STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(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 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. (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	E 039	Deficiency E039 will be corrected by completing the following: A. Team will ensure the completion of an annual tabletop and full emergency plan exercise or mock drill annually and/or as required by regulatory standards. B. DSP's will be in-services on emergency planning and how to facilitate a dull emergency drill/exercise. C. Team will ensure documentation of drill when facilitated. D. QIDP to monitor monthly. E. Areas Supervisor and/or Site Supervisor to monitor monthly.	7/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monica Harrelson, MSW, MPA	Program Manager	5/28/23

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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	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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039	Continued From page 1 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, 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	E 039	Please see page 1 of 19.	7/15/2023

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	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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E 039	Continued From page 2 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 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.	E 039	Please see page 1 of 19.	7/15/2023

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E 039	Continued From page 3 *[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 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):]	E 039	Please see page 1 of 19.	7/15/2023

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	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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E 039	Continued From page 4 (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 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	E 039	Please see page 1 of 19.	7/15/2023

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E 039	Continued From page 5 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. (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	E 039	Please see page 1 of 19.	7/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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E 039	Continued From page 6 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. *[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.	E 039	Please see page 1 of 19.	7/15/2023

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E 039	Continued From page 7 (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. *[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	E 039	Please see page 1 of 19.	7/15/2023

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E 039		E 039		7/15/2023

Continued From page 8

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 document review and interviews, the facility failed to ensure a full scale exercises, mock drill or an annual tabletop activity was conducted and included in the facility's
Emergency Preparedness Plan (EP). The finding is:

Review on 5/15/23 of the facility's EP Plan revealed there was no annual tabletop conducted. Further review no full exercise, mock drill or annual tabletop for 2021 or 2022.

Please see page 1 of 19.

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E 039	Continued From page 9 During an interview on 5/15/23, the Area Supervisor (AS) confirmed the facility EP did not have documentation detailing any exercises to test their EP plan.	E 039	Please see page 1 of 19.	7/15/2023
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 observations, document review and interviews, the facility failed to ensure staff were sufficiently trained in a technique to assist 1 of 3 audit clients (#3) during meals. The finding is: During dinner observations in the home on 5/15/23 at 5:09pm, Staff A was observed grabbing client #3's wrist while he was attempting to lift the spoon to his mouth. Further observations revealed Staff A grabbing client #3's wrist ten times, while client #3 was attempting to put his spoon into his mouth. At 5:15pm, Staff A was observed pushing down on client #3's wrist while he attempted to lift his spoon to his mouth. During an immediate interview on 5/15/23, Staff A stated he was "being physical" with client #3 due to the fact he will put too much food into his mouth because he eats very fast and might choke. Further interview with Staff A revealed he realized he was giving too much physical touch with client #3. Review on 5/16/23 of client #3's Occupational Therapy (OT) evaluation (no date) revealed, "Pt. eats at a fast pace, please offer prompts as	W 189	Deficiency W189 will be corrected by completing the following: A. Team will ensure the completion of training centered around mealtimes. DSPs will be in-serviced on proper hand over hand techniques without use of force. B. QIDP and site supervisor to complete mealtime observations. C. Team will consult with OT to address mealtime guidelines and use of adaptive equipment if applicable. D. QIDP to monitor monthly. E. Area Supervisor and/or Site Supervisor to monitor twice a month.	

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	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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W 189	Continued From page 10 needed to encourage pt. to slow down feeding pace". During an interview on 5/16/23, the Area Supervisor (AS) stated client #3 should have been prompted to slow down his rate of eating with hand over hand assistance only.	W 189	Please see page 11 of 19.	7/15/2023
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to obtain needed initial assessments for 3 of 3 audit clients (#2, #3 and #4). The findings are: A. Review on 5/15/23 of client #2's record revealed he had not received visual examination. Further review revealed client #2 was admitted to the facility on 3/6/23. B. Review on 5/15/23 of client #3's record revealed he had not received visual examination. Further review revealed client #3 was admitted to the facility on 1/18/23. C. Review on 5/15/23 of client #4's record revealed he had not received visual examination. Further review revealed client #4 was admitted to the facility on 2/28/23. During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP)	W 210	Deficiency W210 will be corrected by completing the following: A. Team will ensure the completion of assessments or reassessments within 30 days of a new admission. B. Team will ensure that all outstanding appointments are completed. C. RN will ensure communication and assistance for doctors' appointments that are hard to schedule. D. QIDP to monitor monthly. E. RN to monitor twice a month. F. Area Supervisor and/or Site Supervisor to monitor twice per month.	

