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W 000	INITIAL COMMENTS A follow-up survey was completed on 3/18/24 through 3/20/24 for the complaint survey completed on 1/4/24 and the recertification survey completed on 1/17/24. The facility remains out of compliance with the regulations cited. In addition, a complaint survey was completed on 3/18/24 through 3/20/24 for Intakes #NC00214211, #NC00214220, #NC00214344 and #NC00214611. All complaints were substantiated and deficiencies were cited related to the complaints, including a Condition of Participation in Dietetic Services. In addition, standard level deficiencies were also cited unrelated to the complaint intakes.	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure clients' had the right to dignity and respect regarding the use of incontinence padding, staff interactions with clients, and soiled clothing for 3 of 5 audit clients (#2, #3 and #4). The findings are: A. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, Staff A was observed to talk to client #3 in a very harsh and aggressive tone of voice. For example, while sitting at the	W 125		

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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table, client #3 raised his hand and Staff A was observed to say, "Uh huh, no, don't you do that!" At 4:21pm, Staff A was observed to take client #3 into the living room and he sat in the recliner. Staff A was observed to retrieve a puzzle with two missing pieces and give it to client #3. At 4:26pm, client #3 was sitting at the dining room table. Staff A was observed to go to a dresser in another client's room to get clothing, where she found one of the missing puzzle pieces. Staff A was observed to walk into the dining room, and say to client #3, "Here's your apple puzzle piece," and throw it across the table at client #3.

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) revealed staff are expected to always involve clients in active treatment. The QIDP confirmed staff are expected to be professional and talk to and treat clients with respect.

B. During observations in the home on 3/18/24 at 4:15pm, client #2 was observed to walk to a closet, retrieve an incontinence pad, and place it on the seat of the recliner in the living room and sit down.

Further observation in the home on 3/18/24 at 4:50pm revealed Staff C to instruct client #2 to go to the closet and retrieve another incontinence pad and place it on the seat of the recliner in the living room.

Interview on 3/19/24 with the PM and QIDP revealed an incontinence pad is used as client #2 will have toileting accidents and it prevents the furniture from getting soiled. The QIDP confirmed the use of the incontinence pad in the

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Continued From page 2
manner described is a dignity issue.

C. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, client #4 was observed sitting in her wheelchair with an incontinence pad tucked underneath her in the seat of the wheelchair.

Interview on 3/19/24 with the PM and QIDP revealed an incontinence pad is used as client #3 will have toileting accidents and it prevents the wheelchair from getting soiled. The QIDP confirmed the use of the incontinence pad in the manner described is a dignity issue.

D. During observations in the home on 3/18/24 from 4:00pm - 6:00pm revealed Staff A to repeatedly call client #4 "Grandma."

Review on 3/19/24 of client #4's person centered plan (PCP) dated 4/18/23 revealed her preferred name is her legal, given first name.

Interview on 3/19/24 with the QIDP confirmed staff should not be calling client #4 "Grandma," but should be calling her by her name.

E. During observations at the home on 3/18/24 at 4:00pm, client #3 was observed to get off the van, with his pants soiled with urine. Additional observations at 4:37pm revealed client #3 to ambulate from the dining room to the medication room. The observations revealed client #3's pants to be further soiled with urine. At approximately 5:20pm, client #3 was taken into his bedroom and changed for dinner.

Review on 3/18/24 of client #3's PCP dated 7/17/23 revealed client #3 has moments of

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W 125	Continued From page 3 incontinence and should be prompted regularly to use the restroom and should be changed immediately if incontinence occurs. Interview on 3/19/24 with the QIDP confirmed client #3 should have been changed after his clothing was soiled.	W 125		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the right to privacy for 2 of 5 audit clients (#2 and #3) related to the use of an audio/video monitoring device. The findings are: A. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, an audio/video monitoring device was observed sitting on a table in the living room. The audio/video monitoring device was directed towards client #2's bed. Throughout the observations, there were extended periods of time when no staff were in the living room to watch the monitor while client #2 was in his bedroom. Review on 3/18/24 of client #2's person centered plan (PCP) dated 6/5/23 revealed an audio/visual monitoring device is used to monitor client #2 while in his bedroom. Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) revealed the audio/visual	W 129		

