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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004		

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

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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated as needed. The finding is: Review on 3/22/21 of the facility's EP plan (last reviewed 10/14/20) revealed the plan included information regarding three clients who no longer reside at the facility and no information for three clients who had been admitted in 2020. The EP also did not include any reference to the Qualified Intellectual Disabilities Professional (QIDP) who began working at the home in June 2020. Additional review of the EP plan noted, "This manual will be revised and updated as necessary." Interview on 3/23/20 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he could not be sure if the EP plan had been updated since 10/14/20.	E 004		
E 036	EP Training and Testing CFR(s): 483.475(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		

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procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of

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E 036	Continued From page 3 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 3/22/21 of the facility's EP plan (last reviewed 10/14/20) did not reveal staff had received recent training on the plan. Additional review of the facility documents did not include training for all staff working at the home. During an interview on 3/23/21, the Qualified Intellectual Disabilities Professional (QIDP) indicated no current training on the facility's EP plan could be located.	E 036		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #6's record was maintained with current medical documents. This affected 1 of 4 audit clients. The finding is:	W 111		

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W 111	Continued From page 4 Review on 3/22/21 of client #6's record revealed no current physician's orders. No documentation of the client's current physician's orders could be located. Interview on 3/22/21 via telephone with the facility's nurse revealed physician's orders signed in November '20 should be available for review; however, orders for March are being sent for the physician's signature and are currently unavailable.	W 111		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure clients had the right to a legal guardian. This affected 2 of 4 audit clients (#4 and #5). The findings are: A. Review of 3/22/21 of client #4's record revealed he had been admitted to the home on 6/30/20. The client's Individual Program Plan (IPP) dated 7/30/20 indicated the client acted as his own guardian. Additional review of the record indicated the client was 71 years old and had a diagnosis of Moderate Intellectual Disability, depression, GERD, and high blood pressure and cholesterol. Further review of the client's current physician's orders included routine medications of Norvasc (for hypertension), Atarax (for anxiety),	W 125		

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Loxapine (for mood stabilization), Prilosec (for GERD), Pravastatin (for cholesterol), Seroquel (for aggression), Zoloft (for depression) and a Multivitamin.

Further review of the record revealed several consent forms including Emergency Medical and Dental Services, Funds Management, Consent for Treatment, and General Consent. None of the forms were signed by client #4. The client's hand written signature (only his first name) was noted on an Admission Agreement form dated 6/30/20. Review of a Consent for Medications form identified Norvasc, Cervave cream, Pepcid, Zoloft, Multivitamin, Loxapine, Seroquel, Miralax, Triamcinolone, and Acetaminophen. The Consent for Medications included client #4's name; however, it was not signed or dated by the client.

Review on 3/23/21 of a Psychological Evaluation dated 6/26/20 revealed, "[Client #4's] general cognitive ability is within the extremely low range of intellectual functioning...[Client #4] may experience great difficulty in keeping up with his peers in a wide variety of situations that require thinking and reasoning abilities...[Client #4's] verbal and nonverbal reasoning abilities are in the extremely low range." Additional review of the evaluation noted, "...[Client #4] is functioning at the less than the 1st percentile and his overall level of adaptive functioning can be described as falling in the Extremely Low range. [Client #4] can engage in conversations using simple sentences. He can state his first and last name, and day and month of his birthdate. He was unable to state his correct age and the year he was born. He is unable to answer complex questions. [Client #4] requires prompting to

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complete most activities of daily living. [Client #4] cannot independently take care of personal finances. Academically, [Client #4] can count to 10. He identified two letters of the alphabet when presented out of sequence. He was unable to read sight words."

Continued review of the Psychological Evaluation for client #4 indicated, "His cognitive and adaptive skills are limited to the extent that he would benefit from support provided by an ICF/MR program. The support team should consider the following recommendations: 1. Support is needed to assist [Client #4] in learning, maintaining, and improving skills in areas that directly affect his ability to reside as independently as possible in the community. Skills are needed in self-care to assist [Client #4] in meeting basic needs such as food, hygiene, and health. Services are needed that will provide him the opportunity to learn skills to manage and control his personal life such as decision-making, initiation and follow-through of tasks and self-protection skills."

During an interview on 3/22/21, client #4 responded "No" when asked if he knew the names of any of the medications he takes, what the medications were used for or why he was taking them. When asked if he knew what the medications Seroquel and Zoloft were, he again responded, "No."

