STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	05/03/2022

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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		

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

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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 5/2/22 of the facility's EP plan revealed it was last updated in 2019. The plan noted, "The manual will be revised and updated as necessary." Additional review of the plan did not include any information regarding two clients who were recently admitted to the facility, information for the current Site Supervisor and information about a previous client remained in the plan. Interview on 5/3/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the EP plan needed to be updated with current information.	E 004		
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview with staff, the facility failed to ensure that the comprehensive functional assessment was completed for 2 of 4 audit clients (#3 and #6) in the area of independent living skills. The findings	W 224		

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W 224	Continued From page 2 are: A. Review on 5/2/22 of client #3's record revealed he was admitted to the facility on 3/8/22. Additional review on 5/2/22 of client #3's record revealed no community/home life assessment (CHLA) to assess client #3's independent living skills needed to promote his ability to function in the community. Interview on 5/3/22 with the qualified intellectual disabilities professional (QIDP) confirmed that a CHLA was not completed on client #3 after admission. B. During afternoon observations in the home on 5/2/22, client #6 repeatedly stated, "peanut butter sandwich" while walking throughout the home. At 4:13pm, Staff C told the client she would make him a sandwich. The staff proceeded to make a peanut butter sandwich at the table directly in front of the client as he sat waiting. The staff also brought the client a cup of milk after he began eating the nuggets. At 4:38pm, Staff C then gathered necessary items and cooked several chicken nuggets in an air fryer and took them to client #6 at the table. Client #6 was not prompted or encouraged to assist with making his sandwich, pouring his drink, serving himself or preparing his food using the air fryer. Interview on 5/2/22 with Staff C revealed client #6 will "sometimes" assist with preparing his food but she didn't "want him to act out." Additional interview indicated client #6 doesn't eat the same foods as other clients in the home and usually eats the same thing everyday.	W 224		

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W 224	Continued From page 3 Review on 5/3/22 of client #6's CHLA dated 3/25/22 revealed no assessment of his skills and abilities with making sandwiches, pouring, family style dining, and using an air fryer to assist with preparing his favorite foods. Interview on 5/3/22 with the QIDP confirmed client #6's CHLA does not include an assessment of his ability to make sandwiches, pour, use an air fryer for food preparation and his family style dining skills.	W 224		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive equipment use and family style dining. This affected 1 of 4 audit clients (#5). The findings are: A. During dinner observations in the home on 5/2/22 at 5:15pm, Staff C prepared a plate of food	W 249		

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W 249	Continued From page 4 in the kitchen and took the plate to client #5 as he sat waiting at the table. The staff then retrieved a cup of water and took it to the client. Client #5 was not prompted or encouraged to assist with serving himself or pouring his drink. Interview on 5/2/22 with Staff C revealed they have tried to get him to assist with serving himself and pouring but he will make a noise and get up and walk away. Additional interview indicated they have not been given any specific instructions on how to better assist client #5 with these tasks. Review on 5/3/22 of client #5's Community/Home Life Assessment (CHLA) dated 3/25/22 revealed he requires physical assistance to eat family style. Interview on 5/3/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #5 requires physical assistance to serve himself and pour his drinks. B. During dinner observations in the home on 5/2/22 at 5:18pm, client #5 consumed his food utilizing a plastic fork. No built-up foam handle was noted on the fork. Review on 5/2/22 of client #5's IPP dated 3/25/22 revealed he uses a "comfort grip straight utensil" during dining "use during each meal". Interview on 5/3/22 with the QIDP confirmed client #5 should use a foam grip handle attached to his utensils at meals.	W 249		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii)	W 257		

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W 257	Continued From page 5 The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Individual Program Plan (IPP) was reviewed/revised after client #5 failed to progress towards identified objectives. This affected 1 of 4 audit clients. The finding is: Review on 5/2/22 of client #5's IPP dated 3/25/22 revealed objectives to match coins with 70% accuracy for six months and to brush his teeth with 50% participation for six consecutive months. The plan noted the criteria for each objective would be met with a verbal prompt. Additional review of progress notes for the objectives revealed the following: Match coins 07/21 - 04/22 = "No progress" Toothbrushing 07/21 - 04/22 = "100% Physical Assistance" Interview on 5/3/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5's objectives had been in place for a year and were in need of revisions.	W 257		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs	W 263		

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W 263	Continued From page 6 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#2). The finding is: Review on 5/2/22 of client #2's Behavior Support Plan (BSP) dated 7/10/21 revealed objectives to decrease target behaviors to 5 or less per month for 6 consecutive months. Target behaviors include physical aggression, property destruction, agitation, inappropriate social behavior, elopement, stripping and fecal smearing. The BSP incorporated the use of Aripiprazole, Ziprasidone and Lorazepam. Additional review on 5/2/22 of the record revealed an addendum to the BSP dated 10/28/21 to incorporate bedroom window alarms to address recent incidents of elopement. Review of the physicians orders dated 3/30/22 revealed orders for Aripiprazole (mental/mood disorder), Clonidine (sleep aid), Melatonin (sleep aid), Lorazepam (agitation), Ziprasidone (severe agitation) and Propranolol (mental/mood disorder). Further review on 5/3/22 of the BSP consent signed by the guardian on 10/28/21 did not incorporate the use of Clonidine, Melatonin, Propranolol or bedroom window alarms. Interview on 5/3/22 with the qualified intellectual disabilities professional (QIDP) confirmed written	W 263		

