STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G315	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORBEL RESIDENTIAL	483 CREEK ROAD ORRUM, NC 28369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	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	RECEIVED JUN 07 2024 DHSR-MH Licensure Sect	

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

MAQP — Quality Management Director — 6/1/2024

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 039	Continued From page 1 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	E 039		

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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	The facility strives to meet all requirements for ICF locations. The facility will conduct exercises to test the emergency plan at least twice per year according to the standard. When a full-scale exercise, mock disaster drill, or tabletop exercise or workshop is conducted, documentation of the activity will be maintained by the QP and will be provided upon request. The director and/or quality management representative will ensure documentation for such events is maintained for review at least bi-annually.	7/12/2024

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E 039	Continued From page 7 (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	E 039		

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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 facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. The finding is: Review on 5/14/24 of the facility's EP plan, did not include a full-scale, community-based or tabletop exercise conducted for 2023 or 2024. Interview on 5/15/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed a table	E 039		

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E 039	Continued From page 9 top exercise had not been completed for 2023 or 2024.	E 039		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on interview and facility document review the facility failed to have documentation of good cause in the record for 1 of 1 client (#7) being discharged. The finding is: The facility discharged client #7 without good cause documented in his record. Review on 5/15/24 of client #7's behavior log revealed no documented behaviors for the month of February or March 2024. Further review of discharge note dated 5/14/24 revealed the team met and discharge of client #7 would be effective May 14, 2024. Interview with habilitation specialist on 5/15/24, revealed there were several behaviors and meetings concerning client #7, however, there was no documentation to show there was a meeting. Interview with qualified intellectual disabilities professional on 5/15/24, revealed there was no documentation of the meetings and behaviors for client #7 increased behaviors or interventions.	W 201	The facility conducts team meetings whenever there are issues or concerns regarding the provision of services and one's individual specific needs regarding the agency's ability to provide quality services. Future meetings to discuss discharge, an individual will be identified to record the meeting. The QP will maintain and ensure documentation has been obtained from the meeting recorder and maintain documentation for review of the meeting.	7/12/2024
W 202	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(ii) If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in	W 202		

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W 202	Continued From page 10 emergencies). This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to assure reasonable time was given to prepare client (#7) and his guardian for discharge. The finding is: Review on 5/15/24 of the facility's discharge requirements dated 11/16/20 revealed "... notice of client discharge from services, will be provided in accordance to the state specified time frame of discharge notice, in writing..." Interview on 5/15/24 with the qualified intellectual disabilities professional revealed there was a meeting on 5/15/24 and discharge was agreed upon that day without prior notification being given.	W 202	The agency's policy regarding discharge will be reviewed to determine if an update to the policy is warranted. Changes to the policy, if identified, will be made timely. Should a need for an immediate discharge from services has been determined by the individual's team, Quality Management will be consulted to ensure the agency is addressing all standards, policies, etc. prior to the implementation of the discharge.	7/12/2024
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a final summary of client #7's developmental, behavioral, social, health and nutritional status upon discharge. The finding is: The facility did not develop a comprehensive discharge plan for client #7. Review on 5/15/24 of client #7's facility record revealed no documentation of plans for discharge. Interview on 5/15/24 with the qualified intellectual disabilities professional revealed she was unaware of a discharge summary being completed.	W 203	The facility will develop a final summary of the client's developmental, behavioral, social, health and nutritional status as identified in the standards, timely. The director will ensure a final summary has been completed for each individual discharged.	7/12/2024
W 247	INDIVIDUAL PROGRAM PLAN	W 247		

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W 247	Continued From page 11 CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 6 audit clients (#6) was provided consistent opportunities for choice and self-management. The finding is: During observations in the home throughout the survey on 5/14/24 through 5/15/24, client #6 was observed to only consume clear liquids. Further observations in the home on the morning of 5/15/24 revealed staff B asked client #6 to come into the kitchen to scramble eggs for the other clients. Interview on 5/14/24 with the home manager revealed that client #6 was on clear liquids due to bowel prep instructions for a colonoscopy scheduled on 5/16/24. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #6 should have been given a choice regarding assisting with breakfast as he wasn't being allowed to consume it.	W 247	The QP will inservice all staff on each individual's specific needs regarding consistent opportunities for choice and self-management. The inservice will include a focus on client #6's choice to assist with breakfast when client #6 was not able to partake in the meal due to a scheduled procedure. The Program Manager (PM) will monitor weekly for compliance. The QP will monitor monthly for compliance.	7/12/2024
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record reviews and	W 252		

