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E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(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. *[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. *[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.	E 030	DHSR - Mental Health FEB 19 2020 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/4/20

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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(v) Volunteers.

*[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.

*[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.

*[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.

*[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.

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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: Based on record review and interview, the facility failed to ensure the Emergency Preparedmess (EP) plan was reviewed and updated regarding staff and contact information. The finding is: The facility's EP plan was not reviewed or updated as needed when changes in staffing had occurred. Review on 2/3/20 of the facility's EP plan (dated April 2019) revealed a list of nine staff including their phone numbers. Further review of the plan did not include the phone number for Staff B who began working at the home in September 2019. Interview on 2/3/20 with Staff B confirmed her phone number was not included on the list. Additional interview also indicated four staff on the list no longer work at the home. Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the EP plan had not been updated to include Staff B and her contact information. She acknowledged several staff on the list no longer work at the home; however, their names and phone numbers had not been removed.	E 030		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54,	E 039		

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E 039	Continued From page 3 HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop	E 039		

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exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,
clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient

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E 039	Continued From page 5 care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan	E 039		

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twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the

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emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:

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(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant

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emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is:

The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise.

Review on 2/3/20 of the facility's EP plan (dated April 2019) revealed a training sheet dated 6/27/19 for a tabletop exercise. The sheet did not include supporting documentation regarding completion of the exercise.

Interview on 2/3/20 with Staff A who had signed the sheet as a participant revealed no group exercise or discussion took place on 6/27/19 and staff were only asked to read the information provided and sign the training sheet.

Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she could not be sure if the training dated 6/27/19 included an actual tabletop exercise to test the

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E 039	Continued From page 10 effectiveness of their current emergency plan.	E 039		
W 126	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 5 audit clients (#4) was taught to manage his financial affairs to the extent of his capabilities. The findings is: Client #4 has not received training on money management skills. During observations at the vocational center on 2/3/20, client #4 was observed cleaning water fountains around the facility. Staff told client #4 they needed to record his time to make sure he gets paid for his work. Review on 2/4/20 of client #4's individual program plan (IPP) dated 10/8/19 revealed that client #4 does not understand the value of money and informal training is provided. Review on 2/4/20 of client #4's adaptive behavior inventory (ABI) dated 10/13/19 revealed that client #4 has "very little money management skills." The ABI revalued that client #4 has no independence and cannot perform any portion related to money management including saving money, the value of money, and budgeting.	W 126		

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W 126	Continued From page 11 Interview on 2/4/20 with the qualified intellectual disabilities professional (QIDP) confirmed that client #4 does work at the vocational center and gets paid for the work he does each week. The QIDP also confirmed that client #4 continues to have needs in the area of money management; however, the interdisciplinary team had not discussed money management training.	W 126		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure clients were afforded privacy during personal care. This affected 2 of 5 audit clients (#2, #4). The findings are: A. Client #2 was not afforded privacy while toileting. During observations in the home on 2/3/20 at 3:52pm, client #2 was observed sitting on the toilet, with his shirt pulled up and his pants down around his ankles. Staff B was standing in the bathroom with him, and the door was completely open. Approximately two minutes later, Staff B exited the bathroom and partially closed the door, leaving the door open about three inches. Review on 2/4/20 of client #2's individual program plan (IPP) dated 12/20/19 revealed that client #2	W 130		

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does not utilize the toileting process efficiently and requires staff assistance.

Review on 2/4/20 of client #2's adaptive behavior inventory (ABI) dated 4/30/19 revealed that in the area of toileting, client #2 has no independence to close the door for privacy.

Interview on 2/4/20 with the home manager revealed that anytime a client is in the bathroom or in their bedroom for personal care, the door should be closed for privacy. If the client is unable to close the door, staff should close it. If the client is able to close the door and does not, staff should verbally prompt them to close the door.

Interview on 2/4/20 with the qualified intellectual disabilities professional (QIDP) revealed that when client #2 is toileting, staff should be in the bathroom with him with the door closed, or sit outside the bathroom with the door closed.

B. Client #4 was not afforded privacy while taking a shower.

During observations in the home on 2/4/20 at 6:10am, client #4 was observed in the bathroom, completely unclothed, preparing to take a shower. Staff E was in the bathroom with him. The door was open.

Review of client #4's ABI dated 10/13/19 revealed that client #4 is totally independent in closing the bathroom door for privacy.

