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KONNOAK GROUP HOME	**2901 KONNOAK DRIVE** **WINSTON SALEM, NC 27127**

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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.

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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 ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is: Review on 1/30/24 of the facility's EPP revealed that the facility's EPP was last updated 07/19. Interview on 1/31/24 with the qualified intellectual disabilities professional (QIDP) confirmed that the facility does not have an updated EPP.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

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*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training

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E 037	Continued From page 4 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 5 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness (EP) Plan. The finding is: A review of the facility's EP Plan on 01/30/24	E 037		

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E 037	Continued From page 6 revealed no documentation of the annual staff training. Continued review revealed the last training was conducted on 07/23/19. Interview on 1/31/24 with the qualified intellectual disabilities professional (QIDP) confirmed that the facility did not conduct an updated EPP training and testing.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039		

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(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years,

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opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a

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narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant

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emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency

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scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

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E 039	Continued From page 13 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 14 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's	E 039		

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E 039	Continued From page 15 emergency preparedness plan (EPP). The finding is: Review on 1/30/24 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise. Interview on 1/31/24 with the qualified intellectual disabilities professional (QIDP) confirmed the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise.	E 039		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure privacy during treatment and care of personal needs for 1 of 6 clients (#4). The findings is: Observations in the group home during the 1/30/24 - 1/31/24 survey revealed client #4 to spend most of his time in his room with the door closed. Continued observations revealed client #4's window to not have window coverings. Further observations revealed the ability to see inside the client's bedroom from the outside. Interview with the home manager (HM) on 1/30/24 revealed the client has a history of ripping, pulling, damaging all window covering	W 130		

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placed on the client's window and the facility decided not to put up any window coverings in the attempt to decrease the chances of the client pulling them down. Continued interview with the HM revealed the information is listed in the client's behavior plan and that the facility did consider window tinting, however the facility did not have permission to do so due to the home being a HUD home. Further interview with the HM revealed the client has a fence a few feet away from the client's window which helps with providing privacy while receiving treatment and/or personal care.

Review of client's #4 record revealed a behavior support plan (BSP) dated 4/13/23. Continued review of the BSP revealed the following targeted behaviors; verbal/gestural abuse, physical aggression, cooperation difficulty, property destruction, self injurious behavior, inappropriate toileting, and seeking pornography. Further review of the BSP did not address strategies relative to client #4 not having window covering due to his behaviors.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/31/24 revealed that she was not made aware of client #4 not having window covering in his bedroom to ensure privacy. Continued interview with the QIDP revealed the client should have privacy at all times especially during treatment and personal care in his bedroom.

W 247 INDIVIDUAL PROGRAM PLAN (W 247)

CFR(s): 483.440(c)(6)(vi)

The individual program plan must include opportunities for client choice and

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self-management.
This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure that 6 of 6 clients were given opportunities for choice and self-management with respect to family-style dining. The finding is:

Observations in the group home during the dinner meal on 1/30/24 and the breakfast meal on 1/31/24 revealed the staff to prepare all food, place servings of food into bowls, and place each plate, napkin, and fork on the dining room table before clients entered the room. Continued observation revealed clients were not offered the opportunity to make choices with respect to food preferences, choice of utensils, condiments or second helpings. Further observation revealed all clients appear capable of serving themselves, passing dishes, and taking their dishes to the kitchen. Continued observations revealed staff removing dishes from the dining table, cleaning the dining table, washing the dishes, and mopping the dining room floor with no assistance from the clients.

Record review on 1/31/24 revealed current individual program plan (IPPs) and each client has a meal prep goal. Continued record review revealed all clients to have at least some level of independence during self-care, home management and mealtime activities.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/31/24 confirmed that staff were trained on family style dining and meal preparation. QIDP confirmed that each client has some level of independence and can participate in meal preparation.

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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 3 of 3 audit clients (#2, #3, and #4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Support Plan (ISP) relative to meal preparation. The findings are: During survey observations on 1/30/24 from 4:30 PM until 6:15 PM and 1/31/24 from 6:00 AM until 7:55 AM, revealed Staff C to prepare the dinner meal and the home manager was observed to prepare the breakfast meal and wash dishes. At no point during observations were any clients prompted to assist with meal preparation. A. The facility failed to support client #2 with meal preparation. For example: Observations at the group home on 1/30/24 from 4:30 PM - 5:20 PM revealed client #2 to clean his closet, fold clothes and complete a puzzle activity while in his room. Continued observations at 5:30 PM revealed client #2 to participate in dinner, take dishes to the kitchen then sit in the	W 249		

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livingroom. At no time during observations was client #2 prompted to assist with meal preparation.

