STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G296	A. BUILDING _____ B. WING _____	10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 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 observation and interview, the facility failed to assure that privacy was maintained for 2 of 3 (#1 and #3) sampled clients while toileting. The findings are: A. The facility failed to assure that privacy was maintained for client #3 while toileting. For example: Afternoon observations in the group home on 10/27/20 at 6:00 PM revealed client #3 to sit at the dining room table participating in the dinner meal. Continued observation at 6:20 PM revealed client #3 to be left unattended in the bathroom with the door ajar which could be seen from the hallway. Continued observations at 6:30 PM revealed staff B to search for client #3 and to find the client unattended in the living room with no pants on. Morning observations in the group home on 10/28/20 at 9:15 AM revealed client #3 to stand in the bathroom with the door ajar, no pants on and unattended with the lights off. Further observations revealed client #3 to be visibly seen from the hallway as others passed by. Continued observations at 9:20 AM revealed staff D to find client #3 in the bathroom with the door ajar and to close the door and assist the client with putting his pants back on.	W 130		

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

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W 130	Continued From page 1 Interview with staff C on 10/28/20 verified that client #3 wears adult briefs and requires staff assistance with toileting. Continued interview with staff C confirmed that staff should have ensured the bathroom door was closed prior to assisting client #3 with his toileting needs. Interview with the Program Administrator (interim qualified intellectual disabilities professional) on 10/28/20 confirmed that all clients should receive privacy when toileting or receiving assistance with their toileting needs. B. The facility failed to assure that privacy was maintained for client #2 while taking a shower. For example: Observations in the group home on 10/28/20 at 8:30 AM revealed client #2 to transition by wheelchair to the bathroom to prepare for his shower. Further observations revealed client #2 to be left in the shower unattended with the door ajar which could be seen from the hallway. Continued observations at 8:37 AM revealed staff C to return to the bathroom and close the door behind her to further assist client #2 with his bathing needs. Interview with the Program Administrator (interim qualified intellectual disabilities professional) on 10/28/20 verified that at no point should client #2 have been left unattended in the bathroom with the door ajar. The Program Administrator also confirmed during the interview that all clients should receive privacy when toileting, taking a shower or receiving assistance with their bathing needs.	W 130		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 227		

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W 227	Continued From page 2 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. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews the person-centered plan (PCP) failed to include sufficient training objectives or interventions relative to behavior management for 1 of 3 sampled clients (#1). The finding is: Afternoon observations on 10/27/20 at 4:30 PM revealed client #1 to participate in an activity with staff. Further observations revealed client #1 to stand in front of this surveyor and clothing to smell of urine. Observations revealed staff A to step in front of client #1 and state "you smell like urine. Lets go and get you some clean clothes". Further observations at 4:47 PM revealed client #1 to return to the living area with a clean set of clothes. Morning observations on 10/28/20 at 7:45 AM revealed client #1 to enter the bathroom to prepare for his shower. Further observations revealed client #1's room to smell like urine. Observations revealed staff C to show this surveyor client #1's room and closet upon request. Further observation revealed client #1's room and dresser to smell of urine. Review of the record for client #1 on 10/28/20 revealed a person centered plan (PCP) dated 9/3/20. Further review of the record for client #1 revealed a behavior support plan dated 4/16/20	W 227		

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W 227	Continued From page 3 which included the following target behaviors: AWOL, stripping, inappropriate touching, verbal disruption, refusing to cooperate, physical aggression, property destruction, self injurious behaviors (SIBs), dropping to the floor, and taking others stuff. Review of the record for client #1 did not include training objectives relative to inappropriate toileting. Interview with staff C on 10/28/20 revealed client #1 has been soiling his clothes since early March 2020. Staff C also verified during the interview that client #1 had soiled his linens and numerous clothing items in a laundry hamper and staff would assist the client with washing his laundry. Further interview with staff C also verified that client #1 has previously urinated inside of his clothing hamper and placed clothes on top of it. Interview with the Program Administrator (interim qualified intellectual disabilities professional) on 10/28/20 revealed that she was not aware of client #1's inappropriate toileting. The Program Administrator confirmed that client #1's goals are current and client #1 could benefit from training objectives relative to inappropriate toileting.	W 227		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 3 non-sampled clients (#2) was provided opportunities for choice and self management relative to dining during the breakfast meal. The finding is:	W 247		