Interview on 2/4/20 with the home manager revealed that anytime a client is in the bathroom or in their bedroom for personal care, the door

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W 130	Continued From page 13 should be closed for privacy. If the client is unable to close the door, staff should close it or offer verbal prompts to close it. If the client is able to close the door and does not, staff should verbally prompt them to close the door. Interview on 2/4/20 with the qualified intellectual disabilities professional revealed that when client #4 is in the bathroom, staff should verbally prompt him to close the door and if he doesn't, staff should close it.	W 130		
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 observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to perform their duties effectively. The finding is: The Medication Technician (MT) was not effectively trained to wear gloves appropriately. During observation of medication administration in the home on 2/4/20 from 7:25am - 7:58am, the MT wore latex gloves while assisting four clients with their medications. The staff did not consistently change his gloves between interactions with each client. Throughout the observations, the staff also manipulated cabinet knobs, keys, lock boxes, a cell phone, an ink pen and the medication administration record book	W 189		

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W 189	Continued From page 14 without changing the gloves. Interview on 2/4/20 with the MT revealed they have been trained to wear gloves during the medication pass and to change them between each client. The staff noted they should also wash or sanitize their hands after removing their gloves. Review of a document for personal hygiene/hand washing dated 4/27/17 indicated staff should be washing their hands regularly and "Wear gloves when assisting individuals with tooth brushing & giving eye medications." Interview on 2/4/20 with the facility nurse revealed medication technicians should not be wearing gloves during the administration of medications unless they are applying topicals, administering eye drops or some type of skin-to-skin contact is involved. Additional interview indicated staff should be wearing gloves while assisting clients with personal hygiene tasks including infection control and the prevention of cross-contamination.	W 189		
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.	W 249		

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This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 5 of 5 audit clients (#1, #2, #3, #4, #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, adaptive dining equipment use, and key access/use. The findings are:

A. Clients (#1, #6) were not actively involved or prompted to participate with cooking tasks.

During observations in the home on 2/3/20 from 4:48pm - 6:18pm, Staff B completed the majority of cooking tasks without client partcipation. For example, the staff performed tasks such as obtaining food items and cookware, opening cans using an electric can opener, placing food into pots, stirring food on the stove, operating the microwave, preparing pitchers of drinks and placing food into bowls. During this time, client #1 and client #6 were in the home with client #6 frequently standing in and around the kitchen area watching staff. With the exception of one client using the food chopper to briefly puree food, no clients were actively prompted or encouraged to participate with cooking tasks.

Interview on 2/4/20 with Staff C revealed client #6 can completed various tasks in the kitchen including stirring food, preparing drinks and setting the table. Additional interview indicated client #1 likes helping with clean up tasks in the kitchen.

Review on 2/4/20 of client #1's IPP dated 4/19/19 indicated the client has interests in baking

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cookies and cakes. The client's Adaptive Behavior Inventory (ABI) last updated 4/5/19 revealed she can independently prepare beverages requiring mixing and has partial independence with preparing sandwiches and salads. The ABI also identified needs in preparing frozen and canned foods in the microwave/oven, preparing meat dishes/vegetables in the microwave/oven, preparing combination dishes, preparing breakfast and dinner meals and using an electric can opener.

Review on 2/4/20 of client #6's IPP dated 7/3/19 noted the client can make simple beverages, use the stove with assistance, use a toaster, cook simple items such as eggs, toast and waffles and use a microwave with verbal prompts. The IPP also included an objective to participate in mealtime activities with 50% indenpendent prompts (implemented on 7/2/19). The objective indicated, "[Client #6] should be participating more in meal prep at home. [Client #6] has already been helping oout some in the kitchen and would benefit more if she helped out on a regular basis."

Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be involved with meal preparation tasks and client #6 can assist based on her mood. Additional interview indicated client #1 usually likes to set the table but has little interest in cooking tasks.

B. The key to a locked food pantry was not accessible to the clients.

During observations in the home on 2/3/20 at

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W 249	Continued From page 17 3:47pm, the food pantry was locked and a key to the pantry was not readily available and accessible. During observations in the home on 2/4/20 at 8:25am, the food pantry was locked and a key to the pantry was located on top shelf inside a cabinet next to the pantry door. Interview on 2/4/20 with Staff D revealed the pantry is kept locked due to the behaviors of one client in the home. The staff indicated other clients in the home do not have access to the key and can only enter the pantry when staff unlock it. Review on 2/4/20 of client #1 and client #3's records revealed the following regarding the locked pantry: "Informal Procedures to Assist Service Users With Unlocking the Pantry 1. The key will be kept in same location (hanging from the cabinet) for easy access 2. A spare key will be kept on the house key ring. 3. During meal preps, snack times, etc., the trainer will follow the prompt sequence to assist the service user with the following steps: 1. Obtain key. 2. Carry the key to the pantry 3. Place key in the keyhole. 4. Turn key. 5. Open pantry. 6. Turns light on. ...These procedures will be used with all service users at the Canterbury group home as long as	W 249		

