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W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) 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, interviews and record reviews, the facility failed to ensure 2 of 5 audits clients (#3 and #5) were provided the opportunity for personal privacy. The findings are: A. During observations in the home on 12/30/24 at 10:50am, client #3 was observed to stand in front of the toilet in the bathroom, with the door open and urinate. An additional observation on 12/30/24 at 5:55pm, client #3 was observed to go to the bathroom and urinate with the door open. Review on 12/31/24 of client #3's Human Development Assessment dated 10/30/24, revealed that client #3 does not have the ability to initiate privacy behavior. Interview on 12/31/24 with the Program Director confirmed that client #3 should be afforded privacy and have the door closed. B. During observations in the home on 12/31/24 at 6:00am, the Area Supervisor #2 (AS #2) was in the bedroom with client #5, with the door left open. Client #5 was observed sitting on her bed, with both breasts exposed as she began to get dressed. The AS #2 observed the surveyor at the doorway and left the room, leaving the door open. Review on 12/31/24 of client #5's Individual Program Plan (IPP) dated 4/18/24 revealed she was independent with dressing.	W 130		

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

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W 130	Continued From page 1 Interview on 12/31/24 with the AS #2 revealed she went back to client #5's bedroom while she was still getting dressed, to close her door because other clients were awake.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff used safe practices when transporting clients in wheelchairs. This affected 1 of 5 audit clients (#6). The finding is: Observation on 12/31/24 at 11:00am, Staff A and Staff B were loading clients #2 and #6 on the van, parked in their driveway, using a drop ramp from the rear of the van, to roll the clients into the van. Staff B was observed wearing non-skid open-heel clogged shoes. Staff A was observed to use physical exertion to push client #6's wheelchair up the ramp, at approximately a 30-degree incline. Once the wheelchairs were positioned, Staff A used a five-point harness technique to anchor the wheelchair in the van. Review on 12/30/24 of an Incident Report dated 10/17/24 revealed Staff B was handling client #6's wheelchair on the ramp to the van. Staff B tripped over the bottom of the ramp causing client #6's wheelchair to tilt over. Staff performed a head/body check, contacted management and then transported client #6 to the emergency room. Client #6 sustained no injuries.	W 189		

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W 189	Continued From page 2 Further review on 12/30/24 of an Incident Report dated 12/5/24 at 11:40am, revealed Staff B was handling client #6's wheelchair on the ramp to the van. Staff B and Client #6 "fell over" while using the ramp. A Consultation Report dated 12/5/24 revealed client #6 was seen at the doctor for a "right upper forehead abrasion after falling while being transported out of the wheelchair van in the parking lot." The fall was witnessed by staff, who indicated client #6 was wearing a seatbelt and never fell out of the wheelchair. The injury was treated with an antibiotic ointment. Staff will monitor the forehead 4x a day for swelling and mental status changes. Review of Staff Training In-services for 2024 revealed the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) did not require any staff to get retrained on safe wheelchair transport of clients. Interview on 12/31/24 with Staff B revealed recently she had two accidents pushing client #6 on and off the van, using the rear ramp. Staff B explained the incident occurred because the wheelchair was heavy to push, and the van had parked on a "hill" in the parking lot to unload the wheelchairs. When Staff B attempted to unload client #6 from the van, Staff B revealed the wheelchair moved faster, causing her to lose her balance and they both fell over to the ground. Interview on 12/31/24 with the HM revealed she was present on 12/5/24 when client #6 and Staff B fell off the ramp. The HM acknowledged the parking lot at the doctor's office was crowded and had a sloped hill, where she parked to allow Staff B to unload the wheelchair. The HM revealed she	W 189		

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W 189	Continued From page 3 witnessed Staff B walking backward down the ramp, per instructions, pulling client #6's wheelchair, while client #6 faced the rear of the van. Staff B lost her balance, causing both of them to fall on the ramp. The HM acknowledged she did not unload in a handicapped parking space because the home does not have a handicapped placard for the van, and she did not feel comfortable parking there to unload the vehicle and attempted to park where she could get close to the entrance of the office.	W 189		
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 record review and interview, the facility failed to to implement programs as prescribed for 3 of 5 audited clients (#3, #4 and #6). The findings are: The facility failed to implement client #3's BSP as prescribed. A. Observation in the home during survey on 12/30/24 to 12/31/24, client #6 was observed in a wheelchair, positioned between the television and sofa, while client #3 sat on the sofa during leisure	W 249		

