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W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) 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 reviews and interviews, the facility failed to ensure written informed consent was obtained from the guardian for restrictive programs. This affected 3 of 4 audit clients (#1, #3 and #5). The findings are: A. Review on 2/13/23 of client #1's Behavior Support Plan (BSP) dated 8/9/22 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the BSP identified the use of Fluvoxetine, Aripiprazole and Guanfacine. Further review of the record did not include a written informed consent for the BSP from client #1's guardian. Interview on 2/14/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed a written informed consent for client #1's BSP had not been obtained from his guardian. B. Review on 2/13/23 of client #3's BSP dated 9/5/22 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the BSP included the use of Luvox, Zyprexa, Remeron, Seroquel and Ativan. Further review of the record did not include a written informed consent for the BSP from client #3's guardian. Interview on 2/14/23 with the QIDP confirmed a written informed consent for client #3's BSP had	W 263		

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 263	Continued From page 1 not been obtained from his guardian. C. Review on 2/13/23 of client #5's BSP dated 11/1/22 revealed an objective to exhibit 2 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the BSP identified the use of Risperidone, Zydis and Olanzepine. Further review of record did not include a written informed consent for the BSP from client #5's guardian. Interview on 2/14/23 with the QIDP confirmed a written informed consent for client #5's BSP had not been obtained from his guardian.	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 reviews and interviews, the facility failed to ensure techniques to manage behaviors were included in a formal active treatment program. This affected 2 of 4 audit clients (#3 and #5). The findings are: A. Review on 2/13/23 of client #3's Behavior Support Plan (BSP) dated 9/5/22 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the BSP included the use of Luvox, Zyprexa, Remeron, Seroquel and Ativan. Further review of client #3's physician's orders dated 11/10/22 identified an order for Belsomria 20mg to be given daily at bedtime.	W 288		

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Interview on 2/24/23 with the facility's nurse indicated the Belsomria was ordered to assist client #3 with sleeping at night.

Interview on 2/14/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 receives Belsomria at bedtime for sleep; however, the medication is not included in a formal active treatment plan.

B. During observations in the home throughout the survey on 2/13 - 2/14/23, two bathrooms located in a back hallway of the home did not contain any toilet paper. One client was noted to remove a roll of toilet paper from his bedroom and take into the bathroom when he needed it.

Interview on 2/14/23 with Staff C revealed they do not keep toilet paper in the bathrooms because client #3 will stuff the toilet paper down the toilet and is obsessed with the bathroom.

Review on 2/14/23 of client #3's Behavior Support Plan (BSP) dated 9/5/22 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive months. The plan addressed inappropriate behaviors of polydipsia, pica, wandering off, self-injurious behaviors, severe disruption, aggression, property destruction and making responsible choices. Additional review of the BSP did not include a technique of removing toilet paper from bathrooms to address client #3's inappropriate behaviors.

Interview on 2/14/23 with the QIDP confirmed toilet paper had been removed from the bathrooms to address client #3's stuffing tissue down the toilet. Additional interview confirmed

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W 288	Continued From page 3	W 288		

this technique was not included in a formal active treatment plan.

C. During observations in the home and at the day program throughout the survey on 2/13 - 2/14/23, client #3 was provided with one-to-one staffing with a single staff person assisted to him throughout the day.

Interview on 2/14/23 with Staff A indicated client #3 has a one-to-one staff person assigned to him each day.

Review on 2/14/23 of client #3's BSP dated 9/5/22 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the plan did not identify an assigned one-to-one staff person for client #3.

Interview on 2/14/23 with the QIDP confirmed client #3 has an assigned one-to-one staff; however, this was not included in his current BSP.

D. Review on 2/13/23 of client #5's BSP dated 11/1/22 revealed an objective to exhibit 2 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the BSP identified the use of Risperidone, Zydis and Olanzepine. Further review of client #5's physician's orders dated 11/10/22 identified an order for Melatonin 5mg to be given daily at bedtime.

Interview on 2/14/23 with the QIDP confirmed the Melatonin was not included in a formal active treatment plan for client #5.

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W 340	Continued From page 4	W 340		
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 observations, record reviews, and interviews, the facility failed to ensure staff were sufficiently trained to implement visitation protocols and procedures regarding COVID-19 and facility policies for wearing the appropriate type of face mask. The findings are: A. Upon arrival to the home on 2/13/23 at 3:35pm and 2/14/23 at 6:30am, the surveyor's temperature was taken; however, no COVID-19 screening questions were asked. Review on 2/14/23 of the facility's COVID-19 visitor screening form revealed the visitor's temperature should be taken and five questions regarding their exposure to COVID-19 should be asked. Interview on 2/14/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all visitors to the home should be screened for COVID-19 including having their temperature taken and asked the five screening questions. B. During observations at the day program throughout the survey on 2/13 - 2/14/23, Staff J wore a cloth face mask covering her nose and mouth while interacting with various staff and clients.	W 340		