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W 249	Continued From page 18 there is a need to keep the pantry door locked." Interview on 2/4/20 with the QIDP confirmed the pantry door is kept locked due to the behaviors of a client in the home; however, other clients should continue to have access to the key. C. Client #2 was not provided with his adaptive equipment as required. Observations in the home on 2/4/29 revealed client #2 eating breakfast. Staff D was sitting beside client #2 to provide assistance as needed. Client #2 was utilizing a high sided sectional plate. When he would try to scoop his food from his plate, it was observed the plate would slide back and forth and side to side on the table. Review on 2/4/20 of client #2's IPP dated 12/20/19 revealed that during meals, client #4 requires the use of a high sided sectional plate and dycem mat. Interview on 2/4/20 with Staff D revealed that during meals, client #2 uses a high sided sectional plate and dycem mat. Staff D revealed that during breakfast on 2/4/20, client #2 did not have his dycem mat but should have. Interview on 8/14/19 with the QIDP confirmed client #2 should have had his dycem mat during breakfast. D. Client #4 was not provided with his adaptive equipment as required. During observations in the home on 2/4/20, client #4 was eating breakfast. He did not have on an	W 249		

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W 249	Continued From page 19 adaptive clothing protector and was not prompted to wear it. Review on 2/3/20 of client #4's IPP dated 10/8/19 revealed that client #4 uses an adaptive clothing protector daily during meals. Interview on 2/4/20 with Staff C revealed that client #4 uses an adaptive clothing protector during meals, but does not always need it. Staff C stated that client #4 only uses the adaptive clothing protector when he is drinking liquids without a straw or if he is eating foods he does not like as he will spit them out. Interview on 2/4/20 with the home manager revealed that client #4 should always wear his adaptive clothing protector during meals. The home manager stated that staff are to offer the adaptive clothing protector to client #4, but sometimes he refuses. Interview on 2/4/20 with the QIDP confirmed that client #4 should have been wearing his adaptive clothing protector.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure data relative	W 252		

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W 252	Continued From page 20 to the accomplishment of objectives was documented. This affected 1 of 5 audit clients (#2). The finding is: Client #2's behavior incident was not documented. During observations in the home on 2/3/20 at 4:04pm, client #2 was observed sitting at the dining table with his peers. Client #2 was observed to hit himself in the head. At 4:07pm, client #2 was observed to lean over and pinch client #3 on her arm. At 4:08pm, client #2 was observed to hit himself on the leg, then lean over and grab client #3 on her arm. At 4:47pm, client #2 was observed to hit client #1. Review on 2/4/20 of client #2's Behavior Support Plan (BSP) dated 1/1/20 revealed an objective to address physical aggression. Additional review of client #2's behavior documentation form revealed that no behaviors had been documented since 1/1/20. Interview on 2/4/20 with the qualified intellectual disabilities professional (QIDP) confirmed all behaviors should be documented as they occur.	W 252		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 263		

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W 263	Continued From page 21 failed to ensure client #1's restrictive Behavior Support Plan (BSP) included written informed consent from both guardians. This affected 1 of 5 audit clients. The finding is: Client #1's BSP did not include consent from both co-guardians. Review on 2/3/20 of client #1's record noted both of her parents are her co-guardians. Additional review of the BSP dated 8/29/19 revealed an objective to exhibit 1 or fewer combined episodes of property damage, physical aggression and refusals for a period of 6 consecutive months. Review of the plan also identified the use of Latuda to address behaviors. Further review of the BSP indicated one of two co-guardians had given written informed consent for the plan on 10/14/19. Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed both guardians should have given written informed consent for client #1's BSP.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #4's inappropriate behavior was included in an active treatment program. This affected 1 of 5 audit	W 288		

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W 288	Continued From page 22 clients (#4). The finding is: Medications to address client #4's inappropriate behavior were not included in a formal active treatment program. Review on 2/3/20 of client #4's individual program plan (IPP) dated 10/8/19 identified the use of Melatonin, Propranolol, Cogentin, Lithium and Thorazine to address behaviors. Review on 2/3/20 of client #4's physician's orders dated 12/26/19 included the use of Melatonin, Propranolol, Cogentin, Lithium and Thorazine. Review on 2/3/20 of client #4's Behavior Support Plan (BSP) dated 9/24/19 revealed an objective for client #4 to transition to his new home and routine successfully, displaying physical aggression and self-injurious behavior on 0 occasions for 6 months. Additional review of the BSP identified the use of Lithium, Cogentin and Thorazine to address behaviors. The BSP did not include the use of Melatonin or Propranolol to address client #4's behaviors. Interview on 2/4/20 with the qualified intellectual disabilities professional (QIDP) confirmed client #4's BSP should also include the use of Melatonin and Propranolol to address his behaviors.	W 288		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs.	W 331		

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This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure client #6 was provided nursing services in accordance with her weight loss needs. This affected 1 of 5 audit clients. The finding is:

Client #6's weight gain was not adequately addressed.

During observations in the home on 2/3/20, client #6 wore clothing which appeared to be too small. The shirt consistently rose up over her stomach and back while her jeans were tight fitting in the stomach and thigh area. The client frequently pulled her shirt down throughout the day.

