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| W 000 | INITIAL COMMENTS<br><br>A complaint survey was completed 3/25/25 - 4/9/25 for intakes #NC00228655, #NC00228620, NC00228970, NC00228981 and NC00229147. Intake #NC00229147 was unsubstantiated. The remaining intakes were substantiated and deficiencies were cited. An immediate jeopardy was identified, however a Plan of Protection was developed to remove the immediate jeopardy to the clients in the facility.<br><br>A Condition of Participation in Client Protections and Health Care Services was cited. | W 000 | | |
| W 122 | CLIENT PROTECTIONS<br>CFR(s): 483.420(a)<br><br>The facility must ensure the rights of all clients. Therefore the facility must<br>This CONDITION is not met as evidenced by:<br>Based on observation, record review and interview the facility failed: to implement written policies and procedures that prohibit neglect of the clients (W149).<br><br>The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients. | W 122 | | |
| W 149 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(1)<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure written policies and procedures were implemented to | W 149 | | |

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

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prohibit neglect of the clients. This affected 2 of 2 deceased clients (dc #1 and dc #2) and all of the clients residing in the home. The findings are:

A. The facility failed to ensure nursing services were provided in accordance to dc #1's needs.

Review of the IRIS (Incident Response Improvement System) revealed, a level III incident report for the death of dc #1 on 3/24/25 at 10:00am due to unknown causes. No other information was provided in the report.

Record review on 3/25/25 of dc #1's Person Centered Plan (PCP) dated 10/8/24 revealed, he was ambulatory and required 30 minute bed checks during the night to ensure he was sleeping comfortably. The PCP also revealed dc #1 was non-verbal but used various modes of communication to express his emotions, needs and to respond to conversation of questions.

Interview on 3/25/25 with the Administrator revealed, he was contacted by nurse #6 on 3/24/25 at approximately 7:10am and informed that EMS had been called for dc #1. The facility nurse started CPR until EMS arrived. Once EMS arrived, they took over CPR, but were unable to resuscitate him. Dc #1 was pronounced deceased at the facility. The administrator stated he was not aware of any recent health concerns regarding dc #1.

Interview on 3/25/25 with nurse #1 revealed, she worked on 3/21/25. Dc #1 seemed normal for most of the day. Second shift staff notified her between 5:00pm - 6:00pm that dc #1 had vomited. She checked for fecal impaction however there was none. His stomach was soft

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to touch and he seemed normal. She was later informed that dc #1 vomited again. At that time she notified staff, that if he vomited again to notify nursing so they can contact the PA (physician assistant). However, dc #1 did not vomit again, to her knowledge.

Record review on 3/25/25 of a case note with a service date of 3/21/25 at 6:00pm and was submitted on 3/24/25 at 10:25am by nurse #1, revealed that she was notified that dc #1 had thrown up. Nurse #1 did a fecal check and it was negative, as well as temperature check. Nurse #1 documented that she reported to night shift to monitor client and notify MD if the client threw up again.

Interview on 3/25/25 with the medication technician (MT) revealed, he worked on Saturday (3/22/25) and Sunday (3/23/25). However, he was not aware that dc #1 had vomited Friday night. There wasn't a note documenting dc #1 being sick or instructions to call the PA if he vomited. Dc #1 seemed normal on Saturday. Staff notified him on Sunday that dc #1 looked like he wasn't feeling well. He checked dc #1's temperature, which was 99.9 (temporal) and 100.1 (rectal). He gave dc #1 Tylenol at 7:00am. Dc #1 refused to eat breakfast that morning. The MT checked his temperature again at 9:00am and it had gone down to 98 degrees. He checked his temperature again at 11:00am and it was back up to 100.2. He gave dc #1 more Tylenol. The MT reported he went to lunch and when he returned, staff informed him that dc #1 vomited while he was gone. He completed a rectal check which was negative and checked his vitals at 1:15pm, which were 131/71 - blood pressure, 76 - pulse, 98 - O2, 16 - respiration and 98.7 -

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temperature. He notified nurse #2 of this information. She listened to dc #1's vitals and notified the PA. They were informed to monitor dc #1. He checked dc #1 temperature again at 3:30pm and it was 97.9.

Continued interview on 3/25/25 with the MT revealed, dc #1 ate pudding for snack Sunday afternoon and seemed to be doing a little better. He didn't seem distressed. He was unsure if dc #1 ate dinner that night. He informed the night shift (nurse #8), that the PA said to monitor dc #1.

Interview on 3/25/25 with staff E revealed, she worked first shift at the facility over the past weekend. She was made aware that dc #1 was not feeling well Friday night and she had informed staff F to monitor him on second shift. Staff E further stated dc #1 was still not acting like himself on Saturday. He had not been eating and had been lying in bed most of the weekend. Staff E reported that on Sunday, nurse #2 called the PA to inform him that dc #1 was pale and had not been eating. The PA visited the facility on Sunday, in which afterwards staff were informed to monitor him.

Interview on 3/25/25 with the facility's PA revealed, he was notified by the facility staff that dc #1 vomited twice on Sunday and his temperature was 100 degrees. He visited the facility on Sunday but he believed he was called to see another client and not dc #1. He was not sure if he saw dc #1 while onsite. He further stated the nurse gave him dc #1's vitals, as he did not examine dc #1 himself. Afterwards, he provided a verbal order for clear liquids for 24 hours and to monitor closely. He believed he gave the order to nurse #2 or another nurse.

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He's unable to remember which nurse he provided the order to. He did not provide specific instructions to staff on how often staff were to monitor dc #1 because it was standard protocol when clients were sick. However, it was his expectation that staff would check on dc #1 frequently throughout the shift. If symptoms increased, staff were to call him. The PA reported, he did not hear from the facility staff again until Monday morning.

Interview on 3/25/25 with the Director of Nursing (DON) revealed no verbal order for a clear liquid diet could be located for dc #1.

Review on 3/25/25 of the time tracking sleep log for dc #1 revealed no data was documented after 10:30pm on 3/23/25.