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W 210	Continued From page 11 confirmed clients #2, #3 and #4 had not received their visuals examinations.	W 210	Please see page 12 of 19.	7/15/2023
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 audit clients (#3) had a psychological assessment completed within 30 days of admission. The finding is: Review on 5/15/23 of client #3's record revealed he was admitted to the facility on 1/18/23. Further review indicated client #3's psychological assessment was completed by another agency on 5/22/20. During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 did not have current/updated psychological assessments that were completed within 30 days of admission. Further interview revealed the QIDP is the person who is responsible to ensure psychological assessments are completed for newly admitted clients.	W 214	Deficiency W214 will be corrected by completing the following: A. Team will ensure that a comprehensive function assessment is completed (specific to psychological needs) will be completed within 30 days of admission. B. Team will ensure consultation with Psychologist upon admission to the group home. C. Team will ensure that all psychological data and documentation is current and applicable to residents needs. D. QIDP to complete behavioral notes monthly and consult with psychologist as needed to address ongoing needs of the resident. E. QIDP to monitor monthly. F. Area Supervisor and/or Site Supervisor to in-service staff as changes in psychological assessments occur. G. Area Supervisor and/or Site Supervisor to monitor monthly.	
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an auditory examination for 3 of 3 audit clients (#2, #3 and #4). The findings are:	W 221	Please see page 14 of 19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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(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 221	Continued From page 12 A. Review on 5/15/23 of client #2's record revealed he had not received an auditory examination. Further review revealed client #2 was admitted to the facility on 3/6/23. B. Review on 5/15/23 of client #3's record revealed he had not received an auditory examination. Further review revealed client #3 was admitted to the facility on 1/18/23. C. Review on 5/15/23 of client #4's record revealed he had not received an auditory examination. Further review revealed client #3 was admitted to the facility on 2/28/23. During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #2, #3 and #4 had not received their auditory examinations.	W 221	Deficiency W221 will be corrected by completing the following: A. Team will ensure assessments and examinations specific to audio will be completed within 30 days of admission. B. RN will consult with the team when outdated appointments are noted. C. Team will address pertinent appointments during CORE team meetings. D. QIDP to monitor monthly. E. RN to monitor monthly. F. Area Supervisor and/or Site Supervisor to monitor monthly.	7/15/2023
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 2 of 3 audit clients (#2 and #3) received a continuous active	W 249	Please see page 15 of 19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	05/16/2023

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W 249	Continued From page 13 treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) around adaptive dining equipment. The findings are: A. During dinner observations in the home on 5/15/23, client #2 was observed eating his dinner from a regular plate. Client #2 was observed using a regular fork with a red built up handle. At no time was client #2 prompted to use a high sided divided plate or a small angled built up handle spoon. Additional observations revealed client #2 using his fingers three times to pick up his food, which landed on the table while he was scooping his food. Review on 5/15/23 of client #2's IPP dated 4/14/23 stated he uses a small angled built up handle spoon and high sided divided plate for all his meals. Review on 5/16/23 of client #2's Occupational Therapy (OT) evaluation dated 3/29/23 stated, "Therapist tried a small built up handle angled spoon and pt. was able to use it on his own during observation conducted on 03/29.2023. Therapist is recommending use of a small bowled good grip bendable spoon to prevent spoon overloading and also to provide a comfortable and stable grasp on utensil handle. Therapist left one spoon for pt. to try during visit on 03/29/2023." Further review revealed. "Pt. has difficulty scooping from a regular plate and will benefit from using a High sided divided plate". During an interview on 5/16/23, the Home Manger (HM) stated there was a built up handle spoon for client #2, but it could not be located in the home.	W 249	Deficiency W249 will be corrected by completing the following: G. Team will ensure proper use of adaptive equipment for each resident in the home. H. Team will consult with contract workers (OT, PT, Nutrition, and SLP to ensure appropriate use of adaptive equipment. I. Management will ensure that all staff are trained on resident's use of adaptive equipment. J. Area and/or Site Supervisor to ensure operable adaptive equipment is in the home and ready for use when needed. K. QIDP to monitor monthly. L. Area Supervisor and/or Site Supervisor to monitor monthly.	7/15/2023

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W 249	Continued From page 14 During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) stated there was not a high sided divided plate in the home for client #2 to use. B. During dinner observations in the home on 5/15/23, client #3 was observed eating his dinner from a regular plate. At no time was client #3 prompted to use a high sided divided plate. Further observations revealed client #3 eating food from off the table that landed there while he was scooping his food. Review on 5/16/23 of client #3's OT evaluation (no date) stated "Pt. has difficulty scooping from a regular plate and will benefit from using a High sided divided plate. Therapist left a high sided divided plate for pt. to use, additional ones can be ordered". During an interview on 5/16/23, the QIDP stated there was not a high sided divided plate in the home for client #3 to use.	W 249	Please see page 15 of 19.	7/15/2023
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should ensure 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 restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 3 of 3 audit clients (#2, #3 and #4). The findings are:	W 263		
			Please see page 17 of 19.	

