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	34G228	A. BUILDING _____ B. WING _____	01/25/2022

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(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	E 004	E 004 This deficiency will be corrected by the following actions: A. The Site Supervisor will update the EPP preparedness book for the home to include current information for residents and administrative staff contact information. B. Site Supervisor will monitor and document on this one time a week. C. The Lead Site Supervisor will monitor and document this monthly. D. Qualified Professional will monitor and document this monthly. E. Management will monitor and document this monthly while conducting site review.	3.25.2022

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

Juanita Jefferson | Program Manager | 2/3/2022

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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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. 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/or updated as needed. The finding is: Review on 1/24/22 of the facility's EP plan revealed a management staff directory (last updated 11/1/20) and a client list (last updated 11/6/20). Additional review of the plan did not include any information regarding a client who had recently transferred to the facility or the Qualified Intellectual Disabilities Professional (QIDP) who recently began working at the home. Interview on 1/25/22 with the QIDP confirmed the EP plan did not include current and updated information.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of	E 037		

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E 037	Continued From page 2 the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice	E 037	E 037 This deficiency will be corrected by the following actions: A. The Site Supervisor will ensure that all staff are in-serviced on the updated Emergency Preparedness Plan annually. B. This training will be documented. C. The Lead Site Supervisor will monitor and document this monthly D. Qualified Professional will monitor and document on this monthly E. Management will monitor and document this monthly while conducting site review.	3.25.2022

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E 037	Continued From page 3	E 037		

must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and

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E 037	Continued From page 4	E 037		

procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and

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E 037	Continued From page 5	E 037		

procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure all new staff were trained on the facility's Emergency Preparedness (EP)

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E 037	Continued From page 6 plan. The finding is: Review on 1/24/22 of the facility's EP plan did not indicate all new and/or existing staff had received training on the EP plan. Interview on 1/25/22 with Staff A and Staff C revealed they had recently started working in the home after transferring from another facility. The staff indicated they had not completed training. During an interview on 1/25/22, the Qualified Intellectual Disabilities Professional (QIDP) indicated he could not be sure if all staff in the home had received training on the EP plan and no documentation of the training was provided for any staff working in the home.	E 037		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2 had the right to access her personal grooming supplies. This affected 1 of 4 audit clients. The finding is: During observations in the home on 1/24/22 at 12:38pm, a staff retrieved client #2's grooming basket from a locked hall closet. The staff removed a toothbrush and tube of toothpaste and gave them to client #2. The client was then prompted to the bathroom for toothbrushing.	W 137	W 137 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed. B. All ISP's will be updated to address the current needs and techniques to manage inappropriate behavior. C. Client #2's ISP will be reviewed to assess her current needs and if there are any restrictions needed for safety reasons it will be documented in her ISP and include the proper documentation. D. The Lead Site Supervisor will monitor and document this monthly. E. Qualified Professional will monitor and document on this monthly F. Management will monitor and document this monthly while conducting site review.	3.25.2022

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W 137	Continued From page 7 Interview on 1/24/22 with Staff D revealed client #2's grooming items are kept locked because she will use too much of the items or waste them. Additional interview on 1/25/22 with Staff A and Staff C confirmed the client's personal grooming supplies are kept locked because she will "dump" them out. Review on 1/25/22 of client #2's Individual Program Plan (IPP) dated 2/23/21 revealed no information regarding a restriction of her grooming items. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2's grooming items were kept locked because they will "end up everywhere" and she will try to use them when it's not time. The QIDP acknowledged locking the client's items was a rights restriction.	W 137		
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 4 of 4 audit clients (#1, #2, #4 and #6) received a continuous	W 249		

