STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G341	A. BUILDING _____ B. WING _____	R 11/18/2024

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W 000	INITIAL COMMENTS A revisit was conducted on November 18, 2024 for all previous deficiencies cited on July 31, 2024. A total of 6 of 7 deficiencies were re-cited as the facility did not provide supporting documentation as described in the plan of correction (POC) submitted. The facility remains out of compliance.	W 000		
{W 159}	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) coordinated, integrated, and monitored the changing health status and active treatment of 1 of 3 sampled clients (#5). The finding is: Review of the record during the recertification survey from 7/30/24-7/31/24 revealed client #5 to have five hospitalizations in the last eight months. Continued review revealed client #5 to have hospitalizations and/or emergency department (ED) visits on the following dates: 1/10/24, 1/26/24, 3/22/24, 4/16/24, and 5/30/24. Further review of the record revealed client #5 to have the following diagnoses: urinary tract infection (UTI), pressure sores with purulent drainage, sepsis due to UTI with hematuria, colostomy due to bowel obstruction, acute kidney injury, dehydration, anemia, hyponatremia, and vitamin B12 deficiency. Review of the record did not reveal QIDP documentation to confirm monitoring, follow up after hospital discharge, staff in-service	{W 159}	Pm will in-service QP on properly documenting individuals care and properly documenting any hospital stays, critical incidents and changes in health status. PM will monitor monthly notes and other documentation to ensure that over site is provided Completed by 12/18/24	

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Chris Childers	Program Manager	12/4/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 159}	Continued From page 1 training, or core team meetings to discuss the client's medical status change. Interview with the Program Manager (PM) on 7/31/24 revealed that the facility has not had a full time QIDP for at least four months. Continued interview with the PM indicated that he was filling in as the interim QIDP for this facility along with other facilities. Further interview with the PM verified that there have been no team meetings with the legal guardian relative to client #5's change in health status. Additional interview with the PM verified that QIDP documentation relative to the client's changing health needs were not completed relative to the client's multiple hospitalizations. Interview with the PM also revealed that there was no documented QIDP follow-up for any hospital discharge recommendations for services, program implementation, in-service training, or interventions to ensure client #5 was receiving appropriate personal care in a timely manner relative to the client's changing medical needs. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. It is important to mention that the client is currently in the hospital on 11/18/24 for a UTI. There was no evidence of QIDP follow up for the client's changing medical needs or interventions to address the client's change in health status.	{W 159}		
{W 210}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to	{W 210}		

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{W 210}	Continued From page 2 supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure needed assessments for 1 sampled client (#3) were completed within 30 days after admission. The findings are: Review on 7/31/24 of client #3's record revealed an individual support plan (ISP) dated 12/29/23 with an admission date of 12/28/23. Continued review revealed a diagnosis to include schizoaffective disorder, bipolar type, hypothyroidism, unspecified dementia with behavioral disturbance, unspecified urinary incontinence, essential primary hypertension, peripheral vascular disease, unspecified intellectual disabilities, anxiety disorder, unspecified bipolar disorder, unspecified heart failure. Further review revealed a behavior support plan (BSP) consent for medications and targeted behaviors listed as physical aggression, verbal aggression, property destruction, noncompliance and untrue statements. Subsequent review revealed an eye exam dated 6/19/24, nursing monthly summary dated 1/5/24, labs completed 2/21/24, physical completed 2/7/24, and nutritional evaluation dated 7/29/24. Additional review did not reveal a BSP or guidelines, a dental evaluation but one scheduled for 11/14/24, physical therapy (PT), or occupational therapy (OT) evaluations. Interview on 7/31/24 with the interim qualified intellectual disabilities professional (QIDP) and home manager (HM) verified that current assessments for client #3 which includes a BSP,	{W 210}	PM, QP, HS will ensure that all appointments and assessments for new individuals are completed in a 30 day time period after admission. PM will monitor all new admissions to ensure that all assessments are completed within the 30 day period Completed by 12/18/24	

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{W 210}	Continued From page 3 PT, OT, and dental evaluation were not available during survey for review. Further interview revealed that all assessments should be completed within 30 days after admission for all clients. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. There was no supporting documentation provided according to the POC submitted.	{W 210}		
{W 218}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: The facility failed to assure a prescribed assessment for 2 of 4 sampled clients (#4 and #5) was obtained as evidenced by interview and record verification. The findings are: A. The facility failed to assure OT and PT assessments were completed for client #4. Review of client #4's individual support plan (ISP) dated 8/15/23 revealed a diagnosis of severe IDD, Spastic quadriplegic cerebral palsy, anxiety disorder and in turned right foot. Continued review revealed adaptive equipment to include a four wheeled walker with built in seat, leg braces and eyeglasses. Further review revealed a referral note dated 7/8/14 the need for client #5 to have an annual physical therapy (PT)/occupational therapy (OT) assessment. Subsequent review revealed the last PT assessment was completed 1/13/15 and an OT assessment was not completed.	{W 218}	PM Nurse, QP, HS will ensure that all PT/OT assessments are completed for each individual in the home within a 30 day time frame after admission or on a yearly basis. PM, Nurse, and QP will monitor PT/OT evaluations to ensure that PT/OT needs are met for each individual. Completed by 12/18/24	

