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	34G033	A. BUILDING _____ B. WING _____	11/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure that 1 of 5 clients (#4) was treated with dignity and respect regarding the use of incontinence padding. The finding is: During observations in the home on 11/5/24 at 3:45 PM, client #4 was observed sitting in a recliner with an incontinence pad clearly visible under the client's body. Further observation revealed a chair cover on the same recliner with the incontinence pad sitting of the chair cover in the recliner in the living room. During observations in the home on 11/6/24 at 7:33 AM, client #4 was observed to stand and independently walk a few steps to a nearby chair near the window to sit for a better view outside. Continued observation revealed the incontinence pad in the recliner to become visible underneath the chair cover. Further observation revealed client #4 to return to the recliner after the breakfast meal to sit on the incontinence pad. Interviews with the Qualified Intellectual Disability Professional (QIDP) on 11/6/24 revealed incontinence pads are not to be used in the home in common living areas. Continued interview with the QIDP revealed client #4 is on a toileting schedule which invalidates the need for incontinence padding on his furnishings. Further	W 125		

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

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W 125	Continued From page 1 interview with the QIDP revealed if incontinent padding when used in the home is only used in client's bedding. Subsequent interview confirmed that use of the incontinence pads violates the clients' right to dignity.	W 125		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 observation, record review and interviews, the facility failed to ensure 2 of 5 clients (#2 and #4) person-centered plan was implemented relative to their identified goals for privacy adaptive equipment. The finding is: A. The facility failed to ensure client #2's privacy during personal care: Observation in the group home on 11/06/24 at 9:10 AM revealed staff to assist client #2 to the bathroom to brush his teeth. Continued observation revealed client #2 to sit on the toilet with the bathroom door open wide enough for him to be visible sitting on the toilet from the hallway. Further observation revealed the DSP to be selecting clean clothing items for client #2 in his bedroom,	W 249		

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W 249	Continued From page 2 Review of records for client #2 revealed a person-centered plan (PCP) dated 03/01/2024. Continued review of the PCP for client #2 revealed the following goals: personal space, assist staff with clearing his glasses, housekeeping, recreation, privacy-close the door after entering the bathroom, safety, and exercise in the mornings and evenings. Further review of the PCP for privacy goal clarified that staff should close the bathroom door if client #2 fails to close the door. Interview on 11/06/24 with the Direct Support Staff (DSP) revealed she assisted client #2 to the bathroom to assist brush him with toothbrushing. Continued interview with the DSP revealed she had him sit on the toilet clothed to brush his teeth which inadvertently qued him to urinate. Further interview with the DSP revealed she left the bathroom to retrieve clean clothing for client #2 and she failed to close the door. Interview with on 11/06/24 with the Qualified intellectual disabilities professional (QIDP) revealed client #2's PCP is current. Continued interview with the QIDP revealed all staff have been trained on client #2's PCP. Further interview with the QIDP revealed the DSP should have closed the door to ensure client #2's privacy during personal care. B. The facility failed to ensure client #2's access to prescribed adaptive equipment during meals: Observation in the group home on 11/5/24 at 5:30 PM revealed client #2 to participate in a dinner meal consisting of meat loaf, broccoli, rice, milk, water and a condiment of ketcup. Continued	W 249		

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observation revealed client #2 to have a place setting that consisted of a regular plate, two cups, a fork, case knife, spoon, and napkin. Further observation revealed staff to ask client #2 if he would allow them to use a Rocker knift to cut his meat loaf. Subsequent observation revealed client #2 to comply with the offer to have his meatloaf cut with the rocker knife. Final, observation revealed the rocker knife to be returned to the kitchen.

