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W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure assessments for 1 of 5 audit clients (#1) was accurate. The finding is: Record review on 3/27/23 of client #1's Occupational Therapy (OT) Update from 2/8/23 revealed client #1 was prescribed a mechanical ground/high fiber with honey-thick liquids. The OT revealed staff reported client #1 coughed up his medications and coughed during meals. During the meal observation, the OT revealed he received ground chicken and ground biscuit that appeared dry along with drinks that were slightly thickened. Client #1 had frequent coughing episodes during the meal observation on 4/6/22. An additional record review on 3/28/23 of client #1's Occupational Therapy Update from 4/6/22 revealed client #1 was prescribed a pureed/high fiber diet with honey-thick liquids. The OT revealed staff reported client #1 coughed up his medications and coughed during meals. During the meal observation, the OT revealed he received ground chicken and ground biscuit that appeared dry along with drinks that were slightly thickened. Client #1 had frequent coughing episodes during the meal observation on 4/6/22. Interview on 3/28/23 with the OT revealed that on the 2/8/23 OT update, she copied and pasted the previous year's report and forgot to delete the paragraph of last year's meal observation. The	W 111		

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

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W 111	Continued From page 1 OT acknowledged that client #1 was on a different diet and she did not have report or observations of him coughing during his meals or when taking medication.	W 111		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in medication administration, preparing modified meals to the correct consistency as well as knowledge on the risks of aspiration. This affected 4 of 5 (#1, #4, #5 and #6) audit clients. The findings are: A. During medication administration observations in the home on 3/27/23 at 4:19 PM, Staff C removed a locked container from the medication cabinet that secured controlled medications. Staff C attempted to give client #4 Lorazepam, however the pill was missing for 3/27/23. Staff C notified the nurse and was given instruction to use the Lorazepam for 3/28/23. The medication was given to client #4 at 4:27 PM. Review on 3/27/23 of client #4's Physician's Orders, signed 2/27/23 revealed a prescription for Lorazepam 0.5 MG for 4:00 PM. Interview on 3/27/23 with Staff C revealed she was supposed to count off the controlled medications with the 1st shift staff, but Staff A had left before she arrived at work at 4:00 PM.	W 192		

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Interview on 3/27/23 with the Home Manager (HM) revealed staff administering medications were trained to count off the controlled medications, at the end of their shift.

B. During medication administration observations in the home on 3/27/23 from 4:05 PM until 5:00 PM, Staff C left a container of yogurt, on the medication counter, without maintaining cold temps. The yogurt was given to client #5 at 4:57 PM.

Interview on 3/28/23 with Nurse 1 revealed she did not discuss maintaining cold temps of perishable foods used during medication administration when she orientates new staff.

C. During morning observations on 3/28/23 at 8:23 AM, the HM asked client #1 to interrupt his breakfast so that he could receive his medications. The surveyor followed client #1 into the medication room a minute later and observed Staff A had already opened up 7 blister packs of medications, Ca Cit/Vit D, Dipyridamole, Divalproex, Gabapentin, Levocarnitine, Omeprazole and Tamsulosin and already had them in a medicine cup and was using the device to crush the medications into a powder. Staff C handed the surveyor a bottle of Ocuvite Eye Chew Health and Megestrol Acetate Oral Susp and said that she gave them to client #1 before she crushed the medications. At 8:25 AM, the surveyor watched client #1 ingest the crushed medications and have Calcitoni-Salmon Nasal Spray, inserted up one nostril. On the box of the nasal spray, there was a sticker that read "Date Opened" and there was no date recorded. On the box, the sticker was dated 2/8/23 and it revealed that the nasal spray should be discarded 35 days

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after opening.

Interview on 3/28/23 with the HM revealed staff have been trained to open the medication in the presence of the client. The HM could not determine if the nasal spray was in the original package, thus exceeding 35 days or if it had been refilled because the box was not dated by any of the staff administering medications.

