STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HIGHWAY 117 GROUP HOME	**3801 US 117 NORTH** **GOLDSBORO, NC 27530**

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E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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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a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using

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E 039	Continued From page 2 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 5 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 6 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared

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E 039	Continued From page 8 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure a full scale community/facility-based exercise, mock drill or tabletop exercise to test their Emergency Preparedness (EP) plan was conducted. The finding is: Review on 6/24/24 of the facility's EP plan (last updated on 2/28/24) did not include a full scale community/facility-based exercise, mock drill or tabletop exercise.	E 039		

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E 039	Continued From page 9 Interview on 6/25/24 with the Facility Services Suppotr Director confirmed no full scale community/facility-based exercise, mock drill or tabletop exercise had been conducted.	E 039		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibited neglect (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients, specifically client #4.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record/document reviews, and interviews, the facility neglected to ensure client #4's food consistency was reassessed, specific meal time guidelines were developed/implemented and staff were sufficiently trained regarding his dining needs. This affected 1 of 3 audit clients (#4). The finding is: During lunch observations in the home on 6/24/24 at 11:54am, Staff B served client #4 tomato soup, a turkey lunch meat sandwich, pears (sliced in half), with thin liquids of Kool-aid and water. The staff used their gloved hands to break up the	W 149		

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sandwich into pieces. Once finished, the sandwich pieces were of various sizes resembling the size of a quarter or silver dollar. His pears were then broken into smaller pieces by staff using the edge of a serving spoon and were noted to be about the size of mini carrot sticks. At the meal, client #4 was provided a Provale cup with an adaptive lid which he utilize infrequently to drink from. The client waited until towards the end of the meal and drank his liquid from the cup without the lid applied. Throughout the meal, client #4 coughed frequently. The two staff responded to his coughing by occasionally asking the client if he was ok. No other prompts or interventions were provided.

During dinner observations in the home on 6/24/24 at 4:50pm, Staff C served client #4 two thick slices of meat loaf, dry/thick mashed potatoes with added cheese, cabbage, whole slice of lemon pie, with thin liquids of tea and water. A Provale cup with an adaptive lid was provided at the meal. Client #4 began consuming food items without his meat being cut into smaller pieces. Towards the end of the meal, a staff cut the meat loaf into pieces resembling the size of a quarter to a silver dollar. Other food items remained unaltered. The client initially used the Provale cup with the lid attached to consume his drinks. Towards the end of the meal, client #4 removed the lid and continued to consume his drink. Throughout the meal, the client coughed frequently. The two staff responded to his coughing by occasionally asking him if he was ok. No other prompts or interventions were provided.

During breakfast observations in the home on 6/25/24 at 7:20am, Staff E assisted client #4 to serve himself two whole sausage patties, two

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slices of toast (with added jelly), a whole banana, with thin liquids of juice and water. After serving the food items, Staff E cut the sausage into pieces resembling the size of a quarter. At the meal, client #4 put his two slices of toast with jelly together making a sandwich and consumed it. The client also consumed his banana uncut. A Provale cup was utilized while drinking at the meal; however, the client drank very infrequently while eating but did drink all of his juice once he was finished eating. Throughout the meal, client #4 consistently coughed loudly. Staff E approached the client on two separate occasions and patted him on his back while another staff asked if he was ok.

Observation on 6/24/24 of each client's diet (written by the dietitian, dated 4/10/24) posted in the dining room of the home noted client #4 ingests a "Regular diet, double portions, serve 2nd after eating all on his place. If he does not eat all on his place seconds may not be served. Double snack. Use Provale cup for drinking all liquids." The list did not indicate any information regarding client #4's food consistency.

Interview on 6/25/24 with Staff E (also the Medication Technician) revealed client #4 "coughs a lot" at every meal and sometimes when "he's just sitting" but "mostly eating". The staff indicated client #4's diet was posted in the dining room which only notes that he receives double portions of food; however, does not specify that his food should be altered. Additional interview indicated his coughing is a concern and they have told nursing about it but they have not been provided with any specific instructions on how to address it.