Review on 3/25/25 of a case note with a service date 3/24/25 at 5:55am and submitted on 3/24/25 at 12:06pm by nurse #6 revealed, "staff informed me that individual was making noises and kept attempting to stick hand in mouth. Staff attempted to redirect. Upon assessment noted abdomen hard and tight. Check BM (bowel movement) book and noted that individual had 2 BM's on 3/23/25. Bowel sounds present but sluggish. Staff stated hadn't been eating. Upon talking with staff, indicated it was a behavior for him."

Review on 3/25/25 of case logs revealed no other documentation from nurse #6 throughout his shift.

Interview on 3/25/25 with staff B revealed, she arrived to work on 3/24/25 at 6:30am. She went into dc #1's bedroom and he was lying in bed, moaning as if he was in pain. Dc #1 was blue in

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the face and his fingers were purple. Staff C was in the bedroom at the time. She told staff C to go get the nurse. Staff C went to the nurses station and returned in approximately 30 seconds. However, the nurses did not return with him. Staff A walked into the room and then ran back to the nurses station to get help. The nurses arrived to the room with oxygen tanks. They started performing CPR and instructed staff to leave the room. EMS arrived shortly after.

Interview on 3/25/25 with staff A revealed, he arrived to work on Monday 3/24/25 at 6:45am. Upon arrival, he went into dc #1's bedroom and noticed that he was blue/purple in color. There was a brown spot on his bed that looked as if he had vomited or had diarrhea. Dc #1 sounded like "he was taking his last breath; like he hadn't been checked all night." Staff A ran to the nurses station to get help. The nurses went to dc #1's room with an oxygen tank. Direct support staff were instructed to leave the room.

Interview on 3/25/25 with nurse #7 revealed, she arrived to work on 3/24/25 at 6:30am. The nurses were preparing for their morning meeting, when staff A walked to the door and requested to speak with nurse #4. Nurse #4 and Staff A walked to dc #1's bedroom. They were gone for approximately 3 minutes, so she asked nurse #6 to walk with her to dc #1's room. She stated nurse #6 stated "it's probably just a behavior." When they arrived in the room, dc #1's lips and nails were blue in color. Nurse #8 was also in the room and she called 911.

Continued interview with Nurse #7 revealed, she left the room to get an oxygen tank and a non-rebreather mask. Nurse #6 went to get a

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crash cart. Nurse #4 was working on gathering paperwork to send with EMS to the hospital. She further stated that she, nurse #6 and nurse #8 were in the room attempting to obtain dc #1's vitals. It took a couple minutes and at least two tries to obtain vitals because the manual cup connector for the blood pressure cuff was broken. O2 was started while nurse #8 suctioned dc #1's mouth. Nurse #6 then applied the AED and started chest compressions. He completed 2 rounds of CPR and then EMS arrived. Nurse #7 stated, according to the facility's policy, someone should have called code blue for all hands on deck but a code was not called.

Interview on 3/25/25 with nurse #4 revealed, she worked the morning of 3/24/25. She was at the nurses station for the 6:40am meeting. During the meeting, nothing was mentioned about dc #1 being sick over the weekend. As she was sitting at the desk, staff A asked her to step down the hallway to dc #1's room. She went into the room and noticed dc #1 had vomited on the bed and was grayish in color. She told staff she needed her "nurse on a stick" device. Staff brought it to her. Dc #1 was unresponsive. Nurse #8 called 911. She asked the direct care staff to leave the room. Nurse #6 and #7 were in the room so she left to get the paperwork ready for EMS. When she arrived back to the room, EMS was suctioning brownish blood from dc #1's mouth.

Interview on 3/25/25 with the DON revealed, she wasn't aware that dc #1 had been sick over the weekend. Direct care staff were responsible for completing 30 minute checks throughout the night. It is not the responsibility of nursing staff to complete the checks. "Nursing cannot check on 24 clients every night" and the nurses weren't

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going to wake clients up during the night. Direct care staff should notify nursing of any issues.

Continued interview with the DON revealed, she was not aware staff had not documented any checks after 10:30pm on 3/23/25. She confirmed staff should have checked on dc #1 every 30 minutes throughout the night and documented checks.

Interview on 3/25/25 with the Administrator revealed dc #1 should have been checked every 30 minutes throughout the night on 3/23/25 through 3/24/25. He was only informed that dc #1 had started a new behavior over the weekend of putting his finger in his mouth. He was not aware dc #1 was sick.

B. The facility failed to ensure nursing services were provided in accordance to dc #2's needs.

Review on 4/3/25 of dc #2's PCP dated 6/26/24 revealed, dc #2 was non-verbal and used a wheelchair for ambulation. He could eat and drink independently and weighed 104.7 pounds. Dc #2 had a history of seizures, however he had not experienced any recorded seizures in many years therefore it is unknown how they present.

Review on 4/3/25 of T-Logs completed by staff from 3/27/25 to 3/29/25 revealed documentation that stated on 3/27/25, dc #2 refused breakfast and consumed 240ml of liquids and nursing was notified. On 3/27/25 a T-Log revealed at lunch dc #2 was not feeding himself. Staff used hand over hand assistance and the client ate at that time. At dinner time on 3/27/25, a T-Log revealed that dc #2 was hand over hand for dinner, shaky and needed assistance.

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| W 149 | Continued From page 8<br><br>Review on 4/3/25 of the facility's Meal/Supplement/Snack Intake revealed on 3/27/25 dc #2 consumed all of his breakfast and 240ml of liquid. Dc #2 slept through 10am snack, consumed 50% of lunch with 240ml of liquids, refused 2:30pm snack, consumed all of dinner with 240ml of liquid and refused 8:00pm snack.<br><br>Further review on 4/3/25 of the Meal/Supplement/Snack Intake sheets revealed on 3/29/25, dc #2 consumed 240ml of liquid at breakfast, refused 10:00am snack, refused lunch, was asleep during 2:30pm snack and was out of the facility for dinner and 8:00pm snack.<br><br>Review on 4/3/25 of dc #2's hospital records revealed he was taken to the hospital by car on 3/29/25 for "possible seizure". Caregiver reported that dc #2 had seizure-like activity where he experienced muscle rigidity by straightening his legs out, wandering eye movement and bleeding of his eyes, which lasted approximately 130 minutes and then resolved. Per mother, dc #2 had been acting lethargic over the past 24 hours and not eating or drinking. Although the facility notes he had been eating and drinking normally in the week prior to admission. On Emergency Department (ED) arrival he was awake but not interactive. Dc #2 was in fetal position with no attempt to track or follow. Per ED note, severe advance psoriatic plaque changes extended over thorax arms and legs with skin cracked down to the subdermal layer and multiple areas.<br><br>Continued review of dc #2's hospital records revealed, on arrival to the ED, dc #2 weighed "35.2 kg (77 lb 11.2 oz). blood pressure 89/41; pulse 58; temperature 90.7 degrees Fahrenheit; | W 149 | | |

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respiratory rate 18; and height 5'1.5. creatinine 3.9 serum sodium on admission greater than 180 and magnesium of 4.8." Dc #2 was intubated on 3/29/25.