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W 340	Continued From page 5 Review of the facility's employee proof of vaccination against COVID-19 records revealed Staff J had an approved religious exemption from the vaccination dated 12/1/21. Additional review of the facility's Request for Religious Exemption instruction form noted, "I understand that if I am granted exemption from the vaccination requirement, I will be subject to additional precautions intended to mitigate the transmission and spread of COVID-19 for Staff who are not fully vaccinated, and I must comply with all other applicable universal infection control as well as the additional precautions for Staff who are not fully vaccinated. Additional precautions may include but are not limited to source control measures such as wearing an N95 mask at all times while on CBC premises..." Interview on 2/14/23 with the Regional Director confirmed Staff J had been approved for a religious exemption and was not vaccinated against COVID-19. Additonal interview confirmed the staff should be wearing a N95 mask; however, no N95 masks had been provided by the facility.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all drugs were administered in accordance with physician's orders. This affected 1 of 3 clients (#1) observed receiving medications. The finding is:	W 368		

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W 368	Continued From page 6 During observations in the home on 2/14/23 at 7:08am, client #1 ingested Miralax powder (17 grams) along with four other medications. During the observation, the client was prompted to pour a cup of water. The client filled a 3 - 4 oz plastic cup with water, added the Miralax, stirred the powder and consumed it with his other medications. Immediate interview with the medication technician (Staff A) revealed the plastic cup was approximately 3 - 4 oz in size. Additional interview indicated larger cups were available in the home but they like using the smaller cups for medication administration. Review on 2/14/23 of client #1's physician's orders dated 11/9/22 identified an order for Miralax powder (17 grams) to be dissolved in "8 oz of water" twice a day. Interview on 2/14/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's order for Miralax powder to be mixed in 8 oz of water was current and should have been implemented as written.	W 368		
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 review and	W 436		

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W 436	Continued From page 7 interviews, the facility failed to ensure client #3 was furnished with eyeglasses as indicated. This affected 1 of 4 audit clients. The finding is: During observations throughout the survey on 2/13 - 2/14/23, client #3 did not wear eyeglasses. The client was not prompted or assisted to wear eyeglasses. Interview on 2/14/23 with Staff C revealed client #3 does not wear eyeglasses. Review on 2/13/23 of client #3's record revealed he received an examination of his vision on 8/24/22. The report noted, "...Glasses needed...Glasses prescribed." Interview on 2/14/23 with the facility's nurse confirmed client #3 was prescribed eyeglasses at his vision exam; however, she could not be sure if the eyeglasses had been ordered.	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 each client's diet was followed as indicated. This affected 2 of 4 audit clients (#3 and #4). The findings are: A. During dinner observations in the home on 2/13/23 at 5:40pm, client #3 consumed a turkey	W 460		

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burger patty on a bun. The sandwich was not cut up. Client #3 consumed the sandwich without difficulty.

Observation of a diet list posted on the refrigerator in the kitchen of the home revealed client #3's food should be in bite size pieces.

Interview on 2/13/23 with Staff D revealed they follow each client's diet posted on the refrigerator.

Review on 2/13/23 of client #3's Nutritional Evaluation dated 10/4/22 revealed he consumes a regular diet with food cut into bite size pieces.

Interview on 2/14/23 with the Qualified Intellectual Disabilites Professional (QIDP) confirmed client #3's food should be in bite size pieces as indicated.

B. During dinner observations in the home on 2/13/23 at 5:50pm, client #4 consumed a turkey burger patty and bun, vegetable soup, peaches and crackers. Closer observation of the turkey burger on his plate revealed it contained visible pieces of meat and excess liquid pooling around the meat. Client #4 consumed his meal without difficulty.

Interview on 2/13/23 with Staff D revealed client #4 consumes pureed meats with other food items at a ground consistency.

Review on 2/14/23 of client #4's Nutritional Evaluation dated 3/12/22 revealed he consumes a heart healthy regular diet, with ground texture and pureed meats.

Interview on 2/14/23 with the QIDP confirmed

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W 460	Continued From page 9 client #4's meats should be pureed which would mean no lumps or visible pieces of food.	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 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	W 508		

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W 508	Continued From page 10 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 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	W 508		

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W 508	Continued From page 11 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 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	W 508		

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W 508	Continued From page 12 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 interview, the facility failed to ensure proof of vaccinations against COVID-19 or an approved exemption was provided for all staff at the facility. The finding is: Review on 2/14/23 of the facilty's employee COVID-19 vaccination records revealed at least two contract staff had not provided proof of vaccination for COVID-19 or an approved medical or religious exemption. Review on 2/14/23 of the facility's COVID-19 Vaccination Program (no date) revealed, "By no later than December 5, 2021, all Staff must present proof of having received the one-dose COVID-19 vaccine or the first does of a multi-dose COVID-19 vaccine unless a vaccination exemption, or temporary delay as recommended by the Centers for Disease Control and Prevention (CDC), has been approved." Interview on 2/14/23 with the Regional Director confirmed two contract staff currently employed by the facility have not provided proof of vaccination or an approved exemption against COVID-19 as of the date of the survey.	W 508		