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{W 218}	Continued From page 4 Interview with the interim qualified intellectual developmental professional (QIDP) and home manager (HM) verified the needed assessments for client #4 had not been completed as of the 7/31/24 survey. B. The facility failed to assure OT and PT assessments were completed for client #5. Review of client #5's individual support plan (ISP) dated 12/14/23 revealed a diagnosis of impulsive control disorder, profound IDD, neurogenic bladder NOS, infantile TP, hyperthyroidism, spastic quadreplegia, dysphasia, mild cataracts, and seizure disorder. Continued review revealed adaptive equipment to include built up utensils, high sided dish, wheelchair, hoyer lift, shower chair, communication board, and hospital bed. Further review revealed the last PT assessment was completed on 5/1/17 and an OT assessment was not available to review. Interview with the QIDP and HM verified the needed assessments for client #5 had not been completed as of the 7/31/24 survey. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. It is important to mention that client #5 is currently in the hospital on 11/18/24 for a UTI. Supporting documentation was not completed according to the POC submitted.	{W 218}		Completed by 12/18/24
{W 288}	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client	{W 288}		

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{W 288}	Continued From page 5 behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that all interventions to manage inappropriate behavior were incorporated into a behavior support plan (BSP) for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The findings are: A. Review of records on 7/31/24 for client #3 revealed an informed consent signed by the legal guardian and human rights committee dated 12/29/23. Continued review revealed client #3's BSP consent to address behavior management and prescribed medications; Divalproex 500mg, Divalproex 100mg, Fanapt 4mg, Quetiapine 50mg, Trazodone 100mg, and Hydroxyn 25mg. Further review did not reveal a BSP to address targeted behaviors of physical aggression, verbal aggression, property destruction, non compliance, and untrue statements. Interview on 7/31/24 with the interim qualified intellectual developmental professional (QIDP) revealed that client #3 did not have a BSP. Continued interview revealed that the team had not started the process to complete a BSP for client #3. Further interview with the QIDP also revealed that client #3 is in need of a BSP for interventions and prescribed medications relative to behavior management. B. Review of records on 7/31/24 for client #1 revealed a BSP dated 1/15/23. Continued review did not reveal an updated BSP to address interventions and prescribed medications relative to client's behavior management.	{W 288}	PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24 PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24	

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{W 288}	Continued From page 6 Interview on 7/31/24 with the QIDP revealed client #1's BSP have not been updated due to the absence of a behavior specialist and contractor to complete or update client's BSP. C. Review of records on 7/31/24 for client #2 revealed a BSP dated 6/15/22. Continued review did not reveal an updated BSP to address interventions and prescribed medications relative to client's behavior management. Interview on 7/31/24 with the QIDP revealed client #2's BSP have not been updated due to the absence of a behavior specialist and contractor to complete or update client's BSP. D. Review of records on 7/31/24 for client #4 revealed a BSP dated 8/15/22. Continued review did not reveal an updated BSP to address interventions and prescribed medications relative to client's behavior management. Interview on 7/31/24 with the QIDP revealed client #4's BSP have not been updated due to the absence of a behavior specialist and contractor to complete or update client's BSP. E. Review of records on 7/31/24 for client #5 revealed a BSP dated 12/14/22. Continued review did not reveal an updated BSP to address interventions and prescribed medications relative to client's behavior management. Interview on 7/31/24 with the QIDP revealed client #5's BSP have not been updated due to the absence of a behavior specialist and contractor to complete or update client's BSP. F. Review of records on 7/31/24 for client #6	{W 288}	PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24 PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24 PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24	

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{W 288}	Continued From page 7 revealed a BSP dated 1/15/23. Continued review did not reveal an updated BSP to address interventions and prescribed medications relative to client's behavior management. Interview on 7/31/24 with the QIDP revealed client #6's BSP have not been updated due to the absence of a behavior specialist and contractor to complete or update client's BSP. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. It is important to mention that client #5 is currently in the hospital on 11/18/24 for a UTI. Supporting documentation was not completed according to the POC submitted.	{W 288}	PM, QP, will ensure that all Behavior Support Plans for each individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure that they are signed and remain appropriate for each individual Completed by 12/18/24	
{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 interviews and record verification, nursing services failed to provide staff training to address the clients changing medical needs for 1 of 3 sampled clients (#5). The finding is: Review of the record on 7/31/24 for client #5 revealed several hospitalizations from 1/2024-6/13/24. Continued review of the medical record for client #5 verified the following ED visits and/or hospitalizations: 1/10/24, 1/26/24, 3/22/24, 4/15/24, and 5/30/24. Further review of the medical record revealed client #5 to have the following diagnoses during the hospitalizations: urinary tract infection (UTI), pressure sores with purulent drainage, sepsis due to UTI with hematuria, colostomy due to bowel obstruction,	{W 331}	PM, Nurse, QP, and HS will in-service all staff on properly monitoring of medical needs of individuals in the home as well as any medical changes and how to properly document each incident. PM, Nurse, and QP will monitor documentation and provide staff over site to ensure that any medical changes are properly documented and care is provided Completed by 12/18/24	

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{W 331}	Continued From page 8	{W 331}		

acute kidney injury, severe protein-calorie malnutrition, dehydration, anemia, hyponatremia, and vitamin b12 deficiency.

