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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

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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 (EP) plan was reviewed and/or updated as needed. The finding is: Review on 2/19/24 of the facility's EP plan for Strickland Bridge A revealed a date of December 2023. Additional review of the plan did not include any information regarding two clients who were recently admitted to the facility over the past seven months. Further review of the EP plan revealed information for three clients who no longer reside at the facility. Interview on 2/20/24 with the Business Manager revealed the EP plan was last updated in December 2023. Additional interview indicated information regarding the two newly admitted clients should have been included in the plan after their admission.	E 004		
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 reviews and interviews, the facility failed to maintain a recordkeeping system	W 111		

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that accurately reflected 1 of 5 audit clients (#12). The findings are:

Review on 2/19/24 of client #12's Individual Program Plan (IPP), dated 11/16/23, revealed no adaptive equipment listed with his vision being "normal". His communication was noted as verbal with the ability to communicate his wants and needs. Review of objectives revealed goals for separating clothing and identifying a penny. His dietary information revealed a regular, 1/4" consistency diet with an allergy to seafood.

Further review of the IPP revealed several pages contained another client's name and information inconsistent with client #12's evaluations. In addition, several pages referred to him as "she" and "her".

Review on 2/20/24 of client #12's occupational therapy evaluation, dated 11/22/23, revealed he is non-verbal and communicates through gestures and pointing. The evaluation also recommended a high-sided plate for dining. In addition, he wears glasses and needs reminders to wear them.

Review on 2/20/24 of addendum meeting notes, dated 1/23/24, revealed physical therapy recommendations for a gait belt for client #12 with staff close contact. No adaptive equipment was included in the IPP.

Review on 2/20/24 of client #12's Nutritional Evaluation, dated 11/25/23, differed from the IPP and revealed a prescribed regular diet with optional seconds, and foods cut to bite-size pieces. In addition, he should only have soy milk due to his allergy to gluten, lactose, and fortified protein. No mention of a seafood allergy was

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W 111	Continued From page 3 noted. Review on 2/20/24 of client #12's habilitation goals differed from those in the IPP and revealed the following goals with data: Brush Teeth with 85% verbal prompts by 11/30/24 Attend to a preferred activity with 85% verbal prompting or less by 12/31/24 Wash dishes with 85% verbal prompts or less by 12/31/24 No mention of the goals located in the IPP were noted. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that a clerical error had been made in printing and another client's information had gotten mixed in.	W 111		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in the behavior support program (BSP) for 1 of 5 audit clients (#12). The finding is: Review on 2/19/24 of client #12's Individualized Program Plan (IPP), dated 11/16/23, revealed he was admitted on 11/7/23 and that he had a BSP. No BSP was located in client #12's record. During review on 2/19/24 of client #12's data book, no BSP could be located.	W 189		

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W 189	Continued From page 4 Interview on 2/19/24 with Staff J revealed client #12 had no BSP and was still new. Therefore the facility was still trying to see if he had behaviors. Interview on 2/19/24 with Staff K revealed there was no BSP for client #12, and they had not really seen behaviors from him. Interview on 2/20/24 with Staff I revealed client #12 had no BSP and was still new, and the facility was trying to see if he had behaviors. Interview on 2/20/24 with the home manager revealed client #12 was still new and they were still learning about his behaviors. He does not have a BSP yet. Further record review on 2/20/24 at the day program revealed client #12's BSP, dated 12/5/23, located in the Behavior Analyst's office. Client #12's target behaviors included: Noncompliance, SIB, Aggression, Loud Vocalizations, Regurgitation, Attention Seeking, Food Stealing, Feces Smearing, and PICA. Client #12 was not observed to exhibit target behaviors during surveyor presence. Interview on 2/20/24 with the Behavior Analyst revealed she had trained staff on client #12's BSP. No documentation was presented. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional revealed staff should know about client #12's BSP.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe	W 240		

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W 240	Continued From page 5 relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) included specific information to support 2 of 5 audit clients (#10 and #12) with the use of their eye glasses. The findings are: A. During observations throughout the survey on 2/19 - 2/20/24, client #10 wore eye glasses while at the day program and in the home. Review on 2/19/24 of client #10's IPP did not include any specific information regarding the use of eye glasses for the client. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #10 wears eye glasses; however, his IPP did not include any information regarding the use of eye glasses. B. During observations throughout the survey on 2/19 - 2/20/24, client #12 wore eye glasses while at the day program and in the home. Review on 2/19/24 of client #12's IPP, dated 11/16/23, revealed no specific information regarding the use of eye glasses for the client. Interview on 2/20/24 with the QIDP confirmed client #12 wears eye glasses; however, his IPP did not include any information regarding the use of eye glasses.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 6 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 5 audit clients (#3, #10 and #12) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of family style dining, medication administration, and adaptive equipment use. The findings are: A. During morning observations in the Strickland Bridge A home on 2/20/24, client #3 and client #10 were assisted to serve themselves from a pan of sausage and a pot containing oatmeal located on the stove. The clients were not afforded the opportunity to participate in all aspects of family style dining. Interview on 2/20/24 with Staff A revealed the clients usually participate in family style dining tasks in the morning including serving themselves at the table using serving bowls; however, this morning was a little "hectic." Review on 2/20/24 of client #3's Adaptive Behavior Inventory (ABI) dated 10/10/23 revealed she can serve herself form a bowl/platter and	W 249		