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W 249	Continued From page 8 active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, family style dining and use of eyeglasses. The findings are: A. During observations throughout the survey in the home on 1/24 - 1/25/22, various staff prepared plates of food and drinks for each client without their assistance. Clients were not prompted or assisted to serve themselves or participate in family style dining (i.e. serving, pouring, passing food items). Interview on 1/25/22 with Staff A revealed she assumes the clients participate in family style dining but she added, "When it comes to serving, we do that." Review on 1/25/22 of client #2's Community/Home Life Assessment (CHLA) dated 2/8/21 revealed she eats family style independently. Review on 1/25/22 of client #4's CHLA dated 1/1/20 indicated she eats family style independently. Review on 1/25/22 of client #6's CHLA noted he eats family style independently. Interview on 1/25/22 with Home Manager (HM) revealed since she began working at the home in July '21, she had been told staff should be preparing client's plates for them. The HM could not recall why this was being done. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all of	W 249	W 249 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and revised as needed to ensure that all objectives are met. B. All people served will be afforded the opportunity to be as independent as possible. C. Client #1, #2,34, and #6's ISP's will be reviewed and reviewed and revised as needed to reflect their current needs, abilities, and goals. D. All staff will be in-serviced on all ISP's and active treatment in the home. E. The Lead Site Supervisor will monitor and document this monthly F. Qualified Professional will monitor and document on this monthly G. Management will monitor and document this monthly while conducting site review.	3.25.2022

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the clients can participate with family style dining and should be assisted to do so.

B. During observations throughout the survey in the home on 1/24 - 1/25/22, client's were not actively prompted or encouraged to assist with preparing food items. For example, on 1/24/22 from 11:35am - 12:17pm, while in the kitchen with client #6, Staff B completed various meal preparation tasks such as placing hamburger patties on a pan, cooking them in the oven, making a large bowl of instant mashed potatoes, and making hamburger sandwiches. During this time, client #4 also entered and exited the kitchen area without prompts to participate with cooking tasks. With the exception of putting beans in a pot, client #6 was not actively involved with the preparation of food items.

Interview on 1/24/22 with Staff B revealed client #6 can stir and gather items needed during meal preparation.

Review on 1/25/22 of client #6's Community/Home Life Assessment (CHLA) indicated he can make and pack lunches with verbal cues and utilizes measuring/mixing spoons and other devices independently.

Review on 1/25/22 of client #4's CHLA dated 1/1/20 revealed she can independently make and pack lunches. Additonal review of the CHLA indicates she requires verbal cues to make foods with or without cooking and mixing.

Interview on 1/25/22 with the QIDP indicated staff should be encouraging clients to assist with meal preparation tasks.

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W 249	Continued From page 10 C. During observations in the home on 1/24/22, client #1 sat on the couch in the living area of the home sporadically watching television. Throughout observations in the home, the client did not wear eyeglasses. Client #1 was not prompted or encouraged to wear eyeglasses. Interview on 1/25/22 with Staff C revealed client #1 does wear eyeglasses at school. Review on 1/25/22 of client #1's IPP dated 12/7/21 revealed she wears eyeglasses when needed. Additional review of the client's vision examination report dated 9/30/20 noted, "Patient does need to wear glasses all the time while awake." Interview on 1/25/22 with the QIDP confirmed client #1 should wear her eyeglasses as indicated on the vision report.	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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria specified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 1 of 4 audit clients (#2). The finding is:	W 252		

