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| W 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interviews, the governing body and management failed to exercise general policy, budget and operating direction over the facility by failing to assure damage to the facility fence and van was repaired in a timely manner. The finding is:<br><br>Observations conducted of the group home keypad gated fence on 9/6/22 revealed the gate to be open and broken. Further observations revealed the left entrance gate leaning up against another area of the fence. Continued observations of the facility van revealed damage to the front bumper to be coming apart from the frame of the van.<br><br>Interview with staff D on 9/6/22 revealed the damage to the gate and van had been at least one year although he did not know when the damage occured. Further interview with staff D revealed the group home does not have a secured vehicle for transportation to and from the day program, outings, etc. Continued interview revealed the group home utilizes a van at the day program when clients need to attend doctor's appointments.<br><br>Interview with the qualified intellectual developmental professional (QIDP) on 9/7/22 verified she was aware of the condition the facility van as it has been inoperable due to being involved in an accident. The QIDP further verified administration was considering replacing the facility van although no decision had been made | W 104 | | |

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

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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| W 104 | Continued From page 1<br>that she was aware of relative to its delivery date. Further interview with the QIDP verified the group home does not have a secured van to utilize on a day to day basis but transportation is provided for doctors' appointments. Continued interview with the QIDP revealed administration is also aware of the condition of the broken gate and repair dates have not been secured.<br><br>Interview with the facility administer (FA) on 9/7/22 confirmed the agency is aware of the inoperable van and broken fence but could not verify when both repairs would be completed because of delays. Continued interview with the FA confirmed the group home does not have access to a van on a day to day basis but utilizes the nursing van for doctor's appointments. | W 104 | | |
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure privacy during treatment and care of personal needs for 6 of 6 clients relative to medication administration. The finding is:<br><br>Observation in the group home during the 9/7/22 survey revealed the medication room to be adjacent to the dining room and kitchen area. Continued observation revealed each client to receive their medications in the medication room and for the door to remain wide open for the duration of each medication pass.<br><br>Continued observation on 9/7/22 at 7:07 AM | W 130 | | |

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| W 130 | Continued From page 2<br>revealed client #1 to dance in the medication room's doorway and to enter into the medication room to tap staff F on the shoulder during client # 3's medication administration. Subsequent observation revealed staff E to enter the medication room during the medication administration of client #5 while client #1 and others in the home socialized and interacted outside the medication room door. At no point during the survey period was privacy offered or provided to client's during medication administration.<br><br>Interview with staff F and the facilities qualified disabilities developmental professional (QIDP) on 9/7/22 revealed conducting medication administration while leaving the is door open is not a common practice. Interview with the facilities nurse on 9/7/22 revealed that privacy should be offered to every client during medication unless there is a behavioral justification. | W 130 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interviews, and record | W 249 | | |

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| W 249 | Continued From page 3 | W 249 | | |

reviews, the facility failed to assure a continuous active treatment program was provided to support the achievement of the objectives identified in the person centered plans for 6 of 6 clients (#1, #2, #3, #4, #5, and #6) The findings are:

A. The facility failed to provide adequate active treatment to engage client #2, #3, #4 and #5 during large amounts of unstructured time. For example:

Afternoon observations in the group home on 9/6/22 from 4:00 PM to 6:30 PM revealed clients #2, #3, and #4 to sit in the living room area with the television on. Continued observation revealed client #6 to sit in a recliner in his bedroom. Further observations at 4:25 PM to 5:10 PM to revealed clients #6, #2, #4, and #3 to participate in showers then return to their rooms. Further observations revealed at 5:30 PM all clients to sit and participate in dinner, go to the bathroom and return to their rooms. Subsequent observation revealed client #2, #3, #4, and #6 unengaged without activity for 90 of the 150 minutes of observations. At no point during the observation period were clients offered choices in leisure activities.