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W 247	Continued From page 4 Observations on 10/28//20 at 8:45 AM revealed client #2 to sit at the dining table and to begin eating breakfast which consisted of oatmeal, turkey sausage biscuit, apple juice and milk. Further observations at 9:00 AM revealed staff "D" to tell client #2 to take a pause and come get his medications on two separate occasions. Client #2 immediately consumed a spoon full of oatmeal, got up and headed towards the med closet. Continued observation at 9:05 AM revealed client #2 to return to the dining table to finish his meal. Additional observation revealed client #2 to eat 100% of his breakfast meal and ask for seconds. At no time was client #2 offered the choice or opportunity by staff to finish his breakfast before receiving his morning medications. Interview with the facility administrator on 10/28/20 revealed per the facility schedule, clients usually eat breakfast between 7:30 AM - 8:00 AM. Continued interview with the habilitation specialist and administrator confirmed there was no clinical or medical reason as to why client #2 should not have been offered the opportunity to finish eating breakfast before receiving his medications.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 5	W 249		

This STANDARD is not met as evidenced by:
Based on observations, record review, and interview the facility failed to ensure objectives relative to behavior management were implemented with sufficient interventions for 1 of 3 clients (#4) relative to adaptive equipment.

Observations in the group home on 10/28/20 at 7:30 AM revealed client #4 to sit at the table and participate in the breakfast meal. Further observations from 8:20 AM to 9:25 AM revealed client #4 to transition to the living room area, detach his chest harness and to remove a pillow from his back leaving the chest harness detached. At no point during that time was staff observed to assist client #4 to attach and secure his chest harness.

Review of records for client #4 on 10/28/20 revealed a person-centered plan dated 6/29/20. Further review of client #4's record revealed a behavior support plan (BSP) dated 2/8/18 which included the following target behaviors: endangering self, leaning from wheelchair or bed, removing seatbelt, pushing or pulling furniture such that it may fall on him. Review of the record for client #4 did not include training objectives or guidelines relative to securing his chest harness.

Interview with the Program Administrator (interim Qualified Intellectual Disabilities Professional) on 10/28/20 verified that client #4 has learned how to remove his chest harness which has become a safety concern. The Program Administrator verified that client #4 can have his chest harness removed during mealtimes. Further interview with the Program Administrator confirmed that

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W 249	Continued From page 6 client #4's goals are current and client #4 should always have his chest harness on and secured when ambulating.	W 249		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure 1 of 3 sampled clients (#5) and 1 non sampled client (#2) were provided with appropriate utensils to allow each client to eat as independently as possible in accordance with their highest functioning level. The findings are: A. The facility failed to provide client #5 with appropriate utensils during the dinner meal. For example: Observation in the group home on 10/27/20 at 6:00 PM revealed client #5 to consume his dinner meal consisting of baked chicken breast, mashed potatoes, green peas, juice and water. Further observation revealed client #5 to eat with a small spoon during the meal. Subsequent observation revealed client #5's place setting to include only a spoon and no fork or knife. Review of client #5's record on 10/28/20 revealed a person centered plan (PCP) dated 5/29/20 which indicated client #5 requires a high sided dish during meals. Further review of the record for client #5 revealed an adaptive behavioral inventory (ABI) dated 5/20/20. Review of client #5's ABI revealed the client independently eats with a fork with minimal spillage. Subsequent	W 475		

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W 475	Continued From page 7	W 475		

review of client #5's ABI revealed the client also uses a knife for spreading and cutting with partial independence.

Interview with facilty administrator (interim qualified professional) on 10/28/20 and habilitation specialist indicated client #5 should be provided with a complete place setting consisting of a knife, fork and spoon during all meals.

B. The facility failed to provide client #2 with appropriate utensils during the dinner meal. For example:

Observation in the group home on 10/27/20 at 6:00 PM revealed client #2 to consume his meal that consisted of baked chicken breast, mashed potatoes, green peas, juice and water. Further observations revealed client #2 to eat with a small spoon during the meal. Subsequent observation revealed client #2's place setting to include only a spoon and no fork or knife.

Review of client #2's record on 10/28/20 revealed a person centered plan (PCP) dated 11/19/19 which indicated client #2 requires a high sided dish and rocker knife during meals. Further review of the record for client #2 revealed an adaptive behavioral inventory (ABI) dated 11/19/20. Continued review revealed client #2 independently eats with a fork with minimal spillage. Subsequent review revealed client #2 also uses a rocker knife for spreading and cutting with partial independence.

Interview with facilty administrator (acting qualified professional) on 10/28/20 and habilitation specialist confirmed all clients should

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W 475	Continued From page 8 be provided with a complete place setting consisting of a knife, fork and spoon during all meals.	W 475		