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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to furnish a light source, for all hours of the day, for client use. This had the potential to effect 5 0f 5 clients residing in the home. (#1, #2, #3, #4 and #5). The finding is: During observations in the home on 3/11/24 from 9:30am to 12:00pm and 4:00pm to 5:00pm, clients gathered in the activity room to color and work on puzzles. There were two windows in the room which brought in natural light. An additional observation of the activity room on 3/12/24 at 6:30am, revealed a dark activity room. There were no lamps or ceiling light fixtures in the activity room. Observation on 3/12/24 at 7:00am of client #1 revealed him bringing crayons and paper to color to the dining room table. The dining room area was illuminated with electrical lights. The activity room remained dark until sunrise after 7:15 am. Interview on 3/12/24 with the Home Manager revealed the activity room was dark upon the surveyors arrival to the home at 6:30am because there was no electrical light source.	W 104		
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:	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Based on record review and interviews, the facility failed to develop an organized system for recording client records for new incidents, behavioral data and nursing concerns. This affected 1 of 3 audit clients (#2) and the former client (FC #1). The findings are:

A. Record review on 3/11/24 of the FC #1's medical chart revealed the following events before his discharge to a hospital on 2/27/24:

Individual Program Plan on 9/6/23 revealed the FC #1 on regular diet. All foods need to be cut bite size. Has restricted water intake. Former client must be prompted to slow down, place hands in lap and prompt him to chew his food; he eats very fast.

New Order on 9/19/23 form Physician Assistant to start a puree diet.

Clinical notes on 10/31/23 complaints of FC #1 gagging. Will refer to gastrointestinal (GI) doctor for evaluation.

Registered Dietician (RD) Nutritionist Notes on 12/6/23 recommended continue puree diet and for client to remain at least 30 degrees for approximately 15 minutes after eating or drinking. Encourage/Remind client to eat slowly and to drink slowly. Client continues to cough after drinking and eating food. A swallow study has been scheduled for 12/6/23, will continue to follow-up with recommendations.

Gastroenterology Discharge Instructions on 12/12/23 revealed Fc #1`had a biopsy done. The GI doctor recommended a MBS with speech language pathologist (SLP) consultation to

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evaluate for Oropharyngeal dysphagia. There was no GI report.

Clinical Notes on 12/14/23 revealed the Modified Barium Swallow (MBS) was completed. Recommend "easy to chew, thin liquids diet. No aspiration. Small sips of liquid." by a SLP. There was no copy of the MBS, SLP or GI doctor report.

Qualified Intellectual Disabilities Professional (QIDP) note on 12/21/23, revealed FC #1 complained of not feeling good. Staff called 911 per the nurse, transported to hospital.

QIDP Note on 12/24/23 revealed the FC #1 had surgery and was discharged from hospital. There were no hospital discharge summary records.

QP Note on 1/2/24 revealed the FC #1 was found sitting on the floor, with gash and blood above his right eye. He was sent to the hospital for stitches and was hospitalized. There was no incident report or hospital summary.

Physician's Orders on 1/3/24 for the FC #1 revealed, a regular diet, cut all food into bite size pieces; cut sandwich into 8 pieces. Standing orders for water limited to 6-7 daily: 7:00am, 10:00am, 12:00pm, 4:00pm, 6:00pm and 8:00pm.

RD Note on 1/4/24 revealed FC #1 started taking an antibiotic (ABT) medication on 12/25/23. The doctor's discharge dated 12/21/23 indicates, "Return to previous diet" and has scheduled a 2 month follow-up of a video fluoroscopic swallowing exam. The RD also recommended 4 ounces of fluid at a time with staffing queuing to slowly intake, for safety and promotion. "Will continue to follow-up once receive full report of

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screening."

RD Note on 2/7/24 revealed FC #1 was doing much better since instructed to slow down eating and drink. Continue to cue him on this to avoid possible choking/aspiration. Diet is continued, regular, no added salt, bite size pieces (meat) and sandwiches cut.

After-visit hospital summary on 2/13/24 revealed FC #1 was treated for local pleural effusion and recurrent pleural effusion. This was a follow-up visit after undergoing right thoracotomy with Decortication for recurrent pleural effusion. The FC #1 was doing well postoperatively and incision shows no signs of infection. Respiratory was negative for cough and shortness of breath. It documented on 1/5/24 he had right thoracotomy with Decortication. The FC #1 to start on 2/16/24 taking an ABT by mouth 2 x a day for 21 days.

Annual wellness exam on 2/15/24, labs were ordered. There were no labs results in the chart.