Morning observations on 1/31/24 at 6:00 AM revealed client #2 to come out of his room, participate in the breakfast meal, then take his dishes to the sink. Continued observations at 6:20 AM revealed client #2 to sit in the livingroom watching Barney on the television until surveyors exited the home at 7:55 AM. At no time during observation was client #2 prompted to assist with meal preparation.

Review of client #2's record on 1/31/24 revealed an individual service plan (ISP) dated 1/3/24. Continued review of the ISP revealed training in the areas of exercise, meal preparation, shower, brush teeth and medication administration. Further review revealed, client #2 will assist with meal preparation 70% independence for 3 consecutive months. This includes selecting item to prepare, select item from the cabinet. place item in proper pot/pan, and name item needed from the menu.

Interview on 1/31/24 with the qualified intellectual disabilities professional (QIDP) confirmed client #2 training objectives are current and should have been prompted to participate in meal preparation.

B. The facility failed to support client #3 with meal preparation.

Observations at the group home on 1/30/24 from 4:30 PM until 6:15 PM revealed client #3 to sit at a table in the activity room, coloring in a book. Continued observations revealed to sit in the

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livingroom at 5:20 PM to 5:40 PM falling asleep until prompted for dinner. At no time during observation was client #3 prompted to assist with meal preparation.

Morning observations on 1/31/24 from 6:00 AM revealed client #3 to come out of the bathroom and participate in the breakfast meal. Continued observations at 6:25 AM revealed staff to escort client #3 to the bathroom. Further observations revealed client #3 to sit at a table in the activity room, coloring in a book until surveyors exited the home at 7:55 AM. At no time during observation was client #3 prompted to assist with meal preparation.

Review of client #3's record on 1/31/24 revealed an individual service plan (ISP) dated 2/24/23. Continued review of the ISP revealed training in the areas of laundry, meal preparation, shower, brush teeth and medication administration. Further review revealed, client #3 will assist with meal preparation 70% independence for 3 consecutive months. This includes selecting item to prepare, select item from the cabinet, place item in proper pot/pan, and name item needed from the menu.

Interview on 1/31/24 with the QIDP confirmed client #3 should have been prompted and engaged in other activies than coloring. Continued interview revealed client #3 should have participated in meal preparation as the training objectives are current.

C. The facility failed to support client #4 with meal preparation.

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Observations at the group home on 1/30/24 from 4:30 PM until 6:15 PM revealed client #4 in his bedroom cleaning his room. Continued observations between 5:20 PM-5:40 PM revealed client #4 moving to and from his bedroom and activity room. Further observations reveal from 5:40 PM until prompted for dinner, client #4 was sitting in the living room. At no time during observation was client #4 prompted to assist with meal preparation.

Morning observations on 1/31/24 from 6:00 AM revealed client #4 to come out of his room and participate in the breakfast meal. Further observations revealed at 6:18 AM client #4 was sitting in the living room watching Barney on the television with another peer until surveyors exited the home at 7:55 AM. At no time during observation was client #4 prompted to assist with meal preparation.

Review of client #4's record on 1/31/24 revealed an individual service plan (ISP) dated 4/13/23. Continued review of the ISP revealed training in the areas of laundry, meal preparation, shower, brush teeth and medication administration. Further review revealed client #4 will assist with meal preparation 100% independence for 3 consecutive months. This includes selecting items to prepare from the menu, select item from the cabinet. place item in proper pot/pan, and name item needed from the menu.

Interview on 1/31/24 with the QIDP confirmed client #4 should have been prompted and engaged in other activities than sitting watching television or being in his room. Continued interview revealed client #4 should have

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W 249	Continued From page 22 participated in meal preparation as the training objectives are current.	W 249		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 1 of 6 clients (client #1) were provided the opportunity to participate in medication self-administration or provided teaching relative to name, purpose, and side effects of medications administered. The finding is: Observation on 1/31/24 between 7:23 AM - 7:28 AM revealed client #1 to enter the medication room and the home manger (HM) to administer the following medications: Fexofenadine 180mg, L-Carnitine 500mg, Lamotrigine 100mg, Divalproex 250mg, Divalproex ER 250mg, and Clobazam 20mg. Continued observation revealed HM to prompt client #1 to pop medications into a small cup from blister packet. Client #1 questioned the HM about one of his medications and the HM did not respond. Further observations revealed client #1 to take all pills with a cup of water. Client #1 was not observed to receive any training during medication pass or to participate beyond receiving medications from HM. Interview with the qualified intellectual disabilities	W 371		

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professional (QIDP) on 1/31/24 verified client #1 should have participated in the medication administration with staff providing the basic teaching of name of medications, reason for the medications, and a side effect. QIDP also revealed client #1 having a goal for medication administration and was capable of participating.