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W 249	Continued From page 4 activities. Review on 12/31/24 of the BSP dated 10/26/24 for client #3 revealed a goal to reduce maladaptive behavior, increasing opportunities for him to learn socially appropriate behaviors, increasing adaptive coping strategies, and reinforcing positive alternative behaviors. Client #3's target behaviors were identified as: noncompliance, agitation, physical aggression, property destruction and food seeking. Staff were expected to recognize signs that client #3 was becoming anxious, observe pacing and tension in body to forewarn of an agitated state. In addition, property destruction was defined as turning over objects. The BSP revealed client #3 did not like crowds and during group activities, he should be allowed to be moved to a less crowded area. Review on 12/30/24 of an Incident Report dated 3/28/24 at 4:52pm revealed client #6 was "watching tv when another client (client #3) attacked (client #6) and threw (client #6) to the ground." No injury was document on the head/body check sheet completed on 3/28/24. A second incident happened on 8/25/24 at 7:00pm, it revealed "(client #6) was sitting with all clients inside of the sitting area, when (client #3) walked over to (client #6) and flipped her chair over in front of all staff." Staff triaged client #6 and sent her to the emergency room where she was diagnosed with an acute head injury. Interview on 12/31/24 with the Home Manager (HM) revealed client #3 had a history of targeting the two clients in wheelchairs, clients #2 and #6. Furthermore, she revealed client #3 did not want any clients in wheelchairs to sit in front of the sofa when they are all watching television. In response	W 249		

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W 249	Continued From page 5 to client #3's agitation, the HM had witnessed him stand behind client #6's wheelchair and lift it off the ground causing her to fall out of the chair. The HM revealed the incident in August 2024, client #6 had to go to the hospital because she hit her head on the edge of the table, when client #3 threw her from the wheelchair while they were in the living room. The HM acknowledged staff were still sitting clients #2 and #6 in their wheelchairs in front of the sofa. The facility failed to follow dietary guidelines for client #4. B. During dinner observation on 12/30/24, client #4 finished eating dinner at 5:13 pm and observed lying down at 5:35 pm. Review of client #4's Nutrition Evaluation dated 9/5/24 recommends client #4 remains in upright positioning during and 30 minutes post meal and HOB at all times. Interview on 12/31/24 with the Home Manager revealed that client #4 is supposed to remain up right 30 minutes after meals before lying down.	W 249		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 2 of 5	W 460		

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audits clients (#4 and #6) received a modified and specially prescribed diet. The finding are:

A. Observations in the home on 12/30/24 during lunch, 1:12pm-1:30pm, the Home Manager (HM) prepared tater tots, chicken patty and bread in a blender for client #6. The food was prepared mechanically soft. The Area Supervisor #1 (AS #1) was present in the dining room, examined the plate and was heard telling the HM the food needed to be processed longer to a puree consistency. The HM returned to the kitchen and blended the food longer. The chicken did not achieve a smooth blended consistency, but the tater tots and bread did. Client #6 was fed lunch while sitting in her wheelchair, and her face was hunched over her knees. The HM was observed to randomly push client #6 in an upright position with her left hand and also moved her forehead back, to get her to sit closer to the headrest.

Additional observations on 12/30/24 at dinner, at 5:05 pm, Staff D stood next to client #6's wheelchair and began feeding her chopped green beans, ground chicken and smooth mashed potatoes. Client #6 ate the food without incident.

Interview on 12/30/24 with the HM, while Staff D fed client #6 revealed she processed client #6's dinner to a mechanical ground consistency because of the dietary orders from 9/18/24 by the Registered Dietician that hung inside the kitchen cabinet. The HM acknowledged that she only served client #6's lunch pureed earlier because she was directed to do so by AS #1.

Observations in the home on 12/31/24 at 6:45am during breakfast, the second Area Supervisor (AS #2) processed instant oatmeal, toast, jelly and a

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fresh banana in the blender until processed smooth and blended. Staff B sat in front of client #6 at the table and fed her dinner, while client #6 sat in a tailor position, with the chest strap, high on her upper torso and leaned forward with her chin near the table's edge and consumed her meal, without incident.

Review on 12/30/24 of client #6's Hospital Discharge Summary from 9/27/23 to 10/2/23 due to a seizure revealed she had a diagnosis of dysphagia and was prescribed the International Dysphagia Diet Level 4 and Dysphagia Liquid, Level 0. The facility's nurse signed the summary on 10/3/24 that she reviewed the hospital's recommendations. In addition, client #6's Incident Report from 12/17/23 revealed she had food come out of her mouth and nose, during dinner and was sent to the emergency room.

Review on 12/30/24 of client #6's Incident Reports revealed on 11/17/24 on 2nd shift, revealed client #6 "was spitting a lot, sounded like mucous in chest when she coughed. Staff F tried to feed her and she choked on food/spit and spit up all food. 911 was called. Triage was called and she was taken to the emergency room (ER)." Furthermore, on 12/3/24 during dinner, client #6 ate steak, dinner salad and oranges when she began to "choke and spit food back up. She began to turn red and coughing. Attempted to hold both arms over her head. She continued to spit up, 911 was called."

Interview on 12/31/24 with the Qualified Intellectual Disabilities Professional #3 (QIDP #3) revealed he had trained the staff several times throughout the year on dietary orders. The QIDP #3 acknowledged that client #6 used to be on a

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pureed diet over a year ago but was switched to a mechanical soft/ground diet. The QIDP #3 confirmed there have been two recent choking incidents with client #6 in the home. The QIDP #3 revealed there were staff from another home working with client #6 on 12/3/24. The staff prepared her meal, consisting of steak and salad, cut up the meat with utensils instead of processing it in the blender. The QIDP #3 confirmed this caused client #6 to choke on her dinner and she was sent to the emergency room for treatment. The QIDP #3 also acknowledged that he was not aware the physician changed the diet orders back to pureed after examining client #6 on 12/5/24.