There were no records to document when the FC #1 was admitted and discharged from the hospital in January, 2024. In addition, there were no discharge summary records from the rehabilitation center with new orders for FC #1.

There were no records on 2/26/24 and 2/27/24 regarding the FC #1 having repeated episodes of emesis and bowel incontinence.

Interview on 3/11/24 with the QIDP revealed the FC #1 went to the hospital at the beginning of January after falling in the home and needing stitches. The QIDP revealed he was sent from the hospital to a rehab center but was released

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because he would not participate in therapy. The QIDP did not recall when he was discharged from the rehab center. On 3/12/24, the QIDP revealed the FC #1 had to have some teeth extracted last year and in September his diet consistency was changed to puree for a few months and then he resumed a regular bite size diet. The QIDP revealed the facility did not have a SLP consultant and the former RD last working day was a week ago.

Interview on 3/12/24 with the nurse revealed she had ongoing concerns about the FC #1's neurological condition, fluid intake and swallowing problems. The nurse revealed the facility did not receive hospital or consultation records because they were sent directly to the guardian. The facility had to get information from the guardian or review the summary on the after discharge report. The nurse acknowledged she was not able to review the MBS or SLP report. In addition, the nurse confirmed the FC #1 was treated at the hospital 3 x for fluid in his lungs since December 2023. He received intravenous ABT when hospitalized but was taking an oral ABT in February, 2024. The nurse revealed she suspected the former client had a bacteria pneumonia infection due to the length of ABT treatment.

Interview on 3/12/24 with the former RD revealed the FC #1 would "guzzle down his drinks and it affected his equilibrium, sodium and potassium levels." In December, 2023, the former RD had an opportunity to review a "temporary sheet" of what the SLP summarized. The former RD did not receive any additional reports after her 2/7/24 visit that the FC #1 was taking water from sources in the bathroom, or that he experienced

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W 111	Continued From page 5 emesis and bowel incontinence on 2/26/24-2/27/24. The former RD revealed if he was vomiting and had diarrhea for an extended period, it could cause dehydration and lead to fecal impaction. B. Record review on 3/11/24 of client #2's Behavior Data Sheet revealed his targeted behaviors were identified and charted per occurrence. None of his data sheets had the month or year the data was recorded. Record review on 3/12/24 of client #2's behavior support plan (BSP dated 8/18/23 revealed data collection will be documented on the right side of the sheet for any unusual behaviors. Interview on 3/12/24 with the QIDP revealed she was not aware the data sheets were not fully completed. The QIDP revealed one of the staff who handles record collection of the client's chart was on a leave of absence.	W 111		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure that privacy was maintained for 1 of 3 audit clients (#1) The finding is: During observations in the home on 3/12/24 between 6:38am -7:00am, client #1 was sitting in the bathtub with the the bathroom door open. Client #1 got out of the tub and dried off with his towel with the bathroom door open. Client #1	W 130		

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W 130	Continued From page 6 walked down the hallway wearing no clothes to his bedroom. Further observation, client #1's bedroom door remained opened while he was getting dressed. Interview on 3/12/24 with the home manager confirmed the door should have been closed to maintain his privacy.	W 130		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident of neglect was thoroughly investigated for 1 of 1 former client (Former client #1). The finding is: Review on 3/11/24 of the facility's internal investigation and incident report, indicated that FC #1 had a fall at the facility and emergency services were called. FC #1 received stitches over his right eye. Statements from the facility staff were gathered. There was not other documentation to review Interview on 3/12/24 with the qualified intellectual disabilities professional (QIDP) revealed she was told to gather statements and that was what she did. She further confirmed that was what she had complied for the 1/2/24 fall investigation.	W 154		
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	W 249		

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W 249	Continued From page 7 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 review, and interviews, the facility failed to ensure 1 of 3 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the individual Program Plan (IPP) adaptive equipment use. The finding is: During evening observations in the on 3/11/24 from 4:00pm-6:15pm, client #1 had not worn his left elbow brace, AFO for his left leg, compression hose or his velcro wrist brace. During this time client #1 took off his shoes at the table, colored in a coloring book and was not prompted or encouraged to use any of his adaptive equipment. Review on 3/12/24 revealed, Client #1 Uses adaptive equipment, wears and AFO shoe insert on his left leg and requires the use of tennis hoes on a regular basis, wears a brace on left left hand during awaken hours, also wears compression stocking on left leg. Further review revealed , occupational evaluation dated 6/3/2020 adaptive equipment AFO, Left wrist brace and compression stockings. Additional review of client #1's data book revealed no documentation of refusal of adaptive equipment. Interview on 3/12/24 with home manager	W 249		