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W 252	Continued From page 11 During morning observations in the home on 1/24/22 at 10:55am, client #2 retrieved a cup of water from the kitchen faucet, took it to the dining room table, drank a sip of it and then poured the water onto the table. During afternoon observations in the home on 1/24/22 at 3:30pm, client #2 was seated next to another client at the dining room table eating a snack. Client #2 abruptly picked up the other client's drink and poured it onto the table. During additional evening observations in the home on 1/24/22 at 5:20pm and 5:24pm, client #2 picked up a container of blocks and threw it across the room. Interview on 1/24/22 with Staff B revealed client #2 has a behavior of dumping or pouring liquids out. Review on 1/25/22 of client #2's behavior data sheets did not reveal the observed behaviors on 1/24/22 had been documented. Review on 1/24/22 of client #2's Behavior Support Plan (BSP) dated 7/28/21 revealed objectives to exhibit 0 episodes of dumping food, drinks and other items per month for 12 consecutive months and to exhibit 0 episodes of property destruction per month for 12 consecutive months. Additional review of the plan noted, "All TARGET behaviors and other behaviors will be documented on behavior data log, every time they occur..." Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all client's behaviors should be documented as indicated.	W 252	W 252 *This deficiency will be corrected by the following actions:* A. *The Qualified Professional will review all behavioral support plans (BSP) plans with staff.* B. *All Staff will be in-serviced on the current BSP's and documenting incidents on the behavioral log.* C. *Client #2's BSP will be reviewed and revised as need to address all target behaviors.* D. *The Lead Site Supervisor will monitor and document this monthly* E. *Qualified Professional will monitor and document on this monthly*	3.25.2022
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 12 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 Behavior Support Plan (BSP) for 3 of 4 audit clients (#1, #2, and #4) was only conducted with the written informed consent of the legal guardian. The findings is: A. Review on 1/24/22 of client #1's BSP dated 12/6/20 revealed objectives to address physical aggression, inappropriate verbalizations, PICA, agitation, noncompliance, self-injurious behavior, and crying. The plan identified the use of Abilify, Cogentin, Lexapro, Kapvay, Lithium and Trazadone. Further review of the record noted a consent dated 12/16/20. The consent indicated, "I understand that this authorization will expire on 12/6/21 and will not exceed one year from the date of my original authorization." The record did not include a current written informed consent for client #1's BSP from the guardian. B. Review on 1/24/22 of client #2's BSP dated 7/28/21 revealed objectives to address physical aggression, property destruction, PICA, taking off clothes and dumping food, drinks and other items. The plan identified the use of Zyprexa, Amantadine, Ambien, Gabapentin, and Alprazolam. Further review of the record noted a consent dated 9/17/20. The consent indicated, "I understand that this authorization will expire on 7/30/21 and will not exceed one year from the date of my original authorization." The record did not include a current written informed consent for client #2's BSP from the guardian.	W 263	W 263 This deficiency will be corrected by the following actions A. The Qualified Professional will review all behavioral support plans. B. All behavioral support plans will address the current needs and technique to manage inappropriate behavior. C. All proper techniques will be used to manage behaviors. D. Psychologist will review all plans. E. HRC approval and the proper consents will be obtained for all BSP's. F. The Qualified Professional will review and obtain guardian consent. G. The Lead Site Supervisor will monitor and document this monthly. H. Qualified Professional will monitor and document this monthly. I. Management will monitor and document this monthly while conducting site review.	3.25.2022

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W 263	Continued From page 13 C. Review on 1/24/22 of client #4's BSP dated 7/13/21 revealed objectives to address yelling, screaming, self-injurious behavior and physical aggression. The plan identified the use of Abilify. Additional review of the record did not include a current written informed consent for client #4's BSP from the guardian. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated a written informed consent had been sent to client #1, client #2 and client #4's guardians; however, it had not been returned.	W 263		
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 #2's inappropriate behaviors was included in a formal active treatment program. This affected 1 of 4 audit clients. The finding is: During observations in the home on 1/24/22, a staff retrieved client #2's grooming basket from a locked hall closet. The staff removed a toothbrush and tube of toothpaste and gave them to client #2. The client was then prompted to the bathroom for toothbrushing. Interview on 1/24/22 with Staff D revealed client #2's grooming items are kept locked because she	W 288	W 288 This deficiency will be corrected by the following actions: A. The Qualified Professional will review all BSP plans with staff. B. All Staff will be in-served on the current BSP's and documenting incidents in the behavioral log. C. Client #2's BSP will be reviewed and revised as need to address all target behaviors. D. Client #2 ISP will be review to assess her current needs and if there are any restriction needed for safety reasons it will be documented in her ISP and behavioral support plan. E. HRC approval and the proper consents will be obtained for all BSP's F. The Qualified Professional will review and obtain guardian consent. G. The Lead Site Supervisor will monitor and document this monthly. H. Qualified Professional will monitor and document this monthly.	3.25.2022