Observation in the group home on 11/6/24 at 8:15 AM revealed client #2 to participate in a breakfast meal consisting of one scrambled egg, one piece of toast with butter and grape jelly, 1 cup of coffee, 1 cup of 2% milk, 1 cup of of grape juice and one cup of water. Continued observation revealed client #2 to have a place setting that consisted of a regular plate, one coffee cup, three beverage cups, a fork, case knife, spoon, and napkin. Further observation revealed staff to ask client #2 if he would allow them to use a Rocker knift to cut his slice of toast. Subsequent observation revealed client #2 to comply with the offer to have his toast cut with the rocker knife. Final, observation revealed the rocker knife to be returned to the kitchen.

Review of records on 11/6/24 revealed a Nutritional Assessment (NA) dated 2/29/2024. Continued review of the NA reveals client #2 has a regulary diet with no nuts or nut products , due to an allergy, a rocker knife and requires assistance in using it.

Interview with the QIDP on 11/6/24 confirmed client #2's NA is current. Continued interview with the QIDP confirmed client #2 should have access to his rocker knive durng all meals with staff

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W 249	Continued From page 4 providing assistance to use it. C. The facility failed to ensure client #4s access to prescribed adaptive equipment during meals: Observation in the group home on 11/5/24 at 5:30 PM revealed client #4 to participate in a dinner meal consisting of meat loaf, broccoli, rice, milk, water and a condiment of ketcup. Continued observation revealed client #4 to have a place setting that consisted of a regular plate, two cups, a fork, case knife, spoon, and napkin. Further observation revealed staff to ask client #4 if he would allow them to use a Rocker knift to cut his meat loaf. Subsequent observation revealed client #4 to comply with the offer to have his meatloaf cut with the rocker knife. Final, observation revealed the rocker knife to be returned to the kitchen. Observation in the group home on 11/6/24 at 8:18 AM revealed client #4 to participate in a breakfast meal consisting of one scrambled egg, one piece of toast with butter and grape jelly, 1 cup of coffee, 1 cup of 2% milk, 1 cup of of grape juice and one cup of water. Continued observation revealed client #4 to have a place setting that consisted of a regular plate, one coffee cup, three beverage cups, a fork, case knife, spoon, and napkin. Further observation revealed staff to ask client #4 if he would allow them to use a Rocker knift to cut his slice of toast. Subsequent observation revealed client #4 to comply with the offer to have his toast cut with the rocker knife. Final, observation revealed the rocker knife to be returned to the kitchen. Review of records on 11/6/24 revealed a Nutritional Assessment (NA) dated 8/29/2024.	W 249		

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W 249	Continued From page 5 Continued review of the NA reveals client #4 has a 1700-1800 calorie diet, 49 grams of protien daily, uses a rocker knife and able to use beverage cup/glasses. Interview with the QIDP on 11/6/24 confirmed client #4's NA is current. Continued interview with the QIDP confirmed client #4 should have access to his rocker knive durng all meals. Further interview with the QIDP revealed staff should assist with use of the rocker knife if needed.	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 all drugs were administered without error for 4 of 6 clients (#1, #2, #4, and #5) observed during medication administration. The findings are: A. The facility failed to ensure all drugs were administered without error for client #1. For example: Observation in the group home on 11/6/24 at 8:27 AM revealed staff and client #1 to sanitize hands and prepare for medication administration in the medication room. Continued observation revealed staff to remove client #1's medication basket from the closet and place it on the desk. Further observations revealed staff to crush medications, pour liquid medications, and place non crushed medications into a bowl of applesauce. Subsequent observations revealed staff to	W 369		

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administer the morning medications to client #1 feeding the client applesauce containing medications.

Review of records for client #1 on 11/6/24 revealed physician orders dated 10/1/24. Review of the 10/1/24 physician orders revealed medications to administer at 8:00 AM to be Benztropine tab 0.5 MG, Lacosamide tab 100MG, Lactulose Solution 10/GM/15 Solution, Loratadine 5MG/5ML Syrup Solution, Nitrofurantoin MONO-MCR 100MG, Omeprazole cap 20MG, Tamsulosin cap 0.4MG, Therems-M tab, and Vitamin B-12-tab 1000MCG, and chocolate Ensure. Staff were not observed to provide client #1 with chocolate Ensure which is prescribed twice daily with meals at 8:00 AM and 5:00 PM

Interview with the facility nurse on 11/6/24 confirmed the 10/1/24 physician orders for client #1 to be current. Continued interview with the facility nurse revealed that staff should administer medications as prescribed.

