| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PLEASANT ACRES | 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 |

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| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>§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).<br><br>*[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:]<br>(1) Training program. The [facility] must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(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. | E 037 | E037<br><br>The Qualified Professional and Safety Chairperson will in-service all staff on the EPP. This will include a full-scale emergency drill, mock drill or tabletop activity. The Safety Chairperson will monitor all EPP during the monthly Safety Committee Meeting to ensure they are up to date; drills are completed as required and staff training has been completed. In the future the Qualified Professional will ensure all staff are trained on the Emergency Preparedness Plan along with required drills/tabletop activities. | 9/24/23 |

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 037 | Continued From page 1<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(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.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness | E 037 | | |

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| E 037 | Continued From page 2<br>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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(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. | E 037 | | |

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| E 037 | Continued From page 3<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. | E 037 | | |

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| E 037 | Continued From page 4<br>*[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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness Plan (EPP). The finding is:<br><br>Review of the facility's EPP on 7/25/23 revealed it was reviewed by the facility administrator in June of 2023. Continued review did not reveal evidence of initial or biennial training on emergency preparedness.<br><br>Interview with the program manager on 7/26/23 confirmed that initial training and biennial training for existing staff were not completed. | E 037 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>§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).<br><br>*[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 | E 039 | E039<br><br>Cross Reference E037 | 9/24/23 |

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| E 039 | Continued From page 5<br>§491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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. | E 039 | | |

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| E 039 | Continued From page 6<br>*[For Hospices at 418.113(d):]<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br><br>(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:<br>(i) Participate in an annual full-scale exercise that | E 039 | | |

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| E 039 | Continued From page 7<br>is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, | E 039 | | |

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| E 039 | Continued From page 8<br>facility-based functional exercise; or<br>(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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or | E 039 | | |

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| E 039 | Continued From page 9<br>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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an | E 039 | | |

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| E 039 | Continued From page 10<br>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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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 | E 039 | | |

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| E 039 | Continued From page 11<br>emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(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.<br>(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 | E 039 | | |

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| E 039 | Continued From page 12<br>is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(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.<br>(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. | E 039 | | |

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| E 039 | Continued From page 13<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct biennial testing of the facility's Emergency Preparedness Plan (EPP). The finding is:<br><br>Review of the facility's EPP on 7/25/23 did not reveal evidence of a full scale community and/or facility-based emergency drill, or an additional mock drill or table top exercise.<br><br>Interview with the program manager on 7/26/23 confirmed the facility has not conducted a full scale community and/or facility-based emergency drill, or an additional mock drill or table top exercise. | E 039 | | |
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. | W 130 | | |

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| W 130 | Continued From page 14<br>This STANDARD is not met as evidenced by:<br>Based on observation and interviews, the facility failed to ensure privacy during treatment and care of personal needs for 1 of 6 clients (#3). The findings are:<br><br>Observation upon entry to the group on 7/26/23 at 6:30 AM revealed client #3 to be in the medication room with the door open. Continued observation revealed client #6 to be sitting outside the medication room watching as client #3 received his medication from staff.<br><br>Interview with the facility nurse on 7/26/23 confirmed staff should offer privacy during medication administration. | W 130 | W130<br><br>The Qualified Professional will in-service staff on clients' right to privacy during personal care and medication administration. The clinical team will monitor through Interaction Assessments two times a week for one month and then on routine basis to ensure clients are provided privacy during personal care and medication administration. In the future the Qualified Professional will ensure staff are trained to ensure clients are provided privacy during personal care and medication administration. | 9/24/23 |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions relative to communication were implemented as identified in the person-centered plan (PCP) for client #6. The finding is: | W 249 | W249<br><br>The Qualified Professional will in-service staff on client #6 communication objective. The clinical team will monitor through Interaction Assessments two times a week for one month and then on a routine basis to ensure client #6 communication program is being implemented. In the future the Qualified Professional will ensure staff are trained to implement training objectives as written in the Person-Centered Plan. | 9/24/23 |

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| W 249 | Continued From page 15<br>Observation in the group home on 7/25/23 from 3:45 PM through 5:15 PM revealed client #6 to participate in a leisure activity. Continued observation revealed client #6 to participate in the dinner meal, fix his dinner plate, pour his drinks and take his dishes to the kitchen. Further observation revealed client #6 to return to his room. Subsequent observation revealed staff to verbally prompt client #6 to transition from one activity to another. At no time during observation did staff implement client #6's communication training objective.<br><br>Observation in the group home on 7/26/23 from 6:30 AM through 8:00 AM revealed client #6 to participate in a leisure activity. Continued observation revealed client #6 to set the table. Further observation revealed client #6 to participate in the breakfast meal, fix a bowl of cereal, pour his drinks, eat and take his dishes to the kitchen. Subsequent observation revealed client #6 to return to his room. At no time during observation did staff implement client #6's communication training objective.<br><br>Review of records for client #6 on 7/26/23 revealed a person centered plan (PCP) dated 8/8/22. Further review of the PCP for client #6 revealed training objective goals to include: table manners, oral hygiene and communication TEACCH schedule. Continued review of the communication training objective revealed the following: in order to maintain as much independence as possible and develop life-long routine skills, staff will NOT tell client what to do. Rather, during times of transition, staff will say, "client #6 go check your schedule". Client #6 will read the item, check it off and go to the location with 90% accuracy over a period of two | W 249 | | |