Morning observations in the group home on 9/7/22 from 6:30AM to 9:00 AM revealed five of six clients in their bedrooms with the door closed. Continued observations at 7:05 AM to 7:54 AM revealed clients #1, #2, #3, #4, #5, and #6 to participate in medication administration then return to their rooms or sit in the livingroom until breakfast was ready. Further observation at 8;10 AM revealed staff G to inform staff H that breakfast was ready. Subsequent observations at 8:15 AM revealed clients #1, #2, #3, #4, #5,

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| W 249 | Continued From page 4 | W 249 | | |

and #6 to sit at the dining table to participate in breakfast with their plates already prepared and placed on the table for them. Additional observations between 8:25 AM to 8:30 AM revealed clients to take their dishes to the kitchen. Clients #2, #3, and #4 to return to the living room while client #1, #5 and #6 to return to their rooms. Further observation at 8:47 revealed staff H to prepare all clients for loading the van to be transported to the day program. At no point during the observation period were clients offered choices in leisure activities and unengaged without activity for 90 minutes.

Review of the record for client #1 revealed a person centered plan (PCP) dated 3/4/22. Review of the PCP revealed training objectives to address stating home address, iron shirt, carry up to $1.00, properly cough/sneeze in his elbow, wash hands thoroughly and tolerate wearing a mask.

Review of the record for client #2 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands, cough/sneeze in his elbow and communication.

Review of the record for client #3 revealed a PCP dated 10/24/21. Review of the PCP revealed training objectives to address toothbrushing, remove dishes from table, identify body parts, put clothing protector in basket, wash hands and behavior.

Review of the record for client #4 revealed a PCP dated 1/24/22. Review of the PCP revealed training objectives to address putting on a belt, prepare veggies on stove, money management,

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brush teeth, tolerate wearing a mask, cough/sneeze in elbow, wash hands and behavior.

Review of the record for client #5 revealed a PCP dated 6/14/22. Review of the PCP revealed training objectives to address best health, washing hands, wear a mask, cough/sneeze in his elbow, state current address and improve continuity and security.

Review of the record for client #6 revealed a PCP dated 4/28/22. Review of the PCP revealed training objectives to address tolerate wearing glasses, wash hands thoroughly, put clothes in proper storage area, money management, communication, sweep dining room floor, and behavior.

Interview with the qualified intellectual disabilities professional (QIDP) on 9/7/22 revealed all clients' training objectives are current. Continued interview with the QIDP verified that staff should offer leisure activities during periods of inactivity. Further interview with the QIDP revealed that staff should implement active training programs specific to clients' program goals and ensure that all clients are offered meaningful activities throughout the day.

B. The facility failed to assure clients (#1, #2, #3, #4, #5, and #6) practice good health relative to hand washing and teeth brushing For example:

Afternoon observations in the group home on 9/6/22 from 4:00 PM to 6:30 PM revealed clients #2, #3, and #4 to sit in the living room area with the television on. Continued observation revealed client #6 to sit in a recliner in his

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bedroom. Further observations at 4:25 PM to 5:10 PM to revealed clients #6, #2, #4, and #3, to participate in showers then return to their rooms. Further observations revealed at 5:30 PM all clients to sit and participate in dinner, go to the bathroom and return to their rooms. At no point during observation period were clients prompted to wash their hands before dinner.

Morning observations in the group home on 9/7/22 from 6:30AM to 9:00 AM revealed five of six clients in their bedrooms with the door closed. Continued observations at 7:05 AM to 7:54 AM revealed clients #1, #2, #3, #4, #5, and #6 to participate in medication administration then return to their rooms or sit in the livingroom until breakfast was ready. Further observation at 8:10 AM revealed staff G to inform staff H that breakfast was ready. Subsequent observations at 8:15 AM revealed clients #1, #2, #3, #4, #5, and #6 to sit at the dining table to participate in breakfast with their plates already prepared and placed on the table for them. At no point during the observation period were clients prompted to wash their hands before breakfast or brush their teeth.

Review of the record for client #1 revealed a person centered plan (PCP) dated 3/4/22. Review of the PCP revealed training objectives to address stating home address, iron shirt, carry up to $1.00, properly cough/sneeze in his elbow, wash hands thoroughly and tolerate wearing a mask.