B. The facility failed to ensure all drugs were administered without error for client #2. For example:

Observation in the group home on 11/6/24 at 9:40 AM revealed a pink tablet on the floor in the medication administration room next to the trash can. Continued observations revealed the residential manager (RM) and qualified intellectual disabilities professional (QIDP) identified the tablet to be Carbamazepine chew 100MG to be prescribed to client #2.

Review of records for client #2 on 11/6/24 revealed physician orders dated 10/1/24. Review

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of the 10/1/24 physician orders revealed client #2 to be prescribed Carbamazepine chew 100MG three times daily at 8:00 AM, 2:00 PM, and 8:00 PM.

Interview with the QIDP on 11/6/24 confirmed that Carbamazepine chew 100MG found on the floor belonged to client #2. Continued interview with the QIDP confirmed that client #2 will not receive an additional dose of Carbamazepine chew 100MG per facility nurse due to administration times and not knowing how and when the medication ended up on the floor.

Interview with the facility nurse on 11/6/24 confirmed the 10/1/24 physician orders for client #2 to be current. Continued interview with the facility nurse revealed that staff should administer medications as prescribed including supplements.

C. The facility failed to ensure all drugs were administered without error for client #4. For example:

Observation in the group home on 11/6/24 at 7:54 AM revealed staff and client #4 to wash hands and prepare for medication administration in the medication room. Continued observation revealed staff to remove client #4's medication basket from the closet and place it on the desk. Further observations revealed staff administered client #4's medication and the client took the medication whole with water and staff instilled Restasis EMU 0.05% eyedrops to both eyes.

Review of records for client #4 on 11/6/24 revealed physician orders dated 10/1/24. Review of the 10/1/24 physician orders revealed

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medications to administer at 8:00 AM to be Vitamin D 125 MCG (5000IU), Restasis EMU 0.05% drop, and Lotemax SM Gel 0.38% drop. Staff were not observed to provide client #4 with Lotemax SM Gel 0.38% drops prescribed twice daily instilling 1 drop in both eyes at 8:00AM and 8:00PM.

Interview with the facility nurse on 11/6/24 confirmed the 10/1/24 physician orders for client #4 to be current. Continued interview with the facility nurse revealed that staff should administer medications as prescribed.

D. The facility failed to ensure all drugs were administered without error for client #5. For example:

Observation in the group home on 11/6/24 at 8:04 AM revealed staff and client #5 to walk in the medication room and sanitize hands and prepare for medication administration. Continued observation revealed staff to remove client #5's medication basket from the closet and place it on the desk. Further observations revealed staff administered client #5's morning medications punching hand over hand in pill cup. Subsequent observations revealed the client took all morning medications whole with water and staff instilled 2 prescribed eyedrops to client #5's right eye.

Review of records for client #5 on 11/6/24 revealed physician orders dated 10/1/24. Review of the 10/1/24 physician orders revealed medications to administer at 8:00 AM to be Vitamin D3 25 MCG (1,000IU), Furosemide tab 20MG, Docusate SOD cap 100MG, Certavite antioxid, Calcium vitamin D3 600-10MCG, Atropine SUL Solution 1% drop, Brimonidine

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W 369	Continued From page 9 Solution 0.15% drop, and Dorzolamide Solution 2% drop. Staff were not observed to provide client #5 with Dorzolamide Solution 2% drops prescribed three times daily instilling 1 drop in right eye at 8:00AM, 2:00 PM and 8:00PM. Interview with the facility nurse on 11/6/24 confirmed the 10/1/24 physician orders for client #5 to be current. Continued interview with the facility nurse revealed that staff should administer medications as prescribed.	W 369		