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pass bowls/platters given assistance.

Review on 2/20/24 of client #10's ABI dated 12/15/23 indicated he can serve himself from a bowl/platter and pass bowls/platters independently.

Interview on 2/20/24 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be participating in family style dining tasks and not retrieving food from pots and pans on the stove.

B. Observations during medication administration on 2/20/24 at 7:55am revealed client #12 sitting in the chair in the medication room. Staff G retrieved client #12's medications from the cabinet, punched all medication pills, poured his water, and fed him his medications. Client #12 was not prompted to participate in his medication administration.

Review on 2/19/24 of client #12's Individualized Program Plan (IPP), dated 11/16/23, revealed he can participate in medication administration to punch pills, obtain water, and throw trash away.

Interview on 2/20/24 with the home manager revealed client #12 should be allowed to be independent in all activities with hand over hand if needed.

C. Observations on 2/20/24 in the home revealed inconsistent use of client #12's gait belt. At 6:50am, he was dressed and wearing his gait belt as he sat in the den to watch television. At 7:00am, Staff H went to the den to ask client #12 to help in the kitchen. Client #12 walked to the

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W 249	Continued From page 8 kitchen area with no staff support for gait belt. From 7:00am - 7:15am, he walked around the kitchen and back doorway hall with no staff support for this gait belt. At 7:18am, the home manager entered and redirected staff to support client #12. He then was observed to be wearing two gait belts. Review on 2/19/24 of client #12's IPP, dated 11/16/23, revealed a gait belt was added to his adaptive equipment on 1/23/24 following an addendum meeting and recommendation from physical therapy. In addition, the physical therapist recommended staff to maintain close contact when client #12 was ambulating due to seizures. Interview on 2/20/24 with the home manager revealed staff should be holding the gait belt when client #12 is moving or ambulating. The home manager did not know why he had on two gait belts. Interview on 2/20/24 with the QIDP revealed staff should hold client #12's gait belt when he is waking or moving around.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and	W 252		

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interviews, the facility failed to ensure all data relative to the accomplishment of objectives identified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 1 of 5 audit clients (#3). The finding is:

During observations in the classroom on 2/19/24 from 11:25am - 12:45pm, client #3 began hitting her right arm repeatedly on two separate occasions. The client was redirected by staff both times. During later observations in Strickland Bridge A at 4:26pm, client #3 began biting her thumb causing the skin to break and a small amount of bleeding. Staff A immediately called the nurse and later rendered first aid to client #3's thumb.

Review on 2/20/24 of client #3's behavior data book and Therap did not reveal any documented behavior incidents for 2/19/24.

Interview on 2/20/24 with Staff A revealed they are supposed to be documenting client's behaviors in a behavior notebook and in Therap.

Review on 2/20/24 of client #3's Behavior Support Plan (BSP) dated 10/2/23 revealed an objective to address severe disruption, aggression, self-injurious behavior (SIB) and elopement. Additional review of the BSP indicated SIB was defined as "hitting herself, scratching herself, etc." Further review of the BSP noted, "All episodes of Challenging Behaviors will be documented on the Behavior Interaction Data Sheets in the Behavior Notebook."

Interview on 2/20/24 with the Behavior Analyst confirmed client #3's target behaviors include SIB and staff should be documenting her behaviors in

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W 252	Continued From page 10 the behavior data book and in Therap.	W 252		
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 interview, the facility failed to ensure written informed guardian consent was obtained for 3 of 5 audit clients (#3, #10 and #12). The findings are: A. Review on 2/19/24 of client #3's Behavior Support Plan (BSP) dated 10/2/23 revealed an objective to display 10 or fewer behaviors for 10 out of 12 consecutive months. Additional review of the plan included the use of Haldol, Klonopin and Lubalvi. Further review of the record did not indicate written informed consent for the BSP had been obtained from client #3's guardian. B. Review on 2/19/24 of client #10's BSP dated 12/27/23 revealed objectives to address target behaviors of non-compliance, loud vocalizations, pica, begging for food, inappropriate touch, stealing, public masturbation and physical aggression. Additional review of the plan identified the use of Clonidine and Olanzapine. Further review of the record did not indicate written informed consent for the BSP had been obtained from client #10's guardian. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed written informed consent should be obtained for all restrictive behavior plans.	W 263		

