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W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and verified by interview, the facility failed to complete a thorough investigation for 1 of 1 sampled clients (#4) to investigate an injury of unknown origin. The finding is: Review of internal records on 7/19/21 revealed an incident report from the day program dated 7/13/21 that indicated that client #4 had a bruise on her right bottom area and left stomach area. The incident report also revealed that the day program director contacted the facility home manager (HM) to report client #4's bruises in order to initiate an internal investigation of unknown injury. Continued review of internal records did not reveal that an internal investigation was completed. Further review revealed no evidence of medical consults for client #4 relative to medical treatment received for the bruised areas. Interview with the home manager (HM) on 7/19/21 verified that she was aware of client #4's bruised areas, however the facility nurse had been out of the office since 6/24/21. The HM confirmed that the facility had not secured a substitute in the facility nurse's absence. Additionally, the HM confirmed that client #4 had not received medical attention for the bruising as of the current survey date. Interview with the facility's state regional director	W 154		

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

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W 154	Continued From page 1 on 7/15/21 verified that the facility nurse has been on medical leave since June 2021 and a replacement to provide nursing oversight had not been secured. Further interview with the state regional director verified that upper management had been addressing personnel concerns relative to management staff not completing documentation as required by facility policy. The state regional director confirmed that corrective action would be taken for management staff not completing an internal investigation relative to client #4's reported bruising. Interview with the qualified intellectual disabilities professional (QIDP) on 7/19/21 verified that she was aware of client #4's bruised areas but was not sure why an internal investigation was not initiated. The QIDP verified that it is facility protocol that once an injury occurs the staff are supposed to report it to the nurse immediately. The QIDP also verified during the interview that the HM is required to complete the incident reporting form and initiate an internal investigation. Continued interview with the QIDP verified that the facility nurse had been out of the office on medical leave since 6/24/21 and her return date was unknown. The QIDP further confirmed that a replacement in the facility nurse's absence had not been secured prior to the complaint investigation. Additional interview with the QIDP confirmed that the facility had scheduled a medical appointment to address the bruised areas for client #4 on 7/20/21 at 10:15 AM.	W 154		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing	W 331		

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W 331	Continued From page 2	W 331		

services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to provide nursing services in accordance with client needs relative to accurate transcription of discharge orders, timely assessment of client condition and accessibility to needed services for 2 of 2 sampled clients (#4 and #5). The findings are:

A. The facility failed to provide nursing services based on needs of client #4. For example:

Review of records for client #4 on 7/19/21 revealed a habilitation plan updated 9/15/20. Review of the 9/20 habilitation plan revealed diagnosis to include; severe intellectual disability, adjustment disorder, epilepsy, hypothyroidism and constipation. Continued review of records revealed a nursing note dated 6/7/21 which indicated a call from case management that client #4 required a daily dressing change once the client was discharged from the hospital. Further review of the 6/15/21 note revealed the client was ready for discharge from the hospital (4:25PM). Subsequent review of the 6/15/21 note indicated that client #4 had a ½ flank site with greenish drainage covered by two small bandages (5:20 PM). Subsequent review revealed the facility nurse applied cleaning solution and neosporin to the site and changed client #4's dressing. Additional review of nursing notes revealed no evidence of dressing changes or skin integrity checks completed after 6/15/21. It should be noted that the facility could not provide discharge orders from client #4's hospital visit to surveyors to review.

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Interview with the facilty nurse on 7/19/21 revealed she had staff transport client #4 to the office to complete skin integrity checks and dressing changes on a daily basis. Continued interview with the nurse revealed she had discontinued the daily dressing changes for client #4 and the area was healed. Further interview with the nurse confirmed she had been out of the office on medical leave since 6/24/21.

Interview with the qualified intellectual developmental disability professional (QIDP) on 7/19/21 verified the facility nurse had been out of the office since 6/24/2021. Continued interview with the QIDP revealed the facility had not secured a nurse to provide nursing services to the clients in the group home while the current nurse was out of the office. Further interview with the facility's state regional director verified that the facility nurse has been on medical leave since June 2021 and a replacement had not been secured.

