| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SCI-ROANOKE HOUSE | 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870 |

| (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 |
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| W 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint survey was completed on March 16, 2021 for Intake #NC00172492. No deficiencies were cited for the complaint. However, deficiencies were cited as a result of the recertifiction survey. | W 000 | | |
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure privacy was maintained during personal care. This affected 3 of 6 audit clients (#1, #5 and #9). The findings are:<br><br>A. During observations in House 2 on 3/15/21 at 3:56pm, client #1 was observed standing in front of the toilet, pants down around his ankles. The door to the bathroom was wide open, and during the observation, his peer was pacing up and down the hallway and walking in and out of his bedroom located across the hall from the bathroom. At no time during the observation was client #1 prompted to close the door nor did staff close the door.<br><br>Additional observations in House 2 on 3/15/21 at 4:49pm revealed client #1 telling Staff C he had to go to the bathroom. Staff C told client #1 to go and make sure he washed his hands. Client #1 was observed standing in front of the toilet with his pants down. The door to the bathroom was | W 130 | W130<br>All personnel will receive training regarding clients' right to privacy and how to assure privacy for all clients in various situations in the ICF/IID facility.<br><br>The Director or PC will monitor programs to assure client privacy twice weekly.<br><br>The RQP will monitor programs twice monthly.<br><br>The Executive Director (Corporate Office) will monitor programs once monthly.<br><br>All monitoring will be documented. Any concerns will be followed up on.<br><br>RECEIVED<br>By DHSR Mental Health Licensure & Certification at 5:00 pm, Mar 29, 2021 | 5/15/2021 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Leslie Roughton | Chief Operations Officer- Eastern Region | 3/26/2021 |

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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| W 130 | Continued From page 1 | W 130 | | |

wide open. At no time during the observation was client #1 prompted to close the door.

Further observations in House 2 on 3/15/21 at 5:21pm revealed client #1 standing in his bedroom, undressed from the waist down. At no time during the observation was client #1 prompted to close the door.

Interview on 3/16/21 with Staff G revealed any time a client is in the bathroom or bedroom during personal care needs, the door should be closed to ensure the client has privacy. Staff G revealed staff should prompt the client to close the door or close the door for them.

Interview on 3/16/21 with the Director and qualified intellectual disabilities professional (QIDP) revealed staff should follow the clients to the bathroom or bedroom to ensure the client is provided privacy. The Director and QIDP confirmed staff should have prompted client #1 to close the door or should have closed the door for him while toileting and getting dressed.

B. During observations in House 2 on 3/15/21 at 3:57pm, client #9 was observed sitting on the toilet with the bathroom door wide open. Staff D was observed calling client #9's name several times from the next room, but did not come to the bathroom to ensure the door was closed.

Additional observations in House 2 on 3/16/21 at 8:08am revealed client #9 sitting on the toilet with the bathroom door wide open. At 8:10am, Staff G was observed to walk into the bathroom and wash her hands. After Staff G washed her hands, she turned and began to exit the bathroom until she saw the surveyor standing in

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| W 130 | Continued From page 2 | W 130 | | |

the hall, at which time she closed the bathroom door.

Interview on 3/16/21 with Staff G revealed any time a client is in the bathroom or bedroom during personal care needs, the door should be closed to ensure the client has privacy. Staff G revealed staff should prompt the client to close the door or close the door for them.

Interview on 3/16/21 with the Director and Qualified Intellectual Disabilities Professional (QIDP) revealed staff should follow the clients to the bathroom or bedroom to ensure the client is provided privacy. The Director and QIDP confirmed staff should have prompted client #9 to close the door or should have closed the door for him while toileting.

C. During morning observations in House 1 on 3/16/21 at 8:10am, client #5 left her bedroom, carrying a red top as she walked up the hallway wearing a sports bra and pants. Client #5 wanted Staff J to assist her. Staff J went into client #5's room to assist, the door was closed. Afterwards at 8:13am, the program director (PD) noticed that client #5 had redressed herself, wearing the top wrong. The door to the room was left open, as the PD helped client #5 put the shirt on correctly. Client #5's torso was exposed.