Further review revealed hospital assessment and plan included:
(1) Dehydration with hypernatremia: Profound dehydration on ED arrival. No evidence of excessive fluid loss. Reported history of poor oral intake but only over the 24 hours prior to admission. Suspect gradual reduction over 1 to 2 weeks in reality.
(2) Acute Respiratory Failure: dc #2 with depressed level of consciousness and poor airway control requiring intubation and institution of mechanical ventilation and attempted stabilization in the ED.
(3) Depressed level of consciousness
(4) Acute Renal Failure: Acute profound dehydration contributing to markedly elevated creatinine.
(5) Hypotension: Likely related in part to profound dehydration.
(6) Electrolyte abnormality: Multiple electrolyte abnormalities noted. Hypermagnesemia as well as hyperchloremia and hypernatremia. Dehydration contributing significantly.
(7) Congenital Heart Disease: at birth.
(8) Severe protein-calorie malnutrition
(9) Seizure Disorder: dc #2 with known history of seizure disorder. Concern for seizure prompting this admission with muscle rigidity and wandering gaze. No report of a seizure in the last 2 years. Not currently on the epileptic medication presenting to the ED after reported seizure like activity.
(10) Psoriasis and similar disorder: Severe plaque-like rash over almost entire body. Mother

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reports it has been labeled as psoriasis. Certainly some concern for ichthyosis type syndrome. Unclear if congential. Currently on Dupixent and multiple creams. Has been on steroids recently for this.

Final Primary Diagnoses: Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present; seizure like activity and Hypernatremia.

Hospital records dated 3/29/25 also revealed a wound care consultation documenting dc #2 "has some type of an ichthyotic dermatitis. Has not been characterized by biopsy in the outpatient setting but has been on Dupixent. It appears that despite Dupixent there has been worsening of this dermatologic process as per my discussion with his provider at the [local clinic]. As there is some question as to what the diagnosis truly is and if there is potentially some other superimposed process including but not limited to scabies...I spoke with his treating provider who has been involved in his care since November 2024. He has had no biopsies performed. He has been treated for a suspected eczematous dermatitis. He started Dupixent every 2 weeks on February 17, 2025. He has not had a follow-up with the provider since that time he is only been going for infusions. Per the dermatologist's report, received secondhand through the facility there had been improvement. At the time, his dermatologist provider tells me that these were erythematous plaques on his skin. They are no way representation of what we are currently seeing which are more ichthyotic and fissured areas. The skin is only affected where the patient's hands can reach it spares his buttocks, back and portions of the posterior neck."

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| W 149 | Continued From page 11<br><br>Hospital records further revealed, on 3/31/25 dc #2 remained intubated and unable to follow commands. The family decided to make dc #2 comfort measures only on 4/1/25. Dc #2 was pronounced deceased on 4/2/25.<br><br>Interviews on 4/3/25 with the Administrator and Program Manager (PM) revealed, there was surveillance video of the room in which the events occurred, however they had not reviewed it.<br><br>Review on 4/3/25 of the facility's surveillance footage on 3/29/25 revealed the following:<br>(Per the PM the times are delayed an hour on the camera system because it did not adjust with daylight savings time.)<br><br>17:03 Several staff and clients are in the yellow day room.<br>17:04 (2) Staff went over to check on dc #2 and were seen rubbing his shoulders.<br>17:05 Dc #2 becomes rigid, stretching out his legs while sitting in his wheelchair. Staff grabbed a mat and 3 staff assisted in lying dc #2 on the mat. Med Tech #2 began checking his blood pressure.<br>17:06 A staff left the room and returned with Nurse #10. Nurse #10 walks into the room and stands beside dc #2's mat while Med Tech #2 continues checking vitals. Nurse #10 soon walks out of the room and returns with a notepad. She writes on the pad while the med tech is now at dc #2's feet. Other staff standing over him, watching.<br>17:07 Nurse #2 ran into the room with 2 other staff and stand over dc #2.<br>17:08 Dc #2 starts moving. Nurse #10 leaves the room again. Five other staff standing over him including med tech and nurse #2. | W 149 | | |

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| W 149 | Continued From page 12<br>17:09 Nurse #2 checks dc #2's eyes with a light.<br>17:11 All staff walk away. Dc #2 is seen moving around on the mat.<br>17:13 Dc #2 sits up on mat with legs crossed.<br>17:14 Med Tech #2 checks temperature.<br>17:17 EMS walks into the yellow day room.<br>17:18 Med tech #2 waves for EMS to stop. She talks to them for a few minutes and then makes a phone call. EMS waits while she makes a call.<br>17:19 Med Tech #2 seen shaking her head "no" to EMS. EMS seen leaving the room. At no time did EMS assess dc #2 while on site.<br>17:20 Dc #2 was back and forth between sitting with legs crossed and fetal position.<br>17:35 (2) staff seen assisting dc #2 back to his wheelchair.<br><br>Review on 4/9/25 of the EMS report 3/29/25 revealed "Medic 5 was dispatched routine traffic to a residential institution in reference to convulsions. Upon EMS arrival on scene EMS personnel were met by a med tech in the Nurse area who advised they did not need EMS any longer. The staff advised the patient had been evaluated by 2 of their nurses nurse #10 and #11 . The med tech advised she did not know who called EMS but would contact the Nurses again. After the med tech made a phone call to the Nurses again the Med Tech advised the Nurses stated the subject did not need to be transported to the hospital since the Nurses had evaluated the subject. A signature was obtained from the Med Tech. Medic 5 was clear and back in service."<br><br>According to medical records dated 3/29/25, dc #2 arrived at the local hospital approximately 50 minutes later, transported by staff. | W 149 | | |

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Interview on 4/3/25 with staff J revealed she called 911 on 3/29/25 for dc #2 because it didn't seem like nursing was doing enough to help him, but the med tech turned them away when they arrived. She further stated, staff took him to the hospital after EMS left because he "still didn't look right."

