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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, documentation review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure the interior and exterior of the facility was sanitary and orderly. The finding is: Observations around the exterior of the facility during the recertification survey from 9/10/24-9/11/24 revealed several loose bricks stacked around the front and back door of the facility. Continued observations also revealed additional loose bricks at the rear of the facility close to the left side of the building. Observations also revealed several wooden planks in the backyard with nails protruding out of them and numerous Cobb webs around the perimeter of the home. Further observations revealed a hole behind the hvac unit approximately 6" in depth and a tube extending from the hvac unit which was dumping water into the yard and creating a large puddle of water close to the patio area. Additional observations revealed two large soiled and weathered cardboard boxes labeled "gazebo" on the box approximately 10' in length. Observations also revealed one of the boxes to be weathered and shredded with soiled pieces of cardboard. Subsequent observations inside of the facility revealed a round plastic bin with pieces of wood and nails protruding from the wood pieces to sit in the hallway close to two of the clients' rooms. Observations also revealed two televisions faced	W 104		

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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W 104	Continued From page 1 down, a bed frame, a desk with the drawers missing in entryway to two of the clients' rooms. Continued observations revealed the facing of the kitchen cabinet drawers to be missing. Further observation revealed a face plate to be missing from the outlet in the living area close to the window and two chairs. Additional observations revealed several areas with splatter with a brown and black dried substance in the dining room area. Observations also revealed holes in the wall in several bedrooms and different areas of the facility. Review of facility documentation on 9/11/24 revealed a work order dated 4/1/24 which indicated a request for the broken, cracked, and loose bricks around the perimeter of the facility needed to be removed. Review of work orders dated 3/26/24, 4/1/24 and 5/2/24 revealed a request to replace or fix the front panels of the kitchen cabinet drawers. Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/24 revealed that the cardboard boxes in the backyard should have been removed. Continued interview with the QIDP revealed that the cardboard boxes in the backyard were damaged by rain and weather conditions and were filled with termites. Interview with the QIDP also revealed that the cardboard boxes in the backyard have been there for at least one month. Further interview with the QIDP revealed she was aware of the facing of the kitchen drawers missing and the furniture in the clients' room which should have been removed by facilities maintenance.	W 104		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)	W 130		

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W 130	Continued From page 2	W 130		

The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.
This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure that privacy was maintained for 3 of 6 clients (#1, #5 and #6). The findings are:

A. Observations in the facility from 9/10/24-9/11/24 revealed client #1 and client #6 to each have bedroom windows facing the street and public outdoor areas. Continued observation revealed that the bedroom windows are not covered by any type of window covering such that the bedroom interiors are visible by anyone in the public areas.

Interview with the qualified intellectual disabilities professional (QIDP) verified the clients would be visible in their bedrooms from the outside of the home, potentially violating their right to privacy. Continued interview verified that client #1 and client #6 should be given privacy in their bedrooms.

B. The facility failed to ensure that client #1 received privacy in his room during personal care relative to an entry door. For example:

Observations in the facility during the recertification survey from 9/10/24-9/11/24 revealed client #1 to participate in personal care at various times in his room. Continued observations revealed client #1 to have an entryway to his room with no door, curtain or covering to protect his privacy during personal care. Further observation revealed a hallway door to the bedroom area to remain open throughout

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W 130	Continued From page 3 the observation period. Interview with the QIDP on 9/11/24 revealed that client #1's room is an addition to the facility in which two rooms were added several years ago. Continued interview with the QIDP revealed that client #1's room has not had a curtain or covering to protect his privacy during personal care. Further interview with the QIDP revealed that client #1's privacy should be ensured during personal care or while resting in his room. C. The facility failed to ensure that client #5 received privacy during personal care. For example: Observations in the facility on 9/11/24 at 7:15AM revealed staff A to escort client #5 to the bathroom to take a shower. Continued observations revealed staff A to assist client #5 with taking off their clothes as the door remained open. Further observations revealed staff A to leave client #5 in the bathroom while taking a shower with the door open which could be seen from the hallway as clients went in and out of their rooms. At no point during the observation did staff close the door to ensure client #5's privacy during personal care. Interview with the QIDP on 9/11/24 revealed that client #5 requires 1:1 attention during activities and personal care. Continued interview with the QIDP verified staff have been trained to respect and ensure the privacy of clients during personal care.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan for 3 of 6 clients (#1, #5, and #6) relative to implementing training objectives and providing adaptive equipment. The findings are:

A. The facility failed to provide adaptive equipment for client #6. For example:

Afternoon observations on 9/10/24 revealed client #6 not wearing a protective helmet. Continued observations revealed a soft protective helmet located on client #6's bed. Further observations revealed that at no time did any staff offer or encourage client #6 to wear his protective helmet.