Review of the record for client #2 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands,

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| W 249 | Continued From page 7<br>cough/sneeze in his elbow and communication.<br><br>Review of the record for client #3 revealed a PCP dated 10/24/21. Review of the PCP revealed training objectives to address toothbrushing, remove dishes from table, identify body parts, put clothing protector in basket, wash hands and behavior.<br><br>Review of the record for client #4 revealed a PCP dated 1/24/22. Review of the PCP revealed training objectives to address putting on a belt, prepare veggies on stove, money management, brush teeth, tolerate wearing a mask, cough/sneeze in elbow, wash hands and behavior.<br><br>Review of the record for client #5 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands, cough/sneeze in his elbow and communication.<br><br>Review of the record for client #6 revealed a PCP dated 4/22. Review of the PCP revealed training objectives to address tolerate wearing glasses, wash hands thoroughly, put clothes in proper storage area, money management, communication, sweep dining room floor, and behavior.<br><br>Interview with the QIDP on 9/6/22 revealed all client training objectives were current. Continued interview with the QIDP verified that all clients should have washed their hands before all meals and brushed their teeth to improve dental care. | W 249 | | |
| W 382 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2) | W 382 | | |

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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 reviews and interviews, the facility failed to assure medications were not dispensed before administering to 6 of 6 clients. The findings are:

A. Client #3 was not taught to administer his own medication during the observed morning medication pass on 9/7/22 as staff F punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:

Morning observations in the group home at 7:07 AM revealed client #3 to receive medication with assistance from staff F. Client #3's three medications were noted to be located in a 1 oz paper medicine cup dispenser on the desk accompanied by five additional 1 oz medication cups with client initials of (#1, #2, #4, #5, and #6) written on the paper cup to identify the resident it belonged. The only participation by client #3 was for the client be fed the medication from the cup with applesauce by staff F. Further observation revealed no training was provided for client #3 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #3 to have access his peers medication (#1, #2, #4, #5, and #6) located in the 1 oz paper medicine cup dispenser on the desk.

Review of records for client #3 revealed a person-centered plan (PCP) dated 10/24/21. Review of the PCP for client #3 revealed goals

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for: toothbrushing, removal dishes from table, identify body parts put clothing protector in basket, behavior, and wash hands.

B. Client #5 was not taught to administer his own medication during the observed morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:

Morning observations in the group home at 7:30 AM revealed client #5 receiving medication with assistance from staff F. Client #5's eight medications were noted to located in a 1 oz paper medicine cup dispenser on the desk accompanied by five additional 1 oz medication cups with client initials of (#1, #2, #4, and #6) ) written on the paper cup to identify the resident it belonged.

The only participation by client #5 was for staff F to hand client #5 his 1 oz cup of medications to place in his mouth and a cup of water to drink to swallow his medications. Further observation revealed no training was provided for client #5 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #5 to have access to the medication of client #1. #1, #3,#4, and #6).

Review of records for client #5 revealed a person-centered plan (PCP) dated 6/14/22. Review of the PCP for client #5 revealed goals for: best health, wear mask, wash hands, property cough/sneeze in elbow, improve independent living skills, state current address, and improve continuity and security.

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C. Client #4 was not taught to administer his own medication during the morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:

Morning observations in the group home at 7:30 AM revealed client #4 to enter the medication room with staff F. Client #4's medications were noted to located in a 1 oz paper medicine cup dispenser on the desk accompanied by two additional 1 oz medication cups with client initials of (#5 and #6) written on the paper cup to identify the resident it belonged. Further observation revealed no training was provided for client #4 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #4 to have access his peers medication (#5 and #6) located in the 1 oz paper medicine cup dispenser on the desk.

Review of records for client #4 revealed a person-centered plan (PCP) dated 1/24/22. Review of the PCP for client #4 revealed goals for: put on belt, prepare veggies on stove, behavior, count money consistently up to $1.00, brush teeth, tolerate wearing a mask, cough/sneeze in elbow, and wash hands thoroughly.