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W 249	Continued From page 8 confirmed client #1 does have AFO, compression stockings and wrist brace however client #1 refuses to wear his adaptive equipment.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure techniques used to manage inappropriate behavior were reviewed and monitored by the Human Rights Committee (HRC) for 1 of 3 audit clients (#2). The finding is: During observations in the home throughout the survey on 3/11/24 and 3/12/24, Staff C and the home manager were observed taking a key from a kitchen drawer to unlock the pantry closet on the hallway to get food items. The clients in the home were never observed to use the key to retrieve food items. Additional observations in the home on 3/11/24 at 9:38am, revealed client #2 wearing a mechanic's jumpsuit worn backwards with the zipper and buttons on his back. A return visit to the home on 3/11/24 at 4:00pm, client #2 was wearing a different color mechanic's jumpsuit, worn backwards. At 4:10pm, client #2 laid on the activity room floor on top of his stomach and began to hump the floor with his hands in his pockets until he climaxed. The home manager witnessed client #2's actions and confirmed this	W 262		

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was a behavior, to masturbate in public. Client #2 was observed to go outside with staff twice, wearing a hoodie top over the mechanic's jumpsuit. On 3/12/24 at 6:45am, client #2 was dressed in a mechanic's jumpsuit, worn backwards.

Record review on 3/11/24 of client #2' behavior support plan (BSP) signed 8/25/23 failed to identify a locked food pantry. Further review of the BSP failed to include client #2 would wear restrictive clothing in the home.

Interview on 3/11/24 with Staff A revealed he has worked in the home for several months and have always known client #2 to wear the mechanic's jumpsuit. Staff C revealed it was worn because client #2 had a known history of pulling out his g-tube.

Interview on 3/11/24 with Staff B revealed she has worked in the home for almost year and client #2 was wearing a mechanic's jumpsuit then. Staff B stated that client #2 used to have a g-tube that he pulled out and he had a history of disrobing. Staff B also revealed if client #2 went out in public, he wore something else.

Interview on 3/12/24 with the home manager revealed a the client's father purchased the mechanic's jumpsuit for client #2 because he had been known to pull out his g-tube, smear feces, disrobe and masturbate in public. The home manager acknowledged client #2 no longer had a g-tube. The home manager also revealed that the former client in the home would take beverages that did not belong to him and acknowledged that he saw another client in the home this morning, take food out the kitchen to eat, when staff was

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W 262	Continued From page 10 not present. Interview on 3/12/24 with the qualified intellectual disabilities professional (QIDP) confirmed a non-guardian furnished the mechanic's jumpsuit for client #2 to wear due to a history of stripping and pulling out his g-tube. The QIDP acknowledged his BSP never addressed wearing a mechanic's jumpsuit and she had not viewed it as a restrictive device. The QIDP also acknowledged client #2 was not supposed to leave the home wearing the jumpsuit in public, but changed into "regular clothes." The QIDP did not have evidence the human rights committee approved the mechanic's jumpsuit for client #2.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive Behavior Support Plan (BSP) identified behavioral medications and restrictive behavioral techniques, when seeking consent from the guardian. This affected 1 of 3 audit clients (#2). The findings include: Record review on 3/11/24 of client #2's BSP dated 8/18/23 revealed the following: Client #2 would decrease feces smearing to 1 or fewer incidents for 10 out of 12 continuous review period (CRP). Staff would closely supervise client #2 when using the restroom. If he attempted to smear or eat the feces, staff would say "STOP", assist him to clean up area and wash hands	W 263		

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thoroughly. Also during night time checks, staff were to monitor client #2 to make sure he was not smearing feces.
Client #2 would decrease public masturbation behaviors to 0 or fewer incidents for 10 out of 12 CRP. If client #2 engaged in public masturbation, staff would direct him to stop and if he continued, staff could use a graduated guidance to make sure he stopped or move him to another area. The BSP did not include stripping as a targeted behavior. The BSP did not include client #2 wearing a mechanic's jumpsuit, worn backwards, to prevent access to genitalia.

Record review on 3/11/24 of client #2's individual program plan (IPP) dated 9/28/23 revealed the team agreed, in order to prevent his g-tube from being pulled out, staff would utilize tape and gauze, wraps and mitts to be worn when he attempts to pull it out. The IPP also acknowledged the g-tube had been removed over a year ago. The IPP did not include client #2 wearing a mechanic's jumpsuit, worn backwards, when inside the home.

