive Behavior Inventory (ABI) dated 11/4/19 revealed client #5 is partially independent in eating with a spoon . In addition, in the area of self-administration of medication, client #5 is partially independent in taking her own pills.</p> <p>Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 routinely takes her medication and participates in the administration as directed by staff. In addition, she has a strength of adequate dining skills using adaptive dining equipment.</p> <p>Interview on 1/7/20 with the regional director confirmed staff should have encouraged client #5 to use an adaptive spoon to take her medication and applesauce.</p>	W 249			
W 263	<p>PROGRAM MONITORING &amp; CHANGE CFR(s): 483.440(f)(3)(ii)</p> <p>The committee should insure that these programs</p>	W 263			

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W 263	<p>Continued From page 16</p> <p>are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from client #3's guardian for her restrictive Behavior Support Plan (BSP). This affected 1 of 5 audit clients. The finding is:</p> <p>A current written informed consent was not provided for client #3's BSP.</p> <p>Review on 1/7/20 of client #3's BSP dated 1/30/2019 revealed an objective to address target behaviors of aggression, severe disruptive behavior, property destruction, self-injurious behavior, inappropriate toileting and failure to make responsible choices. The plan also incorporated the use of Xanax, Doxepin and Seroquel. Additional review of the client #3's record indicated that verbal consent was obtained on 3/1/19 but written informed consent was not obtained.</p> <p>Interview on 1/7/20 with the regional director confirmed no current written informed consent for the BSP had been obtained from client #3's guardian.</p>	W 263			
W 441	<p><b>EVACUATION DRILLS</b> CFR(s): 483.470(i)(1)</p> <p>The facility must hold evacuation drills under varied conditions.</p>	W 441			

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W 441	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is:</p> <p>Fire drills were not conducted at varied times.</p> <p>Review of fire drill reports on 1/6/20 revealed the following:</p> <p>For the quarter between September-December 2019 there were 5 fire drills conducted. There were two drills completed on second shift, Two drills wee conducted on first shift. There was one drill completed on third shift which was on 12/14/19 at 6:20am.</p> <p>For the quarter between March 2019-July 2019 there were seven fire drills conducted. Six of these drills were completed on second shift. There was one third shift fire drill on 4/17/19 that was conducted at 6:20am.</p> <p>Interview on 1/6/20 with the Residential Manager confirmed there were no other drills available. Further interview confirmed the clients are awakened in the mornings about 5:30am by direct care staff.</p> <p>Interview on 1/7/20 with third shift staff A revealed fire drills have not been conducted in the middle of third shift as client #3 refuses to comply with being awakened on third shift and becomes very agitated. Further interview revealed client #3's non compliance during fire drills has not been reported to facility management.</p> <p>Interview on 1/7/20 with the regional director</p>	W 441			

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W 441	Continued From page 18 revealed there were no additional fire evacuation drills to review. Further interview revealed staff had not reported to management client #3's non compliance during evacuation drills on third shift.	W 441			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)  Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of providing prescribed diet consistencies. This affected 1 of 3 audit clients (#5). The findings are:  Client #5's mealtime guidelines were not followed.  Observations in the home on 1/6/20 at 6:05pm revealed client #5 eating dinner. Staff E was observed to put one scoop of thickener in client #5's nutritional supplement, stir it, and put one additional scoop of thickener in the supplement using the large scoop on the scooper.  Observations in the home on 1/7/20 at 7:19am revealed Staff C putting thickener in client #5's nutritional supplement and orange juice. Staff C put 2 and a 1/2 scoops of thickener in the orange juice and 2 and a 1/2 scoops of thickener in the nutritional supplement using the large scoop on the scooper.	W 460			

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W 460	<p>Continued From page 19</p> <p>Additional observations in the home on 1/7/20 at 8:14am revealed Staff C getting a glass of water for client #5 to take her medications. Staff C put 3 scoops of thickener in the glass of water using the large scoop on the scooper.</p> <p>Review on 1/7/20 of client #5's individual program plan (IPP) dated 5/10/19 revealed that client #5's diet consists of nectar thick liquids.</p> <p>Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 has a tendency to choke on regular liquids and drinks thickened beverages.</p> <p>Review on 1/7/20 of thickener directions for "nectar" thick consistency revealed that for water, 3 and a 1/2 to 4 teaspoons of thickener are added. For orange juice, 3 to 3 and a 1/2 teaspoons of thickener are added. For nutritional supplements, 4 to 4 and a 1/2 teaspoons of thickener are added. The enclosed scoop for the thickener has a small scoop on one end (teaspoon) and a large scoop on the other end (tablespoon).</p> <p>Interview on 1/7/20 with the residential manager revealed that the staff should have followed the appropriate guidelines for each liquid.</p> <p>Interview on 1/7/20 with the QA consultant revealed that staff have been trained by the facility dietician to follow the recommended dosages for thickener to prevent the liquid from being too loose or too thick.</p>	W 460			