Morning observations on 9/11/24 revealed client #6 not wearing a protective helmet. Continued observations revealed a soft protective helmet located on the dresser in client #6's bedroom. Further observations revealed that at no time did any staff offer or encourage client #6 to wear his protective helmet.

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Record review on 9/11/24 revealed a Person-Centered Plan (PCP) dated 12/3/23 and a Behavior Support Plan (BSP) dated 9/1/24 for client #6 which specifies self-injurious behaviors (SIB) as a target behavior. The plans indicate that, as a prevention strategy for SIB, staff should support client #6 to wear his helmet during the day.

Interview with the qualified intellectual disabilities professional (QIDP) confirmed that the PCP and BSP for client #6 are current and that both plans indicate the need for staff to encourage client #6 to wear his protective helmet. Continued interview confirmed that staff should comply with the guidelines set forth in the plans.
B. The facility failed to ensure that client #5's communication picture book was used in various settings and activities. For example:

Observations in the facility during the recertification survey from 9/10/24-9/11/24 revealed client #5 to participate in various activities including a board game, coloring activity, personal care, and mealtimes. At no point during the recertification survey were staff observed to utilize a communication book for client #5 on the shelf in the living room.

Review of the record for client #5 on 9/11/24 revealed a person-centered plan (PCP) dated 3/26/24 which indicated that the client utilizes communication training with his communication picture book augmentative system in a variety of settings and situations. Continued review of the 3/2024 PCP also revealed instructions to staff, "when it is appropriate, prompt the client to use the communication picture book".

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Interview with the QIDP on 9/11/24 revealed that client #5 requires consistent use of the communication picture book in various settings. Continued interview with the QIDP revealed that staff have been trained to use the communication picture book to transition client #5 to various activities. Further interview with the QIDP verified that staff should use the picture book for the client in various settings and during activities.

C. The facility failed to ensure that client #1's program goals were implemented according to the behavior support plan (BSP). For example:

Observations in the facility during the recertification survey from 9/10/24-9/11/24 revealed several cabinet drawers in the kitchen to be missing. Continued observation revealed that many snack food items were visible inside a kitchen cabinet due to the absence of the drawer facing. Further observation revealed the food items in the cabinets to be readily accessible. Subsequent observation revealed client #1 to have free access to the kitchen cabinet area and to spend time in that area.

Record review on 9/11/24 revealed a Person-Centered Plan (PCP) dated 10/23/23 and a Behavior Support Plan (BSP) dated 1/29/24 for client #1. Review of the BSP revealed a target behavior for client #1 to be inappropriate food acquisition. Continued review of the 10/2023 BSP further states, "In prevention of inappropriate food acquisition, staff should attempt to keep all food and drinks put away and out of sight when not being used."

Interview with the QIDP on 9/11/24 confirmed that client #1's plans are current and that food should

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W 249	Continued From page 7 be kept out of sight due to this client's food seeking behaviors.	W 249		
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 observation, record review and interview, the facility failed to ensure that all drugs were administered without error for 1 of 6 clients (#4). The finding is: Observation in the group home on 9/11/24 at 6:59 AM revealed client #4 to enter the medication room for medication administration. Continued observation revealed client #4 to receive the following twelve medications: PEG powder, 510 grams, Lorazepam .5 mg. - 1 tablet, Vitamin D3 50 mcg - 2 capsules, Carbamazepine 200 mg - 2 tablets, Hydrochlorot 25 mg - 1 tablet, Citalopram 20 mg - 1 tablet, Clonidine .1 mg - 1 tablet, Pantoprazole 40 mg - 1 tablet, Levothyroxine 50 mcg - 1 tablet, Omega 3 1000 mg - Propranolol 20 mg - 1 tablet, Potassium Chloride 10 meq - 1 capsule. Further observation revealed client #4 to ingest the PEG powder with water, then all other medications at once with water. Continued observations revealed client #4 to be eating breakfast at 7:15 AM. Review of client #4's record on 9/11/24 revealed physician orders which indicated client #4's Levothyroxine instructions to be as follows: "take one tablet by mouth daily for Hypothyroidism (8 AM); take 30 minutes before breakfast or other medications".	W 369		