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W 129	Continued From page 4 monitoring device is used to monitor client #2 for seizure activity while he is in his bedroom. The QIDP confirmed the receiving end of the audio/visual monitoring device should be located in the medication room to provide client #2 with privacy when he is in his bedroom. B. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, an audio/video monitoring device was observed sitting on a table in the living room. The audio/video monitoring device was directed towards client #3's bed. Review on 3/19/24 of client #3's PCP dated 7/17/23 revealed no documented reason for the use of the audio/visual monitoring device. Interview on 3/19/24 with the PM and QIDP revealed the audio/visual monitoring device is used to monitor client #3 due to his diagnosis of Pica. The QIDP confirmed the receiving end of the audio/visual monitoring device should be located in the medication room to provide client #3 with privacy when he is in his bedroom.	W 129		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 5 audit clients (#2). The finding is: During observations in the home on 3/18/24 at 4:26pm, Staff C was observed to tell client #2 to	W 130		

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go take his shower. Client #2 was observed to walk into the laundry room, remove his shorts and T-shirt, and walk into the hallway and stand for two minutes wearing nothing but an incontinence brief. Client #2 then walked down the hall, through the dining room and stood in the kitchen where Staff C was preparing dinner.

Staff A was observed to tell client #2 to go put his shorts on, and walked into the bedroom with him with the door remaining open. Staff A was observed to get a pair of shorts, but put them down and walked out of the bedroom. Client #2 was observed to remove his incontinence brief, walk out of his bedroom nude, and stand in the area between the kitchen and dining room. Staff C was observed to physically prompt client #2 back to his bedroom, but left the door opened.

Staff C walked out of the bedroom, followed by client #2. Client #2 stood in the kitchen, nude with no clothing, as Staff A was pushing another client into the room in a wheelchair. Staff A was observed to say, "You know better." Staff A and Staff C then physically prompted client #2 back to his bedroom, where Staff A and Staff C discussed what to do about client #2 taking his shower. The door to the bedroom remained opened with client #2 standing in the doorway, naked.

Record review on 3/19/24 of client #2's adaptive behavior inventory (ABI) dated 6/2023 revealed in the area of Self Help, closes the door for privacy, a score of 1, indicating no independence; cannot perform any portion of this behavior independently.

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities

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W 130	Continued From page 6 professional (QIDP) revealed client #2 should be assisted by staff with taking his shower. The QIDP confirmed that staff should have assisted client #2 with maintaining his privacy and by closing the door when he was in his bedroom and reacting more quickly when assistance is needed.	W 130		
W 194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure staff was able to demonstrate skills and techniques necessary to work with 5 of 5 audit clients (#1, #2, #3, #4 and #5). The findings are: A. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, Staff A was observed to repeatedly use her cell phone by texting and making/receiving phone calls. For example, at 5:36pm, Staff A was observed to sit at the dining room table with client #4, assisting her with eating dinner. A cell phone was lying on the buffet table in the dining room, and when it rang, Staff A was observed to get up, answer the phone, and walk into the living room to have a conversation, leaving client #4 sitting at the table. Review on 3/19/24 of the facility's policy Use of Communication Systems and Mobile Devices, revealed a section titled, "Using Mobile Devices in the Workplace." Review of this information revealed, "While in the workplace during the employee's working time, employees are	W 194		

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expected to focus on work and should not excessively engage in personal use of any personal mobile device in the workplace, including but not limited to engaging in excessive personal conversations, excessively checking personal e-mail, excessively sending or receiving text messages, playing games, listening to audio, watching video content, surfing the internet and/or visiting social media sites. Personal mobile devices should be stored in the employee's desk drawer, briefcase, backpack, purse or vehicle during work time."

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) confirmed staff are not supposed to use their personal mobile devices while working with the clients.

B. During observations in the home on 3/18/24 from 4:00pm - 6:00pm, Staff A was observed to talk to client #3 in a very harsh and aggressive tone of voice. For example, while sitting at the table, client #3 raised his hand and Staff A was observed to say, "Uh huh, no, don't you do that!" At 4:21pm, Staff A was observed to take client #3 into the living room and he sat in the recliner. Staff A was observed to retrieve a puzzle with two missing pieces and give it to client #3. At 4:26pm, client #3 was sitting at the dining room table. Staff A was observed to go to a dresser in another client's room to get clothing, where she found one of the missing puzzle pieces. Staff A was observed to walk into the dining room, and say to client #3, "Here's your apple puzzle piece," and throw it across the table at client #3.