During lunch observations at the day program on 2/3/20 at 12:35pm, client #6 consumed beef-a-roni with vegetables, a bag of Funyun rings and a six pack of regular Lance peanut butter crackers.

During dinner observations in the home on 2/3/20 at 6:37pm, client #6 served herself vegetables, chicken pieces, potato salad, 2% milk and water. The client then obtained a bottle of Ranch salad dressing and poured approximately a cup and a half over her entire plate of food.

During breakfast observations in the home on 2/4/20 at 7:19am, client #6 consumed cereal with 2% milk and a slice of toast with sugar free jelly. No other food items were provided.

Additional review of the menu book revealed the following for a 1200 calorie diet:

Lunch (2/3/20):

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2 oz of turkey sliders
No cheese
2 Hawaiian rolls
No chips
1/2 cup sliced apples
One low sugar cookie
1 cup of low calorie beverage

Dinner (2/3/20):

6 oz of chicken pot pie with vegetables
1/2 cup of chips
1/2 cup unsweetened applesauce
1 slice wheat bread
No margarine
1 cup skim milk
1 cup low calorie beverage

Breakfast (2/4/20):

Seasonal fruit or juice
1 cup of cereal
1 cup skim milk
Yogurt
No toast
1 cup low calorie beverage

Interview on 2/4/20 with Staff E revealed client #6 is on a 1200 calorie diet and the menu should be followed for her specified diet.

Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be following client #6's 1200 calorie diet and she should be encouraged to choose low fat food and snack items.

Review on 2/4/20 of client #6's nutritional

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evaluation dated 4/8/19 revealed the client's current weight was 265 pounds with a 15 pound weight gain over one year. The plan noted she was above her target weight range of 210 - 230 with a body mass index of 39 which is "in the obese range". Additional review indicated, "Due to weight patterns, diet in place to help with healthy weight loss. H/O increased Lipids. Most recent LDL high. Monitor Lipids...estimated nutritional needs for weight loss are 1500 - 1800 cal/day, 62 - 78gr protein/day and 2500cc fluid/day...Main concern is weight gain - desires weight loss. Team has discussed appropriate options/strategies. Mom concerned about [Client #6's] weight gain." Further review of the evaluation noted, "Goal: Adjust diet per team for weight loss. Discussed omitting 1 starchy veg or bread at each meal. Continue free foods. Consider reward program for dietary compliance and healthy weight loss. Monitor weights, labs and PO intake...Weight loss to TWR 210 - 230 # is the goal..."

Review on 2/4/20 of client #6's record revealed the following weights:

01/19 - 265 lbs
02/19 - 266 lbs
03/19 - 285.2 lbs
04/19 - 290.6 lbs
05/19 - 289.6 lbs
06/19 - 291 lbs
07/19 - 295 lbs
08/19 - 297.2 lbs
09/19 - 305 lbs
10/19 - 310 lbs
11/19 - left blank
12/19 - 316.2 lbs
01/20 - 302 lbs

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W 331	Continued From page 26 The weights indicated a 37 pound increase from January '19 - January '20. Review on 2/4/20 of client #6's IPP dated 7/3/19 revealed she receives a 1200 calorie diet with seconds on non-starchy vegetables, offer oatmeal at breakfast, give wheat breads and a cup of sugar free Jell-O if she is still hungry with meals. The plan also indicated the client has an exercise/walking program which was implemented on 4/18/17. Review on 2/4/20 of client #6's medical evaluation dated 6/25/18 revealed a hand written note indicating, "4/8/19 Diet changed to 1200 calorie quarter inch consistency thin liquids." The plan indicated the client has had an increase in her weight; however, it did not include any information or recommendations regarding client #6's weight. Interview on 2/4/20 with the facility nurse revealed at a psychiatry appointment on 2/3/20, the doctor indicated client #6's medications could be causing her to gain weight. During an interview on 2/4/20, QIDP acknowledged client #6 has gained weight and is not within her target weight range. The QIDP indicated team members are aware of the weight gain; however, the interdisciplinary team has not met to discuss recommendations made by the dietitian or other ways to address client #6's weight.	W 331		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing,	W 460		

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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 4 of 5 audit clients (#2, #3, #4, #6) received their modified and specially-prescribed diets as indicated. The findings are:

A. Client #6's low calorie diet was not followed.

During lunch observations at the day program on 2/3/20 at 12:35pm, client #6 consumed beef-a-roni with vegetables, a bag of Funyun rings and a six pack of regular Lance peanut butter crackers.

During dinner observations in the home on 2/3/20 at 6:37pm, client #6 served herself vegetables, chicken pieces, potato salad, 2% milk and water. The client then obtained a bottle of Ranch salad dressing and poured approximately a cup and a half over her entire plate of food.

