STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G272	A. BUILDING _____ B. WING _____	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	**114 GREENHOUSE LANE SOUTHERN PINES, NC 28387**

(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 000	Initial Comments A complaint and recertification survey were completed on 10/22/24 for intake #NC00222434. The complaint was unsubstantiated with no deficiencies cited. However, deficiencies were cited during the recertification.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		

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

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an all-hazards risk assessment that was facility and community based for their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:	E 006		

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E 006	Continued From page 2 Review on 10/22/24 revealed the EP was written on 4/15/23 and did not contain evidence the facility had evaluated their all-hazards risks in the event of an emergency. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she did not have any other material for review and did not receive more information from the office, when requested today.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E 013		

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E 013	Continued From page 3 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies for a pandemic in the emergency preparedness (EP) plan. This had the	E 013		

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E 013	Continued From page 4 potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 10/22/24 of the facility's EP plan revised on 4/13/23 revealed no policies or procedures in event of a Pandemic. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed their EP plan did not contain instructions on how to respond to a pandemic.	E 013		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025		

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E 025	Continued From page 5 to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to develop pre-arranged accomodations for clients in the event services could not be delivered in the home, in the Emergency Preparedness (EP) plan. This potentially affected 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 10/22/24 of the facility's EP plan revised on 4/13/23 revealed alternative housing was not identified for emergency purposes. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she did not have any other material for review pertaining to their EP plan.	E 025		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2)	E 039		

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E 039	Continued From page 6 §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		

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E 039	Continued From page 7 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 8 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 9 *[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 10 (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 11 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 12 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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E 039	Continued From page 13 (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 14 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 record review and interview, the facility failed to conduct a tabletop exercise, full-scale exercise or mock disaster drills to test their emergency preparedness (EP) plan. This had the potential to affect all of the clients (#1, #2, #3, #4, #5 and #6). The finding is: Review on 10/22/24 revealed the facility's EP plan from 4/13/23 did not include training exercises to prepare clients and staff for an emergency with the exception of fire drills.	E 039		

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E 039	Continued From page 15 Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she did not have any additional materials on their EP plan and could not acquire any training materials from the corporate office.	E 039		
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 observation, record review and interviews, the facility failed to ensure nursing services were provided in accordance to the client needs as related to medication administration and nutritional supports. This affected 2 of 6 audit clients (#5 and #6). The findings are: A. Review on 10/22/24 of client #5's medication administration records (MAR) revealed multiple missed doses of medications: Client #5 missed doses of Lamotrigine (Lamictal) 200mg on 6/22/24, 6/27/24, 7/28/24, 7/30/24, 7/31/24, 8/10/24, 8/12/24, 8/23/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 9/13/24, 9/15-9/16/24, 9/26/24 and 9/30/24 due to it being out of stock. On 8/13/24 client #5 was sent to the emergency room for seizure activity. In addition, client #5 missed doses of Risperidone 2mg on 6/12/24, 6/27/24, 6/30/24, 7/11/24, 8/1/24, 8/3/24, 8/10/24, 8/11/24, 8/12/24 and 8/13/24. Review on 10/22/24 of the Policy for Medication Administration, last revised 8/11/24 revealed all	W 331		

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staff received medication administration training within 30 days of their employment start date. The first medication error reported for a staff member; the staff member will be pulled from shift until medication administration training is attended. The second medication error reported for a staff member within six months of the error will result in termination. The Registered Nurse (RN) and/or designee will ensure that all medication administration policies are followed properly.

Interview on 10/22/24 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed their RN is a consultant and does not visit the home every month. They revealed the RN was in the home doing training on 8/13/24 and when client #3 was admitted on 10/14/24. The QIDP revealed she conducted monthly reviews of the MAR, as well as the HM, to ensure medications were given as ordered. The QIDP acknowledged she was aware of multiple medication errors due to not available and had to order a 3 day supply from the pharmacy. The QIDP explained the med techs were supposed to notify them 5 days before the medication ran out. Staff were retrained on medication administration on 8/7/24. The QIDP could not explain why there were intermittent gaps in the same month of the medication being administered if the stock had been replenished. The QIDP also acknowledged medication doses were still missed in September 2024 for client #5 after staff were retrained. She further confirmed that no med techs had been suspended from administering medications.

B. Observations on 10/22/24 at 8:00am revealed there was an unopened case of a chocolate

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nutritional supplement drink sent by the pharmacy in the medication room and a half-opened case of vanilla nutritional supplement drink.

Review on 10/22/24 of client #6's quarterly medication regimen review revealed on 3/7/23 her admission weight was 194 lbs., on 6/20/23 she weighed 174 lbs., on 12/11/23 she weighed 130 lbs. Client #6's weight remained stable for stable through 3/5/24. On 6/12/24 client #6 weighed 114 lbs.