W 440 EVACUATION DRILLS
CFR(s): 483.470(i)(1)

at least quarterly for each shift of personnel.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure fire evacuation drills were conducted at least quarterly on each shift. The finding is:

Review of the facility fire drills on 01/30/24 from 1/2023-12/2023 revealed the following:

Quarter 1: Jan 23 (1/9/23 3rd shift), Feb 23 (none) Mar 23 (none)
Quarter 2: April 23 (4/5/23 2nd shift), May 23 (none), June 23 (none)
Quarter 3: Jul 23 (none), Aug 23 (none) Sept 23(9/21/23 1st shift)
Quarter 4: Oct 23 (10/25/23 2nd shift), Nov 23 (11/20/23 3rd shift), Dec 23 (12/2/23 1st shift)

Interview on 01/30/24 with the home manager (HM) revealed there were no additional fire drills if they were not found in the fire drill book. Continued interview with the HM revealed the agency was trying to use TMP (computer program) to document fire drills but they got lost in the system and could not be retrieved. Further interview with the qualified intellectual disabilities professional (QIDP) revealed fire drills should be

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W 440	Continued From page 24 conducted at least quarterly for each shift of personnel.	W 440		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation of the facility's refrigerator, pantry and emergency supplies food storage, the facility failed to store food in a sanitary manner for 6 of 6 clients. The finding is: Observation of the group home refrigerator, pantry and emergency supply closet on 1/30/24 at 4:30 PM - 6:15 PM revealed expired cans of food, condiments, and milk. Continued observations revealed over 32 expired food cans dated back to 2019. Further observations in the pantry revealed several canned goods and premium crackers with the expiration date back to 3/2021 and 8/2023. It was also noted that the pantry contained one opened box of pancake mix, open box of instant grits. No method to prevent attraction of insects was used for the contents in the pantry. Subsequent observations in the refrigerator revealed a used gallon of milk dated 1/9/24. Additional observations revealed several condiments in the refrigerator with the expiration date 2022. Interview with the home manager (HM) on 1/31/24 revealed he was not aware of the expired can goods, milk and condiments. Continued interview with the qualified intellectual disabilities	W 454		

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W 454	Continued From page 25 professional (QIDP) on 1/31/24 confirmed expired foods should be disposed of or used before the expiration date.	W 454		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure foods were served at appropriate temperature. This potentially affected 5 of 6 clients in the home (#1, #2, #3, #5, and #6). The findings are: During dinner observations in the home on 1/30/24 at 5:47 PM, Staff C was preparing to take the vegetable mix off the stove. Staff C placed the vegetable mix in a large plastic bowl on the kitchen counter steaming hot. At 5:49 PM, five clients were seated at the dining table and the vegetable mix was placed on the table for family-style serving to begin. At no time were food temperatures checked prior to the residents sitting at the dining table. Staff C prompted clients to eat, and surveyor asked staff to check the temperature. Further observations revealed that the food temperature was checked twice at 189.5 degrees. Observed Staff C held the vegetable mix back into the kitchen until the temperature cooled down and she returned it to the dining table. Review of dining protocol within the home dining book revealed that food temperature must reach 135 degrees and not exceed 165 degrees . Interview on 1/30/24 with Staff C revealed that she was unaware of the food temperatures range	W 473		

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W 473	Continued From page 26 and asked the surveyor what it should be. Staff C went into the kitchen to find the protocol in the dining book, and she located the food temperature range. Staff C stated that the food temperature must reach 135 degrees and not exceed 165 degrees. Staff C confirmed that 189.5 was too hot. Interview on 1/31/24 with the qualified intellectual disabilities professional (QIDP) confirmed that food temperature should have been checked prior to consumption.	W 473		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that 6 of 6 clients were provided with appropriate utensils to allow each client to eat as independently as possible. The findings are: Afternoon observations in the group home on 1/30/24 at 5:45 PM revealed all clients to sit at the dining table to prepare for the dinner meal. The dinner meal consisted of the following: fish fillets, green beans and corn mixture. Continued observations revealed staff to provide all clients except client #3 with a fork only as they participated in the dinner meal. Client #3 was provided with a spoon only. Subsequent observations revealed all clients to consume dinner utilizing the the utensil provided with no concerns. At no point during the observation period were clients offered a full place setting of a fork, knife and spoon during the dinner meal.	W 475		