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W 263	Continued From page 15 During observations in the home on 3/6/23, the surveyor noticed that the door leading into the garage was locked. Upon further observations it was noticed that a refrigerator containing food and other food items on shelves were being kept in the garage. Further observations revealed staff had to use a key to unlock the door. A. Review on 5/15/23 of client #2's Individual Program Plan (IPP) dated 4/14/23 did not include a signed consent allowing the door where the food was kept to be locked. B. Review on 5/15/23 of client #3's IPP dated 2/10/23 did not include a signed consent allowing the door where the food was kept being locked. C. Review on 5/15/23 of client #4's IPP dated 4/14/23 did not include a signed consent allowing the door where the food was kept locked. During an interview on 5/15/23, Staff A revealed the door where the food is stored is locked due to the fact that client #3 has diabetes and he has a behavior of stealing food. During an interview on 5/16/23, Staff B confirmed the door to the garage where the food is stored is always locked. Staff B went on to say they were never told the exact reason why the door is kept locked. During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the pantry is locked, due to the fact that client #3 has diabetes and he steals food.	W 263	Deficiency W263 will be corrected by completing the following: A. Team will ensure that all restrictive interventions and practices are noted within the resident's ISP's and BSP/BSG's and consented upon by legally responsible parties (LRP's). B. Team will ensure data collection of behaviors related to food stealing. C. Area supervisor will ensure healthy and safe food options are kept in the main refrigerator in the home and excess food is kept in the refrigerator in the garage. D. QIDP to complete behavioral notes monthly and consult with psychologist as needed to address ongoing needs of the residents. E. QIDP to monitor monthly. F. Area Supervisor and/or Site Supervisor to in-service staff and monitor monthly.	7/15/2023
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE	W 351	Please see page 18 of 19.	

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W 351		W 351		7/15/2023
	Continued From page 16 CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a dental examination for 1 of 3 audit clients (#3). The finding is: Review on 5/15/23 of client #3's record revealed he has not received a dental examination. Further review client #3 was admitted to the facility on 1/18/23. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 has not received an dental examination. Further interview revealed client #3's father normally accompanies client #3 to his medical appointments; but has been unable to do so lately.		Deficiency W351 will be corrected by completing the following: A. Team will ensure that all appointments are completed as recommended by the facility and/or physician. B. Team will ensure that dental appointments are completed within 30 days of admission. C. RN will consult with team concerning medical appointments and provide assistance when needed. D. QIDP to address medical appointments during CORE team meetings. E. QIDP to monitor monthly. F. RN to monitor twice a month. G. Area Supervisor and/or Site Supervisor to monitor twice monthly.	
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, document review and interviews, the facility failed to ensure	W 382	For tag W382 please see page 19 of 19.	

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W 382	Continued From page 17 medications remained locked except when being prepared for administration. The finding is: During observations in the home on 5/15/23, the surveyor opened the refrigerator and noticed a black box inside. The surveyor asked Staff A to remove the box from the refrigerator. Further observations revealed it was unlocked and client #3's insulin was being kept inside. Review on 5/15/23 of client #3's Individual Program Plan (IPP) revealed he was admitted to the facility on 1/18/23. During an interview on 5/15/23, Staff A reported client #3's insulin needs to be refrigerated; that is way is is kept in the refrigerator. During an interview in 5/15/23, the Home Manager (HM) stated he would go get a box with a lock to store client #3's insulin in the refrigerator. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware that client #3's insulin was being stored in the refrigerator.	W 382	Deficiency W382 will be corrected by completing the following: A. Team will ensure proper storage of medications in the home. B. Team will ensure that insulin in kept refrigerated in a locked box. C. QP, RN, AS and/or SS to monitor the fridge when monitoring the medication closet monthly. D. RN and the Site Supervisor to in-service staff on how insulin is to be stored and locked. E. QIDP to monitor monthly. F. RN to monitor twice monthly. G. Area Supervisor and/or Site Supervisor to monitor twice monthly.	7/15/2023