Interview on 3/23/21 with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 was currently acting as his own guardian and this was his status when he was admitted to the home. There was no response when asked how client #4 qualifies to

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W 125	Continued From page 7 serve as his own guardian. B. Review on 3/22/21 of client #5's record revealed he was 22 years old and had been admitted to the home in August '20. Additional review of the record noted the client's parents had petitioned the court for guardianship on 1/10/18 and a hearing had been scheduled on 2/20/18. The record did not include any other information regarding the current status of client #5's guardianship . Interview on 3/23/21 with the Program Manager revealed he felt certain client #5 has a legal guardian; however, the paperwork could not be located. The QIDP indicated he thought the client's mother was his legal guardian.	W 125		
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5's Comprehensive Functional Assessment (CFA) included an assessment of his independent living skills and abilities. This affected 1 of 4 audit clients. The finding is: Review on 3/22/21 of client #5's record revealed a Community/Home Life Assessment (CHLA) form. The form included an assessment of self-care, grooming, dressing, toileting, domestic	W 224		

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W 224	Continued From page 8 tasks, dining, meal preparation, money management, and other skill areas. The CHLA form in client #5's record was completely blank. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the CHLA had not been completed.	W 224		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 4 audit clients (#3, #4, and #6) received a continuous active treatment program consisting of needed interventions and services to support the accomplishment of objectives as identified in the Individual Program Plan (IPP) in the areas of meal preparation and family style dining. The findings are: A. During 2 of 3 meal preparation observations in the home throughout the survey on 3/22 - 3/23/21, clients were not involved in cooking tasks. With the exception of client #3 briefly operating a blender on 3/22/21, no clients were prompted or encouraged to participate.	W 249		

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W 249	Continued From page 9 Interview on 3/22/21 with Staff C revealed clients normally do assist in the kitchen; however, they were afraid of the clients getting hurt. Review on 3/23/21 of client #3's Community/Home Life Assessment (CHLA) dated 8/18/20 revealed she requires physical assistance to make and pack a lunch, make foods with no cooking, make foods with cooking but no mixing, make foods with cooking and mixing and to use recipes as needed. Review on 3/23/21 of client #4's CHLA dated 6/30/20 revealed he requires verbal cues to make and pack a lunch, make foods with no cooking, make foods with cooking but no mixing, make foods with cooking and mixing and to use recipes as needed. Additional review of the assessment noted he can operate a toaster, microwave and stove/oven given a verbal cue. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be assisting with meal preparation tasks given assistance from staff. B. During lunch observations in the home on 3/22/21 at 12:30pm, Staff B served food items onto individual plates and placed the plates at each client's area of the table. Drinks were also poured into individual cups at the table. Clients were not prompted or assisted to participate in family style dining tasks (i.e. serving, pouring, passing dishes). During dinner observations in the home on 3/22/21 at 6:32pm, Staff C prepared plates of food for client #3 and client #4 without their	W 249		

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W 249	Continued From page 10 participation. During breakfast observations in the home on 3/23/21 at 6:59am, Staff D prepared plates of food for client #3 and client #6 without their participation. The clients were not prompted or assisted to participate in family style dining tasks. Interview on 3/22/21 with Staff C revealed clients were not assisted to serve themselves because several clients are on chopped diets. Review on 3/23/21 of client #3's CHLA dated 8/18/20 revealed she requires physical assistance to participate in family style dining and pass food items to others. Review on 3/23/21 of client #4's CHLA dated 6/30/20 revealed no information regarding his family style dining skills; however, the assessment noted he could use a toaster, microwave and stove and complete other cooking and mixing tasks all with verbal prompts. Review on 3/23/21 of client #6's CHLA dated 12/27/19 revealed she requires physical assistance to participate in family style dining and pass food items to others. Interview on 3/23/21 with the QIDP confirmed clients should be participating with family style dining given assistance from staff.	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.	W 252		

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This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure data relative to the accomplishment of objectives specified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 2 of 4 audit clients (#5 and #6). The findings are:

A. Review on 3/23/21 of client #5's goal sheets revealed objectives to load the dryer with 60% independence (trained 2 times weekly), to clean his room with 90% independence (trained in the evening), to complete an exercise program with 50% independence (trained 3 times weekly), to brush his teeth with 90% independence (trained daily), to identify denominations of money with 75% independence (trained 3 times weekly) and to obtain his personal goals with 100% completion (data recorded for each goal). All goals included an implementation date of 8/4/20. Additional review of client #5's training book did not include any data collection for the objectives.