During breakfast observations in the home on 2/4/20 at 7:19am, client #6 consumed cereal with 2% milk and a slice of toast with sugar free jelly. No other food items were provided.

Interview on 2/4/20 with Staff E revealed they follow each client's diet as indicated on the menu. Additional interview indicated client #6 receives a 1200 calorie diet.

Review on 2/4/20 of client #6's IPP dated 7/3/19 revealed she consumes a 1200 calorie diet with dime size pieces, seconds on non-starchy

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	34G045	A. BUILDING ______ B. WING ______	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY ROAD HOME	214 CANTERBURY ROAD SMITHFIELD, NC 27577

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vegetables, offer oatmeal at breakfast, give wheat breads, give a cup of sugar free Jell-O if she is still hungry with meals and all foods need to be cut before brought to the table.

Additional review of the menu book revealed the following for a 1200 calorie diet:

Lunch (2/3/20):

2 oz of turkey sliders
No cheese
2 Hawaiian rolls
No chips
1/2 cup sliced apples
One low sugar cookie
1 cup of low calorie beverage

Dinner (2/3/20):

6 oz of chicken pot pie with vegetables
1/2 cup of chips
1/2 cup unsweetened applesauce
1 slice wheat bread
No margarine
1 cup skim milk
1 cup low calorie beverage

Breakfast (2/4/20):

Seasonal fruit or juice
1 cup of cereal
1 cup skim milk
Yogurt
No toast
1 cup low calorie beverage

Interview on 2/4/20 with Staff E revealed client #6 is on a 1200 calorie diet and the menu should be

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followed for her specified diet.

Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be following client #6's 1200 calorie diet and she should be encouraged to choose low fat food and snack items.

B. Client #2's drink consistency was not followed as indicated.

During dinner and breakfast observations in the home on 2/3 - 2/4/20, client received milk and water. After Thick-it was added to both drinks, the drinks were not stirred. Once client #2 consumed the milk, a large amount of Thick-it was noted at the bottom of the glass. Closer observation of his water glass revealed the liquid appeared clear at the top while remaining portion was cloudy.

Interview on 2/4/20 with Staff E revealed client #2's liquids should be a nectar thick consistency. Additional interview with Staff D indicated they follow the directions on the container of Thick-it and his liquids should be stirred.

Observation of the Thick-it container revealed, "Stir briskley until thickner has dissolved."

Review on 2/4/20 of a document for dysphagia/thickened liquids dated 7/7/17 revealed, "...There are three levels of consistency that liquids may be thickened to 1) nectar thick 2) honey thick, and 3) pudding thick. What is important is that you prepare them according to the directions on the label of the canister or packet of thickner..."

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Interview on 2/4/20 with the QIDP confirmed staff should be preparing client #2's liquids according to the instructions specified on the Thick-it container.

C. Client #3's food consistency was not provided as indicated.

Observations in the home on 2/4/20 at 6:55am revealed client #3 eating breakfast. She was observed to eat a piece of toast, served whole.

Review on 2/4/20 of client #3's IPP dated 11/21/19 revealed client #3's diet order consists of foods being served 1/2" to 1" pieces.

Review of meal preparation guidelines (undated) posted in the home revealed that client #3's food should be cut into 1/2" to 1" pieces.

Interview on 2/4/20 with Staff E revealed that the toast consumed by client #3 was not served in the right consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the home manager revealed that client #3's toast was not the correct consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the QIDP confirmed that client #3's food should be cut to the appropriate size of 1/2" to 1" pieces and cut prior to going to the table for client #3 to consume.

D. Client #4's food consistency was not provided as indicated.

Observations in the home on 2/4/20 at 6:55am

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revealed client #4 eating breakfast. He was observed to eat a piece of toast, served whole.

Review on 2/4/20 of client #4's IPP dated 10/8/19 revealed client #4's diet order consists of foods served as regular whole consistency.

Review of meal preparation guidelines (undated) posted in the home revealed that client #4's food should be cut into 1/2" to 1" pieces and sandwiches cut onto eight pieces.

Interview on 2/4/20 with Staff E revealed that the toast consumed by client #4 was not served in the right consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the home manager revealed that client #4's toast was not the correct consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the QIDP confirmed that client #3's diet order is food is cut into 1/2" to 1" pieces and sandwiches cut into eight pieces. The QIDP revealed that client #4's food should be cut to the appropriate size of 1/2" to 1" pieces and cut prior to going to the table for client #4 to consume.

E. Client #6's food consistency was not provided as indicated.

Observations in the home on 2/4/20 at 7:14am revealed client #6 eating breakfast. She was observed to eat a piece of toast, served as a whole.

Review on 2/4/20 of client #6's IPP dated 7/3/19

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revealed client #6's diet order consists of foods being served 1/2" to 1" pieces.