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| W 249 | Continued From page 16<br>consecutive months. Implementation date 2/2/23.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) on 7/26/23 revealed all training objectives are current for client #6. Further interview with the QIDP and PM verified client #6 communication objectives should be implemented as written to increase communication skills. | W 249 | | |
| W 262 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(i)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure that updated, written informed consent from the human rights committee (HRC) was secured for a gated fence and exterior door alarms for 3 of 6 clients (#2, #4 and #5). The finding is:<br><br>Observations in the group home during the survey period from 7/25/23 - 7/26/23 revealed a gated fence surrounding the facility. Continued observations revealed exterior door alarms to ring upon staff and surveyors entering and exiting the facility.<br><br>Review of client records on 7/26/23 for client #2 did not reveal a signed consent from his guardian or HRC for the gated fence or alarms on exit doors. Continued review of client #4's record revealed a guardian consent dated 12/1/20. Further review of client #5's record revealed a | W 262 | W262<br><br>The Qualified Professional and Behavior Analysist will review and obtain necessary consents from guardians and HCR gate and alarms on doors. The Qualified Professional will monitor during quarterly QP Reviews to ensure all consents for rights limitations are in place. In the future the Qualified Professional will ensure consents from guardians and HRC are obtained for all rights restrictions. | 9/24/23 |

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| W 262 | Continued From page 17<br>guardian consent dated 8/11/21. Subsequent review the clients' record did not reveal updated written informed consents from guardians and HRC relative to a gated fence or exterior door alarms.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) on 7/26/23 revealed that current guardian and human rights consent limitation forms for clients #2, #4, and #5 could not be located during the survey. Continued interview with the QIDP and PM verified HRC limitation consent forms for all clients should be updated and signed by the HRC and legal guardian annually. | W 262 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>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:<br>Based on observation, record review and interview, the facility failed to ensure that all drugs, including those that are self-administered, were administered without error for 1 of 6 clients (#6). The finding is:<br><br>Observation in the group home on 7/26/23 at 6:32 AM revealed client #6 to enter the medication room for medication administration. Continued observation revealed the client to receive the following medications: Vitamin D3 50 mcg, Sertraline 100 mg, Oyster Shell 500 mg, Naltrexone 50 mg, Levothyroxin 50 mcg, and Docusate SOD 100 mg.<br><br>Review of client #6's record on 7/26/23 revealed | W 369 | W 369<br><br>Cross reference W371 | 9/24/23 |

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| W 369 | Continued From page 18<br>physician's orders dated 11/2/22. Review of the physician's orders revealed all the client's morning medications are ordered for 7:00 AM, except the Docusate which is ordered for 8:00 AM. Continued review revealed the client's Docusate prescription was added on 7/6/23.<br><br>Interview with the facility nurse on 7/26/23 confirmed client #6's medication orders are current. Continued interview confirmed client #6 medications should be given as prescribed. | W 369 | | |
| W 371 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(4)<br><br>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the system for drug administration failed to ensure 2 of 2 clients (#5 and #6) observed during medication administration were provided the opportunity to participate in medication self-administration. The findings are:<br><br>A. The system for drug administration failed to assure client #5 was provided the opportunity to participate in medication self-administration. For example:<br><br>Observation in the group home on 7/26/23 at 6:40 AM revealed client #5 to enter the medication room for medication administration. Continued observation revealed staff to punch one medication into a cup and hand to the client with | W 371 | W371 A and B<br><br>The nurse will retrain staff on participation and independence during medication administration. The clinical team will monitor through Medication Administration Assessments two times a week for one month and then on a routine basis to ensure clients are afforded the opportunity for independence during medication administration. In the future nursing will ensure staff are trained to allow and encourage independence during medication administration per their Person-Centered Plan. | 9/24/23 |

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| W 371 | Continued From page 19<br>a glass of water. Further observation revealed no education or identification of the client's medication.<br><br>Review of records for client #5 on 7/26/23 revealed a person-centered plan (PCP) dated 11/10/22. Review of the PCP indicated when prompted client #5 can tell you what his medications are for and can punch pills form the pack.<br><br>Interview with the facility nurse on 7/26/23 confirmed staff should provide education and allow the opportunity for participation to all clients who are capable.<br><br>B. The system for drug administration failed to assure client #6 was provided the opportunity to participate in medication self-administration. For example:<br><br>Observation in the group home on 7/26/23 at 6:32 AM revealed client #6 to enter the medication room for medication administration. Continued observation revealed staff to have six medications prepared in a cup and hand to the client with a glass of water. Further observation revealed no education or identification of the client's medications.<br><br>Review of records for client #6 on 7/26/23 revealed a person-centered plan (PCP) dated 8/8/22. Review of the PCP indicated client #6 needs assistance with administering medications appropriately. He can obtain his beverage, come to the medication closet, and can dispose of medication cups. He will need assistance with ensuring that he is punching the correct pill packets. | W 371 | | |

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| W 371 | Continued From page 20<br><br>Interview with the facility nurse on 7/26/23 confirmed staff should provide education and allow the opportunity for participation to all clients who are capable. | W 371 | | |