Interview on 3/23/21 with Staff E revealed all data for objectives was documented in each client's training book. Additional interview with Staff A indicated they are no longer collecting data for objectives in the training book and a new electronic system for data recording was implemented a few months ago.

Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he felt staff have been completing training on client #5's goals but had not been completing the data collection. The QIDP also indicated the facility

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has recently implemented a new electronic system which allows staff to record objective data.

B. Review on 3/23/21 of client #6's record revealed guidelines written by the Physical Therapist (PT) for exercises (dated 4/13/20), positioning/repositioning (dated 4/13/20) and use of a cervical neck collar (dated 10/26/20). Additional review of exercise guidelines noted, "Staff should document [Client #6's] participation in her exercise program on the monthly exercise program log." Review of positioning/repositioning guidelines indicated, "Staff should complete the positioning log to indicate that positioning and repositioning have occurred throughout the day." Further review of guidelines for use of her cervical neck collar revealed, "1st and 2nd shift staff should note in the communication book that [Client #6] wore (or refused to wear) the collar during their respective shifts." Review of client #6's training book for the months of December '20 - March '21 did not include documentation of the PT guidelines.

Interview on 3/23/21 with Staff E revealed all data for objectives was documented in each client's training book. Additional interview with Staff A indicated they are no longer collecting data for objectives in the training book and a new electronic system for data recording was implemented a few months ago.

Interview on 3/23/21 with the PT confirmed client #6's guidelines were current and staff should be implementing the guidelines and documenting on the sheets provided. Additional interview with the PT revealed she felt staff have been implementing the guidelines but failing to

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W 252	Continued From page 13 document properly.	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 failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 4 audit clients (#3 and #6). The findings are: A. Review on 3/22/21 of client #3's Behavior Support Plan (BSP) dated 3/23/19 revealed an objective to exhibit 0 episodes of agitation per month for 12 consecutive months. The BSP incorporated the use of Clonazepam, Divvalproex, Latuda and Melatonin. Additional review of the record revealed a consent for the BSP dated 3/23/19. The consent noted, "I understand that this authorization will expire on 3/23/20." No current consent could be located. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) did not indicate a current consent was available for review. B. Review on 3/22/21 of client #6's BSP dated 1/28/19 revealed an objective to exhibit 0 episodes of inappropriate verbalizations per month for 12 consecutive months. The BSP incorporated the use of Buspar, Ativan, Cymbalta, Latuda and Valium. Additional review of the	W 263		

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W 263	Continued From page 14 record revealed a consent for the BSP dated 1/28/19. The consent noted, "I understand that this authorization will expire on 1/28/20." No current consent could be located. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) did not indicate a current consent was available for review.	W 263		
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure implementation of policies and procedures which facilitated positive conduct and interactions between staff and clients throughout their daily life. This potentially affected all clients residing in the home, specifically affecting 2 of 4 audit clients (#3 and #4). The finding is: During observations in the home on 3/22/21 from 11:20am - 1:14pm and on 3/23/21 from 3:45pm - 6:45pm, two staff worked in the home with five clients. While one staff's interactions with clients were positive and patient, Staff B was observed speaking with an elevated tone of voice and made negative and abrupt comments when interacting with clients. For example: A. Throughout the observations, Staff B spoke with an elevated tone of voice while interacting with and directing client #3. The staff repeatedly and consistently told the client to "Sit down!",	W 267		

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W 267	Continued From page 15 "Have a seat!", "Uh-uh, wait!" , "Come on, [Client #3]!" When client #3 sat on the couch and put her feet up on the furniture, Staff B yelled, "Get your feet out the chair, that's not a trampoline, it's a couch. Stop bouncing around!" or "Get your feet out the chair!" Staff B constantly redirected client #3 when she stood up from her seat stating abruptly, "Where you going, where you going? Have a seat, you just used the bathroom!" or "Go sit down!" On one occasion when client #3 picked up Staff B's car keys off the kitchen counter, the staff yelled, "Put my keys back, you don't pay no car note, put it back!" B. Throughout the observations, Staff B spoke with an elevated tone of voice while interacting with and directing client #4. As the client walked in to the dining area for lunch and began to speak, Staff B abruptly cut him off stating, "Don't be asking me a bunch of questions, just sit down, eat your lunch and be glad you got that!" Client #4 later attempted to ask Staff B another question. The staff stated, "Uh-uh, no questions, everyday the same questions over and over!" At the dinner meal when client #4 asked for salad, Staff B responded abruptly, "You got broccoli, enjoy it, you don't chew your food and you not chokin' in here tonight!" Later during the meal, client #4 asked about a snack and more salad. Staff B yelled, "You still talkin', I didn't think so", "Do you chew your food, no you don't, you just swallow!" Interview on 3/22/21 with Staff B revealed she	W 267		