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W 252	Continued From page 12 interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 2 of 6 audit clients (#1 and #4). The findings are: A. Review on 5/14/24 of client #4's Individual Program Plan (IPP) dated 11/10/23 revealed formal training programs for shopping skills once weekly at the day program, cleaning glass door 7 days per week at the home, identifying behavior medications 7 days per week at the home and coin identification 5 days per week at the day program. Review on 5/15/24 of client #4's program plan data sheets for April 2024 and May 2024 of goals that are run in the home revealed 15 days of data missing for cleaning the glass door and identifying behavior medications for April 2024 and 8 days of data missing for cleaning the glass door and identifying behavior medication in May 2024. B. Review on 5/14/24 of client #1's IPP dated 7/25/23 revealed formal training programs for toothbrushing, training 7 days a week, shopping skills training every Friday during 1st shift, eating skills, training 7 days a week, community living skills, training anytime it presents itself or as an evening activity, and exercise training 1st Monday-Friday. Review on 5/15/24 of client #1's program plan data sheets for April 2024 and May 2024 of goals that are run in the home revealed 16 days of data missing for toothbrushing, and 30 days of missing data for shopping skills, eating skills, community living skills and exercise training. For the month	W 252	The Habilitation Specialist will inservice staff regarding resident's goals, specifically reviewing the goals and documentation/data collection of clients #1 and #4. Goals to be reviewed for client #1 will include training programs for tooth-brushing, shopping skills, eating skills, community living skills, and exercising and when and how these skills should be addressed. Goals for client #4 will include cleaning the glass door, identifying behavior medications, and coin identification and when and how these skills should be addressed. The PM and Habilitation Speicalist will monitor documentation/data daily for staff compliance for addressing goals. The QP will monitor documentation/data weekly for staff compliance.	7/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G315	A. BUILDING _____ B. WING _____	05/15/2024

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W 252	Continued From page 13 of May 2024, no data collected for any training goals. Interview on 5/15/24 the habilitation specialist revealed she had been out of work and will be working on revising and in-servicing staff on documentation on goals.	W 252		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 6 audit clients (#1 and #4) were reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 5/14/24 of client #4's Behavior Support Plan (BSP) dated 8/6/23 revealed target behaviors consisting of aggression, severe disruptive behavior, property destruction, inappropriate sexual behavior, taking food, stealing, failure to make responsible choices, AWOL and self-injurious behavior. Further review on 5/14/24 of client #4's BSP revealed no written consent by the HRC for the medication Buspar that was added on 11/20/23. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #4 did not have written consent by HRC for the medication Buspar and that she was unaware the medication had been added.	W 262	A. The QP will ensure that clients who have been prescribed restrictive behavior techniques, in the situation for client #4 including psychotropic medications to address targeted behaviors, have been reviewed and written consent provided by the HRC prior to implementation. The QP will follow up after HRC meetings to ensure required documentation is obtained timely and will maintain documentation for review.	7/12/2024

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W 262	Continued From page 14 B. Review on 5/14/24 of client #1's BSP dated 8/26/23 revealed target behaviors consisting of hallucinating/confusing thoughts, agitation, anxious behavior, severe disruptive behavior and failure to make responsible choices. Further review on 5/14/24 of client #1's BSP no written consent by the HRC. Interview on 5/15/24 with the QIDP confirmed that client #7 did not have written consent for the HRC she only received a verbal consent.	W 262	B. The QP will ensure that clients who have a BSP addressing targeted behaviors, as is the situation for client #1, the BSP will be reviewed and written consent provided by the HRC prior to implementation, accordingly. The QP will follow up after HRC meetings to ensure required documentation is obtained timely and will maintain documentation for review.	7/12/2024
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 6 audit clients (#1 and #4). The findings are: A. Review on 5/14/24 of client #4's Behavior Support Plan (BSP) dated 8/6/23 revealed target behaviors consisting of aggression, severe disruptive behavior, property destruction, inappropriate sexual behavior, taking food, stealing, failure to make responsible choices, AWOL and self-injurious behavior. Record review on 5/14/24 of client #4's physician's orders dated 2/21/24 revealed orders for Depakote, Clonazepam, Geodon, Seroquel and Buspar. Further record review on 5/14/24 revealed no	W 263	A. The QP will ensure that clients who have been prescribed restrictive behavior techniques, in the situation for client #4 including psychotropic medications to address targeted behaviors, have been reviewed and written consent obtained by the legal guardian prior to implementation.	7/12/2024

