STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING _____ B. WING _____	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(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 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		

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 030	Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to ensure the plan included names and contact information for all staff. The finding is: Review on 3/11/24 of the facility's EP plan (last reviewed 10/27/23) revealed no names or contact information for any staff working in the home. Interview on 3/12/24 with the Program Director confirmed names and contact information for staff was missing and needed to be included in the EP plan.	E 030		
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	E 037		

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E 037	Continued From page 3 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) 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	E 037		

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E 037	Continued From page 4 must conduct training on the updated policies and procedures. *[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	E 037		

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E 037	Continued From page 5 procedures. *[For LTC Facilities at §483.73(d):] (1) Training 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	E 037		

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E 037	Continued From page 6 procedures. *[For CAHs at §485.625(d):] (1) Training program. 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 interviews, the facility failed to ensure all staff were trained on the facility's Emergency Preparedness (EP) plan.	E 037		

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E 037	Continued From page 7 The finding is: Review on 3/11/24 of the facility's EP plan (last updated 10/27/23) did not indicate all new and/or existing staff had received training and/or retraining on the EP plan. Interview on 3/12/24 with the Program Director confirmed training on the EP had not been completed for all staff working in the home.	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	E 039		

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E 039	Continued From page 8 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 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	E 039		

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E 039	Continued From page 9	E 039		

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 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

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E 039	Continued From page 10 (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. *[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	E 039		

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E 039	Continued From page 11	E 039		

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):]
(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

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E 039	Continued From page 12 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 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	E 039		

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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
E 039	Continued From page 13 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 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	E 039		

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	34G246	A. BUILDING _____ B. WING _____	03/12/2024

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E 039	Continued From page 14 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. (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	E 039		

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E 039	Continued From page 15 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 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:	E 039		

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E 039	Continued From page 16 Based on document review and interviews, the facility failed to ensure a full scale community/facility-based exercise, mock drill or tabletop exercise to test their Emergency Preparedness (EP) plan was conducted. The finding is: Review on 3/11/24 of the facility's EP plan (last reviewed 10/27/23) did not include a full scale community/facility-based exercise, mock drill or tabletop exercise. Interview on 3/12/24 with the Program Director confirmed no full scale community/facility-based exercise, mock drill or tabletop exercise had been conducted.	E 039		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure client #6's active treatment program was monitored to determine the need for program revision based on the client's performance. This affected 1 of 3 audit clients. The finding is: Review on 3/12/14 of client #6's Individual Program Plan (IPP) dated 1/23/24 and his previous IPP dated 1/23/23 revealed the following objectives: - Client #6 will wash his body with no more than 1 verbal prompt 85% of the time	W 159		

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W 159	Continued From page 17 - Client #6 will close the bathroom door for privacy with no more than 1 verbal prompt 85% of the time - Client #6 will identify different denominations of coins (penny, nickel, dime, quarter) with no more than 1 verbal prompt 85% of the time - Client #6 will verbalize different denominations of coins (penny, nickel, dime, quarter) with no more than 1 verbal prompt 85% of the time Additional review of client #6's record did not include a review of the programs to determine progress after the client had trained on the objectives for a year. Interview on 3/12/24 with the current QIDP and the Program Director indicated the previous QIDP would have been responsible for reviewing the objectives and writing progress notes; however, no notes for the programs could be located.	W 159		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was reviewed as necessary after the client had successfully completed objectives. This affected 2 of 3 audit clients (#4 and #6). The findings are: A. Review on 3/11/24 of client #4's Behavior Support Plan (BSP) dated 4/1/23 revealed an	W 255		

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W 255	Continued From page 18 objective to maintain 0 rates of target behaviors that are potentially tissue damaging for 7 out of 12 months. Additional review of BSP progress notes dated January '22 - December '23 revealed only two documented behaviors for client #4 in August '23. B. Review on 3/11/24 of client #6's BSP dated 10/17/23 revealed an objective to exhibit 0 target behaviors per month for 7 out of 12 months. Additional review of BSP progress notes dated January '22 - December '23 revealed only one documented behavior for client #6 in August '23. Interview on 3/12/24 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager confirmed the BSP objectives remain current and have not been reviewed for completion.	W 255		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #4's Individual Program Plan (IPP) was revised at least annually. This affected 1 of 3 audit clients. The finding is: Review on 3/11/24 of client #4's record revealed an IPP dated 2/15/21. No current IPP was located. Interview on 3/12/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no current IPP for client #4 was available for review.	W 260		