Interview on 4/3/25 with the Administrator revealed he was called by the Qualified Professional (QP) on 3/29/25, who stated they were taking dc #2 due to a seizure. He was aware that EMS was called but stated the nurses didn't think he needed to go out.

During an interview with the ASOD (administration staff on duty) for 3/29/25 revealed she received a call from the building charge that dc #2 was being transported to the emergency room due to fever. The ASOD confirmed, she then texted the DON and administrator to notify them.

Interview on 4/3/25 with the Assistant Director of Nursing (ADON) revealed she was not aware that dc #2 had not been eating and drinking well, nor did she know he required hand over hand to eat on 3/27/25. The ADON confirmed dc #2 was capable of eating and drinking independently and it would be unusual for him to require assistance. She further state does not believe dc #2 had lost approximately 22 pounds between his last weight at the facility on 3/1/25 (99.1 pounds) and his hospital admission weight on 3/29/25 (77 pounds).

Interview on 4/3/25 with the DON revealed she was unaware that staff refused to allow EMS to assess dc #2 when they arrived to the facility. The

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DON revealed she was also unaware that facility staff were the ones who transported dc #2 to the emergency room. She was notified via text on 3/29/25 at 6:58pm by the ASOD that dc #2 was being sent out due to a fever.

The DON also stated she was not aware that dc #2 had any issues with eating or drinking. However, she confirmed there were discrepancies between the T-Logs and the Meal/Supplement/Snack Intake sheets for dc #2 on 3/27/25. The DON was unable to provide an explanation for differences and what would be the accurate amount of intake.

Continued interview on 4/3/25 with the DON revealed the PA typically does face to face visits when completing quarterly medication reviews for the clients. The DON confirmed that the documentation written by the PA for dc #2 on 12/23/24 stated that the client was seen by the PA, however no skin abnormalities were noted.

During a subsequent interview on 4/3/25 with the facility administrator revealed he was notified on 3/29/25 via text by the ASOD at 6:58pm that dc #2 was being sent out due to a fever. He had no knowledge of any dehydration issues regarding dc #2. The administrator revealed he was unaware that EMS was sent away from the facility by staff and that dc #2 was transported to the emergency room by facility staff. Continued interview with the Administrator revealed he had a concern, if staff called 911 and did not follow the agency protocol of allowing the nurses to handle it.

C. Cross-reference W455. The facility failed to have an aggressive active program to address

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recurring outbreaks of scabies in the facility resulting in the neglect of its clients.

Review on 4/3/25 of the facility's policy on neglect revealed "neglect is generally defined as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm...unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm. Intentional neglect is defined as a substantiated allegation of neglect whereby staff knowingly placed a person at risk, or resulting in harm or serious injury..."

An immediate jeopardy was identified in the area of Nursing services was neglectful due to the failure to ensure staff recognize and respond to signs and symptoms of medical emergencies; failure to ensure staff were completing appropriate checks and seek medical assistance in a timely manner; failure to ensure staff and nurses respond appropriately to medical crisis and not intervene when medical professionals arrive to assess medically ill clients, failure to ensure nurses complete follow ups with health care professionals, so that clients receive the necessary treatments as ordered. The facility's failure in nursing services directly impacted the care and services delivered to the clients and correlated with the deaths of dc #1 and dc #2.

The facility developed the following plan to remove the immediate jeopardy to the clients in the facility which included: (1) Staff to be in-service on completing 30-minute sleep wake data and documentation. Supervisor will check

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sleep wake data at least twice throughout the night to ensure documentation - completed by Administrator and Program Manager. (2) Staff to be in-service on notify nursing of any medical concerns immediately - completed by Administrator and Program Manager. (3) Nursing staff to be in serviced on monitoring individuals with any medical concerns and documentation in Therap - to be completed by Director of Nursing. (4) Nursing staff will ensure that any order received from PCP (Primary Care Physician) will be precise with direct perimeters and time frame such as check every 2 hours for 24 hours - to be completed by Director of Nursing. (5) All staff will be in-serviced to call Code Blue for any individual that isn't breathing or All nursing staff for any individual in distress - completed by Administrator, Program Manager and Director of Nursing. (6) Nursing staff will be in-serviced on checking crash cart daily to ensure items present, in working order and not expired - to be completed by Director of Nursing. This plan was signed and dated by the facility Administrator on 3/25/25.

An additional Plan of Protection was obtained on 4/3/25 to remove an immediate jeopardy cited after dc #2's death which included: (1) DON/Program Manager will review 100% of weights and inform Dietician/Medical provider of all weight loss that is 5% or greater by Monday 4/7/25. (2) DSP (Direct Support Professional) and medical personnel will be inserviced on signs and symptoms of dehydration and the need to report to the on-call medical provider - to be completed by DON and Program Manager. Corporate team will ensure that all training is completed by making on-site visits and interviewing staff to ensure the training is

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| W 149 | Continued From page 17<br>completed and staff understand process which will be documented on the staff supervision log. (3) A log of communication has been created. the ASOD will log all communications in reference to people supported who require medical attention daily and email to the Administrative Team and corporate team will review log daily and spot check individuals to ensure the required treatment was rendered. (4) All personnel will be trained on calling EMS and communicating with the team about the call - to be completed by Program Manager, DON and Administrator - Corporate Team will ensure the training is completed and staff understand process which will be documented on the staff supervision log.<br><br>Upon reviewing the above plan of protection dated 4/3/25 , the team on site accepted the plan and observed the Administrator and Program manager providing on-site training therefore the immediate jeopardy to the clients in the home was removed, effective 4/3/25. | W 149 | | |
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure all staff were sufficiently trained to ensure clients were safe from falls during client care. This affected 1 of 16 audited clients (#3). The finding is:<br><br>Review on 4/3/25 of an incident report dated 3/16/25 at 6:00am revealed client #3 had fallen | W 189 | | |