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W 263	Continued From page 15 written informed consent by the legal guardian for the use of Buspar. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #4 did not have written consent by the legal guardian for the medication Buspar and that she was unaware the medication had been added. B. Review on 5/14/24 of client #1's BSP dated 8/26/23 revealed target behaviors consisting of, hallucinating/confusing thoughts, agitation, anxious behavior, severe disruptive behavior and failure to make responsible choices. Further review on 5/14/24 of client #1's BSP no written consent by a legal guardian. Interview on 5/15/24 with the QIDP confirmed that client #7 did not have written consent for the BSP she only received verbal consent.	W 263	B. The QP will ensure that clients who have a BSP addressing targeted behaviors, as is the situation for client #1, the BSP will be reviewed and written consent provided by the legal guardian prior to implementation.	7/12/2024
W 331	NURSING SERVICES 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 observations, records review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 6 audit clients (#6) relative to assuring that physician's orders were documented. The finding is: A. During observations in the home throughout the survey on 5/14/24 through 5/15/24, client #6 was observed to only consume clear liquids. Interview on 5/14/24 with the home manager revealed that client #6 was on clear liquids due to bowel prep instructions for a colonoscopy scheduled on 5/16/24.	W 331		

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W 331	Continued From page 16 Record review of bowel prep instructions dated 4/17/24 for client #6 revealed the client could only consume clear liquids on 4/17/24 for a colonoscopy scheduled on 4/18/24. Interview with the facilty nurse revealed that client #6 was scheduled for a colonoscopy on 4/18/24. However, upon arrival, the procedure was unable to be completed because the client had not cleared out his bowels. The nurse stated that this time the facility was doing 2 days of clear liquids prior to the colonoscopy to ensure client #6 was cleaned out. The nurse revealed that she did not have any documentation or physician orders to show that this was the recommendation made by the doctor. B. Review on 5/15/24 of client #1's individual program plan dated 7/25/23 revealed a diagnosis of a history of sleep apnea. Further review of nurses note dated 9/20/23 revealed a history of sleep apnea. Interview on 5/15/24 with the Registered Nurse (RN) confirmed client #1 has a diagnosis of sleep apnea history. There has been no sleep study completed while client #1 has been at the current facility. RN confirmed a sleep study needed to be completed.	W 331	A. The nurse will ensure that all written physician orders are obtained prior to implementation. For client #6, the nurse will ensure written orders by a physician match the dates of order prior to initiating physician's orders. B. In regards to client #1's diagnosis of a history of sleep apnea as found on the Individual Program Plan dated 7/25/23, the nurse will follow up with client' #1's doctor to obtain a sleep study and schedule accordingly. The nurse will follow up on the results of the sleep study accordingly. A checklist will be developed identifying the needs of both nursing and IDD clinical topics to ensure and assist in identifying all medical, behavioral, etc. needs a new referral might have within the initial 30 days of admission. The development of the checklist will include input from nursing and clinical staff, along with the assistance of quality management. This checklist will ensure a checks and balance, monitoring, to ensure the needs of new referral are addressed timely.	7/12/2024 7/12/2024
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and	W 369		

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W 369	Continued From page 17 interview, the facility failed to ensure all medications were administered without error. This affected 1 of 6 clients (#4) observed receiving medications. The findings are: During observations in the home on 5/15/24 at 7:35am, clients were observed eating breakfast. Further observations in the home at 8:37am, the home manager was observed assisting client #4 with administering his medications, which included Metformin ER 500mg and Synthroid 50mcg. Review on 5/15/24 of client #4's physician's orders dated 2/21/24 revealed an order for Metformin ER 500mg take 1 tablet by mouth, twice daily before meals and was ordered for 7:00am and 6:00pm and Synthroid 50mcg, take 1 tablet every morning and was ordered for 7:00am. Interview on 5/15/24 with the facility nurse revealed the facility's medication policy states medications can be given one hour before or one hour after scheduled medication time. The facility nurse also confirmed that client #4 received medication outside the approved time frame. The nurse also confirmed client #4 should have received Metformin before eating breakfast.	W 369	The nurse will inservice staff to ensure staff are administering medication as ordered, specifically in regards to client #4. To ensure staff are administering medication as ordered, client #4's medication for Metformin ER 500 mg and Synthroid 50 mcg will be administered by third shift (12 am to 8 am shift) to ensure the medication is administered before meals as ordered. The Program Manager and Nurse will conduct random daily MAR checks to ensure compliance. The QP will conduct monthly checks of the MAR to ensure compliance.	7/12/2024
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:	W 460		