Interview on 3/28/23 with Nurse 1 acknowledged she did not know if the medication had been refilled by examining the box, since it was not dated. Nurse 1 revealed she had to pull pharmacy records and was able to determine the Calcitoni-Salmon Nasal Spray was refilled on 3/7/23 and delivered to the home on 3/9/23,

D. During observations in the home on 3/27/23 at 4:15 PM, client #1 received a snack to eat and pudding during medication administration at 4:35 PM, before Staff D and the HM placed him in the bed, without the head of the bed elevated.

Review on 3/27/23 of client #1's Modified Barium Swallow study on 5/10/22 revealed he was a moderate to severe aspiration risk. It was recommended that client #1 sit up for 30-60 minutes after meals.

Interview on 3/28/23 with the Occupational Therapist revealed client #1 was an aspiration risk and should sit up for at least 30-60 minutes after eating.

Interview on 3/28/23 with Nurse 1 revealed client #1 had dysphagia and should sit up anytime after he eats. Nurse 1 acknowledged that she did not emphasize in her training with staff, that client #1

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W 192	Continued From page 4 should sit up after he ate snacks. E. During observations at the day program and home throughout the survey 3/27/23 - 3/28/23, the HM was present and instrumental in the modification of the client #1 and #5's meals. The HM was observed to add liquid to the food content before blended, but the pureed food was not blended consistently to a smooth, lump free texture. Staff F prepared oatmeal on 3/28/23 for breakfast for clients #1 and #5 and did not achieve a smooth blended consistency for clients on a pureed diet. Review on 3/27/23 of client #1's diet revealed on 5/10/22 a Modified Barium Swallow study recommenced a pureed consistency diet. An additional review on 3/27/23 of client #5's nutritional evaluation dated 5/6/22 recommended a regular pureed consistency diet. Interview on 3/28/23 with the HM revealed that she thought she was preparing a pureed consistency diet for clients #1 and #5. The HM revealed the proper technique had not been demonstrated for her or the staff. Interview on 3/28/23 with Nurse 1, Nurse 2 and the OT revealed they do not train staff on how to modified diets that it should be demonstrated by the Dietician. F. During observations in the home on 3/27/23 at 4:15 PM, Staff C was present in the medication room with client #1 when the surveyor heard client #1 wheeze after eating a snack, ingest crushed medications and drink honey thickened liquid. Staff C remarked to the surveyor that she heard client #1 wheeze, but she did not inform	W 192		

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W 192	Continued From page 5 the HM or the Nurse. Review on 3/27/23 of client 1's Physician's Orders signed 2/27/23 revealed he had a prescription for Ipratropium/Sol Albuter to be used as needed coughing, due to diagnosis of asthma. An additional review on 3/28/23 of the Nurse's Note signed 2/2/23 revealed client #1 had been coughing and staff had reported audible wheezing. Client #1 was given a nebulizer treatment and a verbal order given for a chest x-ray. Interview on 3/28/23 with the HM revealed she was unaware that Staff C heard client #1 wheeze while giving him medication yesterday. The HM revealed that she was on the phone with the nurse on 3/27/23 at 5:00 PM and would have requested a nebulizer treatment because client #1 had needed it last month when he became congested. Interview on 3/28/23 with Nurse 1 revealed she was not informed by Staff C that she overheard client #1 wheeze on 3/27/23. Nurse 1 revealed that staff are trained to report any changes with breathing to her and the HM. Interview on 3/28/23 with the Administrator revealed today she became aware that there have been some communication issues between staff and that they were gathering material to retrain staff.	W 192		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs.	W 331		