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| W 189 | Continued From page 18<br>out of bed while a direct care staff was preparing to bathe him. The report noted the client was "lying on floor" and his "padded board was off" of his bed at the time. Additional review of the report also indicated the client was placed on "head trauma" precautions for 72 hours. Review of the incident report noted, "Inservice will be done with staff on bathing precautions."<br><br>Further review of client #3's Person Centered Plan (PCP) dated 10/29/24 revealed, "[Client #3] needs full-on assistance for transfer and positioning needs ...[Client #3's] risk for falls is minimized by the consistent use of safety measures/protocol put in place. These safety precautions include the use of padded bedrails when positioned in bed."<br><br>Interview on 4/3/25 with Staff G confirmed client #3 had fallen out of bed as the staff turned away from him during bathing while attempting to retrieve grooming supplies. Staff G indicated some training on precautions while bathing clients on beds had been completed; however, it was completed before client #3's fall on 3/16/25. Additional interview with Staff G revealed no additional staff training regarding these safety precautions could be located. | W 189 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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 | W 249 | | |

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| W 249 | Continued From page 19<br>plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure the Person Centered Plan (PCP) for 1 of 16 audited clients (#15) included objective training to address the clients behavioral needs as required. The finding is:<br><br>Review on 4/9/25 of client #15's current hospitalization records revealed, the client was taken to the local emergency department (ED) on 4/4/25 for evaluation of possible bowel obstruction following reports that staff at the facility pulled a rubber glove from the client's rectum earlier in the day. According to hospital records, client #15 reportedly consumed a rubber glove, paper towels and other nonedible items and had complained of abdominal pain earlier in the day. Scans were completed and client #15's stomach was noted to be very well distended and to have contained a large filling defect that had the appearance which suggested bezoar or trichobezoar.<br><br>Review on 4/9/25 of client #15's PCP dated 10/15/24 revealed the client did not have a current behavior support plan (BSP). However, the PCP mentioned the client has exhibited inappropriate behaviors towards female staff (popping their bra straps or popping their backside). The PCP also revealed that staff should be aware client #15 may reach over and be aggressive toward peers and peers should not be seated close enough to where he can easily hit, pinch, etc. The PCP also stated that client #15 should be monitored closely while wearing | W 249 | | |

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eyeglasses as he has thrown them in the trash or attempted to break them by throwing them on the floor. The PCP revealed that client #15 may throw items, scream/yell, spit, flail in chair, curse and use the bathroom on himself.

Review on 4/9/25 of an incident report completed by the facility on 3/27/25, revealed client #15 had a behavior at 8:30pm during bathtime. The report revealed that while in the tub, client #15 hit his head on the tub because he wanted a Coke. The report also revealed that the client has a diagnosis of "other specified disruptive impulsive control and conduct disorder" that may have contributed to the incident/injury. An order was given for client #15 to be placed on head trauma protocol for 72 hours.

Interview on 4/9/25 with staff E revealed client #15 would frequently become upset and have behaviors ranging from eating paper towels, popping staff's behinds, faking seizures, poring beverages out on the floor and acting like he was going to fall when ambulating. Staff E revealed client #15 appeared to be attention seeking and the behaviors had worsened in the past two months. In addition, staff E revealed that client #15 always had an escalation in behaviors around holidays because he wanted to go home.

Interview on 4/9/25 with staff A revealed he had witnessed client #15 eat or attempt to eat paper towels since he began working at the facility approximately 5 years ago. Staff A revealed that client #15 would do numerous things to get the attention of staff and they would always just redirect him. Staff A revealed that the behaviors had not been reported to upper management to his knowledge. He further stated that staff

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working with client #15 was responsible for documenting his behaviors.

Interview on 4/9/25 with staff B revealed she worked on 4/4/25 and was told by client #15 earlier during the day that his stomach was hurting. Staff B revealed she assisted client #15 to the bathroom and he had a small bowel movement. Staff B revealed that later in the day she was walking by the bathroom where client #15 was being assisted to bathe with another staff and the staff alerted her to get a nurse. Staff B stated she saw what appeared to be a blue glove hanging partially out of the client's rectum. Staff B revealed client #15 can toilet independently but needs to be monitored because he often balls up toilet paper and floods the toilet. Staff B confirmed that she has witnessed client #15 spit, eat paper towels and slap other's on the behinds if he is upset about something. Staff B stated she has never reported these behaviors to management because the behaviors are so frequent she thought they knew about them.

Interview on 4/9/25 with nurse #1 revealed she was working on 4/4/25 and was asked to go to the bathroom where client #15 was preparing for a bath. Nurse #1 revealed when she walked in, client #15 was standing beside the bathtub with what appeared to be a blue exam glove partially hanging out of his rectum. Nurse #1 revealed she carefully pulled the remainder of the glove out and placed it in a biohazard bag. Nurse #1 then notified the physician assistant (PA) who instructed her to just do an incident report and notify the charge nurse. The PA instructed her to do whatever the charge nurse deemed necessary if the charge nurse did not agree with him. Nurse

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| W 249 | Continued From page 22<br>#1 revealed she notified the charge nurse who instructed her that the client should be sent out to the hospital for evaluation. Nurse #1 revealed she had never seen client #15 eat paper towels or foreign objects but she had witnessed him hit his head, throw tantrums and throw himself on the floor.<br><br>Interview on 4/9/25 with the facility's behavior specialist revealed that client #15 had not had an active BSP since 2008. The behavior specialist was not aware of the behaviors mentioned in client #15's PCP and she was not aware client #15 continued to exhibit any behaviors. The behavior specialist revealed a BSP was now being drafted for client #15 since this incident to include a diagnosis of Pica. | W 249 | | |
| W 318 | HEALTH CARE SERVICES<br>CFR(s): 483.460<br><br>The facility must ensure that specific health care services requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to: provide nursing services in accordance to client's needs (W331); failed to ensure direct care staff were trained in detecting signs and symptoms of illness (W342) and failed to ensure medications were administered in accordance with physician's orders (W368).<br><br>The cumulative effects of these systemic practices resulted in the facility's failure to provide statutory mandated services in the area of health | W 318 | | |