OMB NO. 0938-0391

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W 288	Continued From page 14 will use too much of the items or waste them. Additional interview on 1/25/22 with Staff A and Staff C confirmed the client's personal grooming supplies are kept locked because she will "dump" them out. Review on 1/25/22 of client #2's Individual Program Plan (IPP) dated 2/23/21 and Behavior Support Plan (BSP) dated 7/28/21 identified an objective to address inappropriately dumping of food, drinks and other items. Additonal review of the BSP did not include a technique of locking away client #2's grooming supplies to address her inappropriate behaviors. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2's grooming items were kept locked because they will "end up everywhere" and she will try to use them when it's not time. The QIDP confirmed the technique of locking away the client's grooming items was not included in her BSP.	W 288		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 4 audit clients (#1, #2 and #4) received vision and hearing examinations as indicated. The findings are: A. Review on 1/24/22 of client #2's record revealed a vision examination report dated 3/3/20 and 11/11/20. Additional review of both reports	W 323		

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W 323	Continued From page 15 noted, "Recommendation: Eye exam under General Anesthesia". Further review of client #2's record did not reveal a vision examination had been completed. B. Review on 1/24/22 of client #4's record revealed her last vision examination had been completed on 9/13/19. Additional review of the record did not include a current vision examination. Further review of client #4's Individual Program Plan (IPP) noted, "Ophthalmology due every 2 years (ordered yearly)." C. Review on 1/24/22 of client #1's record revealed her last vision examination had been completed on 9/30/20 with a diagnosis of "Myopia, astigmatism, left extropia..." Additional review of the report noted, "RTC 1 year, glasses needed." D. Review on 1/24/22 of client #4's record revealed no audiological examination. No current audiological examination could be located. Additional review of client #4's IPP dated 2/23/21 noted, "Audiology: complete every 2 years otherwise directed by physician." Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1, client #2, client #4 were in need of vision examinations; however, these appointments have not been scheduled as of the date of the survey. Additional interview confirmed client #4 has not had an audiological examination. The QIDP noted these examinations are generally completed annually.	W 323	W 323 This deficiency will be corrected by the following actions; A. The Site Supervisor will ensure that all assessments and annual examinations are scheduled and completed. B. The examinations mentioned in the statement of deficiencies for client #1, #2, and #4 will be completed. C. The Site Supervisor will monitor and document this weekly. D. The Qualified Professional will monitor and document this monthly. E. The nurse will ensure these appointments are completed and monitor and document them monthly.	3.25.2022
W 340	NURSING SERVICES	W 340		

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W 340	Continued From page 16 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 observation, record review and interviews, the facility failed to ensure staff were sufficiently trained to appropriately document on the Medication Administration Record (MAR). The finding is: During observations of medication administration in the home on 1/25/22 at 7:01am, Staff A dispensed medications for client #4 into a pill cup and immediately signed the MAR. Afterwards, Client #4 ingested her medications. Immediate interview with Staff A revealed she usually does not sign the MAR before clients take their medications but she doesn't have a problem with client #4 not taking their medications. Review on 1/25/22 of a note posted inside the medication closet are indicated, "Do Not Sign the MAR in advance." Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) and the Program Manager confirmed staff should not be signing the MAR prior to clients ingesting their medications.	W 340	W 340 This deficiency will be corrected by the following actions: A. The nurse will be responsible for in-serving/training staff on the proper way to document when administering medications. B. The Site Supervisor will monitor and document this weekly. C. The Lead Site Supervisor will document on this monthly. D. The Qualified Professional will document this monthly. E. The nurse will document this monthly.	3.25.2022
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2)	W 352		