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W 263	Continued From page 11 C. Review on 2/20/24 of client #12's Behavior Support Plan (BSP) dated 12/5/23 revealed an objective to display 10 or fewer target behaviors for 10 out of 12 consecutive months. Additional review of the plan included the use of Aripiprazole and Buspirone, Fluoxetine, Guanfacine, and Zonisamide . Further review of the record did not indicate written informed consent for the BSP had been obtained from client #12's guardian. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed written informed consent should be obtained for all restrictive behavior plans.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #3 was provided recommended services in accordance with her needs. This affected 1 of 5 audit clients. The finding is: Review on 2/19/24 of client #3's record revealed the following medical appointments: 10/24/23 - Audio: "impacted wax AU...both canals impacted with wax needs referral for ENT" 10/25/23 - ENT: Wax impaction, Recommendations: suggest daily irrigation of ears with peroxide, follow-up 12/11/23 12/11/23- ENT: cerumen impaction,	W 331		

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W 331	Continued From page 12 noncooperative, "pt Refer [local hospital] ENT Department" Additional review on 2/20/24 of client #3's record did not indicate she had been seen by the ENT department at the local hospital. Interview on 2/20/24 with the Facility Nurse confirmed client #3 was seen for wax impaction in her ears. Additional interview indicated she was not sure if irrigation of the client's ears had been attempted and no referral to local ENT Department had been made as of the date of the survey.	W 331		
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 review and interviews, the facility failed to ensure staff were sufficiently trained to implement appropriate grooming methods regarding client #5. This affected 1 of 5 audit clients. The finding is: During observations throughout the survey on 2/19 - 2/20/24, client #5's fingernails were very long and extended well beyond the tips of his fingers. Additional observations of a note posted in the office of the home revealed, "Nail trimming and shaving should occur every Monday, Wednesday and Friday after bath time! Men and Women. No exceptions!" The note was dated	W 340		

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W 340	Continued From page 13 11/2/23. Interview on 2/20/24 with Staff A revealed group home staff only file client #5's fingernails and do not cut/trim them since he's a diabetic. The staff indicated nursing staff trim his fingernails once a week or as needed, usually on Wednesdays. Review on 2/20/24 of client #5's record confirmed his has Type II Diabetes. Additional review of his Adaptive Behavior Inventory (ABI) last updated 9/14/23 indicated the client has no independence with cleaning, trimming and filing his nails. Interview on 2/20/24 with the Facility Nurse revealed direct care staff from the home can trim and file client #5's fingernails; however, nursing staff cut his toenails. The nurse revealed his fingernails should be cut once weekly.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to administer medications as ordered for 1 of 5 audit clients (#12). The finding is: Observations during medication administration on 2/20/24 at 7:55am revealed Staff G administering medications to client #12. Staff G punched client #12's pills and capsules into a small pill cup. She then placed a small amount of applesauce in the bottom of a second, small, pill cup and emptied client #12's capsules on top of the applesauce.	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G152	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 369	Continued From page 14 Staff G then crushed the remaining pills and further stacked the pill powder on top of the applesauce. Staff G then attempted to stir/mix the applesauce with the crushed medication in the small pill cup, with visual pill powder overflowing and falling to the ground twice, causing some medication to be lost. Review on 2/20/24 of client #12's doctor orders revealed no directives on whether to crush or not crush pills. Review on 2/20/24 of the facility medication administration policy revealed medications are to administered in accordance with written physician orders. Interview on 2/20/24 with the facility nurse revealed staff should use a different container to mix applesauce with medications when it is too much for a small pill cup to ensure it does not spill.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all medications remained locked except when being administered. The finding is: Observation in the home on 2/20/24 at 7:55am revealed Staff G administering medications to client #12. Staff G walked out of the medication room to the cabinet and retrieved a cup. The surveyor and client #12 remained in the	W 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 382	Continued From page 15 medication room, with medications on countertop. Review on 2/20/24 of the facility medication administration policy revealed medications are not to be left unattended in the presence of a person. Interview on 2/20/24 with the home manager revealed staff should not leave the medication door unlocked and never unattended while giving medications. Interview on 2/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff had been trained to never leave medications unattended. Interview on 2/20/24 with the facility nurse revelaed staff should never leave door unlocked or leave the room during medication administration.	W 382		