Review on 10/22/24 of a nurse progress note from 11/9/23 for client #6 revealed the dietician placed her on an 1800 calories diet due to recent weight gain. In addition, the April-July 2024 Quarterly Nursing Assessment listed client #6 at 217 lbs. and Height 84"; noting no significant weight change. The July 2024 nurse progress note revealed client #6 was in overall stable health. There were no other nurse's notes that indicated staff were communicating continued weight loss and episodes of diarrhea.

Review on 10/22/24 of the nutritional evaluation from 7/11/24 for client #6 revealed her current weight was 110 lbs. and height 4'10". It was noted she was eating less possibly due to gastrointestinal issues. A nutritional supplement was ordered for twice daily due to decrease in intake and weight loss.

Interview on 10/22/24 with Staff D revealed client #6 experienced repeated episodes of diarrhea after drinking her nutritional supplements, which led to refusals sometimes. Staff D acknowledged client #6 had lost a lot of weight.

Interview on 10/22/24 with the HM revealed client

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W 331	Continued From page 18 #6 was a picky eater. The HM remarked in the year she has worked with client #6, she has remained the same size. The HM revealed client #6 was compliant with consuming her nutritional supplement drinks. Interview on 10/22/24 with the QIDP revealed client #6 had started to experience episodes of diarrhea several months and initially it was believed it was a behavior. The QIDP revealed the nurse had visited the home on 8/14/24 and 10/14/24 as was available by request. Further, she acknowledged the diarrhea was still occurring but was unaware it was held in the evening. The QIDP revealed she took client #6 to visit a new nutritionist last week and she explored if the milk in the nutritional supplement drinks were causing client #6 to have diarrhea. The nutritionist told the QIDP the drinks were not made with milk or caused diarrhea. The nutritional supplement was increased to 3x a day due to weight at 106 lbs. The QIDP also confirmed the nutritionist noticed a discrepancy in the weight and height for client #6 that was recorded in her medical record.	W 331		
W 361	PHARMACY SERVICES CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to establish a back-up emergency	W 361		

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system to ensure medications were available to dispense to 1 of 6 audit clients (#5). The finding is:

Review on 10/22/24 of client #5's medication administration records (MAR) revealed multiple missed doses of medications:

Client #5 missed doses of Lamotrigine (Lamictal) 200mg on 6/22/24, 6/27/24, 7/28/24, 7/30/24, 7/31/24, 8/10/24, 8/12/24, 8/23/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 9/13/24, 9/15-9/16/24, 9/26/24 and 9/30/24 due to it being out of stock. In addition, client #5 missed doses of Risperidone 2mg on 6/12/24, 6/27/24, 6/30/24, 7/11/24, 8/1/24, 8/3/24, 8/10/24, 8/11/24, 8/12/24 and 8/13/24.

Interview on 10/22/24 with the Home Manager (HM) revealed on 8/7/24 staff were retrained on medication administration.

Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she conducted monthly reviews of the MAR, as well as the HM, to ensure medications were given as ordered. The QIDP acknowledged she was aware that medications were out of stock on multiple occasions and had to order a 3 days supply from the pharmacy. The QIDP revealed med techs were required to notify the HM or QIDP 5 days before the medication ran out. The QIDP could not explain why there were intermittent gaps in the same month of the medication being administered if the stock had been replenished. The QIDP confirmed they did not have a back-up pharmacy to receive medications for clients.

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W 363	Continued From page 20	W 363		
W 363	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on record review and interview, the pharmacist failed to alert the physician after completing quarterly medication regimen reviews (QDRR) that 1 of 6 audit clients (#5) were missing multiple doses of medications. The finding is: Review on 10/22/24 of client #5's medication administration records (MAR) revealed multiple missed doses of medications: Client #5 missed doses of Lamotrigine (Lamictal) 200mg on 6/22/24, 6/27/24, 7/28/24, 7/30/24, 7/31/24, 8/10/24, 8/12/24, 8/23/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 9/13/24, 9/15-9/16/24, 9/26/24 and 9/30/24 due to it being out of stock. In addition, client #5 missed doses of Risperidone 2mg on 6/12/24, 6/27/24, 6/30/24, 7/11/24, 8/1/24, 8/3/24, 8/10/24, 8/11/24, 8/12/24 and 8/13/24. Additional review on 10/22/24 of client #5's After Summary Report on 8/13/24 revealed he was treated in the emergency room for a seizure. Review on 10/22/24 of the Consultant Pharmacist Medication Regimen Reviews for client #5 revealed on 9/5/24 there were no irregularities noted. Interview on 10/22/24 with the pharmacy agency representative revealed the consultant should	W 363		

