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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 review and interviews, the facility failed to ensure 2 of 3 sampled clients (#1, #6) and 1 non-sampled client (#2) received a continuous active treatment program consisting of needed interventions as identified in the person centered plan (PCP) relative to dietary needs and privacy. The findings are: A. The facility failed to ensure a program objective relative to diet consistency during meals was implemented with sufficient frequency to support the needs of client #1. For example: Observation in the group home on 4/6/21 from 5:30 PM to 5:50 PM revealed client #1 to sit in his wheelchair at the dining table and participate in the dinner meal which consisted of: salisbury steak, gravy, mashed potatoes, applesauce, and water. Continued observation revealed client #1 to utilize his adaptive spoon and attempt to cut the steak serving into bite sized pieces. Further observation revealed client #1 to use hands at various times to pick up his steak serving then place various bites in his mouth using his fingers.	W 249		

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

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Additional observation revealed staff to visually monitor client #1 throughout the dinner meal with no verbal or physical redirection to cut his meat into one inch size pieces or to address the use of his fingers to eat.

Review of records for client #1 on 4/6/21 revealed a person centered plan (PCP) dated 4/10/20. Review of the PCP revealed a diet consistency of a regular diet, seconds as desired; 2 grams of sodium diet, whole meats cut into one inch consistency. Continued review of the PCP revealed the need to monitor for choking and/or aspiration with signs to look for that included: Monitor for choking, coughing, drooling and congestion during or immediately following meals. Staff should follow diet and eating guidelines as written during all mealtimes.

Further review of the PCP revealed an occupational therapy (OT) evaluation dated 2/22/19. Review of the OT evaluation revealed meats should be cut to one inch consistency. Continued review of the OT evaluation revealed a Health and Safety goal is in place to monitor and prevent choking. Follow aspiration precautions and choking hazards.

Interview with the interim qualified intellectual disabilities professional (QIDP) verified staff should follow client #1's diet consistency as prescribed. Continued interview with the QIDP verified client #1's staff should have cut client #1's meat into one inch pieces and provided verbal redirection when the client used his hands to eat.

B. The facility failed to ensure that program objectives were implemented as prescribed to

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support the needs of client #6 relative to aspiration guidelines. For example:

Afternoon observations in the group home on 4/5/21 from 5:35 PM to 5:50 PM revealed client #6 to participate in the dinner meal, which included: salisbury steak, gravy, mashed potatoes, applesauce, and water. Continued observation revealed client #6 to eat at a fast pace and consume large bites of mashed potatoes and salisbury steak with a spoon. At no point during the dinner meal was client #6 prompted to slow his rate of eating, drink a sip of water between bites or eat smaller bites of food.

Morning observations in the group home on 4/6/21 from 7:50 AM to 8:00 AM revealed client #6 to participate in the breakfast meal which included: oatmeal with raisins and cinnamon, 1 tsp. sugar, 2 whole slices of cheese toast, and a glass of milk and water to drink. Continued observation revealed client #6 to eat at a fast pace, consume large bites of oatmeal and eat a whole piece of toast using both hands. At no point during the meal observation was client #6 prompted to slow his rate of eating, drink a sip of water between bites or eat smaller bites of food. It should also be noted that staff did not offer to cut up client #6's toast into bite size pieces during the observation.

Review of the records for client #6 on 4/6/21 revealed a PCP dated 11/15/20 which indicated client #6 to have a history of seizures, choking, and coughing. Further review of the PCP for client #6 revealed a nutritional evaluation dated 9/23/20 that included aspiration precautions during mealtimes. Continued review of the nutritional evaluation revealed staff should

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monitor client #6 to ensure he does not overfill his mouth, encourage small bites, encourage liquids between bites, prompt client #6 to use his napkin and spoon, remain upright, use no straws and monitor throughout the meal to ensure safe pace and appropriate sized bites.

Interview with the home manager (HM) on 4/6/21 verified that staff have been trained on client #6's aspiration guidelines and have been monitoring the client during mealtimes. Further interview with the HM verified that all of the interventions and objectives for client #6 are current. Continued interview with the HM confirmed that client #6's aspiration guidelines should be followed as prescribed.

Interview with the interim qualified intellectual disabilities professional (QIDP) on 4/6/21 verified that client #6's program objectives are current. Further interview with the interim QIDP confirmed that program objectives for client #6 relative to aspiration guidelines should be followed as prescribed during mealtimes.