D. Client #6 was not taught to administer his own medication during the morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:

Morning observations in the group home at 7:45

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| W 382 | Continued From page 11<br>AM revealed client #6 to enter the medication room with staff F. Client #6's medications were noted to located in a 1 oz paper medicine cup dispenser on the desk accompanied by two additional 1 oz medication cups with client initials of written on the paper cup to identify the resident it belonged. Further observation revealed no training was provided for client #6 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #6 to have access to the medication two peers.<br><br>Review of records for client #6 revealed a person-centered plan (PCP) dated 4/28/22. Review of the PCP for client #6 revealed goals for: trim nails, tolerate wearing glasses, wash hands thoroughly, put clothes in proper storage area, identify the use of money, communication, behavior, and sweep dining room floor.<br><br>E. Client #2 was not taught to administer his own medication during the morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:<br><br>Morning observations in the group home at 7:53 AM revealed client #2 entering the medication room with staff F. Client #2's medications were noted to be located in a 1 oz paper medicine cup dispenser on the desk. Further observation revealed no training was provided for client #2 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #2 to have access to the medication of one of his peers. | W 382 | | |

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Review of records for client #2 revealed a person-centered plan (PCP) dated 1/8/22. Review of the PCP for client #2 revealed goals to operate washing machine, identify coins, tolerate daily routing, cough/sneeze in elbow, wash hands, and communication.

F. Client #1 was not taught to administer his own medication during the morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example:

Morning observations in the group home 8:00 AM revealed client #1 to enter into the medication room with staff F for medication administration. Client #1's medications were noted to located in a 1 oz paper medicine cup dispenser on the desk. Further observation revealed no training was provided for client #1 to learn about his medications, their side effects or how to increase the self-administration of medications.

Review of records for client #1 revealed a person-centered plan (PCP) dated 3/4/22. Review of the PCP for client #3 revealed goals for: state home address, iron shirt, carry up to $1.00, properly cough/sneeze in elbow, wash hands thoroughly, tolerate wearing a mask and behavior.

Interview with staff F on 9/7/22 revealed it is common practice to close the medication room door to allow for privacy. Continued interview with staff F revealed it is also common practice to have clients participate in the medication administration by punching their medication out of the bubble packs. Further interview with staff F

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| W 382 | Continued From page 13<br>revealed they were "behind scheduled so staff F dispensed the clients medications into the individual 1 oz medication cups to speed up the morning medication administration".<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 9/7/22 revealed that it is not common practice to leave the medication room door open during medication administration. Further interview with the QIDP revealed staff are to allow clients to participate in their medication administration and staff are not to pre-punch medications beforehand.<br><br>Interview with the facility nurse on 9/7/22 revealed all staff have been trained on all medication administration procedures and all staff will be trained. | W 382 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review, and interview the facility failed to provide teaching for 2 clients (#5 and #6) relative to eyeglasses. The finding is:<br><br>A. Observation in the group home on 9/6/22 from 6:00 PM to 6:30 PM revealed client #5 to return home from an appointment without his eyeglasses on his face. Continued observation in the group home on 9/7/22 from 6:45 AM to 8:25 | W 436 | | |

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| W 436 | Continued From page 14 | W 436 | | |

AM revealed client #5 to participate in various activities to include: to get dressed, to participate in his medication administration, to participate in his breakfast meal, to get his supplies ready for the work placement and to board the van to go to his work placement. At no point throughout the morning observations on 9/7/22 was client #5 offered or prompted to wear his glasses.

Review of records for client #5 revealed a person-centered plan (PCP) dated 6/14/22. Review of the PCP for client #5 revealed training objectives to address best health, wear a mask, wash hands, property cough/sneeze in elbow, improve independent living skills, state current address and improve continuity and security. Continue review of record reveals a behavior support plan (BSP) dated 3/8/22.

Review of the BSP addresses client #5's target behavior of refusals and strategies for how staff should respond when client #5's exhibits signs of psychosis-delusions, hallucinations or disorganized thoughts or behaviors. Further review of records for client #5 revealed a vision consult dated 1/4/22 with a new prescription and recommendations that client #5 requires prompts to tolerate and wear glasses.