Review on 3/16/21 of client #5's IPP dated 6/23/20 revealed that client #5 required staff's assistance with not putting her clothes on inside out or backwards. Client #5 also required cues to close the door for privacy.

Interview on 3/16/21 with the PD revealed that

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| W 130 | Continued From page 3 she forgot to shut the door when she assisted client #5.<br><br>Interview on 3/16/21 with the director revealed that the door should be shut when staff assist clients with dressing. | W 130 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 5 of 6 audit clients (#1, #3, #5, #6 and #7) received a continuous active treatment program consisting of needed interventions and services to support the acheivement of objectives identified in the Individual Program Plan (IPP) in the areas of program implementation, self-help skills and dining. The findings are:<br><br>A. During observations in House 2 on 3/15/21 at 5:01pm, client #1 was observed to walk into the kitchen and looked around for staff. Client #1 was observed to open a cabinet, get a can of diet mountain dew, pour half into a cup, and drink it. Client #1 was observed to pour the rest of the diet mountain dew into the cup, drink it, and throw the | W 249 | W249<br>All staff will receive training in:<br><br>1- ICF-IID Level of Care Basics:<br>• Active Treatment<br>• Encouraging Independence<br>• Providing the least assistance necessary<br><br>2- Client #1 and All Clients Behavior Intervention Programs<br><br>3- Client # 3's and all clients mobility guidelines<br><br>4- All clients guidelines for independence in medication administration<br><br>5- Mealtime Program<br>• Participation in Meal Preparation<br>• Promoting Independence in mealtime<br>• Guidelines and goals for all clients<br>• Participation in Mealtime cleanup<br>• Assuring all utensils and mealtime basics ( napkins etc.) are provided<br><br>The Director or PC will monitor behavior programming, mobility, medication administration and mealtime programs twice weekly.<br><br>The RQP will monitor programs twice monthly.<br><br>The Executive Director (Corporate Office) will monitor programs once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 249 | Continued From page 4 | W 249 | Type text here | |

empty soda can in the trash can and put the cup in the sink. At 5:03pm, client #1 was observed to exit the kitchen and walk into the activity room. Staff C was sitting at the table and when he observed client #1 exit the kitchen, Staff C stated "You took a soda, didn't you?" Client #1 replied "Yeah."

Review on 3/16/21 of client #1's Behavior Support Program (BSP) dated 3/22/19, revealed a target behavior of taking/consuming unscheduled food, which includes taking/trying food that is not part of his dietary schedule.

Further review of client #1's BSP revealed the actions staff are to take when client #1 exhibits this identified target behavior, which includes:
1. Remember first to monitor closely when client #1 is eating meals or working in the kitchen.
2. It he tries to take unscheduled food, try to block his efforts.
3. If he has unscheduled food items in his hands, staff may remove the item from his hands and discard it in the trash. Use social disapproval when removing the item, "No [Client #1], that is not yours."
4. If he actually consumes the food, use social disapproval, "No [Client #1], that was not yours." Simply document as a target behavior episode.

Interview on 3/16/21 with the Director and qualified intellectual disabilities professional (QIDP) revealed that this identified target behavior does include sodas/beverages. The Director and QIDP confirmed staff should have followed client #1's BSP as written.

B. During observations in House 2 throughout the survey on 3/15/21- 3/16/21, client #3 was

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| W 249 | Continued From page 5 | W 249 | | |

observed sitting in his wheelchair. Whenever client #3 would move around his home, staff were observed to push him in his wheelchair and at times, client #3 would propel his wheelchair to where he was intending to go.

Review on 3/16/21 of client #3's IPP dated 10/1/20, revealed client #3 is ambulatory with staff assistance in using his walker with a seat in the facility, and uses his wheelchair for all mobility outside the facility. Further review of client #3's IPP revealed he is supported by a service objective regarding mobility guidelines, "to provide guidance in ambulating."

Review of client #3's mobility guidelines revealed:
1. Gait belt should be placed around his waist.
2. Staff should hold gait belt to assist client #3 in maintaining his balance and as he maneuvers his walker forward.
3. Staff should allow client #3 to sit and relax as needed.
4. Staff should allow client #3 to use his wheelchair on outings, when transporting and when he is too weak to use his walker.