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities

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professional (QIDP) revealed staff are expected to always involve clients in active treatment. The QIDP confirmed staff are expected to be professional and talk to and treat clients with respect.

C. During observations in the home on 3/18/24 from 4:00pm - 6:00pm revealed Staff A to repeatedly call client #4 "Grandma."

Review on 3/19/24 of client #4's person centered plan (PCP) dated 4/18/23 revealed her preferred name is her legal, given first name.

Interview on 3/19/24 with the QIDP confirmed staff should not be calling client #4 "Grandma," but should be calling her by her name.

W 249 PROGRAM IMPLEMENTATION W 249

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 each client received a continuous active treatment program consisting of needed interventions and services as identified in the person centered plan (PCP) and behavior support plan (BSP) for 1 of 5 audit

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W 249	Continued From page 9 clients (#3). The finding is: During an unannounced complaint investigation conducted on 1/4/24, observations at the day program at 12:00PM revealed two staff and six clients in a workshop room. Continued observations revealed client #3 to sit on a bean bag on the floor surrounded by 1 and 1/2 inch hollow rubber teddy bears and lego pieces. Further observations revealed client #3 to hold a cardboard box in hand, bite several pieces and digest it. Subsequent observations revealed after surveyor brought the incident to staff B's attention, staff B immediately removed the cardboard box from the client's hand, open his mouth and attempt to sweep his mouth. Additional observations revealed staff B to check on the client, then proceed to gather the other clients for lunch. Additional observations revealed staff A and B to prepare clients' lunch, lay open lunch boxes and clients' plates on top of the table five feet away from where client #3 was sitting. Observations at 12:15PM revealed client #3 to get up and sit at the table to participate in his lunch meal which consist of chicken and dumplings, chips and water which was consistent to his prescribed mechanical soft diet. After a few spoonful, client #3 sat back down on the bean bag, drinking water from from a sippy cup. At 12:20PM, client #3 got up, sat in his chair to finish eating his lunch. It was also observed that staff stood next to client #3 while eating and encouraged him to drink water from a cup with a lid and straw. Continued observations revealed client #3 to consume his meal with the exception of his chips. Review of the client's record on 1/4/24 revealed a	W 249		

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person centered plan (PCP) dated 7/17/2. Continued review of the record revealed an admission date of 6/19/23 with the following diagnosis listed: binge eating disorder, insomnia, PICA, profound IDD, epilepsy, cerebral palsy, angelman syndrome, GERD, and scoliosis.

Review of an updated behavior support plan (BSP) dated 12/27/23 revealed the following target behaviors; uncooperative, food searching, eye touching or poking, throwing items, PICA, physical aggression, medication refusal, and leaving a supervised area.

Continued review of the BSP revealed interventions for inappropriate food acquisition to include: arrange the environments to limit client taking food without supervision. Be neutral as you move to arrange items to ensure safety, as the client can be driven to seek negative attention. Routinely do PICA sweeps to ensure small items at risk for ingestion are kept out of his environment. Block client and remove items as needed to limit him taking items inappropriately. Utilize environmental supports, i.e. restricted gate to kitchen areas when preparing food, limit openings for grabbing food off counters, etc. Store and dispose of food appropriately to limit having food items out unnecessarily. Have the client participate in skill development and leisure activities in areas away from food preparation activities.

Further review of the BSP revealed the client will move into the eating area when it is time to eat and move out of the eating area when the meal is over under supervision. The client will consume food when seated at the table. The client will have increased supervision during meals. The staff

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assigned to provide increased supervision will sit beside the client, being within arm's reach, throughout the duration of the meal. The client will not be left unattended when food items are out. Ensure the client has adequate caloric and beverage consumption daily, through routine monitoring of health and weight. Maintain awareness of the RHA protocol. Ensure appropriate food consistency, including when having foods brought in, i.e. restaurants, parties, etc.

Subsequent review of the BSP revealed PICA strategies listed to include: if the client attempts to put a non-edible object in his mouth, block the behavior and redirect. Limit touch. Redirection is the key. Refrain from talking about the negative behavior. If the client is successful in putting items in his mouth, prompt him to open his mouth while requesting the object. If he doesn't return the object and it is visible, finger sweep the item out or request the assistance of a nurse immediately, but do not leave his side. Implement choking protocol if needed, as trained.