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W 352	Continued From page 17 Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1 received a comprehensive dental examination at least annually. This affected 1 of 4 audit clients. The finding is: Review on 1/24/22 of client #1's record revealed her last dental examination and cleaning had been completed on 10/19/20. Additional review of the record did not include a current dental examination. Interview on 1/25/22 with the Home Manager revealed client #1 had been to the dentist in 2021; however, no cleaning could be completed. Additional interview indicated the dental cleaning had not been rescheduled. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 had not received her annual dental examination as of the date of the survey.	W 352	W352 This deficiency will be corrected by the following actions: A. The Site Supervisor will ensure that all assessments, appointments, and annual examinations are scheduled and completed. B. The comprehensive dental diagnostic service mentioned in the statement of deficiencies #4 will be scheduled or completed. Any issues with non-compliance are to be documented. C. The Site Supervisor will monitor and document this weekly. D. The Qualified Professional will monitor and document this monthly. E. The nurse will ensure these appointments are completed and monitor and document them monthly.	3.25.2022
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #4 received comprehensive	W 356		

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W 356	Continued From page 18 dental treatment services for the maintenance of her dental health. This affected 1 of 4 audit clients. The finding is: Review on 1/24/22 of client #4's record revealed a dental examination report dated 3/8/21. Additional review of the report noted, "Diagnosis: #28 needs to be extracted...Recommendation: Complete extraction in hospital setting." Further review of the record did not reveal any further dental treatment had been provided to address her dental concerns. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no appointment has been scheduled for client #4's recommended tooth extraction as of the date of the survey.	W 356		3.25.2022
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were kept locked except when being prepared for administration. The finding is: A. During observations of medication administration in the home on 1/24/22 at 4:49pm, the Home Manager (HM) exited the medication administration area to retrieve a client, leaving the door to the medication closet wide open. Interview on 1/24/22 with the HM revealed she generally locks the medication closet when	W 382		

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W 382	Continued From page 19 leaving the area. B. Upon arrival to the home on 1/25/22 at 6:06am, the door to the medication closet was wide open and no one was in the room. The door remained open with the area unmonitored until 6:17am. During this time, drugs and biologicals remained unlocked and accessible to anyone in the home. Interview on 1/25/22 with Staff A revealed she had recently given a client her morning medications. Additional interview indicated she generally leaves the door to the medication closet open if no clients are up and walking throughout the home. Review on 1/25/22 of the facility's Policy and Procedure Manual (rev. 9/12) for Medication Storage revealed, "Only authorized persons will have access to the medication storage area." Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the door to the medication closet should not be left open and unattended.	W 382	W 382 This deficiency will be corrected by the following actions: A. The nurse will be responsible for ensuring all staff on the proper storage of medication. B. The Site Supervisor will monitor and document this weekly. C. The Qualified Professional will monitor and document this monthly. D. The nurse will ensure these appointments are completed and monitor and document them monthly.	3.25.2022
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 reviews and interviews, the facility failed to ensure 2 of 4 audit	W 436		