C. The facility failed to ensure that program objectives were implemented as prescribed to support the needs for client #2 relative to privacy. For example:

Observations in the group home on 4/6/21 at 7:55 AM revealed staff to prompt client #2 to use the bathroom. Observations revealed client #2 to enter and use the bathroom with the door open. Continued observations revealed client #2 to exit the bathroom, to not wash his hands, while pulling up his pants and to fasten his pants in the hallway.

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W 249	Continued From page 4 Subsequent observations at 8:15 AM revealed staff to prompt client #2 a second time to go to the bathroom. Additional observation revealed client #2 to enter and use the bathroom with the door open. At no point during the observation period did staff offer assistance or prompt the client to close the bathroom door to ensure his privacy. Review of records for client #2 on 4/6/21 revealed a PCP dated 2/23/21. Continued review of the PCP revealed that staff should prompt and direct client #2 to close all doors for privacy due to issues with disrobing with the door open. Interview with the HM on 4/6/21 verified that client #2 has a history of disrobing in public areas and has to be prompted to close his door to ensure privacy. The HM also verified that staff have been trained to assist client #2 in prompting the client to his room, ensuring he closes his bedroom door or to close the door for him while toileting or undressing. Continued interview with the HM verified that client #2's training objectives are current. The HM additionally confirmed that client #2's program objectives should be followed as prescribed. Interview with the interim QIDP on 4/6/21 verified that all of client #2's program objectives are current. The interim QIDP confirmed during the interview that staff should follow client #2's program objectives as prescribed to ensure privacy while dressing or toileting.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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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 interview, the facility failed to assure that clients have access to adaptive equipment as recommended for 1 sampled client (#6) and 1 non-sampled client (#2). The findings are:

A. The facility failed to ensure eyeglasses for client #6 were accessible as prescribed. For example:

Morning observations in the group home on 4/6/21 from 7:00 AM to 8:15 AM revealed client #6 to participate in various activities throughout the group home to include hand washing, structured activities, to assist with placing breakfast items on the table, take dishes to the kitchen sink and to participate in medication administration. At no point during the observation period was client #6 observed to wear eyeglasses.

Review of records for client #6 on 4/6/21 revealed a person centered plan (PCP) dated 11/15/20. Review of the PCP revealed an active treatment goal to tolerate wearing glasses. Continued review of records for client #6 revealed a vision assessment dated 7/25/19 to include a cataract diagnosis.

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Interview with Staff E on 4/6/21 revealed that eyeglasses for client #6 are kept locked in the medication closet when not in use to lessen the chances of being lost or broken. Staff E further verified that client #6 is given his eyeglasses following the administration of his morning medications and the client wears them the rest of the day. Interview with the interim qualified intellectual disabilities professional (QIDP) verified that client #6 should wear eyeglasses at all times due to vision deficits. Continued interview with the QIDP verified client #6 had no history of improper care of their eyeglasses. The QIDP also verified client #6 should have access to eyeglasses at all times and should not be locked in the medication room.

B. The facility failed to ensure eyeglasses for client #2 were accessible as prescribed. For example:

Afternoon observations in the group home on 4/6/21 from 7:00 AM to 8:15 AM revealed client #2 to participate in various activities in the group home that included participation in a coloring activity and participation in the breakfast meal. Continued observation of client #2 while coloring revealed the client to squint as he viewed the coloring pages during the activity. At no point during the observation period did staff offer or prompt client #2 to wear his eyeglasses.

Review of records for client #2 on 4/6/21 revealed a person centered plan (PCP) dated 2/23/21. Further review of client records revealed a medical consult dated 9/18/19 which indicated visual acuity fixation for both eyes. Review of records did not reveal the need to lock client #2's

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W 436	Continued From page 7 eyeglasses from access to the client. Interview with Staff E on 4/6/21 verified that client #2's has eyeglasses that are kept locked in the medication closet when not in use to prevent being lost or broken. Staff E further verified that client #2 is given his eyeglasses to wear following the administration of morning medications and the client wears them the rest of the day. Interview with the interim QIDP on 4/6/21 verified client #2 should wear eyeglasses at all times due to vision deficits. Continued interview with the QIDP verified client #2 had no history of improper care of their eyeglasses. Interview with the QIDP additionally verified the eyeglasses for client #2 should not be locked in the medication room away from client access.	W 436		