Interview on 3/16/21 with the Director and QIDP revealed client #3 is supposed to use his walker in the home. The Director and QIDP revealed that when client #3 attends the day program, he uses his wheelchair and when he returns home in the afternoon from the day program, he prefers to use his wheelchair. The Director and QIDP confirmed that staff should have followed client #3's mobility guidelines and prompted client #3 to use his walker.

C. During observations of medication administration in House 2 on 3/15/21 at 5:04pm,

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| W 249 | Continued From page 6<br>Staff D was observed to put apple sauce into a medicine cup, and then retrieve client #6's bin of medications. Staff D punched client #6's pills out of the bubble pack, crush them, and mix them in the apple sauce. Staff D then exited the med room, walked down the hall to get client #6 and brought her into the med room where she spoon fed her the apple sauce and crushed pills.<br><br>Review on 3/15/21 of client #6's IPP dated 12/3/20 revealed client #6 is supported by a medication administration protocol. Review of the protocol revealed client #6 is to get the applesauce out of the refrigerator and put the applesauce back when done in order to maintain some independence during medication administration.<br><br>Interview on 3/16/21 with the director and QIDP confirmed staff should not prepare client #6's medications to be administered prior to client #3 entering the med room, and staff should follow the medication administration protocol and allow client #6 to get the applesauce and put the applesauce up when done.<br><br>D. During observations of medication administration in House 2 on 3/15/21 at 7:11am, Staff I was observed to retrieve client #1's bin of medications. Staff I punched five pills from the bubble packs into a medicine cup, and then called client #1 into the medication room to take his medicine.<br><br>Review on 3/16/21 of client #1's IPP dated 4/2/20 revealed client #1 is supported with guidelines to maintain his current level during medication administration. Review of these guidelines revealed: | W 249 | | |

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| W 249 | Continued From page 7<br>1. Client #1 will come to the med room when notified.<br>2. Client #1 will take his med bin out of the cabinet.<br>3. Client #1 will obtain his own water or juice.<br>4. Client #1 punch the pills out of bubble pack with staff assistance.<br>5. Client #1 will take his meds followed by liquids, and throw his trash away.<br><br>Interview on 3/16/21 with the Director and QIDP confirmed that staff are not supposed to prepare client #1's medications prior to him entering the med room, and should allow client #1 to be as independent as possible by following the medication administration guidelines.<br><br>E. During observations in House 2 on 3/15/21 at 11:48am, client #6 was observed sitting at the dining table with adaptive equipment that consisted of a high-sided divided plate, plate wedge, and built-up handle spoon. During the lunch observations, the Director was observed to provide hand-over-hand assistance with client #6 while she was eating. Additional observations revealed the Director talking to cient #6 about the food she was eating, and using the plate wedge to spin the plate around for easier access for client #6 to get to each of the items on her plate.<br><br>Observations in House 2 on 3/15/21 at 5:34pm revealed client #6 sitting at the dining table with adaptive equipment that consisted of a high-sided divided plate, plate wedge, and built-up handle spoon. During the observation, Staff D was observed to feed client #6 her entire meal, and did not offer hand-over-hand assistance during the meal. | W 249 | | |

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| W 249 | Continued From page 8<br>Observations in House 2 on 3/16/21 at 7:49am revealed client #6 sitting at the dining table with adaptive equipment that consisted of a high-sided divided plate, plate wedge, and built-up handle spoon. During the observation, Staff G was observed to feed client #6 her entire meal, and did not offer hand-over-hand assistance during the meal.<br><br>Review on 3/15/21 of client #6's IPP dated 12/3/20 revealed client #6 is supported with meal guidelines to ensure she doesnt eat too quickly.<br><br>Interview on 3/16/21 with the Director and QIDP revealed client #6 uses adaptive equipment during meals. The Director revealed that client #6 is visually impaired, and that staff are supposed to use the plate wedge to spin the plate around for client #6 and tell her what each item is that she is eating. The Director revealed staff are supposed to feed client #6 using hand-over-hand assistance and allow her to hold the spoon. The Director and QIDP confirmed that staff should not have fed client #6 her entire meal at dinner on 3/15/21 and breakfast on 3/16/21, but should have allowed her to participate by providing hand-over-hand assistance.<br>F. During dinner observations in House 1 on 3/15/21 at 5:44pm, the program director (PD) removed client #5's dirty dishes from the table and took them to the kitchen, without asking client #5 to participate.<br><br>Review on 3/16/21 of client #5's IPP dated 6/23/20 revealed that she was able to clear her own dishes.<br><br>Interview on 3/16/21 with the PD revealed that the facility recently lifted their COVID restrictions and | W 249 | | |