Record review on 3/12/24 of the BSP Consent form signed by the guardian on 8/25/23 revealed it only identified client #2's targeted behaviors and failed to list behavioral medications and/or restrictive devices.

Interview on 3/12/24 with the home manager revealed he was not working in the home at the time the BSP consent was signed.

Interview on 3/12/24 with the qualified intellectual disabilities professional (QIDP) revealed she was not the QIDP until December, 2023.

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W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the use of systematic interventions to manage clients inappropriate behaviors were incorporated into the client's individual program plan (IPP). This affected 1 of 3 audit clients (#2). The finding is: During survey observations in the home on 3/11/24 through 3/12/24, client #2 was placed in several mechanic's jumpsuits, worn backwards. On 3/11/24 at 4:30pm, client #2 was observed wearing a hoodie top over his jumpsuit when going outside to sit on the porch. Review on 3/11/24 of client #2's IPP dated 9/28/23 revealed client #2 had a history of non-compliance, physical aggression, loud vocalization, spitting, severe disruptive behaviors, feces smearing, public masturbation and pulling out the g-tube (which was surgically removed). Client #2 benefited from the use of mitts to be worn when attempting to pull out g-tube. The team agreed to utilize the following to aide in prevent client #2 from not pulling tube out: tape and gauze, wraps, mitts to be worn when attempting to unlogged the g-tube. Staff were to follow his behavior support plan (BSP) to manage his behaviors.	W 289		

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THE CARTER CLINIC RESIDENTIAL HOME	235 KINLAW RD FAYETTEVILLE, NC 28301

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Record review on 3/11/24 of client #2's BSP dated 8/18/23 revealed the following:
Client #2 would decrease feces smearing to 1 or fewer incidents for 10 out of 12 continuous review period (CRP). Staff would closely supervise client #2 when using the restroom. If he attempted to smear or eat the feces, staff would say "STOP", assist him to clean up area and wash hands thoroughly. Also during night time checks, staff were to monitor client #2 to make sure he was not smearing feces.
Client #2 would decrease public masturbation behaviors to 0 or fewer incidents for 10 out of 12 CRP. If client #2 engaged in public masturbation, staff would direct him to stop and if he continued, staff could use a graduated guidance to make sure he stopped or move him to another area.
The BSP did not include stripping as a targeted behavior. The BSP did not include client #2 wearing a mechanic's jumpsuit, worn backwards, to prevent access to genitalia.

Review on 3/11/24 of an undated behavior data sheet marked for the first of a month, revealed client #2 did not have any incidents of smearing or public masturbation. Further stripping off clothes was not listed as a target behavior.

Interviews on 3/11/24 with Staff A, Staff B , Staff C and Staff D confirmed client #2 wore a mechanic's jumpsuit, furnished by non-staff because he used to have a g-tube, would disrobe, smear feces and masturbate in public. Staff were instructed to dress client #2 in regular street clothes when outside of the home.

Interview on 3/12/24 with the home manager revealed non-staff and the facility purchased the mechanic's jumpsuits for client #2 to wear due to

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W 289	Continued From page 14 his behaviors. The home manager acknowledged that client #2 no longer had a g-tube. Interview on 3/12/24 with the nurse revealed client #2 wore the jumpsuit backwards originally to prevent him from removing a peg tube because the wraps were not working. The nurse revealed the guardian told them whenever the tube was discontinued, client #2 "might resort back to throwing feces like he did when he was younger." The nurse acknowledged when the jumpsuit was "turned around the other way, [client #2] will strip and throw feces." Interview on 3/12/24 with the qualified intellectual disabilities professional (QIDP) revealed client #2 wore the mechanical jumpsuit due to g-tube and now for stripping. The QIDP confirmed his plan never addressed wearing a jumpsuit that was provided from nonstaff.	W 289		
W 312	DRUG USAGE 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 interview, the facility failed to ensure 1 of 3 audit clients (#2) had a behavior support plan (BSP) developed to address the administration of medication for behavioral control. The finding is: Review on 3/12/24 of client #2's BSP dated 8/18/23 revealed medications used to treat his behavioral disorder included Risperdal,	W 312		

