STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to review and maintain a copy of their emergency preparedness (EP) plan; as well as make it accessible for all staff to review. The finding is: Record review on 9/6/23 revealed the facility did not have a hard copy of their EP or an electronic copy of their complete EP. Further, some documents revealed EP policies were drafted in 2018, yet performed disaster drills and table top activities in 2023. Interview on 9/6/23 with the qualified intellectual disabilities professional (QIDP) revealed not having access to the EP plan has been a repeated problem. The QIDP also acknowledged he had not been asked to review the EP or train staff on the policies and procedures.	E 004		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 2	E 022		

policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

[(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].

*[For Inpatient Hospices at §418.113(b):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(i) A means to shelter in place for patients, hospice employees who remain in the hospice.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to develop a shelter in place policy for the emergency preparedness (EP) plan. The finding is:

Review on 9/5/23 of the facility's EP revealed the qualified intellectual disabilites professional (QIDP) only had a copy of a Table Top exercise he conducted in February, 2023 and disaster drills. The two newest employees, Staff A and Staff B did not receive any training. In addition, the facility did not have a policy on sheltering in place for review.

Interview on 9/6/23 with the QIDP revealed he did not have a copy of the shelter in place policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 3 was not given information from management how to get the plan, after making requests. The QIDP acknowledged there was an "Active Shooter" manhunt in the community last week, however they were not asked to lockdown.	E 022		
W 207	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(2) Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure, the individual program plan (IPP) meeting was attended by the members of the interdisciplinary (IDT) team for 1 of 3 audit clients (#6). The finding is: Record review on 9/6/23 of client #6's annual assessments revealed there were no current records of reviews by the speech language therapist, dietician or occupational therapist. The IPP was in draft form and was completed by the QIDP on 8/16/23. There were no signatures of any IDT professionals on the document. Interview on 9/6/23 with the QIDP confirmed the facility had been challenged by staffing and he had not met all of the IDT team members. The QIDP also acknowledged the guardian had recently been working outside of the country.	W 207		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 3 audit	W 217		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 217	Continued From page 4 clients (#6) received an annual nutritional evaluation. The finding is: During morning observations on 9/6/23 at 9:00 am, client #6 ate bite size pieces of toast and sausage for breakfast. Review on 9/5/23 of client #6's electronic records revealed there was no nutritional evaluation available to review. Further review of the annual nurse assessment dated on 6/19/23 revealed the dietician prescribed a regular calorie diet. Interview on 9/6/23 with the QIDP revealed he had never seen a nutritionist come to the home to assess client #6. The QIDP acknowledged client #6 received bite size pieces of food, at the guardian's request.	W 217		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plan (BSP) for 1 of 3 audit clients (#1) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 9/6/23 of client #1's BSP, updated November 2022, revealed the following objectives: By 10/31/23, client #1 will decrease physical aggression at his residence to ten or less	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 5	W 262		

incidents per month for nine of twelve months.
By 10/31/23, client #1 will decrease incidents of physical aggression at Life Options to zero incidents per month for six of twelve months.
By 10/31/23, client #1 will reduce incidents of self-injurious behavior at his residence to six or less per month for ten of twelve months.
By 10/31/31, client #1 will reduce incidents of self-injurious behavior at Life Options to one or less incidents per month for seven of twelve months.
By 10/31/23, client #1 will decrease his frequency of unsafe behavior during meals at residence to one or less incidents per month for eight of twelve months.