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| W 249 | Continued From page 9<br>now permitted clients to enter the kitchen. Beforehand, staff were instructed to avoid having clients enter the kitchen, so staff would clear the dishes.<br><br>Interview on 3/16/21 with the director revealed that staff should encourage the clients to put their own dishes away.<br><br>G. During dinner observations in House 1 on 3/15/21 at 5:42pm, the PD removed client #7's dirty dishes from the table without asking client #7 to participate. The PD placed the dishes in the sink and Staff O rinsed off the plates. An additional observation on 3/16/21 during breakfast at 8:04am, Staff J took client #7's plate off the table, without prompting client #7 to take her dirty dishes to the kitchen.<br><br>Review on 3/15/21 of client #7's IPP dated 9/3/20 revealed that she had training goals to scrape the scraps in the trash after meal, rinse her plate and place plate in the dishwasher with verbal cues.<br><br>Interview on 3/16/21 with the PD revealed that the facility recently lifted their COVID restrictions and now permitted clients to enter the kitchen. Beforehand, staff were instructed to avoid having clients enter the kitchen, so staff would clear the dishes.<br><br>Interview on 3/16/21 with the director revealed that staff should encourage the clients to put their own dishes away.<br><br>H. During breakfast observations in House 1 on 3/16/21 from 7:30-8:00am, client #7 fed herself yogurt, oatmeal and drunk a dairy drink. The food left residue around client #7's mouth and was | W 249 | | |

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| W 249 | Continued From page 10<br>dripping from her lips and chin. Client #7 did not have any napkins available to her and did not wipe her mouth. At 7:55am, Staff J placed several paper towels on the corner of the table near client #7, but did not prompt her to wipe her mouth. Staff J stepped away from the table and returned at 8:04am and started wiping client #7's mouth, without client #7 participating.<br><br>Review on 3/15/21 of client #7's IPP dated 9/3/20 revealed that she should receive verbal reminders to use a napkin to wipe her mouth.<br><br>Interview on 3/16/21 with the PD revealed that staff do not always remember to put napkins on the table. Napkins should be used so that clients can wipe their mouths.<br><br>Interview on 3/16/21 with the director revealed that staff should encourage client #7 to wipe her mouth with napkin. | W 249 | | |
| W 342 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(iii)<br><br>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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to ensure staff demonstrated competency in detecting signs of | W 342 | W342<br>The RN team leader will provide training to all staff on detecting signs of injury.<br><br>The RN team leader will assure that all staff demonstrate competency in this skill.<br>All staff will receive training on:<br>• incident reporting procedures<br>• guidelines for reporting incidents to medical staff<br>• assessing clients after an injury<br><br>The Director will monitor incident reporting and follow up once weekly.<br><br>The RN team leader will monitor incident reporting and follow up twice monthly.<br><br>The Executive Director (Corporate Office) will monitor incident reporting and follow up once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 342 | Continued From page 11<br>injury and reporting new falls to the facility nurse. This affected 1 of 6 audit clients (#5). The finding is:<br><br>During observations in House 1 on 3/15/21 at 4:07pm, client #5 was sitting on the edge of her chair, pulled away from the table, when she dropped a crayon on the floor. The crayon landed underneath the table. Client #5 reached for the crayon until she fell out of her chair, falling on her left side. Staff A standing next to the table, helped client #5 off the floor. None of the staff present, checked over client #5 for injuries and no one mentioned to contact the nurse.<br><br>An additional observation in House 1 on 3/16/21 at 8:30 am, client #5 sat at the table doing leisure activities. Client #5 had a raised surface in between her eyebrows.<br><br>Review on 3/15/21 of the RN Team Leader On Call Guidelines dated 11/11/20 read: "When you have a client that has a medical need or concern and there is not a nurse in your facility, please notify that nurse."<br><br>Review on 3/16/21 of the Internal Incident Report dated 3/15/21, time unknown, read that Staff L and Staff O noticed a knot in the middle of client #5's forehead. The date of her injury was unknown. Neither the doctor or nurse were notified.<br><br>Interview on 3/16/21 with the program director (PD) revealed that initially she could not recall an incident from yesterday that client #5 had fallen. The PD acknowledged that she did not receive an internal incident report from the 3/15/21 fall. The PD stated that if a fall occurred, staff were | W 342 | | |