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W 312	Continued From page 15 Guanfacine and Diazepam. Review on 3/12/24 of client #2's BSP consent signed on 8/25/23 by his guardian, psychotropic medications were not listed, to treat behaviors. Interview on 3/12/24 with the qualified intellectual disabilities professional (QIDP) revealed she was unaware the BSP consent should include behavioral medications used.	W 312		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff demonstrated competency in recognizing signs and symptoms to report to nursing for 1 of 3 audit clients (#1) and the former client (FC #1). The findings are: A. Record review on 3/11/24 of the Incident Report Improvement System (IRIS) from incident on 2/27/24 with FC #1 revealed he experienced repeated emesis episodes and was incontinent of bowel during the night. The report revealed Staff E contacted the home manager the morning of 2/27/24 to report the FC #1's symptoms. A decision was made to contacted ambulance to transport the FC #1 to the hospital.	W 342		

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W 342	Continued From page 16 Review on 3/12/24 of the Medical Chain of Command, posting in the staff office revealed to call the nurse, then the medical coordinator, the QIDP, the home manager and then the resident director. Interview on 3/12/24 with Staff E revealed he began his shift on 2/26/24 at 11:00pm and received a report from Staff C and D who worked the previous shift, the FC #1 was not feeling well and had been vomiting. Staff E revealed the FC #1 vomited twice by 4 am and he observed that there were chunks of poorly chewed food, in his vomit. Staff E also observed the FC #1 had defecated on himself and still did not feel well. Staff E further revealed he cleaned up the FC #1, who went back to bed. Between 5:30-6:00am, the FC #1 took his morning medications, but vomited the pills soon afterwards. Staff E stated around 6:20am he contacted the home manager (HM) because he was very concerned about the FC #1. Staff E reached out to the medical coordinator after the call and was instructed to call the ambulance, who arrived around 7:00am. Staff E acknowledged "I panicked a little bit" and did not call the nurse. Interview on 3/12/24 with Staff D revealed he worked 2nd shift on 2/26/24 with Staff C. Staff D revealed that they were told the FC #1 had been vomiting during the day, in their shift report. Staff D stated the FC #1 had also had bowel accidents on himself because he could not make it to an unlocked bathroom door in time. Staff D revealed the former client required his food to be cut up into small pieces and sometimes he would request for his food to be softened or puree. Staff D had witnessed the former client "chowing down	W 342		

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non-stop, eating too fast with his fingers" at some meals. Staff D observed FC #1 had trouble chewing "stringy meats" like chicken and beef, as well he commented the FC #1 was "prone to choking".

Interview on 3/12/23 with Staff C revealed he worked 2nd shift on 2/26/24 with Staff D. For dinner, Staff C prepared a frozen beef tips dinner, mashed potatoes and green beans to the former client. Staff C stated he did not have to cut up the food before serving, he only reheated it. After dinner, the FC #1 told Staff C he wanted to lay down, which was something he usually did after dinner. Staff C said at 8:00pm, he was doing laundry and noticed the FC #1 standing up next to his bed. The FC #1 told Staff C he had vomited. Staff C went in the room and noticed FC #1 had vomited food contents, that looked like fruit chunks, on the floor. Staff C stated that fruit was not on the dinner menu; he suspected former client may have eaten it earlier in the day. Staff C revealed after the FC #1 had to vomit again, he contacted the nurse and reported his symptoms. Staff C revealed the nurse wanted the FC #1 to lay back down, to give him Tylenol and instructed Staff C to hold his meds in case he vomited them. Staff C stated he hoped to give FC #1 medication to treat nausea, but there was none in stock. By 11:00pm when his shift ended, Staff C revealed the FC #1 vomited two more times, but he did not call back the nurse; he shared an update with Staff E.

Interview on 3/11/24 with Staff B revealed she worked the morning of 2/27/24 with Staff E. Staff B revealed FC #1 had been sick this year, in the hospital, had surgery and sent to rehab before returning to the group home last month. Staff B

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acknowledged she was aware FC #1 had vomited throughout the night and she had saw vomited in his room when she arrived. Staff B confirmed an ambulance was called for the FC #1 on her shift and he needed to be hospitalized.

Interview on 3/11/24 with the HM revealed he received a phone call the morning of 2/27/24 from Staff E about the FC #1 had vomited throughout the night and had bowel incontinence. The HM revealed "they always call the medical coordinator (MC) when discussing medical concerns and the MC would call the nurse, who would tell them what to do." The HM acknowledged he contacted the MC on 2/27/24 to report the FC #1 not feeling well. The HM also acknowledged the MC was not a nurse, she transported clients to their medical appointments.