Interview on 12/31/24 with the Nurse revealed previously client #6 was placed on a pureed diet but she had been getting a mechanical soft diet for over a year. The Nurse did not know the reason the diet had been upgraded back to a mechanical soft consistency. The Nurse acknowledged she was part of the CORE Team and has been notified in their monthly meetings of any medical incidents involving the clients. The Nurse recalled she had reviewed the new order on from 12/5/24 to prepare all of client #6's pureed, and contacted the Family Nurse Practioner #2 (FNP #2) about clarifying the order and questioned if client #6 should be on mechanical soft. The Nurse revealed the doctor's practice has different FNP who see client #6 and FNP #1 wrote an order in September, 2024 for client #6 to be on a pureed diet but the Registered Dietician recommended a mechanical soft diet with nectar thick liquids on 9/18/24. The nurse also acknowledged that client #6 not sitting in an upright sitting position during meals, could contribute to choking during her meal. The nurse

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revealed she requested a Speech Language Swallow Study for client #6 after the last choking incident, but it has not been completed yet.

Interview on 12/31/24 with the AS #1 revealed she was aware client #6 should be on a pureed diet and told staff yesterday at lunch and dinner, to be sure client #6 received a puree consistency.

B. During lunch and dinner observations on 12/30/24, client #4's meat was not ground, it was chopped into 1/2 pieces and he was not prompted to sip between bites. The majority of his liquid consumption occurred after his meal.

Record review on 12/30/24 of client #3's Dietary Assessment recommends a regular calorie diet, 1/4 inch pieces except all meat ground. Guidelines for meal time for September 24 recommend "alternate small bites (quarter sized) and offer sips between bites. small sips."

Interview on 12/31/24 with the Home Manger revealed she thought client #4's diet consistency was bite size, and he should be drinking between bites because he is an aspiration risk.

Interview on 12/31/24 with the Program Director revealed that she did not know client #4's diet consistency, but she was aware that he has an alternate food texture and has to have a 1:1 staff at meals. She was unsure of the sipping between bites recommendations. She advised staff will place a small amount of food on the plate for client #4 to eat and continue the same until he has consumed all of his meal.

Interview 12/31/24 will the AS #1 revealed that she was aware of client #4 being required to sip

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W 460	Continued From page 10 between bites according to what she remember from his dietary plan.	W 460		
W 489	DINING AREAS AND SERVICE CFR(s): 483.480(d)(5) The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all clients were fed in an upright position. This affected 1 of 5 audit clients (#6). The finding is: Observations in the home on 12/30/24 during lunch, 1:12pm-1:30pm, the Home Manager (HM) fed client #6 from her wheelchair, while client #6 was hunched over her folded knees, with chin close to the dining room table. The HM was observed to randomly push client #6 in an upright position with her left hand and also moved her forehead back, to get her to sit closer to the headrest. Client #6 was not using any shoulder or chest device to support her upper trunk. Client #6 also sat in a Tailor sitting position, the entire meal. An additional observation on 12/31/24 at 7:15am, Staff B sat in front of client #6, seated in her wheelchair and fed her breakfast. Client #6 did not sit up right and was hunched over in the wheelchair with her face close to the table's edge. Record review on 12/31/24 of the Occupational Therapy In-service dated 11/12/24 for client #6's feeding protocol revealed the following terms: "Please make sure [client #6] is sitting upright chest strap on to assist with maintaining an optimal posture for feeding (15-45 degrees	W 489		

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wheelchair backrest recline). In addition to the chest strap, staff may offer intermittent physical prompts to sit straight (as much as possible). Please maintain this position during and 30 minutes after feeding."

An Interview on 12/31/24 with Staff B revealed she was aware client #6 was not sitting upright when she fed her, but responded, "she still has to get fed."

An interview on 12/31/24 with the HM revealed client #6 used to have a chest harness like client #2 to help her sit upright but the Occupational Therapist (OT) discontinued it last month, allowing staff to just use a chest strap. When asked why would the OT write an order to discontinue the chest harness, the HM responded because it was felt client #6 was most comfortable sitting in with her knees (tailer sitting position) and she could not sit that way with the harness.

An interview on 12/31/24 with the nurse revealed she was part of the CORE TEAM and client #6's choking incidents had been reported at their monthly meetings. The Nurse acknowledged client #6 was supposed to sit upright during her meals. The Nurse also acknowledged client #6 not sitting upright could contribute to her choking on her foods during meals.

An interview on 12/31/24 with the Area Supervisor #1 (AS#1) revealed the OT had changed the order last month to discontinue the shoulder/chest harness, to help support client #6 sit upright. The AS #1 also acknowledged client #6 was unable to independently sit up right in her wheelchair.

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