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| W 342 | Continued From page 12<br>supposed to report it to her and the director, then complete an incident report. The nurse should be contacted to come and look at the client. When staff help the client up, the staff should assess if there are any noticeable injuries. The PD stated that staff did prepare an internal incident report when they noticed that client #5 had a lump on her forehead.<br><br>Interview on 3/16/21 with the director revealed that if a client hit the ground, staff should write up a report and notify the nurse. The director also indicated that the nurse was on vacation this week. | W 342 | | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure client #1's medication was administered in accordance with physician's orders. This affected 1 of 6 audit clients. The finding is:<br><br>During observations of medication administration in House 2 on 3/15/21 at 12:13pm, Staff A was observed to administer one Benztropine 2mg tablet and one Lorazepam 2mg tablet to client #1.<br><br>Review on 3/16/21 of client #1's physician's orders dated 12/28/20 revealed an order for Benztropine 2mg, "Take one tablet by mouth three times a day at 8am, 2pm and 8pm" and an | W 368 | W368<br><br>In the future client #1 and all clients will receive medications as ordered.<br>All Nurses and Medication Monitors will be re-trained in the SCI medication administration procedure 206-001 by the RN Team Leader.<br><br>The Director will monitor medication administration at least twice monthly.<br><br>The RN Team Leader will monitor medication administration once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 368 | Continued From page 13<br>order for Lorazepam 2mg, "Take one tablet by mouth three times a day at 8am, 2pm and 8pm."<br><br>Interview on 3/16/21 with the Director and qualified intellectual disabilities professional (QIDP) confirmed that client #1 should have received his medications at 2:00pm in accordance to the physician's orders. | W 368 | | |
| W 382 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2)<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to ensure that medications were secured. This affected all clients in the home (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11). The findings are:<br><br>A. During observations in House 1 on 12:00pm, Staff J brought client #5 into the medication room. Staff J removed the medications from the cabinet, placed on the counter, then tried to put on gloves. The gloves kept tearing before Staff J could start her med pass. Staff J commented, that she would be right back and left the cabinet unlocked, the bin of blister packs of medications on the counter, plus client #5 and the surveyor alone in the medication room, with the door ajar. Staff J returned to the room at 12:02pm and gave client #5 her dose of Fluvoxamine 15mg.<br><br>Review on 3/16/21 of the facility's medication administration policy revealed "medication | W 382 | W382<br>In the future, all drugs and biologicals will be stored in the medication room in the locked cabinet. The medication room and all medication cabinets will be locked at all times except during medication preparation.<br><br>Additionally materials needed for medication administration will be fully stocked in the medication room. ( gloves etc.)<br><br>The RN Team leaders will provide training to all nurses and med monitors on Nursing policy 206-001.<br><br>The Director will monitor medication administration at least twice monthly.<br>The RN Consultant will monitor medication administration once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 382 | Continued From page 14<br>cabinets/closets are locked at all times except during medication preparation."<br><br>Interview on 3/15/21 with Staff J revealed that she considered bringing client #5 with her when she left the room, but thought it was okay because the surveyor was with client #5.<br><br>Interview on 3/16/21 with the director and qualified intellectual disabilities professional (QIDP) revealed that all medications are double locked, in a cabinet and then the door to the medication room should be locked. The Director and QIDP confirmed the medication should not have been left out when the staff walked out of the medication room, and the door of the medication room should have been locked.<br><br>B. During observations in House 2 on 3/16/21 at 5:04pm, Staff D was observed to prepare client #6's medication in preparation for med pass. Staff D placed the medicine cup of pills and applesauce on the counter, walked out of the medication room and down the hallway to get client #6. During the observation, the door to the medication room was left open, with the pills still on the counter.<br><br>Review on 3/16/21 of the facility's medication administration policy revealed "medication cabinets/closets are locked at all times except during medication preparation."<br><br>Interview on 3/16/21 with the Director and QIDP revealed that all medications are double locked, in a cabinet and then the door to the medication room should be locked. The Director and QIDP confirmed the medication should not have been | W 382 | | |