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W 331	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that 1 of 5 (#1) audit clients medication was clarified with the prescriber to prevent swallowing difficulties. The finding is: During morning observations on 3/28/23 at 8:25 AM, Staff A was standing out the counter crushing some of client #1's medications. Staff A presented three separate medications that she gave to client #1 without the surveyor present, that included a bottle of Ocuvite Eye Chew Health, that were gummies. Review on 3/28/23 of client #1's Physician's Orders from 2/27/23 revealed he had Barrett's Esophagus, that he was an aspiration precaution and was on a pureed consistency diet. An order had been written for Ocuvite Eye Chew Health on 7/9/19. An additional review of client #1's Modified Barium Swallow Study on 5/10/22 revealed his diet was changed from ground consistency to pureed consistency with honey thickened liquids. Interview on 3/28/23 with Staff A revealed that she was aware that client #1 was on a pureed diet and crushed his medications before giving to him. Staff A revealed that when she gave client #1 the Ocuvite Eye Chew Health, a gummie, he chewed a little before swallowing it. Interview on 3/28/23 with Occupational Therapist (OT) revealed client #1 had a swallow delay which meant that his muscles do not work quickly. The OT stated she did not think the form of a gummie could be modified, plus it stuck to the mouth, did not dissolve and would be	W 331		

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W 331	Continued From page 7 swallowed in chunks. Interview on 3/28/23 with Nurse 1 revealed that she did not know a technique to crush Ocuvite Eye Health Chew, a gummie, prescribed to client #1. Nurse 1 suggested that maybe the gummie could be mashed before client #1 swallowed it. Nurse 1 acknowledged that she was aware that client #1 was an aspiration risk and was on a pureed consistency diet. Nurse 1 revealed she did not question client #1's order for a chewable medication because the physician wrote the order and had a list of his diagnoses.	W 331		
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 observations, record review and staff interviews, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 2 of 5 (#1 and #6) audit clients. The findings are: A. During morning observations in the home on 3/28/23 at 7:17 AM, Staff A poured Miralax powder to the 1st line in the cap, below the 17G (grams) indicator. The powder was mixed in 4 ounces of water and given to client #5 to drink. Review on 3/28/23 of client #6's Physician's Order signed 2/27/23 revealed a prescription for Miralax with instructions to mix 17 grams (1 capful) in 4-8 ounces of water and take by mouth. Interview on 3/28/23 with Nurse 1 revealed Staff A	W 368		

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W 368	Continued From page 8 was newly trained to administer medications and she observed her a few weeks ago. Nurse 1 revealed Miralax 17 grams should be poured to the top of the white line in the cap, underneath the purple rim. The Nurse revealed the arrow inside of the cap, should be the guide to pour the powder until the white and purple lines meet. B. During morning observations in the home on 3/28/23 at 8:22 AM, client #1 had started to consume part of his breakfast when the Home Manager (HM) asked for him to go take his medications. Client #1 stopped eating and went immediately into the medication room with Staff A. An additional observation at 8:25 AM, Staff A gave client #1 Omeprazole 20MG and Tamsulin 0.4MG to ingest. Staff A was not observed giving client #1 Linzess 145 MCG. Review on 3/28/23 of client #1's Physician's Orders signed 2/27/23 revealed a prescription for Omeprazole 20MG to take before breakfast at 7:30AM; Tamsulin 0.4MG give 30 minutes after breakfast and Linzess 145MCG at 8:00AM. Interview on 3/28/23 with Nurse 1 revealed Staff A recently received her orientation on medication administration and she had observed her a few weeks ago. Interview on 3/28/23 with the Administrator revealed she has just become aware that there has been some communication problems with client #1 and they will in-service staff.	W 368		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to-	W 441		

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W 441	Continued From page 9 This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that fire drills were conducted with varying times and conditions. The finding is: Review on 3/27/23 of the facility's fire drill reports from 3/31/22 to 3/20/23. Second Shift: 6/1/22 at 7:56 PM 8/14/22 at 7:02 PM 11/14/22 at 6:36 PM 2/13/23 at 6:33 PM Third Shift: 3/31/22 at 1:12 AM 12/30/22 at 1:10 AM 3/20/23 at 1:06 AM Interview on 3/28/23 with the Home Manager (HM) revealed that she reviewed the monthly fire drills and staff had been trained to vary the times of the drills. The HM revealed that she has a staff to come in on third shift, just to conduct the drill.	W 441		
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 staff interviews, the facility failed to ensure that	W 460		