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W 460	Continued From page 18 Based on observations, record review and interviews, the facility failed to ensure 3 of 6 audit clients (#3, #4 and #5) received their specially prescribed diet as indicated. The findings are: A. During observations in the home on 5/14/24 at approximately 3:45pm, client #4 sat down at the table for snack. Client #4 received chocolate pudding. At 5:16pm, client #4 sat down at the table for dinner. Client #4 received 1 piece of baked chicken, 1 serving of peas and carrots mixed and 1 serving of rice. Further observations in the home on 5/15/24 at 7:35am, client #4 sat down at the table for breakfast. Client #4 received 2 waffles with sugar free syrup and one serving of eggs. Interview on 5/15/24 with the home manager revealed that client #4's diet is low concentrated sweets with sugar free jello, peanut butter and jelly sandwich for snack twice daily and double portions. Record review of client #4's nutritional evaluation dated 10/17/23 revealed a diet of regular, heart healthy, low concentrated sweets, double portions at all meals, 1 peanut butter and jelly sandwich for snack twice daily, may have sugar free jello, pudding or low fat yogurt, Ensure Clear twice daily and no corn, tomatoes or chocolate. Interview on 5/15/24 with the facility's nurse revealed client #4 should have received double portions at dinner and breakfast and should not have had chocolate pudding for snack. B. During observations in the home on 5/15/24 at 7:35am, client #3 was served waffles and eggs. The consistency of the waffles was ground and eggs were the consistency of scrambled with a	W 460	A. The Dietitian will inservice staff on Client #4's specially prescribed diet to include a diet of regular, heart health, low concentrated sweets, double portions at all meals, 1 peanut butter and jelly sandwich for snack twice daily, may have sugar free jello, pudding or Low fat yogurt, Ensure Clean twice daily and no corn, tomatoes or chocolate. The Program Manager will monitor weekly for compliance of orders. The QP will monitor monthly for compliance.	7/12/2024

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W 460	Continued From page 19 runny liquid. Interview on 5/15/24 with staff B revealed she mixed some milk in with the waffles and eggs to make it smooth but it didn't work. Staff B revealed the consistency should look like baby food but the waffle or eggs were not smooth like baby food. Interview on 5/15/24 with the home manager revealed client #3 diet is pureed and his food, should be smooth consistency. C. During observations in the home on 5/14/24 at 5:15pm, client #5 was at the table for dinner. Client #5 received baked chicken, peas and carrots and rice. Client #5 attempted to cut baked chicken with skin on with his knife. Client #5 chicken was a shredded consistency and not a bite size. Further observation in the home on 5/15 at 7:30am client #5 was at the table for breakfast. Client #5 received 2 waffles and eggs for breakfast. Client #5 cut the waffles with a knife into long slim pieces. Interview on 5/15/24 with staff C revealed client #5 was on a bite size diet. Staff C revealed as long as client #5 cut his food up it would be bite size. Review on 5/15/24 on client #5's nutritional evaluation dated 4/15/24 revealed diet as heart healthy regular diet in bite size pieces.	W 460	B. The Dietitian will inservice staff on Client #3's specially prescribed diet to include pureed food with a smooth consistency. The Program Manager will monitor weekly for compliance of orders. The QP will monitor monthly for compliance.	7/12/2024
			C. The Dietitian will inservice staff on Client #5's specially prescribed diet to include a heart healthy regular diet in bite size pieces. The Program Manager will monitor weekly for compliance of orders. The QP will monitor monthly for compliance.	7/12/2024
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is:	W 481		

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W 481	Continued From page 20 During observations in the home on 5/14/24, the home manager was observed cooking baked chicken, carrots and peas and rice. Review on 5/14/24 of the facility's menu book for 5/14/24 revealed beef taco shell with cheese, tomato, lettuce, sour cream, taco sauce, tator tots, rosy applesauce, margarine and beverage of choice. Review on 5/15/24 of the menu substitution book revealed the substitutions made on 5/14/24 had not been documented. Interview on 5/15/24 with the home manager revealed menu substitutions should have been documented. However, she confirmed they had not been documented for substitutions made on 5/14/24.	W 481	The staff will be in-serviced by the QP on documenting when to document within the menu substitution book. The Program Manager will monitor weekly for compliance of documenting substitutions to the menu. The QP will monitor the substitution book monthly for compliance.	7/12/2024