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	34G294	A. BUILDING ______ B. WING ______	01/31/2024

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W 475	Continued From page 27 Morning observations on 1/31/24 at 6:55 AM revealed all clients to sit at the dining table to prepare for the breakfast meal. The breakfast meal consisted of the following: cereal, juice and milk. Continued observations revealed staff to provide clients with a spoon only as the clients participated in the breakfast meal. Interview with the qualified intellectual disabilities professional (QIDP) on 1/31/24 revealed all clients should have been offered a full place setting including a fork, knife and spoon during all meals. Continued interview with the QIDP verified that all clients should be provided a full place setting to promote independence during mealtimes.	W 475		
W 478	MENUS CFR(s): 483.480(c)(1)(ii) Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to assure clients residing in the home were offered the variety of foods listed on the menu. This affected 6 of 6 clients. The finding is: Observations in the group home on 1/30/24 revealed staff D cooking fish fillets and a mixture of green beans and corn for dinner. Further observations revealed some clients to receive one fish fillet for dinner. Continued observations indicated banana splits for the clients' dessert. At no time were the clients offered a desert or any additional sides with their dinner meal. Review on 1/30/24 of the facility's menu book for	W 478		

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W 478	Continued From page 28 fall/winter week IV revealed hotdog, bun, mustard, ketchup, onion rings, tomato, salad, banana split, 2% milk and beverage of choice for dinner. Observations on 1/31/24 revealed the home manager to prepare a bowl of toasted cinnamon crunch cereal for all clients and asked if they preferred juice or milk. At no time were the clients offered additional sides with their breakfast meal. Additional observations revealed there were eggs and wheat bread recently purchased in the refrigerator. Review on 1/31/24 of the facility's menu book for fall/winter week IV revealed cereal, egg of choice, wheat toast, margarine, jelly and milk for breakfast. Interview with the home manager (HM) on 1/31/24 revealed the egg of choice and wheat toast were optional for all clients. Continued interview revealed there are three clients currently on diabetic diets. Further interview with the qualified intellectual disabilities professional (QIDP) on 1/31/24 confirmed the clients should have been offered a variety of food during all meals according to their prescribed diets.	W 478		
W 483	DINING AREAS AND SERVICE CFR(s): 483.480(d)(2) The facility must provide table service for all clients who can and will eat at a table, including clients in wheelchairs. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews the facility failed to provide table service for 1 of 6 clients (client #4). The finding	W 483		

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W 483	Continued From page 29	W 483		

is:

Observation on 1/30/24 between 5:47 PM- 6:13 PM revealed client #4 was prompted to come to the dining room for dinner. Client #4 walked into the dining room and was told to have a seat next to a short sideboard cabinet that staff had placed a fork and napkin. Client #4 was positioned away from the dining table near the back wall. Continued observation revealed the other five clients residing in the home to be seated at the dining table. Further observation reveal client #4 having to eat his dinner from the side of his body not facing his plate and cup alone. Staff did not encourage client #4 to join his peers at the dining room table.

Observation on 1/31/24 between 6:12 AM -6:18 AM revealed client #4 in the dining room away from the table and near the back wall sitting at a short sideboard cabinet. Observed client #4 while eating his breakfast, he was sitting to the side of his body not facing his plate and cup. Continued observation revealed five other clients sat at the dining room table for breakfast. Staff did not encourage client #4 to join his peers at the dining room table.

Record review on 1/31/24 of client #4's behavior support plan (BSP) dated 4/13/23 did not reveal any target behaviors related to sitting at the dining room table with peers or isolation during mealtimes.

Interview with the home manager (HM) on 1/31/24 revealed that client #4 did sit at the sideboard cabinet daily and HM stated that client #4 doesn't like sitting at the dining table with his peers. HM stated that staff does not encourage

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W 483	Continued From page 30 him to sit at the dining table because he prefers the sideboard table. Client #4 is non-verbal. Interview with the qualified intellectual disabilities professional (QIDP) on 1/31/24 revealed that client #4 should have been asked to sit at the dining table with peers first. QIDP stated that she was unaware that client # 4 was sitting alone at a sideboard cabinet and that was inappropriate dining.	W 483		