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W 263	Continued From page 7 informed consent for client #2's BSP did not incorporate the use of all medications prescribed or window alarms.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the interdisciplinary team (IDT) developed active treatment programs to use in conjunction with client's psychotropic medications for the reduction and/or elimination of restrictive behavior medications. This affected 1 of 4 audit clients (#3). The finding is: Review on 5/2/22 of client #3's individual program plan (IPP) dated 4/8/22 revealed he was admitted to the facility 3/8/22. Client #3's diagnoses are listed as Attention Deficit Hyperactivity Disorder, Mild Intellectual Disabilities, Post Traumatic Stress Disorder, Intermittent Explosive Disorder, Bipolar 2 Disorder and Autism Spectrum Disorder. Review on 5/2/22 of client #3's physician orders dated 3/24/22 revealed he receives Sertraline to address symptoms of post traumatic stress disorder and Prazosin to address nightmares. Review on 5/2/22 of client #3's record did not include a formal active treatment program to use in conjunction with his psychotropic medications.	W 312		

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W 312	Continued From page 8 Interview on 5/3/22 with the qualified intellectual disabilities professional (QIDP) confirmed client #3 does not have a BSP in place at this time.	W 312		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were sufficiently trained to implement appropriate techniques during medication administration. This affected 1 of 4 audit clients (#6). The finding is: During morning observations in the home on 5/3/22 at 6:01am, client #6 was at the table consuming a bowl full of chocolate ice cream. After he finished, closer observation of the bowl revealed a powdery brownish substance at the bottom of the bowl. The substance covered the majority of the bowl's surface. Client #6 retrieved the bowl, took it to the kitchen and dumped the contents into the sink. During this time, Staff A (the medication technician) was at the back of the home assisting another client. Interview on 5/3/22 with Staff A revealed client #6's morning medications were in the bowl of ice cream and the client will not take his medicine without ice cream. Additional interview indicated he had placed Reguloid powder, Haldol, Lamictal, Clonidine and Children's Chewable in the client #6's ice cream. The staff noted all of the pills	W 340		

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W 340	Continued From page 9 were crushed, except the Clonidine, and placed at the bottom of the bowl with ice cream on top. The staff revealed he usually mixes the medicine in the ice cream but he may not have mixed it up well enough this morning. Further interview indicated the staff did not know client #6 had emptied an unknown amount of his medication in the sink. Review on 5/3/22 of client #6's physician's orders dated March 2022 revealed orders for Reguloid powder, Haldol, Lamictal, Clonidine and Child Chewable at 6:00am. Interview on 5/3/22 with the facility's nurse confirmed client #6's morning medications, with the exception of Clonidine, can be crushed and given in yogurt or ice cream. Additional interview confirmed based on the description of amount left in the bowl, it can't be determined how much of the client's medication was consumed. The nurse further stated the staff should have placed the crushed medicine on top of the ice cream, mixed it in and remained with client #6 to ensure ingestion of his medications.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all drugs were administered without error. This affected 2 of 4 audit clients (#2 and #6). The findings are: A. During observations of medication	W 369		

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W 369	Continued From page 10 administration in the home on 5/3/22 at 6:18am, client #2 ingested Metformin, Cetirizine, Aripiprazole, Doxycycline, Propranolol and Vitamin D3. No other medications were ingested. Review on 5/3/22 of client #2's physician's orders dated 3/30/22 reveals Polyethylene Glycol Powder 3350 NF to be administered by mouth once daily at 6:00am. Interview on 5/3/22 with the medication technician revealed client #2 had not received Polyethylene Glycol Powder during the medication pass on 5/3/22 at 6:18am due to client refusal. Interview on 5/3/22 with the facility nurse confirmed client #2 should have received Polyethylene Glycol Powder as indicated during the medication pass. B. During morning observations in the home on 5/3/22 at 6:01am, client #6 was at the table consuming a bowl full of chocolate ice cream. After he finished, closer observation of the bowl revealed a powdery brownish substance at the bottom of the bowl. The substance covered the majority of the bowl's surface. Client #6 retrieved the bowl, took it to the kitchen and dumped the contents into the sink. During this time, Staff A (the medication technician) was at the back area of the home assisting another client. Interview on 5/3/22 with Staff A revealed client #6's morning medications were in the bowl of ice cream and the client will not take his medicine without ice cream. Additonal interview indicated he had placed Reguloid powder, Haldol, Lamictal, Clonidine and Children's Chewable. The staff	W 369		

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W 369	Continued From page 11 noted all of the pills were crushed, except the Clonidine, and placed at the bottom of the bowl with ice cream on top. The staff revealed he usually mixes the medicine in the ice cream but he may not have mixed it up well enough this morning. Further interview indicated the staff did not know client #6 had emptied an unknown amount of his medication in the sink. Review on 5/3/22 of client #6's physician's orders dated March 2022 revealed orders for Reguloid powder, Haldol, Lamictal, Clonidine and Child Chewable at 6:00am. Interview on 5/3/22 with the facility's nurse confirmed client #6 morning medications, with the exception of Clonidine, can be crushed and given in yogurt or ice cream. Additional interview confirmed based on the description of amount left in the bowl, it can't be determined how much of the client's medication was consumed.	W 369		
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 review, and interview, the facility failed to ensure 1 of 4 audit clients (#2) received their specially prescribed diet as indicated. The finding is: During observations in the home on 5/2/22 at 5:14pm, client #2 was observed eating dinner which consisted of Viola brand frozen	W 460		

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W 460	Continued From page 12 cheeseburger skillet meal that included penne pasta, hamburger in a butter sauce and green beans. Client #2 received 3 large servings of the cheeseburger skillet. Review on 5/2/22 of client #2's annual physical (dated 7/30/21) and physician's orders (dated 3/30/22) revealed a prescribed diet for low sugar/low fat. Interview on 5/2/22 with staff C regarding the appropriate diet and portion size for client #2 revealed client #2 is on a regular diet. Interview on 5/3/22 with facility dietitian revealed client #2 should be on a low sugar/low fat diet and 3 servings of pasta would not be appropriate.	W 460		