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| W 318 | Continued From page 23<br>care. | W 318 | | |
| W 331 | NURSING SERVICES<br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 deceased clients (dc #1 and dc #2) and 2 of 16 audited clients (#10 and #12) were provided nursing services in accordance with their needs regarding timely and appropriate medical interventions and failed to ensure the crash cart was stocked with necessary supplies to efficiently respond to a code. The findings are:<br><br>A. The facility failed to ensure nursing services were provided in accordance to dc #1's needs.<br><br>Review of the IRIS (Incident Response Improvement System) revealed, a level III incident report for the death of dc #1 on 3/24/25 at 10:00am due to unknown causes. No other information was provided in the report.<br><br>Record review on 3/25/25 of dc #1's Person Centered Plan (PCP) dated 10/8/24 revealed, he was ambulatory and required 30 minute bed checks during the night to ensure he was sleeping comfortably. The PCP also revealed dc #1 was non-verbal but used various modes of communication to express his emotions, needs and to respond to conversation of questions.<br><br>Interview on 3/25/25 with the Administrator revealed, he was contacted by nurse #6 on 3/24/25 at approximately 7:10am and informed | W 331 | | |

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that EMS had been called for dc #1. The facility nurse started CPR until EMS arrived. Once EMS arrived, they took over CPR, but were unable to resuscitate him. Dc #1 was pronounced deceased at the facility. The administrator stated he was not aware of any recent health concerns regarding dc #1.

Interview on 3/25/25 with nurse #1 revealed, she worked on 3/21/25. Dc #1 seemed normal for most of the day. Second shift staff notified her between 5:00pm - 6:00pm that dc #1 had vomited. She checked for fecal impaction however there was none. His stomach was soft to touch and he seemed normal. She was later informed that dc #1 vomited again. At that time she notified staff, that if he vomited again to notify nursing so they can contact the PA (physician assistant). However, dc #1 did not vomit again, to her knowledge.

Record review on 3/25/25 of a case note with a service date of 3/21/25 at 6:00pm and was submitted on 3/24/25 at 10:25am by nurse #1, revealed that she was notified that dc #1 had thrown up. Nurse #1 did a fecal check and it was negative, as well as temperature check. Nurse #1 documented that she reported to night shift to monitor client and notify MD if the client threw up again.

Interview on 3/25/25 with the medication technician (MT) revealed, he worked on Saturday (3/22/25) and Sunday (3/23/25). However, he was not aware that dc #1 had vomited Friday night. There wasn't a note documenting dc #1 being sick or instructions to call the PA if he vomited. Dc #1 seemed normal on Saturday. Staff notified him on Sunday that dc #1 looked

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like he wasn't feeling well. He checked dc #1's temperature, which was 99.9 (temporal) and 100.1 (rectal). He gave dc #1 Tylenol at 7:00am. Dc #1 refused to eat breakfast that morning. The MT checked his temperature again at 9:00am and it had gone down to 98 degrees. He checked his temperature again at 11:00am and it was back up to 100.2. He gave dc #1 more Tylenol. The MT reported he went to lunch and when he returned, staff informed him that dc #1 vomited while he was gone. He completed a rectal check which was negative and checked his vitals at 1:15pm, which were 131/71 - blood pressure, 76 - pulse, 98 - O2, 16 - respiration and 98.7 - temperature. He notified nurse #2 of this information. She listened to dc #1's vitals and notified the PA. They were informed to monitor dc #1. He checked dc #1 temperature again at 3:30pm and it was 97.9.

Continued interview on 3/25/25 with the MT revealed, dc #1 ate pudding for snack Sunday afternoon and seemed to be doing a little better. He didn't seem distressed. He was unsure if dc #1 ate dinner that night. He informed the night shift (nurse #8), that the PA said to monitor dc #1.

Interview on 3/25/25 with staff E revealed, she worked first shift at the facility over the past weekend. She was made aware that dc #1 was not feeling well Friday night and she had informed staff F to monitor him on second shift. Staff E further stated dc #1 was still not acting like himself on Saturday. He had not been eating and had been lying in bed most of the weekend. Staff E reported that on Sunday, nurse #2 called the PA to inform him that dc #1 was pale and had not been eating. The PA visited the facility on Sunday, in which afterwards staff were informed to

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monitor him.

Interview on 3/25/25 with the facility's PA revealed, he was notified by the facility staff that dc #1 vomited twice on Sunday and his temperature was 100 degrees. He visited the facility on Sunday but he believed he was called to see another client and not dc #1. He was not sure if he saw dc #1 while onsite. He further stated the nurse gave him dc #1's vitals, as he did not examine dc #1 himself. Afterwards, he provided a verbal order for clear liquids for 24 hours and to monitor closely. He believed he gave the order to nurse #2 or another nurse. He's unable to remember which nurse he provided the order to. He did not provide specific instructions to staff on how often staff were to monitor dc #1 because it was standard protocol when clients were sick. However, it was his expectation that staff would check on dc #1 frequently throughout the shift. If symptoms increased, staff were to call him. The PA reported, he did not hear from the facility staff again until Monday morning.

Interview on 3/25/25 with the Director of Nursing (DON) revealed no verbal order for a clear liquid diet could be located for dc #1.

Review on 3/25/25 of the time tracking sleep log for dc #1 revealed no data was documented after 10:30pm on 3/23/25.

Review on 3/25/25 of a case note with a service date 3/24/25 at 5:55am and submitted on 3/24/25 at 12:06pm by nurse #6 revealed, "staff informed me that individual was making noises and kept attempting to stick hand in mouth. Staff attempted to redirect. Upon assessment noted

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abdomen hard and tight. Check BM (bowel movement) book and noted that individual had 2 BM's on 3/23/25. Bowel sounds present but sluggish. Staff stated hadn't been eating. Upon talking with staff, indicated it was a behavior for him."