Interview with the facility nurse on 1/4/24 revealed that staff did not inform her of the client's cardboard ingestion incident. The nurse then proceeded to assess client #3 and reported that his lung sounds and vitals are okay. The nurse also followed up with the client's primary care physician who reported that the cardboard will be eliminated naturally. Continued interview with the nurse confirmed client #3's diet was changed to mechanical soft on 10/24/23 and an inservice with staff was completed. Further interview confirmed following the chocking incident, mealtime guidelines were put in place along with increase in supervision during mealtimes and his

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BSP was updated. Subsequent interview with the nurse also revealed that that the workshop needs to follow the same guidelines as the home.

Interview with the facility program manager, residential team lead and home manager on 1/4/24 revealed client #3's BSP is current and all staff have been trained on 12/29/23 following its implementation. Continued interview with the program manager and nurse revealed staff should have followed the BSP as prescribed.

The follow-up survey and complaint survey completed on 3/18/24 through 3/20/24 revealed the regulation remains out of compliance. For example:

During observations in the home on 3/18/24 at 4:00pm, staff shift change was observed. At no time during the shift change was an environmental sweep of the home completed. In addition, throughout the observations, there were several small painted rocks left sitting out on the buffet table in the dining room. Further observations revealed client #3 to sit in the living room for extended periods of time, with no staff present.

Review on 3/18/24 of client #3's PCP dated 7/17/23 revealed client #3 requires visual supervision at mealtimes due to Pica and choking.

Review on 3/19/24 of client #3's BSP Addendum dated 1/15/24 revealed the following:
-Once per shift, staff will document Pica sweeps of client #3's environment.
-Additionally, throughout the shift, staff will routinely maintain awareness of visually

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scanning, as client #3 enters the environment, to ensure small items at risk for ingestion are put away.
-Client #3 will be provided with increased supervision, as designated on a sign-up sheet, for 1st and 2nd shift. The staff responsible for providing increased supervision and will ensure routine awareness of visually scanning the environment, be within 2 - 4 feet, within direct eyesight and able to intervene quickly.

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) revealed staff are expected to provide environmental sweeps at each shift change, and should be providing increased supervision to client #3 as indicated in his BSP.

W 331 NURSING SERVICES W 331
CFR(s): 483.460(c)

The facility must provide clients with nursing services in accordance with their needs.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure client #1 was provided nursing services in accordance with their needs regarding communication with the client's physicians and other health care professionals and monitoring needed interventions for health and safety. The findings are:

A. Record review on 3/18/24 of client #3's Person Centered Plan (PCP) dated 7/17/23 revealed client #3 was admitted to the facility on 6/19/23. Client #3 was identified as having PICA, GERD and being at risk of falling, aspirating and eloping.

Further record review on 3/18/24 revealed health

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service goals to monitor for skin breakdown, monitor for falls, monitor for choking, remain within IBW, monitor for seizures, monitor for GERD and monitor for constipation.

Record review on 3/19/24 of client #3's medication administration record (MAR) revealed a daily task for staff to enter their initials confirming client #3 remained sitting up after all meals and snacks at 8am and 8pm. This daily task was added to the MAR on 2/21/24.

Interview on 3/19/24 with the facility's LPN revealed all clients with a history or risk of aspiration should remain upright thirty minutes following all meals and snacks.

Interview on 3/20/24 with the facility's registered nurse (RN) revealed she is unsure if client #3 was admitted as an aspiration risk. However, she confirms that client #3 remaining upright thirty minutes after meals should have been implemented on admission due to GERD and recent aspiration/choking events and there should have been a health service goal for aspiration.

B. Record review on 3/18/24 of client #3's physician's orders (dated 2/15/24) for readmission to the facility following a hospital stay revealed an order to "Monitor intake and report if drinks less than 1000 ml in 24 hours" and "Monitor output and report if less than 3 wet diapers in 24 hours".