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Interview on 6/25/2024 with Staff D revealed client #4's food is supposed to be cut or chopped up because he has no teeth and cannot chew it. Additional interview indicated client #4 doesn't cough much but it depends on what he eats. The staff noted his Provale cup slows down the liquid so he won't choke.

Review on 6/25/24 of client #4's old physician's orders dated 4/14/15 revealed the following: "Diet double portions to be served on plate except meal ordered in a restaurant from menu. Double snacks, cut food into approximately ¼ to ½ pieces. Use Provale cup for drinking fluids, monitor while eating." Additional review of the clients' current physician's orders 6/1 - 6/30/24 indicated he receives a regular diet with double portions and a Provale cup should be used for drinking. The current order did not specify any information regarding his food consistency.

Review on 6/25/24 of client #4's Speech and Pathology swallow study dated 08/06/20 revealed a diagnosis of oropharyngeal dysphagia. The study noted client #4 was trialed with "thin, puree, thick puree, honey thick liquids, via spoon with intermittent penetration and aspiration noted across trials with throat clear or cough responses. These volitional responses were not fully effective in clearing aspiration. Although swallow is improving, patient is not appropriate for resumption of po (by mouth) intake."

Review on 6/25/24 of client #4's record revealed the interdisciplinary team had held a meeting a year ago to discuss the client's risk for aspiration. The Core Meeting summary dated 6/28/23 revealed the following: "A swallow study

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 13 previously completed show that client #4 aspirates and a feeding tube was recommended. At the time, the guardian denied the feeding tube with emphasis on quality of life. Due to his coughing episodes, we wanted to reopen discussion on what the team is doing to provide him with as much care as possible. He uses a Provale cup when drinking liquids to prevent over delivery of liquids. [Physician's name], [Client #4's] physician, has ordered a chest x-ray. He does not recommend another swallow study at this time but will order one upon guardian request. Staff monitor him as he eats and will be re-inserviced on the signs of aspiration. The team is fully aware of client #4's cough and will work together to ensure that he remains healthy." Review on 6/25/24 of a local hospital's discharge summary dated 7/29/20 - 8/11/20 revealed the following: "At baseline patient has a known history of aspiration; speech therapy was following along, he underwent repeat modified barium study and after further discussion with the facility along with his guardian, we were informed he has a diet of regular consistency with thin liquids and use of Provale cup (allows 5-10 cc per sip). Guardians wish was not to move forward with any kind of PEG tube placement for long-term feeding, which I agree with. I believe this will need to be an ongoing discussion with her/the organization and his PCP." Review of client #4's Nutritional Evaluation addendum dated 08/03/23 revealed the following: "Diet Regular double portions to be served only after he eats all food on first plate, double snacks, use Provale cup for drinking all liquids." Additional review of the Nutritional evaluation also noted: "He uses a Provale cup to slow liquid volume and	W 149		

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W 149	Continued From page 14 reduce risk of aspiration. Goals: continue current diet. Monitor mealtime closely for signs and symptoms of aspiration. Guidelines in place for monitoring." Additional review of the addendum did not indicate the client's current food consistency. During Staff D's interview on 6/24/24, the staff revealed they document the frequency of client #4's coughing, choking or vomiting during meals on food intake sheets. Additional interview indicated the sheets are pulled monthly by the nurse. Review of client #4's food intake chart revealed daily documentation of food consumed by the client and any observed coughing, choking and vomiting. The documentation noted coughing on a daily basis during various meals while consuming a variety of foods over several months. Interview on 6/25/24 with the Residential Support Supervisor (RSS) revealed that she retrieves the food intake charts for client #4 monthly. The RSS indicated she reviews the data, but does not share the information with anyone, unless they ask for it. She stated she thought it was supposed to go to nursing for them to review but she was told to keep it. During the interview, when asked what she does when staff voice concerns about client #4's coughing while eating, she revealed she refers staff to the nurse. When asked did she know if client #4's food is to be chopped up, she responded, staff told her that his food is to be chopped up, but she thought only his meats were chopped. During the interview, the RSS also indicated if client #4 takes the top off his Provale cup, staff should prompt him to put it back on.	W 149		