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W 267	Continued From page 16 had worked in the home for 3 years. When asked if she had received any training, she replied, "If you want to call it that." The staff indicated she was "not impressed" with the training provided by the facility. Interview on 3/23/21 with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed the interactions and comments made by Staff B were inappropriate. Additional interview indicated staff training includes discussions about appropriate interactions and staff conduct with clients which would be covered during abuse/neglect training. The Program Manager also indicated an investigation into Staff B's conduct on 3/22/21 would be initiated.	W 267		
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 observations, record review and interviews, the facility failed to ensure a technique to manage client #3's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: During observations in the home on 3/22/21 at 12:32pm, clients began gathering at the table for lunch. As client #3 approached the table, Staff B prompted her to sit away from the table in a chair against the wall and next to Staff B. The client remained there for several minutes before the	W 288		

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W 288	Continued From page 17 staff prompted her to go to the table for lunch. Immediate interview with Staff B revealed client #3 was made to wait before going to the table because "she eats fast and shoves food in her mouth." Review on 3/23/21 of client #3's Behavior Support Plan (BSP) dated 3/23/19 revealed an objective to exhibit 0 episodes of agitation per month for 12 consecutive months. Additional review of the record did not indicate a technique of making client #3 wait to eat due to consuming her food too fast. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the client should not have been made to wait before eating and this technique was not included in her IPP.	W 288		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used to manage client #4's inappropriate behaviors was used only as an integral part of his Individual Program Plan. This affected 1 of 4 audit clients. The finding is:	W 312		

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W 312	Continued From page 18 Review on 3/22/21 of client #4's physician's orders signed 11/15/20 revealed orders for Seroquel 50mg, take 1 tablet by mouth at bedtime, Zoloft 100mg, take 1 and 1/2 tablets by mouth once daily and Loxapine 5mg, take 2 capsules by mouth at bedtime. Additional review of the record indicated the medications were used for depression (Zoloft), aggression (Seroquel) and mood stabilization (Loxapine). Further review of the record did not identify a formal behavior plan. The use of Seroquel, Zoloft and Loxapine were not included in a formal behavior plan for client #4. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 ingests the medications for behavior support; however, the medications were not included in a formal behavior plan.	W 312		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to implement the facility's current COVID-19 visitor screening process and to appropriately use a digital thermometer. The finding is:	W 340		

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W 340	Continued From page 19 A. Upon arrival to the home on 3/23/21 at 6:05am, Staff D invited the surveyor into the home. The surveyor's temperature was not taken. Interview on 3/23/21 with Staff D revealed the COVID-19 visitor screening consisted of a temperature check and completion of questions regarding COVID-19. Review on 3/23/21 of the facility's COVID-19 screening tools revealed temperatures should be taken for staff, clients (returning from home visits) and visitors upon entry into the home. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed everyone's temperature should be taken in order to enter the home. B. During observations in the home on 3/22/21 at 4:11pm, Staff B used a digital thermometer to take the temperature of all five clients in the home. The staff pressed the device against the temple of each client without cleaning it between uses. Immediate interview with Staff B revealed she had not been given any specific instructions on proper use of the thermometer between clients. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the device should have been cleaned between uses.	W 340		
W 381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security.	W 381		

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W 381	Continued From page 20	W 381		

This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure drugs were stored under secure conditions. The finding is:

During observations in the home throughout the survey on 3/22 - 3/23/21, a hall closet was locked. Various staff utilized a key to unlock the closet to obtain items. Closer observation of the closet revealed numerous pill cards containing medications. The closet also contained controlled drugs (i.e, Clonazepam) inside of an unlocked metal box. The drug labels included the names of several clients currently living in the home and clients who had been discharged.