Review of meal preparation guidelines (undated) posted in the home revealed that client #6's food should be cut into 1/2" to 1" pieces.

Interview on 2/4/20 with Staff E revealed that the toast consumed by client #6 was not served in the right consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the home manager revealed that client #6's toast was not the correct consistency and should have been cut into 1/2" to 1" pieces.

Interview on 2/4/20 with the QIDP revealed that client #6's food should be cut to the appropriate size of 1/2" to 1" pieces and cut prior to going to the table for client #3 to consume.

F. Client #2's diet order was not followed as prescribed.

Observations in the home on 2/4/20 revealed Staff C getting ready to puree cream of wheat for client #2 to have at breakfast. Staff E stopped Staff C and told her that she was making things to complicated and to just puree the regular cereal for client #2.

Additional observations in the home on 2/4/20 at 6:55am revealed client #2 eating pureed cereal flakes with milk and Thick It.

Review of client #2's IPP dated 12/20/19 revealed client #2 is on a pureed diet.

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W 460	Continued From page 33 Review of meal preparation guidelines (undated) posted in the home revealed client #2 is on a pureed diet. Review of meal guidelines in the home revealed that individual's whose diets are served as pureed are not to eat cold cereal, but should only consume hot cereals. Interview on 2/4/20 with Staff C revealed that she started to make client #2 hot cereal, which was the cream of wheat. Staff C stated that she believed that individual's on a pureed diet should not consume cold cereal. Interview on 2/4/20 with the home manager revealed that client #2 should not consume cold cereal, and should only be served hot cereal, which is cream of wheat or oatmeal. Interview on 2/4/20 with the QIDP revealed that client #2 should not have been given cold cereal at breakfast as this does not follow his diet order. G. Client #4's diet order was not followed. Observations in the home on 2/4/20 revealed client #4 eating breakfast. He was observed to drink a glass of 2% low fat milk, pour 2% low fat milk in his cereal and observed to eat the cereal and a Yoplait Original yogurt. Review on 2/3/19 of client #4's IPP dated 10/8/19 revealed client #4 is lactose intolerant and should not have dairy products. Review on 2/4/20 of meal preparation guidelines (undated) posted in the home revealed that client #4 is on a lactose free diet.	W 460		

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W 460	Continued From page 34 Interview on 2/4/20 with Staff E revealed that she had no knowledge of client #4 being lactose intolerant. After reviewing the meal preparation guidelines (undated), Staff E stated that based on that information, client #4 should not have eaten the yogurt or drink the 2% low fat milk or out the milk in his cereal. Interview on 2/4/20 with the home manager revealed that client #4 is lactose intolerant and should not have consumed the milk or yogurt. The home manager revealed that almond milk is purchased for client #4 to use. Interview on 2/4/20 with the QIDP confirmed that client #4 uses almond milk because he is lactose intolerant. The QIDP revealed that client #4 should not have been given the yogurt or milk as this does not comply with his diet order.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all foods were served at an appropriate temperature. This affected all clients residing in the home. The finding is: Food was not served at an appropriate temperature. During meal preparation observations in the home on 2/3/20 at 5:05pm, staff removed	W 473		

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vegetables from the stove, poured them into a bowl and placed a lid on the bowl. At 5:10pm, one container of potato salad was removed from the refrigerator while another container was removed from the refrigerator at 5:20pm. The vegetables remained on the kitchen counter until 5:58pm when Staff B removed them and reheated them in the microwave. The microwave stopped at 6:00pm and the vegetables remained inside until 6:26pm when clients began serving themselves the food items. The temperature of food items was not taken prior to serving.

During additional observations in the home on 2/3/20 at 5:52pm, client #2 was assisted to puree his food including the vegetables which had remained on the counter since 5:05pm and potato salad which had remained out of the refrigerator since 5:10pm. Chicken broth was also removed from the refrigerator and added to the vegetables prior to processing. The temperature of food items was not taken.

Interview on 2/4/20 with Staff C revealed they did not know exactly what temperature foods should be served at but they thought it should be served within "10 or 15 minutes".

Review on 2/4/20 of a document regarding food and drink temperatures dated 10/3/17 revealed, "Food and drink should be at appropriate temperature. Foods should be consumed within 15 minutes of cooking. Check the temperature of the foods to ensure that they are not too hot. Use the food temperature thermometer to check temperatures. Hot food should be served at least at 140 degrees for food safety to prevent bacteria growth...Do not allow for items that are meant to be cold to sit until warm. Reheat items if needed,