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W 369	Continued From page 8 Interview with the Registered Nurse (RN) on 9/11/24 verified client #4's physician orders to be current. Continued interview with the RN confirmed that client #4 should have received his Levothyroxine 30 minutes before breakfast or other medications and that failing to follow this order is a medication error. Further interview with nursing services revealed that staff have been trained to administer client medications as prescribed.	W 369		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to provide functional furniture for 1 sampled client (#6). The finding is: Observations during the recertification survey from 9/10/24-9/11/24 revealed client #6's dresser to be broken with no knobs on the drawers. Continued observation revealed the drawers to the dresser to be broken with the wooden frame exposed. Further observation revealed the client's drawers to be broken with clothing housed inside of the dresser. Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/24 revealed at times client #6 breaks his furniture due to property destruction behaviors. Continued interview with the QIDP revealed she is not sure how long client #6's dresser has been broken, however she was seeking an alternative so that the client won't	W 420		

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W 420	Continued From page 9 break his bedroom furniture. Interview with the QIDP verified that client #6 is in need of a new dresser for his room.	W 420		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: A review of the facility fire drill reports on 9/10/24 revealed that between 10/2023-8/2024 the facility conducted no third shift fire drills. Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/24 verified fire drills should have been conducted quarterly for each shift of personnel.	W 440		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to serve food in a form consistent with the developmental level of 1 of 6 clients (#4) relative to prescribed diet consistency. The finding is: Observations in the group home on 9/10/24 at 5:30 PM revealed the dinner meal to be soft and crunchy tacos, rice and tortilla chips. Continued observations revealed staff to serve client #4 two whole crunchy tacos and several whole tortilla	W 474		

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W 474	Continued From page 10 chips. Further observation revealed client #4 to eat the dinner meal. At no time during observation was staff observed to assist client #4 with preparing the meal at a ¼" consistency. Review of client #4's record on 9/11/24 revealed a nutritional evaluation dated 11/29/23. Review of the nutritional evaluation revealed that client #4's prescribed diet to be 1800 calorie, weight loss, heart healthy, ¼" consistency due to seizure activity. Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/24 verified that client #4's prescribed diet is current and the meal served on 9/10/24 was not the appropriate consistency for client #4. Further interview with the QIDP verified specially modified diets should always be followed as prescribed.	W 474		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed ensure that meals were served with appropriate utensils for 2 of 6 clients (#1, #5) to eat as independently as possible according to their highest functioning level. The findings are: A. The facility failed to provide appropriate eating utensils for client #1 during mealtimes. For example: Afternoon observations in the group home on 9/10/24 at 5:30PM revealed the dinner meal to be soft and hard shell tacos, rice, and tortilla chips.	W 475		

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W 475	Continued From page 11 Continued observations revealed staff to set client #1's plate at the table with a high sided divided dish, dycem mat, shirt protector and a regular spoon. Further observation revealed client #1 to consume the dinner meal using a regular sized spoon. Morning observations in the group home on 9/11/24 at 7:25AM revealed client #1 to sit at the dining table and eat a bowl of cereal using a tablespoon. Continued observation revealed client #1 to finish his breakfast meal in its entirety using a tablespoon. At no point during the observation did staff offer client #1 a small maroon spoon during mealtimes. Record review on 9/11/24 revealed a person-centered plan (PCP) for client #1 dated 10/10/23 which indicates client #1 requires a maroon spoon for meals. Continued record review revealed a nutritional evaluation dated 12/28/23 stating that the client requires the following adaptive equipment for mealtimes: high sided divided dish, small maroon spoon. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that client #1's diet order is current, and that staff should have offered him a maroon spoon during the evening meal. B. The facility failed to provide appropriate eating utensils for client #5. For example: Observations in the group home on 9/10/24 at 5:30 PM revealed the dinner meal to be soft and hard shell tacos, rice and tortilla chips Continued observations revealed staff to set client #5's place at the table with a high sided divided dish, dycem	W 475		

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mat, a regular spoon and two regular drinking cups. Further observation revealed client #5 to drink from the regular cup during the dinner meal.

Observations in the group home on 9/11/24 at 7:15 AM revealed client #5 to be served oatmeal for breakfast. Continued observation revealed client #5 to be offered and use regular drinking cups during the breakfast meal. At no point during the observation did staff provide the client (#5) with a cup and lid with a straw or a sippy cup during mealtimes.

Record review on 9/11/24 revealed a person-centered plan (PCP) for client #5 dated 3/26/24 which indicates client #5 requires a sippy cup or straw for drinking during meals.

Interview with the qualified intellectual disabilities professional (QIDP) confirmed that client #5's diet order is current, and that staff should have offered him a sippy cup or a straw during the dinner meal.