Review on 3/25/25 of case logs revealed no other documentation from nurse #6 throughout his shift.

Interview on 3/25/25 with staff B revealed, she arrived to work on 3/24/25 at 6:30am. She went into dc #1's bedroom and he was lying in bed, moaning as if he was in pain. Dc #1 was blue in the face and his fingers were purple. Staff C was in the bedroom at the time. She told staff C to go get the nurse. Staff C went to the nurses station and returned in approximately 30 seconds. However, the nurses did not return with him. Staff A walked into the room and then ran back to the nurses station to get help. The nurses arrived to the room with oxygen tanks. They started performing CPR and instructed staff to leave the room. EMS arrived shortly after.

Interview on 3/25/25 with staff A revealed, he arrived to work on Monday 3/24/25 at 6:45am. Upon arrival, he went into dc #1's bedroom and noticed that he was blue/purple in color. There was a brown spot on his bed that looked as if he had vomited or had diarrhea. Dc #1 sounded like "he was taking his last breath; like he hadn't been checked all night." Staff A ran to the nurses station to get help. The nurses went to dc #1's room with an oxygen tank. Direct support staff were instructed to leave the room.

Interview on 3/25/25 with nurse #7 revealed, she arrived to work on 3/24/25 at 6:30am. The

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nurses were preparing for their morning meeting, when staff A walked to the door and requested to speak with nurse #4. Nurse #4 and Staff A walked to dc #1's bedroom. They were gone for approximately 3 minutes, so she asked nurse #6 to walk with her to dc #1's room. She stated nurse #6 stated "it's probably just a behavior." When they arrived in the room, dc #1's lips and nails were blue in color. Nurse #8 was also in the room and she called 911.

Continued interview with Nurse #7 revealed, she left the room to get an oxygen tank and a non-rebreather mask. Nurse #6 went to get a crash cart. Nurse #4 was working on gathering paperwork to send with EMS to the hospital. She further stated that she, nurse #6 and nurse #8 were in the room attempting to obtain dc #1's vitals. It took a couple minutes and at least two tries to obtain vitals because the manual cup connector for the blood pressure cuff was broken. O2 was started while nurse #8 suctioned dc #1's mouth. Nurse #6 then applied the AED and started chest compressions. He completed 2 rounds of CPR and then EMS arrived. Nurse #7 stated, according to the facility's policy, someone should have called code blue for all hands on deck but a code was not called.

Interview on 3/25/25 with nurse #4 revealed, she worked the morning of 3/24/25. She was at the nurses station for the 6:40am meeting. During the meeting, nothing was mentioned about dc #1 being sick over the weekend. As she was sitting at the desk, staff A asked her to step down the hallway to dc #1's room. She went into the room and noticed dc #1 had vomited on the bed and was grayish in color. She told staff she needed her "nurse on a stick" device. Staff brought it to

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her. Dc #1 was unresponsive. Nurse #8 called 911. She asked the direct care staff to leave the room. Nurse #6 and #7 were in the room so she left to get the paperwork ready for EMS. When she arrived back to the room, EMS was suctioning brownish blood from dc #1's mouth.

Interview on 3/25/25 with the DON revealed, she wasn't aware that dc #1 had been sick over the weekend. Direct care staff were responsible for completing 30 minute checks throughout the night. It is not the responsibility of nursing staff to complete the checks. "Nursing cannot check on 24 clients every night" and the nurses weren't going to wake clients up during the night. Direct care staff should notify nursing of any issues.

Continued interview with the DON revealed, she was not aware staff had not documented any checks after 10:30pm on 3/23/25. She confirmed staff should have checked on dc #1 every 30 minutes throughout the night and documented checks.

Interview on 3/25/25 with the Administrator revealed dc #1 should have been checked every 30 minutes throughout the night on 3/23/25 through 3/24/25. He was only informed that dc #1 had started a new behavior over the weekend of putting his finger in his mouth. He was not aware dc #1 was sick.

B. The facility failed to ensure nursing services were provided in accordance to dc #2's needs.

Review on 4/3/25 of dc #2's PCP dated 6/26/24 revealed, dc #2 was non-verbal and used a wheelchair for ambulation. He could eat and drink independently and weighed 104.7 pounds.

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Dc #2 had a history of seizures, however he had not experienced any recorded seizures in many years therefore it is unknown how they present.

Review on 4/3/25 of T-Logs completed by staff from 3/27/25 to 3/29/25 revealed documentation that stated on 3/27/25, dc #2 refused breakfast and consumed 240ml of liquids and nursing was notified. On 3/27/25 a T-Log revealed at lunch dc #2 was not feeding himself. Staff used hand over hand assistance and the client ate at that time. At dinner time on 3/27/25, a T-Log revealed that dc #2 was hand over hand for dinner, shaky and needed assistance.

Review on 4/3/25 of the facility's Meal/Supplement/Snack Intake revealed on 3/27/25 dc #2 consumed all of his breakfast and 240ml of liquid. Dc #2 slept through 10am snack, consumed 50% of lunch with 240ml of liquids, refused 2:30pm snack, consumed all of dinner with 240ml of liquid and refused 8:00pm snack.

Further review on 4/3/25 of the Meal/Supplement/Snack Intake sheets revealed on 3/29/25, dc #2 consumed 240ml of liquid at breakfast, refused 10:00am snack, refused lunch, was asleep during 2:30pm snack and was out of the facility for dinner and 8:00pm snack.

Review on 4/3/25 of dc #2's hospital records revealed he was taken to the hospital by car on 3/29/25 for "possible seizure". Caregiver reported that dc #2 had seizure-like activity where he experienced muscle rigidity by straightening his legs out, wandering eye movement and bleeding of his eyes, which lasted approximately 130 minutes and then resolved. Per mother, dc #2 had been acting lethargic over the past 24 hours

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and not eating or drinking. Although the facility notes he had been eating and drinking normally in the week prior to admission. On Emergency Department (ED) arrival he was awake but not interactive. Dc #2 was in fetal position with no attempt to track or follow. Per ED note, severe advance psoriatic plaque changes extended over thorax arms and legs with skin cracked down to the subdermal layer and multiple areas.

