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W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that privacy was maintained for 4 of 6 clients in the group home (#1, #3, #4, and #5) during personal care. The findings are: A. The facility failed to assure that privacy for client #1 was maintained during personal care. For example: Observation in the group home on 8/16/22 at 6:00 AM revealed client #1 to sit in a rocker recliner chair with a ball. Continued observation at 6:14 AM revealed staff E to enter client #1's room and take client #1 into a bathroom inside of the bedroom. Further observation revealed client #1 to shower with the door open to the bathroom and bedroom. Subsequent observation at 6:18 AM revealed staff G to close client #1's bedroom door. Interview with the qualified intellectual disabilities professional (QIDP) on 8/16/22 verified that staff should be observing privacy during personal care by closing the client's bathroom and bedroom doors. B. The facility failed to assure that privacy for client #3 was maintained during personal care. For example: Observation in the group home at 5:35 AM revealed staff E to take client #3 to the bathroom and to change the client's incontinence brief. Continued observation revealed staff E to change	W 130		

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

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the client with the door open. Further observation at 5:37 AM revealed client #3 to exit the bathroom and go to the living room to sit beside keyboard.

Interview with the qualified intellectual disabilities professional (QIDP) on 8/16/22 verified that staff should be observing privacy during personal care by closing the client's bathroom door.

C. The facility failed to assure that privacy for client #4 was maintained during personal care. For example:

Observation in the group home on 8/16/22 at 5:00 AM revealed client #4 to be awake and in the bed. Continued observation revealed client #4 to start crying and for staff E to enter the client's bedroom. Further observation at 5:43 AM revealed staff E to change the client's incontinence brief with the door open and to exit the bedroom.

Interview with the qualified intellectual disabilities professional (QIDP) on 8/16/22 verified that staff should be observing privacy during personal care by closing the client's bedroom door.

D. The facility failed to assure that privacy for client #5 was maintained during personal care. For example:

Observation in the group home on 8/16/22 at 7:17 AM revealed client #5 to sit in the living room floor. Continued observation at 7:18 AM revealed staff E to take client #5 to the bathroom walking through the client's bedroom leaving both doors open while sitting on the toilet. Further observation revealed client #5 to exit the bathroom to walk in the living room and sit on the

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W 130	Continued From page 2 floor. Interview with the qualified intellectual disabilities professional (QIDP) on 8/16/22 verified that staff should be observing privacy during personal care by closing the client's bathroom and bedroom doors.	W 130		
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: The facility failed to assure 4 of 4 sampled clients (#1, #3, #5 and #6) received a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency as evidenced by observations, interviews and record verification. The findings are: A. The facility failed to provide a continuous active treatment program for the 4 sampled clients in the day program on 8/15/22. For example: 1. Review of client #5's person centered plan (PCP) dated 2/10/22 revealed the client to have several objectives to be trained in the day	W 249		

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program including programs for a leisure activity, task completion and following 2 step directions. However, afternoon observations in the day program at 1:20 PM revealed client #5 to be sitting in a chair by in entry way of the day program. The client was observed to sit cross-legged in the chair facing the wall without activity for 45 of 50 minutes of observations. Day program staff's only engagement with the client besides handing him a drink was to verbally and physically prompt him up from his chair to move to a table to look at a book at 1:45 PM and to use go use the bathroom at 2:00 PM. After both brief engagement attempts client #5 was observed to immediately go back to his chair by the entry way to sit unengaged.

2. Review of client #3's PCP dated 10/15/21 revealed the client to have several objectives to be trained in the day program including programs to answer yes/no questions regarding mealtimes, work on daily living skills, and participate in a group leisure activity. Observations in the day program at 1:20 PM revealed client #3 to be laying down on a bed in the back of the day program while holding a toy. Staff was observed to prompt the client up at 1:30 PM. The client was observed after this prompt to walk around the day program and return to the bed to lay back down. Further observations at 2:00 PM revealed staff to prompt the client up at which point the client walked around the room again but another staff was observed to assist the client with an activity at a table. The client was observed to be prompted to go to the bathroom at 2:04 PM but returned to the table and stay engaged for the last 5 minutes of observations.