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W 473	Continued From page 36 if food is pureed with a cold liquid, the food must be reheated because now the food is cold." Additional review on 2/4/20 of the menu book located in the home indicated, "All hot food and beverages must be held at 140 or higher. All cold food and cold liquids must be held at 40 or lower. Once items taken from heat keeping and/or cold keeping devices they must be served to clients within 15 minutes or reheated to 165, then served." Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be serving food at the identified temperature.	W 473		
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 observations, document review and interviews, the facility failed to assure clients residing in the home were offered the variety of foods listed on the menu. This affected 5 of 5 audit clients (#1, #2, #3, #4, #6). The finding is: The facility failed to follow the menu as written. During observations in the home on 2/4/20 at 6:55am, the clients were observed to be eating breakfast. On the table was two choices of cereal, yogurt, toast, a pitcher of water and a pitcher of milk.	W 478		

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W 478	Continued From page 37 Review on 2/4/20 of the home menu confirmed that breakfast should have consisted of seasonal fruit or juice, choice of cereal, yogurt, toast, a beverage of choice and milk. Interview on 2/4/20 with the home manager revealed that the clients should have been given seasonal fruit or juice. In addition, the home manager revealed that the clients should have been given a choice of a beverage plus the milk, not just water and milk. Serving just the water was not giving the clients a choice of another option. Interview on 2/4/20 with the qualified intellectual disabilities professional (QIDP) confirmed that the clients did not receive the full menu as written and should have been given choices of beverages as well as seasonal fruit or juice.	W 478		

CANTERBURY ROAD HOME
PLAN OF CORRECTIONS
FOR
Recertification Survey Conducted on February 3 - 4, 2020

E 030 NAMES AND CONTACT INFORMATION

The Facility Safety Committee will update the names and contact information of all homes Emergency Plan.

The Safety Chairperson will update the Emergency Preparedness Plan to include a contact list of current staff with the facility.

The Safety Chairperson will re-in-service all staff on the emergency preparedness plan. An in-service will be used to document dates and times of training. QMRP will monitor in-services on a quarterly basis. If any errors are notated the contact information will be updated immediately.

Completion Date: April 4, 2020

E 039 EP TESTING REQUIREMENT

The Facility will provide a full-scale exercise, a mock disaster drill or a tabletop exercise or workshop to all homes and document it accordingly. QMRP will provide emergency preparedness training to all staff. An in-service will be used to document dates and times of training.

QMRP and Unit Safety Committee to ensure program staff are trained on pertinent aspects of the Emergency Preparedness Plan to provide specific details regarding the plan.

QMRP will monitor in-services on a quarterly basis. If any errors are found, additional drills will be conducted.

Completion Date: April 4, 2020

W126 PROTECTION OF CLIENTS RIGHTS

The Facility will ensure Client Rights are protected when performing work for the facility. QMRP and/or Habilitation Specialist to assess vocational needs for all persons living in the home using the Adaptive Behavior Inventory (ABI). QMRP will review all individuals Program Plan (PCP) to ensure it reflects if individuals want to work for pay. Staff will receive training on rights related to client performing work for facility. Training will consist of tasks clients must be compensated for if performed.

Staff will be in serviced on jobs client # 4 could work for pay. Habilitation Specialist will implement a formal money management goal.

QMRP will monitor status of each person's work interest to ensure all needs are being addressed in a timely manner using Quarterly Reviews are performed by QMRP.

Completion Date: April 4, 2020

W130 PROTECTION OF CLIENT RIGHTS

The Facility will ensure client rights are protected. All PCPs will be reviewed by the QMRP for the level of support needed in all domains. Staff will be re-in-serviced on the needs and strengths of all clients.

Client # 2 strengths in privacy while toileting will be re-in-serviced by QMRP & Habilitation Specialist.

Client #4 strengths while showering will be re-in serviced by QMRP & Habilitation Specialist.

Monitoring to be accomplished at least three times per month using Mealtime and direct observations/assessments done by QMRP, Habilitation Specialist, Behavior Specialist, Home Supervisor and OT/PT Habilitation Assistant. Assessments and results of observations will be reviewed during monthly Clinical and Home Meetings.

Completion Date: April 4, 2020

W189 STAFF TRAINING

The Facility will ensure staff are trained on cross contamination. Nursing will re-in service all staff on when to use gloves.

All staff will be re-in serviced to change contaminated gloves when completing a single task.

Monitoring to be accomplished at least three times per month using Medication/Interaction and direct observations/assessments done by QMRP, Habilitation Specialist, Behavior Specialist, Home Supervisor and OT/PT Habilitation Assistant. Assessments will be reviewed during monthly Clinical and Home Meetings. Clinical staff will make on-site corrections.

Completion Date: April 4, 2020
W249 PROGRAM IMPLEMENTATION

The Facility will ensure all Person Centered Plans (PCP) will be implemented as written to ensure continuous active treatment. The Interdisciplinary Team will review and re-in service each person's diet consistency, adaptive equipment usage, key access use and different ways each person can participate in meal preparation.