Subsequent review of the most current hospital discharge summary dated 6/13/24 revealed the following recommendations: repositioning every two hours to eliminate pressure sores, face to face assessment of consumer within 24 hours of client's return to the facility, review of discharge orders and treatment plan, post-inpatient stay nursing assessment. Review of the record for client #5 did not reveal repositioning guidelines, interventions, vital signs, or in-service training for staff upon discharge from the hospital. Review of the record also did not reveal core team meetings to discuss the client's changing medical needs.

Interview with the home manager (HM) on 7/31/24 revealed that staff have been repositioning client #5 every two hours however, it has not been documented or recorded in the client's record. Continued interview with the HM and program manager (PM) on 7/31/24 verified that staff have not received in-service training from nursing services relative to monitoring vital signs and repositioning to prevent pressure sores.

Interview with the PM on 7/31/24 revealed that there have been no changes in personal care for client #5 since he has had a change in medical status. Continued interview with the PM also revealed that there is no evidence of monitoring client's #5 vital signs, repositioning guidelines, or special instructions from nursing services relative to the client's changing medical needs. Further interview with the PM revealed nursing services has not provided any training relative to client #5's

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{W 331}	Continued From page 9 post-discharge care and instructions. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. It is important to mention that the client is currently in the hospital on 11/18/24 for a UTI. Supporting documentation was not available according to the POC submitted. There was no evidence of documentation relative to nursing services oversight regarding the client's changing medical status.	{W 331}		
{W 340}	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to provide nursing services in accordance with the clients' needs relative to changing medical status for 1 of 3 sampled clients (#5). The finding is: Review of the record during the recertification survey from 7/30/24-7/31/24 revealed client #5 has had five hospitalizations over the last eight months. Continued review of the record for client #5 indicated the following diagnoses: urinary tract infection (UTI), pressure sores with purulent drainage, sepsis due to UTI with hematuria, colostomy due to bowel obstruction, acute kidney injury, severe protein-calorie malnutrition, dehydration, anemia, hyponatremia, and vitamin B12 deficiency. Further review of the medical	{W 340}	PM, Nurse, QP, HS will in-service all staff on properly identifying medical conditions and changes and properly documenting finding as well as prevention of UTI's, pressure sores, etc. PM, Nurse, and QP will provide monitoring to ensure that changes in medical conditions are cared for, treated, and documented in an appropriate manner. Completed by 12/18/24	

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{W 340}	Continued From page 10	{W 340}		

record for client #5 verified the following ED visits and/or hospitalizations: 1/10/24, 1/26/24, 3/22/24, 4/15/24, and 5/30/24.

Review of the hospital discharge summary dated 6/13/24 revealed client #5 had the following diagnosis: Sepsis due to UTI with hematuria, acute kidney injury, O2 reading at 83%, and pressure sores with purulent drainage. Review of the nursing monthly summary signed 6/13/24 and hospital discharge summary dated 6/13/24 revealed the following recommendations: repositioning every two hours to eliminate pressure sores, face to face assessment of consumer within 24 hours of client's return to the facility, review of discharge orders and treatment plan, post-inpatient stay nursing assessment. Review of the record did not reveal a nursing assessment or in-person contact with client #5 upon discharge from the hospital.

Subsequent review of the medical record for client #5 indicated nursing triage notes on the following dates: 3/10/24, 3/22/24, 4/15/24, 4/16/24, 4/20/24, 5/30/24, and 5/31/24. Review of the medical record revealed the last hospitalization for client #5 was from 5/30/24-6/13/24. Review of the record did not reveal nursing services follow up or contact notes since the client was discharged. Review of the medical record for client #5 did not reveal nursing assessments, follow up care, in-person contact or in-service training relative to the client's hospital discharge recommendations and changing medical needs. Review of the record for client #5 did not reveal nursing contact from 6/13/24 - 7/31/24.

Interview with the Program Manager (PM) on

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{W 340}	Continued From page 11 7/31/24 revealed the facility has not had a full-time nurse since 1/2024. Continued interview with the PM verified that the interdisciplinary team including nursing services has not met to further discuss client #5 change in medical status. Further interview with the PM revealed a home health provider has been providing wound care services to client #5 two times a week. Additional interview with the PM verified facility nursing services has not completed nursing assessments or in-person contact with client #5 to assess his changing medical needs. A revisit was completed on 11/18/24 to review the plan of correction (POC) and supporting documentation. It is important to mention that the client is currently in the hospital on 11/18/24 for a UTI. Supporting documentation was not available according to the POC submitted.	{W 340}		