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W 436	Continued From page 20 clients (#2 and #4) were furnished, taught to use and to make informed choices about the use of their eyeglasses. The findings are: A. During observations throughout the survey in the home on 1/24 - 1/25/22, client #4 did not wear eyeglasses. The client was not prompted or encouraged to wear eyeglasses. Interview on 1/25/22 with Staff C revealed she did not know if client #4 wears eyeglasses and has not seen her wearing eyeglasses. Review on 1/25/22 of client #4's Individual Program Plan (IPP) dated 2/23/21 did not include any information regarding eyeglasses. Additional review of the client's last vision examination report dated 9/13/19 noted, "Plan/Recommendations: Get new eyeglasses..." Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he was not aware of client #4 wearing eyeglasses and did not know if she has eyeglasses. B. During observations throughout the survey in the home on 1/24 - 1/25/22, client #2 did not wear eyeglasses. The client was not encouraged to wear eyeglasses. Interview on 1/25/22 with Staff C revealed she did not know if client #2 wears eyeglasses and has not seen her wearing eyeglasses. Review on 1/25/22 of client #2's IPP dated 2/23/21 revealed, "She has eyeglasses, but requires redirection and encouragement to wear because she takes them off less than a minute of putting them on." Additional review of the plan	W 436	W 436 This deficiency will be corrected by the following actions: A. The Qualified Professional will be responsible for reviewing all ISPs to reflect the current needs of the consumers to include any adaptive equipment needed. B. All staff will be in-serviced on all ISP's. C. Client #2 and #4 will be provided the adaptive equipment needed and any issues of refusal to wear them or training that occurs to assist them with putting them and keeping them on will be documented. D. The Site Supervisor will monitor and document this weekly. E. The Qualified Professional will monitor and document this monthly.	3.25.2022

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W 436	Continued From page 21 noted, "She should wear glasses while making choices between objects..." Further review of the IPP did not include any training to address the client's refusal to wear her eyeglasses. Interview on 1/25/22 with the QIDP confirmed client #2 has eyeglasses and should be encouraged to wear them. The QIDP indicated he was not aware of any formal training to teach client #2 to wear her eyeglasses.	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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure client #4's modified and specially-prescribed diet was provided as indicated. This affected 1 of 4 audit clients. The finding is: During lunch observations in the home on 1/24/22 at 12:17pm, client #4 consumed a hamburger sandwich cut into quarter inch pieces, a tossed salad with dressing, kidney beans and lemonade. With the exception of coughing on one occasion, the client consumed the meal without difficulty. During dinner observations in the home on 1/24/22 at 5:50pm, client #4 consumed chicken stir fry with rice and vegetables mixed in (peas and bites of carrots), peach slices about a quarter inch in size, water and Kool-aid. During additional breakfast observations in the home on 1/25/22 at 7:52am, client #4 consumed two whole cinnamon	W 460	W 460 This deficiency will be corrected by the following actions: A. The Qualified Professional will be responsible for reviewing all ISPs to reflect the current needs of the consumers to include each individual's diet. B. Client #4 will obtain updated speech and nutritional assessments to determine whether a change in her diet is needed. C. The Qualified Professional will update client #4's ISP to reflect any changes. D. All staff will be in-serviced on all ISP's. E. The Site Supervisor will monitor and document this weekly. F. The Qualified Professional will monitor and document this monthly. G. The nurse will observe client #4 at mealtime and document on this monthly.	3.25.2022

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W 460	Continued From page 22	W 460		

rolls, three sausage links cut into nickel and quarter inch pieces, milk and water. The client consumed her dinner and breakfast meals without difficulty.

Interview on 1/24/22 with Staff D revealed client #4's food can be pureed or regular. The stated,"It's her choice." Additional interview indicated the client will let you know if the food needs to be pureed for consumption.

Interview on 1/25/22 with Staff A revealed client #4 consumes a soft diet with her food "mashed up". The staff indicated the client eats her food fine without it being pureed.

Review on 1/24/22 and 1/25/22 of client #4's Individual Program Plan (IPP) dated 2/23/21, current Physician's orders, a Nutritional evaluation dated 12/1/21 and a Speech Therapist Quarterly note dated 1/3/19 revealed the client receives a regular "puree" diet.

Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) also confirmed client #4's food should be served at a pureed consistency as indicated.

Interview via phone on 1/25/22 with the Dietitian and facility nurse confirmed client #4 should consume a pureed diet and no changes have been made to her food consistency. Additional interview indicated an assessment by the Speech Language Pathologist needs to be obtained for client #4 to ensure no changes need to be made to her food consistency.