1. Staff will be re in serviced by Habilitation Specialist on Client #1 & #6 skills during meal preparation and encourage full participation.
2. Staff will be re in serviced on client #1 # 3 informal guidelines to unlock the pantry room door.
3. Client # 2 use of adaptive equipment will be re-in serviced by OT/PT Habilitation Assistant.
4. Staff will be re-in serviced on the needs and strengths of client # 4 use of an adult clothing protector.

Monitoring to be accomplished at least three times per month using Interaction/Engagement and formal program assessments and direct observations/assessments by QMRP, Habilitation Specialist, Behavior Specialist, Home Supervisor, and OT/PT Habilitation Assistant. Assessments and results of observations will be reviewed during monthly Clinical and Home Meetings.

Completion Date: April 4, 2020

W252 PROGRAM DOCUMENTATION

All IPPs will be reviewed by the QMRP for the level of support needed in all domains. Behavior Specialist will re in-service all clients BSP's documentation.

Clients #4 behavior support plan will be re-in serviced by Behavior Specialist.

Monitoring to be accomplished at least three times per month using Interaction/Engagement assessments and direct observations/assessments done by QMRP, Habilitation Specialist, Behavior Specialist, and Home Supervisor. Assessments and results of observations will be reviewed during monthly Core Team and Home meetings.

Completion Date: April 4, 2020

W263 PROGRAM MONITORING & CHANGE

The Facility will updated consents when there is a change in individuals Behavior Support Plan that requires use of medication to address behavior concerns.

QMRP will ensure co-guardians sign client #4 Behavior Support Plan.

The Clinical team will conduct chart reviews quarterly to ensure all required consents are obtained from guardians. QMRP will monitor during quarterly case reviews to determine if significant changes have occurred in the client's treatment, thus indicating the need for an updated consent and document changes.

Completion Date: April 4, 2020

W288 MGMT OF INAPPROPRIATE CLIENT BEHAVIOR

The Facility will review each client's medications identified to manage inappropriate behaviors to ensure medications prescribed are part of the active treatment plan. If any medications being used are not currently incorporated in the plan, the Psychologist will revise the behavior support plan to include the medication.

Client #4 medications regime will be added to his plan. Behavior Specialist will in-service the Behavior Support Plan updates.

To ensure all interventions are implemented appropriately in the future, ongoing monitoring will be done through quarterly QMRP reviews, scheduled chart reviews, and quarterly Human Rights Committee Reviews.

Completion Date: April 4, 2020

W331 NURSING SERVICES

The Facility will follow all doctor's orders for each service user without error.

1. Nursing staff will address client #6 weight gain in a Team Health Note.

Monitoring to be accomplished at least twice per month using weight management records. Monitoring staff will include; QMRP, Hab. Spec., Home Supervisor, and /or Nursing. . Nursing will immediately address any discrepancies.

Completion Date: April 4, 2020

W460 FOOD AND NUTRITION SERVICES

The Facility will re in-service all staff on individuals feeding guidelines, food consistency and diets. The OT/PT Habilitation Assistant will re-in service the following:

Client # 6 diet consistency will be re-in serviced to staff.
Client # 2 drink consistency will be re-in serviced to staff.
Client # 3 food consistency will be re-in serviced to staff.
Client # 4 food consistency will be re-in-serviced to staff.
Client #2 diet order will be re-in serviced to staff

Monitoring to be accomplished at least three times per month using Mealtime/assessments by QMRP, Habilitation Specialist, Home Supervisor, and OT/PT Assistant. Assessments and results of observations will be reviewed during monthly Core Team and Home Meetings.

Completion Date: April 4, 2020

W473 MEAL SERVICES

The Facility will re-in serviced all staff trained to work with individuals at the home on meal preparation; emphasizing the importance of food being served at an appropriate temperature.

Client #2 food not being served at an appropriate temperature. QMRP and Habilitation Specialist will in-service staff on the importance ensuring food is served at an appropriate temperature.

Monitoring will occur with at least three times per month; using the Meal Time/Interaction/Engagement assessments; assessments are conducted by QMRP, Hab. Spec., Home Supervisor and OT/PT Hab. Assistant. Staff will receive immediate feedback/correction on assessment results. Assessment results will be reviewed at monthly house meetings.

Completion Date: April 4, 2020

W478 MENUS

The Facility will provide a variety of foods at each meal. QMRP/ Home Supervisor will in-service all staff on menu substitution for all diets, including the therapeutic diets. Meal preparation sheet will be completed on a daily basis.

Client #1, #2, #3, #4 & #6 menu will be followed as written or appropriately substituted on the meal preparation sheet. QMRP to re-in-service therapeutic menu usage.

Monitoring to be accomplished daily using the meal preparation sheet and at Mealtime/assessments by QMRP, Habilitation Specialist, Home Supervisor, and OT/PT Assistant. Assessments and results of observations will be reviewed during monthly Core Team and Home Meetings.

Completion Date: April 4, 2020