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| W 382 | Continued From page 15<br>left out when the staff walked out of the medication room, and the door of the medication room should have been locked. | W 382 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to maintain leisure activities equipment in good condition for 1 of 6 audit clients (#7). The findings are:<br><br>During observations in House 1 during 3/15/21-3/16/21, there were missing wooden pieces from 4 puzzles and missing plastic shapes from another puzzle that client #7 continued to seek out for leisure activities. Staff A, Staff J, Staff L, Staff O and the program director (PD) were all observed looking for the extra pieces in a large plastic container and on the bookshelf, when setting up the puzzle for client #7 during the survey.<br><br>Interview with Staff L on 3/16/21 revealed that the puzzles had been bought recently and were now missing pieces.<br><br>Interview with the PD on 3/16/21 revealed the 2 puzzles she offered client #7 this morning both | W 436 | W436<br>All leisure activities and equipment will be maintained in good condition.<br>When leisure equipment is discovered to be missing pieces or not in good condition it will be replaced.<br><br>The Director or PC will monitor leisure equipment to assure it is in good condition once weekly and replace as needed.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 436 | Continued From page 16<br>had missing pieces. She had looked for the pieces but could not recover them and was not sure why the pieces were not put back in place. She commented that client #7 really liked the puzzles so she had bought several puzzles for her. During the interview, Staff A commented that Staff O had looked for the missing puzzle pieces yesterday and could not find them. | W 436 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11). The findings are:<br><br>A. During observations in House 2 on 3/15/21 at 3:50pm, Staff C was observed in the kitchen, cutting up pieces of raw chicken and wearing gloves. At 4:10pm, Staff C and client #1 were observed to gather the trash bag in the kitchen and take it outside. At 4:15pm, Staff C and client #1 were observed in the living room tossing a ball back and forth. At 4:20pm, Staff C and client #1 were observed to get a broom and dust pan, and sweep the floor in the kitchen, dining room and living room. At 4:22pm, Staff C was observed to use his hand to adjust his face mask. Between 4:25pm and 4:41pm, Staff C and client #1 were observed to wipe off plates and bowls, empty the dishwasher, and wipe off the kitchen counters | W 454 | W454<br><br>The Director and RN team leader will provide training to all personnel in:<br><br>• infection control and the spread of infection<br>• Providing a sanitary environment<br>• Glove usage and disposal<br>• Precautions to promote a healthy environment and prevent cross contamination<br>• The importance of hand washing and hand hygiene for staff and clients<br>• Disinfecting training materials<br>• Proper use of face masks including covering your nose and mouth<br><br>The Director or PC will monitor infection control practices twice weekly.<br><br>The RN team leader will monitor infection control practices twice monthly.<br><br>The Executive Director (Corporate Office) will monitor infection control practices once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 454 | Continued From page 17 | W 454 | | |

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with a dish cloth. Throughout the observation, Staff C wore the same gloves without changing them.

B. During observations in House 2 on 3/15/21 at 3:57pm, client #9 was observed in the bathroom, toileting. Client #9 was observed to exit the bathroom without washing his hands. Client #9 was then observed to go sit at the activity table, and Staff D gave client #9 a puzzle. After completing the puzzle, Staff D was observed to give client #9 a box of crayons and a shape sorter. The box of crayons and shape sorter were passed back and forth from client #9 and client #6. At 5:15pm, Staff D put the puzzle, box of crayons and shape sorter on the shelf in the activity room. At no time during the observation was client #9 prompted to wash his hands, nor did the activity items get cleaned before they were put away.