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Interview on 6/25/24 with the facility nurse revealed client #4's food consistency is regular, but staff cut larger pieces into bite size pieces to make it easier for him to swallow. She also indicated he has no teeth, has dentures but does not like them and does not wear them. Additional interview with the nurse confirmed client #4 has a history of aspiration, and she was told the guardian refused a feeding tube. During the interview, when asked if food consistency instructions are written in his IPP or on his current physician's orders, she indicated there are no food consistency instructions for client #4 written in his IPP or on a current physician's order. She stated, "Staff just go on word of mouth." Additionally, when asked how new staff would know to cut client #4's food, she indicated the old staff verbally pass the information to new staff. When asked if she knew about the form used to document food intake and coughing, choking, or vomiting during meals, she indicated not knowing anything about a form, but stated her supervisor may know.

Interview on 6/25/24 with Nurse Supervisor confirmed client #4 has a history of aspirating and has Provale cups which should be used with the lids attached. When asked what steps she has taken to ensure his safety while eating, she indicated someone must be at the table with client #4 while eating to ensure his safety. When asked if food consistency has been discussed with the interdisciplinary team, she revealed that food consistency has not been discussed and she has not received a call or any written notification about client #4's coughing at meals. When ask if she was aware of a physician's order for client #4 dated 4/15/15 which recommended his food be

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W 149	Continued From page 16 cut in ¼ and ½ pieces, she indicated having no knowledge of the order and why the cut food consistency was not in his most current physician's order. During the interview, when asked what guidelines are in place for monitoring and safety, she revealed that the guideline for monitoring is to complete the food intake sheets and for staff be present at the table with client #4. However, the nurse supervisor also indicated that she does not review or monitor the food intake sheets for client #4. Interview on 6/25/24 with the Qualified Interdisciplinary Disabilities Professional (QIDP) revealed client #4's on a 1800 calorie, regular diet with double portions and double portion snacks. Additionally, when asked if his food should be cut, she noted his most current physician's orders dated 6/1/24- 6/30/24 do not indicate his food should be cut. When asked if client #4 uses the Provale cup, she responded, "He uses his Provale cup when drinking, and if he takes the lid off, he should be redirected by staff, I think." The QIDP indicated she would have to review the previous physician's order for client #4 dated 4/15/15 which recommended his food to be cut into ½ and ¼ pieces. During further interview with the QIDP, when asked if she was aware of the data being gathered and kept regarding client #4's food intake at the meal, she responded that she heard about the data sheet but the data is not being reviewed. Additionally, the QIDP stated she did not know staff have been trained regarding cutting the client's food. The QIDP indicated staff are to observe client #4 closely when eating to keep him safe during meals because of his risk of aspirating.	W 149		

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W 149	Continued From page 17 Review on 6/25/24 of the facility's Consumer Rights/Affair's policy (last review 01/01/14) noted neglect is defined as "Negligence generally represents acts or omission rather than commission, the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. To be classified as neglect, an act (or omission of an act), must constitute actual damage to the physical, emotional, or social development of the consumer. Further definition of neglect is as follows: A. Inadequate supervision or control of consumer. B. Failure to assure essential medical care. C. Failure to assure the consumer attends or participates in habilitation program to which the consumer has previously agreed. D. Exposure to unwholesome or demoralizing circumstances." Based on client #4's diagnosis of dysphasia, his risk of aspiration while eating and his observed coughing at meals, the facility failed to ensure the client's food consistency was reassessed, specific mealtime guidelines/instructions were developed and staff were sufficiently trained to ensure the client's safety during dining. This failure constituted neglect.	W 149		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record reviews and interviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the Individual Program Plan (IPP) was reviewed and revised as needed.	W 159		