B. Observation in the group home on 9/6/22 from 4:00 PM to 6:30 PM revealed client #6 to participate in various activities to include: to watch television, participation in the dinner meal, to carry his dinner dished to the sink and to participate in self-care routine. At no point throughout observations on 9/6/22 was client #6 offered or prompted to wear his glasses.

Observation in the group home on 9/7/22 from

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| W 436 | Continued From page 15<br>7:00 AM until 9:00 AM revealed client #6 to participate in various activities to include: to wake and complete his morning self-care routine with staff assistance, to participate in medication administration, to watch television, to participate in the breakfast meal, to carry his dishes to the sink and to board the homes van to go to his work placement. At no point throughout the morning observations on 9/7/22 was client #6 offered or prompted to wear his glasses.<br><br>Review of records for client #6 on 9/7/22 revealed a person-centered plan (PCP) dated 4/28/22 Review of the PCP for client #6 revealed training objectives to address: trim nails, tolerate wearing glasses, put clothes in proper storage area, identify the use of money, communication, behavior, sweep dining room floor, and privacy. Continued review of records for client #6 revealed a behavior support plan (BSP) dated 2/23/21 to reflect sleep difficulties and difficulty tolerating intrusive dental procedures.<br><br>Interview with the facilities qualified intellectual developmental professional (QIDP) on 9/7/22 verified both client #5 and #6 wear prescribed glasses. Continued interview with the QIDP revealed client #5's eye glasses are kept in his bedroom and he wears them to read and watch television. Further interview with the QIDP revealed client #6 eye glasses are kept in the medication room and staff should have offered the glasses to him. | W 436 | | |
| W 460 | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(1)<br><br>Each client must receive a nourishing, well-balanced diet including modified and | W 460 | | |

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| W 460 | Continued From page 16<br>specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to assure 6 of 6 clients received diets prescribed as ordered. The findings are:<br><br>Observation in the group home on 9/6/22 at 5:30 PM revealed the start of the dinner meal where no client washed or was prompted to wash their hands for the meal. Continued observation revealed the dinner meal to consist of rice, chicken cut in approximate 1 inch pieces, green peas, gravy, water and apple juice. Further observation revealed the serving utensils to be regular large size mixing spoon. Subsequent observation revealed clients were not offered a full place setting nor were they offered a preferred beverage, milk.<br><br>Observation in the group home on 9/7/22 at 8:15 AM revealed the start of the breakfast meal no clients washed or was prompted to wash their hands for the breakfast meal. Further observation revealed the meal to consist of cut up pieces of french toast, cut up pieces of sausage, fruit, water and apple juice. Subsequent observation revealed staff G to place each client's plate on the table already prepared and ready for them to consume. Clients were not offered the opportunity to participate in the selection of the food they preferred to eat for breakfast as their plates were prepared and placed on the table for them.<br><br>A. Observation in the group home revealed client #1 to be served with hand over hand assistance | W 460 | | |

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by staff C several large spoons full of rice, a regular portion of green peas and chicken and a cup full of water and apple juice. Further observation revealed clients were not offered a full place setting nor were they offered a preferred beverage, milk.

Observation in the group home on 9/7/22 revealed client #1 to consume his breakfast receiving no second servings. Continued observation revealed client #1 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.

Review of records for client #1 revealed a nutritional evaluation dated 12/15/21. Further review of the nutritional evaluation revealed client #1's current diet is 1500 calorie weigh loss, heart health, 1 inch consistency, double portion of vegetables, add 2-8 oz of water daily, (low fat, low cholesterol), low sodium, no concentrated sweets, no added salt, and, hand over hand assistance cutting food as needed.

B. Observation in the group home revealed client #2 to be served with hand over hand assistance by staff C several large spoons full of rice, a regular portion of green peas, chicken, water and apple juice. Continued observation revealed client #2 to be given seconds of rice, chicken and green peas during the meal.