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modified diets were prepared to the correct consistency for 2 of 5 (#1 and #5) audit clients. The findings are:

A. During lunch observations at the day program on 3/27/23 at 12:30 PM, the Home Manager (HM) gave client #1 a mechanically soft serving of green peas, a pasta dish containing a brown meat and tomato sauce and vanilla pudding for desert. The food was not blended smooth. Client #1 consumed the meal without incident.

During snack observations in the home on 3/27/23 at 4:18 PM, the HM assisted client #1 to prepare crackers in the food processor that had a "soupy" texture and still had noticeable cracker flecks in the mixture. The crackers had been blended for 10 seconds, with liquid added. Client #1 was observed to wheeze one time when drinking a thickened liquids after taking his medication at 4:15 PM.

During dinner observations in the home on 3/27/23 at 6:30 PM, the HM assisted client #1 to prepare baked skinless/boneless chicken breast, great northern beans and cooked carrots. The chicken resembled chicken salad and was not blended smooth, without lumps. Client #1 consumed the meal without incident.

During morning observations in the home on 3/28/23 at 8:35 AM, Staff F prepared oatmeal with milk added, then blended in the food processor for 45 seconds. The mixture remained grainy, clumped and was not blended smooth. Client #1 consumed the meal without incident.

Review on 3/27/23 of client #1's Modified Barium Swallow study on 5/1022 revealed he was on a

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high fiber pureed diet with honey thickened liquids.

Interview on 3/28/23 with the HM revealed that she was unaware that client 1's food was not considered blended smooth.

Interview on 3/28/23 the Occupational Therapist confirmed client #1 had dysphagia, was an aspiration risk and his food needed to be blended smooth with liquids resting 2 minutes after thickener is added. The OT revealed that she does not demonstrate food consistency with the staff, it would be done by the dietician.

B. During lunch observations at the day program on 3/27/23 at 12:30 PM, client #5 received mechanically soft green peas, with the shell of the peas still intact, a pasta dish with brown meat and a tomato sauce. The meal was lumpy and not processed until blended smooth. Client #5 was also given sugar-free jello for dessert. Client #5 eats a very slow pace. Client #5 consumed the meal without incident.

During snack observations in the home on 3/27/23 at 4:13 PM, the HM assisted client #5 to blend 4 grilled cheese crackers with lactose free milk in the food processor briefly. The finished texture was soft but grainy; it was not blended smooth.

During dinner observations in the home on 3/27/23 at 6:23 PM, the HM assisted client #5 to blend her baked, boneless/skinless chicken breast in a food processor. The food resembled chicken salad and was not blended smooth, without lumps. Client #5 also received ice cream, stirred to a liquid form by the HM for dessert.

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W 460	Continued From page 12 Client #5 eats a very slow pace. Client #5 consumed the meal without incident. During breakfast observations in the home on 3/28/23 at 8:15 AM, Staff E prepared the cooked oatmeal and added milk when blending. The oatmeal appeared sticky and clumped, similar to the texture of prepared tuna salad. Client #5 consumed the meal without incident. Review on 3/27/23 of client #5's nutritional evaluation dated 5/6/22 revealed she was prescribed a regular diet with pureed consistency. Interview on 3/28/23 with the HM revealed that she was unaware that they were not preparing a smooth and blended meal for clients on a pureed consistency diet. Interview on 3/28/23 with Nurse 2 revealed a pureed consistency was free of lumps. An additonal interview with Nurse 1 revealed that she had not considered if clients on a pureed consistency should receive ice cream and jello products because they were soft foods. Nurse 1 revealed she had not considered that both jello and ice cream liquefies when consumed.	W 460		