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	34G065	A. BUILDING ______ B. WING ______	10/25/2022

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W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to ensure 1 of 3 audit clients (#5) consumed all his prescribed medications. The finding is: During morning medication administration in the home on 10/25/22, client #5 accidentally dropped his Lisinopril/HCTZ pill on the floor while pushing it out of the bubble pack. Further observations revealed Staff A did not have client #5 push out another Lisinopril/HCTZ pill from the bubble pack. Staff A then proceeded to have client #5 put up his container of pills. Additional observations revealed even after the Site Manager (SM) explained to Staff A that client #5 should be given a replacement pill, Staff A was observed letting client #5 finish up his medication administration without getting the replacement pill. It was only after being told by the SM for a second time to give client #5 a replacement pill, did Staff A do it. Immediate interview revealed Staff A was going to let his manager know one of client #5's pills dropped on the floor. When asked if client #5 was going to get a replace pill, Staff A stated, "He won't get another one until the next day". During an interview on 10/25/22, the SM explained to the surveyor client #5 should be given a replacement of his Lisinopril/HCTZ pill, before Staff A was verbally cued by both him and the surveyor.	W 189		

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 189	Continued From page 1 During an interview on 10/25/22, the facility's nurse stated "absolutely" a replacement pill should always be given. During an interview on 10/25/22, the Qualified Intellectual Disabilities Professional (QIDP) stated staff have been trained to ensure they are giving replacement pills to the clients.	W 189		
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 1 of 3 audit clients (#6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of medication administration. The finding is: During morning medication administration in the home on 10/25/22 at 7:22am, Staff A spoon fed client #6 his medications. Additional observations revealed Staff A did not prompt client #6 to spoon fed himself his own medications.	W 249		

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W 249	Continued From page 2 During an interview on 10/25/22, Staff A stated he spoon fed client #6 his medications because he will spit them out. Further interview revealed if client #6 spits out his medications the staff will have to fill out a form indicating a pill or pills were spit out. Review on 10/24/22 of client #6's IPP dated 12/17/21 indicated he can feed himself. During an interview on 10/25/22, the Site Manager stated staff should not be feeding client #6 his medications. During an interview on 10/25/22, the facility's nurse revealed client #6 can feed himself his own medications. Further interview revealed staff should be giving client #6 as much independence as possible during medication administration. During an interview on 10/25/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 should not have been spoon feed his medications.	W 249		
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 each client received a nourishing, well balanced diet including modified and specially prescribed diet as prescribed. This affected 2 of 3 audit clients	W 460		

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W 460	Continued From page 3	W 460		

(#4 and #6). The finding is:

A. During dinner observations in the home on 10/24/22 at 6:34pm, both clients #4 and #6 received whole hamburgers. Further observations revealed clients #4 and #6 taking bites bigger than bite size. At no time were either client #4's or #6's prompted to cut up their food.

Review on 10/24/22 of client #4's Individual Program Plan (IPP) dated 1/6/22 stated, "Diet: regular bite sized pieces diet, not to exceed 1 inch ...."

Review on 10/24/22 of client #6's IPP dated 12/17/21 revealed, " ...bite sized pieces ...."

Review on 10/24/22 of the homes' Diet List dated 7/5/22 revealed, "[Client #4] Bite Size Pieces."

Review on 10/24/22 of the homes' Diet List dated 7/5/22 revealed, "[Client #6] Bite Size Pieces."

During an interview on 10/25/22, the Site Manager (SM) indicated both clients #4 and #6 hamburgers should have been cut up into bite size pieces.

During an interview on 10/25/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed both clients #4 and #6 hamburgers should have been cut into bite sized pieces.

B. During breakfast observations in the home on 10/25/22 at 6:37am, client #4 was not offered anything to drink. Further observations revealed another client took client #4's cup and used it to drink coffee out of. At no time was client #4 offered another cup, so he could have something

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W 460	Continued From page 4 to drink with his breakfast. During an interview on 10/25/22, the SM stated he did not notice that client #4 did not have anything to drink during his breakfast, During an interview on 10/25/22, the QIDP revealed client #4 should have received something to drink during breakfast.	W 460		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section	W 508		

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W 508	Continued From page 5 do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	W 508		

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W 508	Continued From page 6 as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received	W 508		

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monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
(ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure that 100 percent of their staff have been vaccinated or had an approved exemption against COVID-19. The finding is:

During review on 10/25/22 of the facility's COVID-19 vaccination information, it was discovered that one staff had not been vaccinated or approved for an exemption.

Review on 10/25/22 of the facility's COVID-19 Vaccine Immunization Requirements for Staff in ICFs/IDD dated 1/28/22 stated, "The documentation of all vaccinations will be maintained and available to serve as proof of compliance and presented on demand to regulatory bodies". Further review revealed, "The following exemptions are permitted in accordance with federal law ...Exemption requests will be processed through the Operation's HR representative".

During an interview on 10/25/22, the Site

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W 508	Continued From page 8 Manager confirmed one staff did not provide the paperwork for the exemption from the COVID-19 vaccination. During an interview on 10/25/22, the Qualified Intellectual Disabilities Professional (QIDP) stated there was one staff who did not provide the paperwork for an exemption from the COVID-19 vaccination. Further interview revealed the staff was planning on filing out the paperwork, but it still had to be approved with the facility's Human Resource office.	W 508		