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W 159	Continued From page 18 This affected 2 of 3 audit clients (#3 and #4). The findings are: A. Review on 6/24/24 of client #3's IPP dated 5/23/24 revealed the following objectives: "In the residential setting, when instructed, [Client #3] will match the Depakote bubble pack to the MAR for 6 consecutive sessions for 6 consecutive months." "In the residential setting, when [Client #3] spends money, he places his receipts from purchases in his lock box for 6 consecutive sessions for 6 consecutive months." "In the residential setting, when instructed, [Client #3] brushes his teeth for 6 consecutive sessions for 6 months." Additional review of client #3's written programs in his training book located in the home revealed the objectives had been implemented on 7/7/20. Although the client had continued to train on the objectives for almost 4 years, further review of progress notes for the last 3 months indicated the client will "continue training" and his projected completion dates had been extended. Interview on 6/24/24 with Staff A and Staff C indicated the objectives in client #3's training book were current and continue to be implemented in the home. Interview on 6/24/24 with the Habilitation Specialist (HS) confirmed client #3's objectives were current and have been in place for a long time. The HS indicated the team will be updating the client's objectives at his next planning	W 159		

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W 159	Continued From page 19 meeting. Interview on 6/24/24 with the QIDP also confirmed client #3's objectives were current and updates occur at planning meetings. B. Review on 6/24/24 of client #4's IPP dated 10/5/23 revealed the following objectives: "In the residential setting when requested, [Client #4] will correctly button up the button board for 9 consecutive data sessions per month for 6 consecutive months." (Implemented on 2/7/20) "In the residential setting when requested, [Client #4] will brush all surfaces of his teeth using an electric toothbrush for 10 data sessions per month for 6 months." (Implemented on 7/10/20) "In the residential setting, [Client #4] will verbally repeat the name of a specific medications for 8 consecutive data sessions within one month reporting period." (Implemented on 2/23/22) Review on 6/25/24 of the HS progress notes showed that client #4 continues to train on the same objectives after two to four years. Interview on 6/25/24 with the HS confirmed that client #4 continues to work on these objectives, and they would be reviewed at the next planning meeting.	W 159		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for	W 288		

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W 288	Continued From page 20 an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to manage client #3's inappropriate behavior was included in a formal active treatment program. The finding is: During morning observations in the home on 6/25/24, Staff E locked the television remote in the medication room. Interview on 6/25/24 with Staff E revealed the television remote is often locked in the medication room because client #3 and another client in the home will have arguments over it and what to watch on television. Review on 6/25/24 of client #3's Behavior Support Plan (BSP) dated 6/11/24 revealed an objective to address noncompliance. Additional review of the plan did not include a technique of removing the television remote to address his inappropriate behaviors. Interview on 6/25/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the remote should not be kept locked.	W 288		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		

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W 436	Continued From page 21 Based on observations, record review and interviews, the facility failed to ensure eye glasses were furnished as indicated. This affected 1 of 3 audit clients (#5). The finding is: During observations throughout the survey on 6/24 - 6/25/24, client #5 did not wear eye glasses. Client #5 was not prompted or encouraged to wear eye glasses. Interview on 6/25/24 with Staff E revealed the client does wear eye glasses but she thought they were broken. Review on 6/24/24 of client #5's Individual Program Plan (IPP) dated 9/11/23 revealed he has eye glasses. Additional review of the client's vision examination report dated 11/16/23 noted, "Glasses full time". Interview on 6/25/24 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not sure where client #5's eye glasses were.	W 436		
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, interviews and record reviews, the facility failed to ensure 1 of 3 audit clients (#4) received their specially-prescribed diets as indicated. The finding is: During observations of supper on 6/24/24 at	W 460		

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W 460	Continued From page 22 5:00pm, client #4 was served a single portion of meat loaf, cabbage and potatoes onto his plate. During observation of Lunch on 6/24 at 11:59 am, client #4 was served a single portion of turkey/Swiss sandwich, with tomato soup and pears. During observations of breakfast on 6/25/24 at 7:11am, client #4 was served a single portion of oatmeal, turkey sausage and toast. Review of client #4's Individual Program Plan (IPP) dated 10/5/23 revealed a regular diet, double portions. Review on 6/24/24 of client #4's diet plan dated 4/10/24 posted in the dining area revealed that Client #4 receives a regular diet, double portions. Interview on 6/25/24 with Staff D revealed that client #4 gets double portions with mostly lunch or dinner, but in the morning client #4 does not get double portions. Interview on 6/25/24 with the facility Nurse Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's diet is current and should be followed.	W 460		