Further review revealed client #1's target behaviors to include aggression toward others, self-injurious behavior to include biting himself, and throwing items, or attacking others, during home meals. Interventions included communication, scheduling, mealtime, and calming supports as preventative measures for behaviors. Mealtime supports included "intermission" time away from others during meals. Additional restrictive interventions included the following:
If aggressive in the community, the outing will be terminated, and client #1 will return home.
Restriction from metal eating utensils until client #1 refrains from unsafe behavior during meals for seven consecutive days.
Client #1's CD player and party light should to be restricted to bedtime use only. Support professionals should put them away after he gets up for good in the morning. If he gets up way early for 1st breakfast and then goes back to sleep, it is okay for them to stay in his bedroom at this time. When he is up for the day, they should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 6 be moved to their designated location (currently the Shadylawn staff office). Client #1's cello and violin (and any other instruments he may get in the future) will only be used in the main common room when client #1 is giving "a concert." His keyboard will stay in his bedroom at this time but as it may be too big for him to throw. If he does attempt to throw it, support professionals should remove it from his bedroom until he is calm and document in his behavior data and a t-log that it was temporarily removed. Review on 9/6/23 of the client #1's physician's order revealed Prozac and Thorazine for behaviors with Melatonin and Thorazine PRN for sleep. Review on 9/6/23 of client #1's BSP consent information revealed no evidence that client #1's BSP had been reviewed, approved or monitored by the HRC. Interview on 9/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the BSP had been approved. However, the QIDP could not locate HRC documentation.	W 262		
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 review and interview, the facility failed to ensure written informed consent was obtained for restrictive Behavior Support Plans	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 7 (BSPs) for 3 of 3 audit clients (#1, #3, and #6). The findings are: A. Review on 9/6/23 of client #1's BSP, updated November 2022, revealed the following objectives: By 10/31/23, Paul will decrease physical aggression at his residence to ten or less incidents per month for nine of twelve months. By 10/31/23, Paul will decrease incidents of physical aggression at Life Options to zero incidents per month for six of twelve months. By 10/31/23, Paul will reduce incidents of self-injurious behavior at his residence to six or less per month for ten of twelve months. By 10/31/31, Paul will reduce incidents of self-injurious behavior at Life Options to one or less incidents per month for seven of twelve months. By 10/31/23 Paul will decrease his frequency of unsafe behavior during meals at residence to one or less incidents per month for eight of twelve months. Further review revealed client #1's target behaviors to include aggression toward others, self-injurious behavior to include biting himself, and throwing items, or attacking others, during home meals. Interventions included communication, scheduling, mealtime, and calming supports as preventative measures for behaviors. Mealtime supports included "intermission" time away from others during meals. Additional review of client #1's BSP revealed restrictive interventions to include the following: If aggressive in the community, the outing will be terminated, and client #1 will return home.	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 8 Restriction from metal eating utensils until client #1 refrains from unsafe behavior during meals for seven consecutive days. Client #1's CD player and party light should to be restricted to bedtime use only. Support professionals should put them away after he gets up for good in the morning. If he gets up way early for 1st breakfast and then goes back to sleep, it is okay for them to stay in his bedroom at this time. When he is up for the day, they should be moved to their designated location (currently the Shadylawn staff office). Client #1's cello and violin (and any other instruments he may get in the future) will only be used in the main common room when client #1 is giving "a concert." His keyboard will stay in his bedroom at this time but as it may be too big for him to throw. If he does attempt to throw it, support professionals should remove it from his bedroom until he is calm and document in his behavior data and a t-log that it was temporarily removed. Review on 9/6/23 of the client #1's physician's order revealed Prozac and Thorazine for behaviors, as well as Melatonin and Thorazine PRN for sleep. Review on 9/6/23 of client #1's BSP consent information revealed no evidence that client #1's BIP had been reviewed or approved by client #1's guardian. Interview on 9/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the BSP had been approved with consent signed on 9/5/23. However, the QIDP could not locate consent documentation.	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	901 SHADYLAWN DR CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 9 B. Review on 9/6/23 of client #3's BSP, updated November 2022, revealed an objective by 10/31/23, client #3 will exhibit zero incidents of interfering anxiety at his residence per month for eleven of twelve months. Further review revealed client #3's target behaviors to include anxiety. Review on 9/6/23 of client #3's physician's order revealed Zoloft for anxiety behaviors. Review on 9/6/23 of client #3's BSP consent information revealed no evidence that client #3's BIP had been reviewed or approved by client #3's guardian. Interview on 9/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the BSP had been approved. However, the QIDP could not locate consent documentation. C. Review on 9/5/23 of client #6/s BSP developed on 11/8/22 revealed the following objective: By 10/31/23 he will reduce his frequency of physical aggression and property destruction at his residence to five of less incidents per month for ten of twelve months. His target behaviors were identified as physical aggression and property destruction. Medications that were prescribed to aid in managing behaviors were: Trazadone, Memantine (Namenda), and Fluoxetine (Prozac). The medication Melatonin that he took every night was not included in the BSP. Further review of the BSP revealed, client #6's	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G255	A. BUILDING ______ B. WING ______	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADYLAWN	**901 SHADYLAWN DR CHAPEL HILL, NC 27516**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 10 last signed the consent for behavior management interventions was on 12/21/21. Interview on 9/6/23 with the QIDP revealed client #6 parents were "COVID-19 cautious" and avoided entering the home. The QIDP acknowledged he did not mail a copy of the consent to the guardian, to request signature.	W 263		
W 363	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that 1 of 3 audit clients (#6) avoided duplicate drug therapy. The finding is: During morning observations in the home, the other five clients were up and eating breakfast before 8:00am with the exception on client #6. Client #6 remained in bed until after 8:30 am and did not eat breakfast until 9:00 am. Record review on 9/6/23 of client #6's Physician Orders signed on 8/12/23 prescribed Melatonin 5 mg, 30 minutes before bed time and Trazadone 25 mg at 8:00 pm. There were no pharmacy quarterly drug regimen notes to review. Interview on 9/6/23 with the Qualified Intellectual Disabilities Professional offered no explanation for why client #6 was taking two sleep aid agents.	W 363		