3. Review of client #1's PCP dated 5/12/22

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revealed the client to have several objectives to be trained in the day program including programs to choose a leisure activity from 2 choices, complete simple chores and put dishes in the sink. Observations in the day program at 1:20 PM revealed the client walking around the room unengaged until staff handed him a ball to hold. The client was observed during the entire 50 minutes of observations to walk around holding the basketball unless staff directed the client to sit in a chair because he was standing in front of the television that people were watching. Further observations revealed the client was also observed to briefly lay on a bed in the back of the room at 1:45 PM and again at 1:55 PM. After laying down briefly the client was observed to stand in the bed requiring staff to move quickly over to assist him to get down safely from the bed. No other activity or engagement was provided for the client.

4. Review of client #6's PCP dated 5/12/22, substantiated by observations during the 8/15-16/22 survey, revealed the client to be dependent on a wheelchair for mobility. Further observations revealed the client to use an electric wheelchair to independently maneuver as the client does not have movement in her lower extremities and limited upper body strength. Further review of the PCP, substantiated by interview with the home manager, revealed the client requires the use of shoes and wheelchair footplates with straps to appropriately position her feet and legs while in her wheelchair.

Observations in the day program at 1:20 PM revealed the client to be able to appropriately engage herself in activities using her IPad and headphones. However, further observations

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revealed the client to be wearing only socks with her feet dangling without support off of her footpads. Continued day program observations revealed the client remained this way while in her wheelchair.

B. The facility failed to provide a continuous active treatment program for the 4 sampled clients during morning observations on 8/16/22. For example:

1. Review of client #6's PCP dated 5/12/22 revealed the client to have only one objective to be trained in the group home to fold washcloths. Interview with the qualified intellectual disabilities professional (QIDP) revealed the client has many needs and the team was in the process of developing and implementing additional programming for the client. However, as of the 8/15-16/22 survey, the facility failed to assure the client was provided with an adequate active treatment program to meet the client's needs.

2. Morning observations in the group home revealed client #5 to be up at the beginning of observations at 5:05 AM. Interview with 3rd shift staff revealed the client has an early medication administration is awakened for that even earlier at 4:30 AM. The client was observed during 125 of 175 minutes of observations unengaged in meaningful activity of sitting on his bed listening to his radio, sitting in the living room floor hitting and kicking at peers near him or being prompted to get up off the floor by 3rd shift staff. During the remaining 50 minutes the client was observed to get coffee and refuse breakfast at 5:05 AM, take a bath and get dressed at 5:50 AM, go to the bathroom at 7:20 AM and take a 30 minute walk with the group home manager at 7:30 AM.

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Review of client #5's PCP dated 2/10/22 revealed the client to have several objectives to be trained in the home including coffee making, requesting creamer, drying hair and washing chest. Further observations in the morning revealed the client did assist with making his coffee however the client did not use a voice output device to request creamer with staff observed to add it for him without his request. Continued observations during the morning did revealed the client to get a bath with staff assistance that was unobserved where the client's bathing and drying hair program could have been implemented. Subsequent review of the PCP, substantiated by interview with the home manager, revealed no additional objective training to be included in the client's PCP to appropriately engage the client during the over 3 hours the client has each morning, excluding the 5 minutes to make coffee and the 5 minutes for the client to learn to wash his chest and dry his hair.

3. Morning observations in the group home revealed client #3 to get up and finishing breakfast at the beginning of observations at 5:05 AM. Further observations revealed the client's hair to be wet and interview with 3rd shift staff revealed the client has a medication prescribed for 30 minutes before breakfast so the client gets up at 4:30 AM to get her medication, takes a bath and then is ready to eat breakfast. Observations during the 175 minutes of observations revealed the client take her medications for 5 minutes and go to her bathroom where staff changed her incontinence product for 5 minutes each at 5:35 AM and 7:55 AM. During the remaining 160 minutes of observations the client was observed to sit on a bench in the living room with her head

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on a keyboard listen to recorded music or sit on the couch. Staff was observed to give the client a stuffed toy to hold and textured fabric to manipulate, however no other options or active treatment was observed by staff.