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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 2 of 3 audit clients (#4 and #6). The findings are: A. Review on 3/11/24 of client #4's Behavior Support Plan (BSP) dated 4/1/23 revealed an objective to maintain 0 rates of target behaviors that are potentially tissue damaging for 7 out of 12 months. Additional review of the plan included the use of Risperdal. Further review of the record did not indicate written informed consent for the BSP had been obtained from client #4's guardian. B. Review on 3/11/24 of client #6's BSP dated 10/17/23 revealed an objective to exhibit 0 target behaviors (aggression, disruption, other behaviors) per month for 7 out of 12 consecutive months. Additional review of the plan included the use of Klonopin and Risperdal. Further review of the record included a written informed consent for the BSP signed by the guardian on 1/10/21. The consent form noted, "This consent expires in 365 days." Further review of the record did not include a current written informed consent for the BSP from client #6's guardian. Interview on 3/12/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no current BSP consent had been obtained from client #4 and client #6's guardians.	W 263		
W 312	DRUG USAGE	W 312		

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W 312	Continued From page 20 CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the interdisciplinary team (IDT) had considered a reduction and/or elimination of restrictive behavior medications after a decrease in target behaviors was identified. This affected 2 of 3 audit clients (#4 and #6). The findings are: A. Review on 3/11/24 of client #4's Behavior Support Plan (BSP) dated 4/1/23 revealed an objective to maintain 0 rates of target behaviors that are potentially tissue damaging for 7 out of 12 months. Additional review of the plan included the use of Risperdal. Review of client #4's physician's orders dated 9/27/23 revealed the client ingests Risperdal 1 mg every morning and Risperdal .5 mg at bedtime. Further review of BSP progress notes dated January '22 - December '23 revealed two documented behaviors for client #4 in August '23. Review of the progress notes and the record did not indicate the IDT had considered a reduction and/or elimination of the behavior medications based on the absence of target behaviors for 2 years. B. Review on 3/11/24 of client #6's BSP dated 10/17/23 revealed an objective to exhibit 0 target behaviors per month for 7 out of 12 months. Additional review of the plan included the use of Klonopin and Risperdal. Further review of client #6's physician's orders dated 9/27/23 revealed	W 312		

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W 312	Continued From page 21 the client ingests Klonopin 1 mg every evening and Risperdal .5 mg at bedtime. Further review of BSP progress notes dated January '22 - December '23 revealed one documented behavior for client #6 in August '23. Review of the progress notes and the record did not indicate the IDT had considered a reduction and/or elimination of the behavior medications based on the absence of target behaviors for 2 years. Interview on 3/12/24 with the Qualified Intellectual Disabilities Professional (QIDP) and Program Director confirmed the IDT had not considered a reduction or elimination of behavior medications for client #4 and client #6 based on their significant decrease in inappropriate behaviors.	W 312		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a review of each client's health status was completed by the nurse on at least a quarterly basis. This affected 3 of 3 audit clients (#4, #5 and #6). The findings are: Review on 3/12/24 of client #4, client #5 and client #6's records did not include a quarterly nursing assessment. Interview on 3/12/24 with the facility nurse indicated she was not aware a quarterly nursing assessment was required and has not been	W 336		

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W 336	Continued From page 22 completing them for any clients in the home. Interview on 3/12/24 with the Program Director confirmed quarterly nursing assessments are a requirement and the nurse should be completing them.	W 336		
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 observation, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 clients (#4) observed receiving medications. The finding is: During observations of medication administration in the home on 3/12/24 at 6:20am, the Medication Technician (MT) mixed two tablespoons of Metamucil powder in a glass of water. Client #4 consumed the mixture with his other medications. Review on 3/12/24 of client #4's physician's orders signed 9/27/23 revealed an order for, "Natural Fiber powder, mix 1 rounded teaspoon in 8 oz of water and take by mouth every day, 7am". Interview on 3/12/24 with the MT (also the Home Manager) confirmed client #4 had ingested two tablespoons of the powder instead of one teaspoon as ordered.	W 369		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing,	W 460		

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W 460	Continued From page 23 well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #6 received his specially-prescribed diet as indicated. This affected 1 of 3 audit clients. The finding is: During breakfast observations in the home on 3/12/24 at 7:03am, client #6 consumed cereal, a fruit cup, milk, juice and water. He refused his bagel with peanut butter. No other food/drink items were offered at the breakfast meal. Review on 3/12/24 of client #6's physician's orders signed 9/27/23 revealed an order for "Carnation breakfast powder drink in the morning, 7am". Interview on 3/12/24 with the Home Manager confirmed client #6 receives Carnation breakfast drink in the morning; however, none was available in the home.	W 460		