Interview on 3/12/24 with the nurse revealed she received a phone call from a staff at the home between 10:00-11:00pm on 2/26/24 that FC #1 was vomiting. The nurse confirmed she told Staff D to let FC #1's stomach rest because she was aware that a "bug was going around." The nurse stated she was not told the former client had bowel movements and she did not ask for details about the contents of his vomit. The nurse expressed there had been ongoing concerns with the FC #1's chewing and diet consistency; he had a Modified Barium Swallow test but had been cleared by a speech language pathologist to return him to a regular diet with bite size pieces. The nurse acknowledged the facility did not have access to his medical tests or detailed summaries, but she confirmed the FC #1 had a general decline in health over the past few months. On 2/27/24, the nurse stated she was contacted by the MC about the FC #1 was still

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W 342	Continued From page 19 sick and she gave the order to send him out to the hospital. The nurse acknowledged the MC did not have a medical background; she was a transporter to appointments. The nurse revealed the current protocol for notification of change in condition, the home manager contacted the medical coordinator, who then called the nurse. The nurse stated her number is posted in the facility and staff can call her directly too. B. During observations in the home on 3/11/24 at 5:02pm in the dining room, client #1 fell on the floor, next to his dining room chair. His head landing on the floor, resting on the right side. The home manager witnessed the fall, while Staff D helped him stand. The home manager was heard asking client #1 if he was okay and he responded, "yes". The home manager was not observed contacting the nurse before 6:00 pm, although surveyors witnessed him contacting the medical coordinator to report another client not feeling well. Interview on 3/12/24 with the home manager revealed he did not call the nurse about client #1 because he witnessed the fall and when he checked him out later, he did not see an injury. Interview on 3/12/24 with the nurse revealed she should be contacted any time the client falls. The nurse affirmed if contacted, she can assure the client be transported to the emergency department for further testing of head injury or fracture from brittle bones.	W 342		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure	W 368		

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W 368	Continued From page 20 that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure physician's orders were being followed. This affected 1of 3 audit clients (#2). The finding is: During observation on 3/11/24 at 5:00pm, medication pass, client #2 consumed his sodium benzoate 40ml. Client #2 drank the medication mixed with a cup of water with a flavored syrup mix. Review on 3/12/24 of client #2's physician orders dated 11/6/23 revealed the following ordered: Sodium Benzoate give 10ml via the G-tube at 5am 11am 5pm and 10pm daily. Interview on 3/11/24 staff C confirmed client #2 does not have a g-tube and takes medication by mouth. Interview on 3/12/24 facility nurse confirmed client #2 no longer has a g-tube and there should be a new prescription and the physician orders should reflect the change of taking medication by mouth.	W 368		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were conducted during varying times and conditions. This had the potential to effect all of the clients (#1, #2, #3, #4 and #5). The finding is:	W 441		

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W 441	Continued From page 21 Record review on 3/11/24 revealed the following fire drills in the home: Second Shift 5/11/23 at 3:34pm 7/left blank/23 at 3:30pm 2/15/24 at 3:05pm Third Shift 6/13/23 at 6:30am 9/10/23 at 6:55am 12/7/23 at 6:14am Drills conducted on 10/17/23, 11/6/23 and 1/17/24 lacked information on the time it started and how long it took to evacuate the clients. Interview on 3/12/24 with the home manager revealed he acknowledged that he forgot to record the times of the drills that he conducted.	W 441		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 3 of 3 audit clients (#1, #2 and #3) utilized hand hygiene before meals. The findings are: A. During observations in the home between 4:00-5:30pm, client #2 dropped to the floor often, resting his palms on the floor. Client #2 was not directed by staff to wash his hands before sitting at the dining room table to eat dinner. Client #2	W 454		

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W 454	Continued From page 22 was observed taking dinner rolls on his plate, with bare hands and consuming them. Review on 3/11/24 of client #2's IPP dated 9/28/23 revealed he needed verbal prompting to ensure personal hygiene. B. During observations of the medication pass throughout the survey 3/11/24-3/12/24, client #1 was administered his medications without sanitizing his hands. Staff C had not sanitized his hands prior to the medication pass. Further observation of the morning of 3/12/24 medication pass staff B did not wash or sanitize her hands prior to client #1 entering the medication area. Client #1 did not wash or sanitize his hands before the medication pass began. Client #1 poured the medications into his hands before putting them in his mouth. Interview on 3/12/23 with staff B revealed she probably should have sanitized the clients hands, she was trained to sanitize hands when doing the medication pass. Interview on 3/12/23 with the qualified intellectual disabilities professional revealed clients and staff should sanitized there hands before the medication pass.	W 454		