Review of client #3's PCP dated 10/15/21 revealed only 3 objectives to be trained in the group home including wash face, toileting, and asking for more vegetables with an output communication device. Continued observations during the morning of 8/15/22 revealed the client took a bath prior to observations at 5:05 AM, did go to the bathroom on 2 occasions for a total of 10 minutes and did not use any kind of output communication device at breakfast or any other time during the morning. Subsequent review of the PCP, substantiated by interview with the home manager, revealed no additional training is included in the client's PCP to provide the client with a continuous active treatment program during the over 3 hours of time the client has in the morning before time to go to the day program.

4. Morning observations in the group home revealed client #1 to be awakened by staff to take his medications at 5:15 AM. Further morning observations revealed the client to take his medications for 5 minutes, eat breakfast for 10 minutes, use the bathroom and bathe for 20 minutes and take a walk with the group home manager for 25 minutes. During the remaining 105 minutes of observations, client #1 was observed to lay back down in bed for 10 minutes and sit in the living room rocking in a recliner.

Review of client #1's PCP dated 5/12/22 revealed to help pour water during medications, load utensils in the day program, take out the trash

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W 249	Continued From page 8 and open his closet. Further review of the PCP, substantiated by interview with the group home manager, revealed no other objective training is available to engage the client in a continuous active treatment program during the almost 3 hours of time from when the client gets up in the morning and leaves for the day program.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: The facility failed to assure a technique to manage the inappropriate behavior of 1 of 4 sampled clients (#1) was not used for the convenience of staff as evidenced by observations, interviews and record verification. The finding is: Morning observations on 8/26/22 at 5:15 AM revealed staff waking client #1 to go take his medications. Further observations of client #1 revealed the client to be wearing a black 1 piece garment with snaps in the back. Interview with third shift staff, substantiated by review of client #1's individual support plan (ISP) dated 5/12/22, revealed the client has feces smearing as a target behavior of his behavior plan. Further interview with third shift staff revealed the client usually had problems with this behavior during the night but since staff started using this garment for client #1 at night, client #1 has not had any incidents as the client cannot remove the garment to get into his pants.	W 287		

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W 287	Continued From page 9 Further review of client #1's ISP, substantiated by interview with the qualified intellectual disabilities professional (QIDP), revealed the use of the restrictive garment intervention is not currently part of the client's behavior plan and has not been approved by the client's guardian and facility Human Rights Committee.	W 287		
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 assure all drugs were administered without error for 1 of 3 clients sampled (#1) observed during medication administration. The finding is: Observation in the group home on 8/16/22 at 5:11 AM revealed client #1 to obtain a cup for medication administration and to sanitize hands. Continued observation revealed staff F to pour prescribed Ensure chocolate into client's cup and for client #1 to drink all the Ensure. Further observation revealed staff F to spray Fluticasone nasal spray 50 MCG with 1 spray in each nostril for client #1. Subsequent observation revealed client #1 to take Levocetirizine 5 MG in applesauce and for client to drink 1 capful of Polyethylene Glycol 3350 powder in water. Review of records for client #1 on 6/8/22 revealed physician orders dated 8/16/22. Review of the 8/16/22 physician orders revealed medications to administer at 6:00 AM to be Ensure chocolate, Fluticasone nasal spray 50 mcg spray,	W 369		

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W 369	Continued From page 10 Levocetirizine 5mg tab, and Polyethylene Glycol powder-3350 17 GM/1 capful in 80oz of beverage. Further review of physician orders revealed client #1 prescribed Fluticasone nasal spray 50 mcg with 2 sprays in each nostril every day for allergic rhinitis. During survey observation staff F was observed to administer Fluticasone nasal spray 50 mcg with 1 spray in each nostril. Interview with qualified intellectual disabilities professional (QIDP) on 8/16/22 verified the physician orders dated 8/16/22 to be current. Continued Interview with the QIDP confirmed that staff should have administered the prescribed nasal spray as ordered by physician. The facility nurse was unavailable for interview.	W 369		