B. The facility failed to provide a nursing assessment following bruises on unknown origin for client #4 and #5. For example:

Observations at the day program on 7/19/21 at 1:00 PM revealed client #5 to sit at her work table engaged in a coloring activity. Continued observations revealed a bruise on the client's lower left arm. Further observations revealed client #5 to stretch out her arm to show the bruise to the surveyor.

Interview with a staff at the day program for client #5 on 7/19/21 revealed it was her first day back at work and was unaware of the bruise on client #5's

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arm. Continued interview with another day program staff revealed she had informed the group home manager of the bruise on client #5's arm a few days prior. Interview with the day program manager revealed she was not made aware of the bruise on client #5's arm.

Review of the group home incident reports from May 2021 through July 19, 2021 revealed no documented incidents for the group home. Review of incident reports from the Day Program revealed an incident dated 7/13/21 and entered on 7/16/21. Further review of the 7/13/21 incident report revealed client #4 and staff went to the restroom before eating lunch in the cafeteria where staff noticed a large bruise on client's right buttocks and a small bruise on the lower left side of her stomach. Continued review revealed the day program manager was notified directly by staff. Additional review of the 7/13/21 incident report revealed corrective actions taken to include the day program manager followed up with the home manager (HM) and all staff to confirm no unreported falls or incidents to the client had occurred and further corrective actions were to continue to report all incident or injuries related to the client appropriately.

Interview with the medical assistant on 7/19/21 revealed she was not made aware of any reports of bruises on client #5's arm. Continued interview with the medical assistant revealed she was made aware of the bruises on client #4 on 7/13/21 and assessed the client, noticing a large purple spot. Further interview with the medical assistant revealed she had contacted the qualified intellectual disabilities professional (QIDP) to make her aware of client #4's bruising. Further interview with the medical assistant

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W 331	Continued From page 5 confirmed she was not a licensed registered nurse and client #4 had not received medical attention for the bruising to date. Interview with the HM on 7/19/21 verified that she was not aware of client #5's bruising, however she was made aware of client #4's bruising on 7/13/21 by the day program manager. Continued interview with the HM confirmed the facility nurse had been out of the office since 6/24/21. The HM also confirmed that the facility had not secured a substitute in the facility nurse's absence. Additionally, the HM confirmed that client #4 had not received medical attention for the bruising to date. Interview with the QIDP on 7/19/21 revealed she was not made aware of any bruises on client #5's arm. Continued interview with the QIDP revealed she was made aware of the bruises on client #4 on 7/13/21 and requested the HM complete an incident report. Further interview with the QIDP revealed the facility nurse had been out of the office since 6/24/21 and the facility had not secured a nurse. Additional interview with the QIDP confirmed the facility medical assistant is not a licensed nurse and cannot provide nursing services. The QIDP also confirmed the facility secured medical appointments for client #4 and #5 for 7/20/21.	W 331		
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	W 340		

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health and hygiene methods.

This STANDARD is not met as evidenced by:
Based on record review and verified by interview, the facility failed to ensure that staff were adequately trained to report changes in health status for 1 of 1 sampled clients (#4). The finding is:

Review of internal records on 7/19/21 revealed an incident report from the day program dated 7/13/21 which indicated that client #4 had a bruise on her right bottom area and left stomach area. The incident report also indicated that the day program director contacted the facility home manager (HM) to initiate an internal investigation and follow up on the client #4's injuries of unknown origin. Further review of internal records did not reveal formal reporting of the bruises by facility staff. Continued review revealed no evidence of incident reporting or an internal investigation relative to client #4's injuries of unknown origin.

Interview with qualified intellectual disabilities professional (QIDP) on 7/19/21 verified that it is the responsibility of the HM to initiate an internal investigation and complete an incident report for all injuries and medical concerns. Continued interview with the QIDP revealed that she could not determine why an incident report and internal investigation were not completed for client #4's injuries. The QIDP also verified that the facility nurse has been out of the office since 6/24/21 and could not confirm if client #4 received medical attention for the bruises. Additional interview with the QIDP verified that she had not been able to make contact with the HM to

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W 340	Continued From page 7 determine if an internal investigation or incident report were completed relative to client #4's bruises of unknown origin. Subsequent interview with the QIDP confirmed that staff should be trained on how to appropriately report injuries and medical concerns in a timely manner.	W 340		