C. During observations in House 2 on 3/15/21 at 3:56pm, client #1 was observed in the bathroom toileting. Client #1 exited the bathroom without washing his hands. Client #1 was then observed to go into the kitchen and assist Staff C with taking out the trash, toss a ball back and forth with Staff C, sweep the floors, wipe clean dishes dry and put them away, and wipe down the kitchen counters. At no time during the observation was client #1 prompted to wash his hands.

D. During observations in House 2 on 3/15/21 at 5:43pm, Staff D was observed to feed client #6 her dinner. Staff D was wearing gloves and her mask was hanging below her nose. Staff D was observed to put cilent #6's spoon down, bring her hand to her mouth and cough, and then pick up

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| W 454 | Continued From page 18<br>client #6's spoon to continue feeding her. Staff D did not remove her gloves or wash/sanitize her hands after coughing into it.<br><br>E. During observations in House 2 on 3/16/21 at 6:39am, Staff F was observed to exit the bathroom, carrying an adult diaper in her hands. Staff F was wearing gloves. At 6:41am, Staff F was observed to enter client #1's bedroom, gathered some clothes and placed them on the bed. At 6:43am, Staff F was observed to enter client #9's bedroom and shave him with an electric razor. At 6:46am, Staff F walked into client #3's bedroom, where she was physically prompting him to get up and get ready for the morning. At 6:50am, Staff F was observed to walk into the kitchen, remove her gloves, open the refrigerator to get a container of yogurt and soda. Staff F was observed to open the yogurt and soda and place it on the table. Throughout the observations, Staff F was not observed to change her gloves and did not wash her hands after removing the gloves.<br><br>Interview on 3/16/21 with the Director and qualified intellectual disabilities professional (QIDP) revealed staff are supposed to wear gloves when assisting clients in the bathroom and with personal care. The Director and QIDP confirmed staff are to wash their hands after removing their gloves. In addition, the Director and QIDP revealed all activities are supposed to be cleaned and sanitized after use, and staff should prompt clients to wash their hands after using the bathroom. | W 454 | | |
| W 460 | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(1) | W 460 | | |

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| W 460 | Continued From page 19<br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to follow dietary orders for 1 of 6 audit clients (#7). The findings were:<br><br>During dinner observations in House 1 on 3/15/21 between 5:20pm-5:42pm, client #7 was not offered any prune juice with her meal. On the refrigerator door were dietary orders to give client #7 prune juice at breakfast. There was also a dietary order chart hung on dining room wall that did not list prune juice at any meal for client #7.<br><br>Review on 3/15/21 of client #7's physician's orders signed on 2/4/21 read to give 4 ounces of prune juice at lunch/supper.<br><br>Interview with Staff J on 3/16/21 revealed that she was unaware that client #7 was supposed to get prune juice, based on her following the chart hung on the dining room wall.<br><br>Interview with the program director on 3/16/21 revealed that she did not know which meal client #7 should receive prune juice but went to look at the orders in the kitchen and said it should have been given at breakfast. Their intent was for the dietary orders posted on the refrigerator to be the current dietary orders. The dietary orders in the kitchen were not dated.<br><br>Interview with the director on 3/16/21 revealed that the dietary orders posted in the kitchen were | W 460 | W460<br>All diet rosters posted in the facility will be current, according to physician orders.<br>The Director will be responsible for assuring that the diet orders are maintained and current.<br>All staff will be trained in current diet orders, to assure that all clients receive any specially prescribed diets as ordered.<br><br>The Director will monitor the diet roster to assure it is current once weekly.<br>The Director or PC will monitor mealtime programs to assure diets are provided as ordered (as specified in W249) twice weekly.<br><br>The RQP will monitor mealtime programs twice monthly.<br><br>The Executive Director (Corporate Office) will monitor mealtime programs once monthly.<br><br>All monitoring will be documented.<br>Any concerns will be followed up on. | |

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| W 460 | Continued From page 20<br>supposed to be kept current, based on the physician's orders. One of the staff who had been responsible for updating the form, had been on leave of absence. | W 460 | | |