Interview on 3/23/21 with Staff E (the medication technician) revealed the drugs had been in the hall closet for months and were supposed to be picked up by the nurse. The staff also indicated the drugs were no longer being used. Additional interview indicated the controlled drugs should be kept double locked.

Review on 3/23/21 of the facility's Medication Disposal (Rev. 11/10) revealed, "All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion."

Interview on 3/23/21 with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed the medications were no longer being used and belonged to current and former clients. Additional interview indicated the drugs were awaiting disposal, should not be kept in the hall closet and needed to be removed.

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W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4 was furnished and taught to use and make informed choices about the use of his eyeglasses and dentures. This affected 1 of 4 clients. The finding is: A. During observations in the home throughout the survey on 3/22 - 3/23/21, client #4 did not wear eyeglasses. The client was not prompted or encouraged to wear eyeglasses. Interview on 3/23/21 with Staff E revealed they had never seen client #4 wearing eyeglasses in the home and they were not sure if he has eyeglasses. Interview on 3/23/21 with client #4 revealed he does not have eyeglasses. Review on 3/22/21 of client #4's Individual Program Plan (IPP) dated 7/30/20 revealed under adaptive equipment, "Eyeglasses". The plan noted his eyeglasses were needed, "Daily". Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he did	W 436		

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W 436	Continued From page 22 recall seeing client #4 wearing eyeglasses; however, he had not seen them recently. B. During observations in the home throughout the survey on 3/22 - 3/23/21, client #4 did not wear dentures. The client was not prompted or encouraged to wear dentures. Interview on 3/23/21 with Staff E revealed client #4 does have dentures but does not like to wear them and will often refuse to put them in. During an interview with client #4 on 3/23/21, when asked about his dentures, the client retrieved a pair of dentures from under his pillow in his bedroom. The client indicated he did not like to wear his dentures. Review on 3/23/21 of client #4's IPP dated 7/30/20 revealed under adaptive equipment, "Dentures". The plan noted his dentures were needed, "Daily". Additional review of an Occupational Therapy (OT) quarterly update (dated 1/11/21) revealed, "...Per GHM reports pt refuses to wear his dentures..." Interview on 3/23/21 with the QIDP confirmed client #4 has dentures but "won't tolerate them." The QIDP did not indicate any training had been implemented to teach client #4 wear his dentures and make informed choices about wearing them.	W 436		
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.	W 460		

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W 460	Continued From page 23 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure modified diets for 2 of 4 audit clients (#3 and #4) were followed as indicated. The findings are: A. During breakfast observations in the home on 3/23/21 at 6:59am, client #3 consumed two round waffles and a sausage patty. The waffles and sausage were cut into large pieces. Client #3 consumed the food without difficulty. Interview on 3/23/21 with Staff A revealed client #3 consumes a "mechanical soft" diet and her food goes into the blender to be chopped up. Review on 3/23/21 of client #3's Individual Program Plan (IPP) dated 8/24/20 revealed she consumes a mechanical soft diet. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 consumes a mechanical soft diet which would mean her food should be chopped in the food processor and not simply cut up. B. During breakfast observations in the home on 3/23/21 at 6:59am, client #4 consumed three round waffles and a sausage patty. The waffles were cut into large pieces by staff while the client used the edge of his fork to break apart his sausage patty before consuming it. Interview on 3/23/21 with Staff A revealed client #4 consumes a "mechanical soft" diet and his food goes into the blender to be chopped up. Review on 3/23/21 of client #4's Occupational	W 460		

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W 460	Continued From page 24 Therapist (OT) update dated 1/11/21 revealed his diet had been changed to mechanical soft from bite-size pieces. Interview on 3/23/21 with the QIDP confirmed client #4 should receive a mechanical soft diet with his food chopped in the blender.	W 460		
W 477	MENUS CFR(s): 483.480(c)(1)(i) Menus must be prepared in advance. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a copy of menus was available for meal planning. The finding is: During 3 of 3 meal preparation observations in the home on 3/22 - 3/23/21, no menus were available for review. Interviews on 3/22 - 3/23/21 with Staff B, Staff C and Staff D revealed they used to have menus in the home to follow; however, the menus could not be located. Additional interview indicated no menus had been available for several months. When asked how they know what to cook, the staff indicated they use food available in the home or can recall from previous menus what days certain foods were served on. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he could not be sure why no menus were available in the home.	W 477		