Observation in the group home on 9/7/22 revealed client #2 to consume his breakfast receiving no second servings. Continued observation revealed client #2 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.

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| W 460 | Continued From page 18<br>Review of records for client #2 revealed a nutritional evaluation dated 3/3/21. Further review of the nutritional evaluation revealed client #2's current diet is regular, 1/2 inch consistency, hearth healthy, may use applesauce to give medications, pace as needed due to difficulty with rate of eating, thin liquids, eat/drink only when alert, sit upright 60 minutes after eating, stop eating/drinking if coughing, monitor temperature/lung sounds for change, eat slowly, no straws, small sips, alternate food then liquids, and, stop eating if choking.<br><br>C. Observation in the group home revealed client #3 to be served with hand over hand assistance by staff C several large spoons full of rice, a regular portion of green peas and chicken and a cup full of water and apple juice.<br><br>Observation in the group home on 9/7/22 revealed client #3 to consume his breakfast receiving no second servings. Continued observation revealed client #3 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.<br><br>Review of records for client #3 revealed a nutritional evaluation dated 7/30/22. Further review of the nutritional evaluation revealed client #3's current diet is weigh gain, 1/2 inch consistency, encourage seconds, high calorie snack BID with milk, may give medications with food, strict aspiration precautions, encourage small bites and slow eating, stop eating if choking, only eat when alert, sit upright 30 minutes after eating, Ensure 1 can BID, 4 oz applesauce, and, yogurt or pudding with lunch daily. | W 460 | | |

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D. Observation in the group home revealed client #4 to be served with hand over hand assistance by staff C two large spoons full of rice, a regular portion of green peas, chicken, water and apple juice.

Observation in the group home on 9/7/22 revealed client #4 to consume his breakfast receiving no second servings. Continued observation revealed client #4 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.

Review of records for client #4 revealed a nutritional evaluation dated 1/27/22. Further review of the nutritional evaluation revealed client #4's current diet is weight loss 1800 calorie heart healthy, whole consistency, GERD diet, may have seconds of fruits, veggies and low calorie beverages, avoid fried foods, 1 cup oatmeal of oat bran cereal 2 days a week, and limit butter or margarine.

E. Observation in the group home revealed client #5 to be at an appointment during the dinner meal. Continued observation revealed client #5 returned from the appointment at 6:30 PM and planned to shower and have his dinner after the shower. When asked the following day of observation on 9/7/22, client #5 shared he did eat his dinner meal.

Observation in the group home on 9/7/22 revealed client #5 to consume his breakfast receiving no second servings. Continued observation revealed client #5 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.

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Review of records for client #5 revealed a nutritional evaluation dated 6/5/22. Further review of the nutritional evaluation revealed client #5's current diet is weight loss 1800 calorie, 1 inch consistency, heart healthy, thin, eat/drink only when alert, sit upright 6 minutes after eating, stop eating/drinking if coughing, monitor temp/lung sounds for change, eat slowly, no straws, small sips, alternate food then liquids and stop eating if sighs of choking. Review of client #5's 6/14/22 person-centered plan (PCP) alerts a change in diet with a recent medical event to a PUREED diet with thin liquids with choking/aspiration precautions/eating guidelines to remain the same as previously listed.

F. Observation in the group home revealed client #6 to be served with hand over hand assistance by staff C several large spoons full of rice, a regular portion of green peas, chicken, water and apple juice. Continued observations revealed client #6 to get seconds of rice, chicken and gravy.

Observation in the group home on 9/7/22 revealed client #6 to consume his breakfast receiving no second servings. Continued observation revealed client #6 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores.

Review of records for client #6 revealed a nutritional evaluation dated 3/3/21. Further review of the nutritional evaluation revealed client #6's current diet is regular, hearth healthy, high fiber, seconds of vegetables only, cut food into 1/2 inch pieces with hand over hand assistance as needed.

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| W 460 | Continued From page 21<br>Interview with the facilities nurse on 9/7/22 verified the nutritional assessments are current for each client. Continued interview with the nurse verified staff should follow the diet orders and precautions identified for each client. | W 460 | | |