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W 363	Continued From page 21 report drug irregularities to the physician for a response. The consultant also acknowledged that medications taken for a seizure disorder may have a recommendation to the doctor to conduct laboratory tests. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she conducted monthly reviews of the MAR, as well as the home manager, to detect medication errors. On 8/7/24 staff were retrained on medication administration.	W 363		
W 472	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received an appropriate quantity of food. The finding is: During dinner observations in the home on 10/21/24 at 5:20pm, Staff C prepared corn, green beans and turkey burgers. There appeared to be one can of corn in a midsize pot on the stove, heating up the food. The food was placed on the table for family size dining at 6:05pm. Clients #1, #4, #5 and #6 chose to receive corn and had approximately 1/4 cup of corn each. Review on 10/22/24 of the Menu Cycle 1 spread sheet revealed the portion size for corn should be 1/2 cup for a regular diet and 6 ounces for a high calorie diet. Interview on 10/22/24 with the Home Manager (HM) revealed yesterday she observed Staff C	W 472		

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W 472	Continued From page 22 cooking dinner and instructed her to add another can of corn. The HM acknowledged Staff C expressed the food might be wasted because some of the clients did not like vegetables. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff have been trained when preparing meals to cook enough food in case second portions are requested.	W 472		
W 487	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client receives enough food. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 6 audit clients (#6) received enough nutrition to prevent an undesired weight loss. The finding is: During dinner observations in the home on 10/21/24 at 6:20pm, client #6 received corn, green beans and turkey burger on a bun. Client #6 consumed less than 75% of her meal before discarding it. Observations on 10/22/24 at 8:00am revealed there was an unopened case of a chocolate nutritional supplement drink sent by the pharmacy in the medication room and a half opened case of vanilla nutritional supplement drink. Review on 10/22/24 of client #6's quarterly medication regimen review revealed on 3/7/23 her admission weight was 194 lbs, on 6/20/23 she weighed 174 lbs, on 12/11/23 she weighed 130 lbs. Client #6's weight remained stable at 130	W 487		

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lbs through 3/5/24. On 6/12/24 client #6 weighed 114 lbs.

Review on 10/22/24 of a nurse progress note from 11/9/23 for client #6 revealed the dietician placed her on a 1800 calories diet due to recent weight gain. The July 2024 nurse progress note revealed client #6 was in overall stable health. The note also recorded client #6's height at 84 inches and weight at 217 lbs.

Review on 10/22/24 of the nutritional evaluation from 7/11/24 for client #6 revealed her current weight was 110 lbs and height 4'10". It was noted she was eating less possibly due to gastrointestinal issues. A nutritional supplement was ordered for twice daily de to decrease in intake and weight loss. In addition, client #6 had new dietary orders from 10/17/24 to increase the nutritional supplement drink to 3x a day with weekly weights due to weight loss. Her weight was recorded at 106 lbs.

Interview on 10/22/24 with Client #6 revealed she did not get a supplement after dinner or after breakfast today.

Interview on 10/22/24 with Staff D revealed client #6 had fruit, scrambled eggs and sausage with pancakes for today's breakfast. Staff D revealed client #6 had an order to receive two nutritional supplement drinks at 4:00pm and 8:00pm, but there were patterns of her refusing them because it seemed to cause diarrhea. Staff D acknowledged she does not always give the 8pm supplement since it leads to more incontinence of bowel accidents overnight.

Interview on 10/22/24 with the Home Manager

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W 487	Continued From page 24 (HM) revealed client #6 was a picky eater. The HM remarked in the year she has worked with client #6, she has remained the same size. The HM revealed client #6 was compliant with consuming her nutritional supplement drinks. The HM acknowledged staff did not record if client #6 consumed the nutritional supplements. Interview on 10/22/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #6 had started to experience episodes of diarrhea several months ago and initially it was believed it was a behavior. The QIDP also shared client #6 had recent dental surgery and had seen a gastrointestinal doctor last month for the diarrhea and was cleared from having a new condition. The QIDP acknowledged she knew the diarrhea was still occurring but was unaware it was held in the evening. The QIDP revealed she took client #6 to visit a new nutritionist last week and she explored if the milk in the nutritional supplement drinks were causing client #6 to have diarrhea. The nutritionist told the QIDP the drinks were not made with milk or caused diarrhea. The nutritional supplement was increased to 3x a day due to weight at 106 lbs. The QIDP also confirmed the nutritionist noticed a discrepancy in the weight and height for client #6 that was recorded in her medical record.	W 487		