Further record review on 3/20/24 revealed intake/output records for client #3 as follows:

Client #3 was on a home visit 3/15/24 - 3/18/24
3/14/24- Intake 874 ml; output 2 voided in brief

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3/13/24- Intake 555 ml; output 4 voided in brief
3/12/24- Intake 557 ml; output 4 voided in brief
3/11/24- Intake 348 ml; output 3 voided in brief
3/10/24- Intake 1751 ml; output 4 briefs, 3 times in the toilet
3/9/24- Intake 720 ml; output 5 voided in brief
3/8/24- Intake 25 ml; output 3 voided in brief
3/7/24- Intake 905 ml; output 5 voided in brief
3/6/24- Intake 247 ml; output 3 voided in brief
3/5/24- Intake 675 ml; output 5 voided in brief
3/4/24- Intake 787 ml; output 3 voided in brief
3/3/24- Intake 1000 ml; output 5 voided in brief
3/2/24- Intake 474 ml; output 3 voided in brief
3/1/24- Intake 474 ml; output 3 voided in brief
2/29/24- Intake 1630 ml; output 3 voided in brief
2/28/24- Intake 1183 ml; output 7 voided in brief
2/27/24- Intake 1094 ml; output 4 voided in 4 briefs (also a note that client is on therapeutic leave)
2/26/24 - 2/24/24 therapeutic leave
2/23/24- Intake 30ml; output 4 voided in brief
2/21/24- Intake 1182 ml; output 5 voided in brief
2/20/24- Intake 611 ml; output 3 voided in brief
2/19/24- Intake 723 ml; output 6 voided in brief
2/18/24- Intake 0 ml; output 3 voided in brief
2/17/24- Intake 0 ml; output 3 voided in brief
2/16/24- Intake 600 ml; output 2 voided in brief

Interview on 3/20/24 with the RN revealed intake and output parameters for client #3 are that staff are to notify nursing if he consumes less than 1000 ml in a 24 hour period or less than 3 wet briefs. The RN confirmed that staff has never contacted nursing and notified them that client #3 has not met those parameters.

C. Interview on 3/19/24 with the facility's licensed practical nurse (LPN) revealed when client's are taken on medical appointments staff should take

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W 331	Continued From page 16 a medication list/physician's orders, notes from the last primary care appointment, bowel records, notes from specialty visits and client demographics with the client to each appointment. The LPN confirmed that there have been instances in which staff have gone on appointments and did not take the necessary documentation and nursing would have to fax or email the information to the doctor's office during the appointment.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders for 1 of 5 audit clients (#3). The finding is: During medication pass in the home on 3/18/24 at 4:37pm, client #3 received Buspirone 10mg. Staff C placed the medication inside of a "Magic Cup" and fed client #3 the medication. Review on 3/19/24 of client #3's physician's orders dated 1/5/24 revealed an order for Buspirone 10 mg. Take one tablet by mouth twice daily for anxiety. *Please crush before administering*. Interview on 3/19/24 with the facility's licensed practical nurse (LPN) revealed client #3's medication should have been crushed as indicated in the physician's orders.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING	W 382		

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W 382	Continued From page 17 CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all medications remained locked except when being administered. The findings are: A. During observations in the home on 3/18/24, the medication room was noted to be secured by a lock pad on the door. A dry erase board was observed hanging on the wall outside of the medication room. The dry erase board had the entry key code to the medication room written on it. B. During the medication pass in the home on 3/18/24 between 4:24pm and 4:37pm, staff C walked in and out of the medication room multiple times to get other clients, leaving the surveyor in the medication room unattended. C. During observations in the home on 3/18/24, the qualified intellectual disabilities professional (QIDP) entered the medication room. The surveyor knocked on the door and inquired as to where the controlled medications are kept. The QIDP revealed a box on the counter that was opened and unlocked. Interview on 3/19/24 with the facility's licensed practical nurse (LPN) revealed the dry erase board should not have the entry code to the medication room written on it. The LPN also confirmed that surveyor should never have been left in the medication room unattended, and the	W 382		

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W 382	Continued From page 18 control box should remain locked at all times.	W 382		
W 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure for 2 of 5 audit clients (#3 and #5) received their modified and specially-prescribed diets (W460) and were served food in form consistent with their developmental level (W474). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.	W 459		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide a specially prescribed diet for 2 of 5 audit clients (#3 and #5). The findings are: A. During observations in the home on 3/18/24 at 4:09pm revealed client #3 to sit down and eat a snack which consisted of yogurt mixed with chunky peaches. At no time during the observation was the food placed in the food	W 460		

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processor.

Additional observations in the home on 3/18/24 at 5:18pm revealed client #3 to eat dinner. Client #3's dinner consisted of chicken stew with carrots, green beans and carrots mixed together, mashed potatoes and cranberry sauce. Staff C was observed to mash the chicken stew, cranberry sauce and green bean and carrot mixture with a spoon. The chicken stew continued to have chunky carrots and pieces of chicken, the cranberry sauce was chunky and the green bean and carrot mixture remained chunky. At no time during the observations was client #3's food placed in the food processor.

In addition, a 12 ounce cup of water was observed sitting on the table. The staff and QIDP were discussing if the cup of water needed to be thickened. It was finally determined that the cup of water should be thickened, and the QIDP took a tablespoon from the kitchen and dipped out two large spoonfuls and put them in the water. Client #3 was offered the water two minutes later, but he declined to drink it.

Review on 3/18/24 of client #3's person centered plan (PCP) dated 7/17/23 revealed a diet order consisting of 1/4" pieces of food with thin liquids.

Review on 3/19/24 of the homes diet list dated 2/26/24, provided by the QIDP, revealed a diet for client #3 consisting of mechanical soft diet and nectar thickened liquids.

Review on 3/18/24 of the facility's meal preparation guidelines, completed daily by staff in the home during meals, revealed a diet order for client #3 consisting of mechanical soft, thin

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liquids. The last documented meal preparation guidelines was dated 3/18/24 by staff in the home.

Review on 3/18/24 of the liquid thickener directions revealed for 8 ounces of water, you add two tablespoons and two teaspoons of thickener and let sit for 5 minutes before serving.

Review on 3/19/24 of the facility's "Consistency of Diet Orders" provided by the QIDP revealed that mechanical soft foods should be placed in the food processor for a specific amount of time, depending on what the food substance is.

Interview on 3/19/24 with the facility's licensed practical nurse (LPN) revealed for 12 ounces of water, you would add 3 tablespoons and 3 teaspoons of thickener and let sit for 5 minutes.

Interview on 3/19/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) confirmed that client #3's diet order is mechanical soft, blended in the food processor, with nectar thickened liquids.

Review of client #3's medical records revealed a choking incident on 12/26/23 whihc resulted in aspiration. In addiiton, further review of medical records revealed a second aspirarion event in 2/24.

B. During observations in the home on 3/18/24 at 5:18pm revealed client #5 to be offered dinner which consisted of chicken stew, green beans and carrots mixed together, cranberry sauce and mashed potatoes. Client #5 refused all food items except the mashed potatoes. Staff offered client #5 a substitution, and she requested a can

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W 460	Continued From page 21 of spaghetti and meatballs. She was provided the spaghetti and meatballs, which were served larger than 1" in size. Client #5 was observed to eat all of the meatballs and some of the spaghetti. Review on 3/19/24 of client #5's PCP dated 2/13/23 revealed a diet of regular, food cut into 1" pieces. Review on 3/19/24 of the homes diet list dated 2/26/24, provided by the QIDP, revealed a diet for client #5 consisting of regular, food cut into 1" pieces. Interview on 3/19/24 with the PM and QIDP confirmed staff should have followed client #5's diet order by cutting her food into 1" pieces.	W 460		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations and record review the facility failed to follow the prescribed diet for 1 of 5 clients (#5). The finding is: Observation in the group home on 1/17/24 at 7:06 AM revealed client #5 to participate in a breakfast meal: scrambled eggs, two hash rounds with ketchup, one inch cut ham and orange juice. Continued observation at 7:45 AM revealed client #5 to eat two additional hash brown with ketchup. Review of records on 1/17/24 revealed a person-centered plan (PCP) dated 02/12/23. Continued review of the PCP revealed client #5 to	W 474		

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W 474	Continued From page 22 have a diet that no longer restricts grapefruit from her diet. Further review revealed a regular diet cut into 1-inch pieces. Review of records on 1/17/24 revealed a nutritional assessment dated 11/30/23. Continued review of the nutritional assessment revealed a diet order for a regular diet, one inch pieces and no seconds. Interview with the qualified intellectual disabilities professional (QIDP) revealed that the PCP and Nutritional Assessments are current. Continued interview with the QIDP revealed that all staff were in-serviced on client #5's PCP. During the follow-up and complaint survey on 3/18/24 through 3/20/24, observations in the home revealed diets for 2 of 5 audit clients to be served incorrectly. This regulation remains out of compliance.	W 474		