Continued review of dc #2's hospital records revealed, on arrival to the ED, dc #2 weighed "35.2 kg (77 lb 11.2 oz). blood pressure 89/41; pulse 58; temperature 90.7 degrees Fahrenheit; respiratory rate 18; and height 5'1.5. creatinine 3.9 serum sodium on admission greater than 180 and magnesium of 4.8." Dc #2 was intubated on 3/29/25.

Further review revealed hospital assessment and plan included:
(1) Dehydration with hypernatremia: Profound dehydration on ED arrival. No evidence of excessive fluid loss. Reported history of poor oral intake but only over the 24 hours prior to admission. Suspect gradual reduction over 1 to 2 weeks in reality.
(2) Acute Respiratory Failure: dc #2 with depressed level of consciousness and poor airway control requiring intubation and institution of mechanical ventilation and attempted stabilization in the ED.
(3) Depressed level of consciousness
(4) Acute Renal Failure: Acute profound dehydration contributing to markedly elevated creatinine.
(5) Hypotension: Likely related in part to profound dehydration.
(6) Electrolyte abnormality: Multiple electrolyte

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abnormalities noted. Hypermagnesemia as well as hyperchloremia and hypernatremia. Dehydration contributing significantly.
(7) Congenital Heart Disease: at birth.
(8) Severe protein-calorie malnutrition
(9) Seizure Disorder: dc #2 with known history of seizure disorder. Concern for seizure prompting this admission with muscle rigidity and wandering gaze. No report of a seizure in the last 2 years. Not currently on the epileptic medication presenting to the ED after reported seizure like activity.
(10) Psoriasis and similar disorder: Severe plaque-like rash over almost entire body. Mother reports it has been labeled as psoriasis. Certainly some concern for ichthyosis type syndrome. Unclear if congential. Currently on Dupixent and multiple creams. Has been on steroids recently for this.

Final Primary Diagnoses: Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present; seizure like activity and Hypernatremia.

Hospital records dated 3/29/25 also revealed a wound care consultation documenting dc #2 "has some type of an ichthyotic dermatitis. Has not been characterized by biopsy in the outpatient setting but has been on Dupixent. It appears that despite Dupixent there has been worsening of this dermatologic process as per my discussion with his provider at the [local clinic]. As there is some question as to what the diagnosis truly is and if there is potentially some other superimposed process including but not limited to scabies...I spoke with his treating provider who has been involved in his care since November 2024. He has had no biopsies performed. He

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has been treated for a suspected eczematous dermatitis. He started Dupixent every 2 weeks on February 17, 2025. He has not had a follow-up with the provider since that time he is only been going for infusions. Per the dermatologist's report, received secondhand through the facility there had been improvement. At the time, his dermatologist provider tells me that these were erythematous plaques on his skin. They are no way representation of what we are currently seeing which are more ichthyotic and fissured areas. The skin is only affected where the patient's hands can reach it spares his buttocks, back and portions of the posterior neck."

Hospital records further revealed, on 3/31/25 dc #2 remained intubated and unable to follow commands. The family decided to make dc #2 comfort measures only on 4/1/25. Dc #2 was pronounced deceased on 4/2/25.

Interviews on 4/3/25 with the Administrator and Program Manager (PM) revealed, there was surveillance video of the room in which the events occurred, however they had not reviewed it.

Review on 4/3/25 of the facility's surveillance footage on 3/29/25 revealed the following:
(Per the PM the times are delayed an hour on the camera system because it did not adjust with daylight savings time.)

17:03 Several staff and clients are in the yellow day room.
17:04 (2) Staff went over to check on dc #2 and were seen rubbing his shoulders.
17:05 Dc #2 becomes rigid, stretching out his legs while sitting in his wheelchair. Staff grabbed a mat and 3 staff assisted in lying dc #2 on the

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mat. Med Tech #2 began checking his blood pressure.
17:06 A staff left the room and returned with Nurse #10. Nurse #10 walks into the room and stands beside dc #2's mat while Med Tech #2 continues checking vitals. Nurse #10 soon walks out of the room and returns with a notepad. She writes on the pad while the med tech is now at dc #2's feet. Other staff standing over him, watching.
17:07 Nurse #2 ran into the room with 2 other staff and stand over dc #2.
17:08 Dc #2 starts moving. Nurse #10 leaves the room again. Five other staff standing over him including med tech and nurse #2.
17:09 Nurse #2 checks dc #2's eyes with a light.
17:11 All staff walk away. Dc #2 is seen moving around on the mat.
17:13 Dc #2 sits up on mat with legs crossed.
17:14 Med Tech #2 checks temperature.
17:17 EMS walks into the yellow day room.
17:18 Med tech #2 waves for EMS to stop. She talks to them for a few minutes and then makes a phone call. EMS waits while she makes a call.
17:19 Med Tech #2 seen shaking her head "no" to EMS. EMS seen leaving the room. At no time did EMS assess dc #2 while on site.
17:20 Dc #2 was back and forth between sitting with legs crossed and fetal position.
17:35 (2) staff seen assisting dc #2 back to his wheelchair.

Review on 4/9/25 of the EMS report 3/29/25 revealed "Medic 5 was dispatched routine traffic to a residential institution in reference to convulsions. Upon EMS arrival on scene EMS personnel were met by a med tech in the Nurse area who advised they did not need EMS any longer. The staff advised the patient had been evaluated by 2 of their nurses nurse #10

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and #11 . The med tech advised she did not know who called EMS but would contact the Nurses again. After the med tech made a phone call to the Nurses again the Med Tech advised the Nurses stated the subject did not need to be transported to the hospital since the Nurses had evaluated the subject. A signature was obtained from the Med Tech. Medic 5 was clear and back in service."

According to medical records dated 3/29/25, dc #2 arrived at the local hospital approximately 50 minutes later, transported by staff.

Interview on 4/3/25 with staff J revealed she called 911 on 3/29/25 for dc #2 because it didn't seem like nursing was doing enough to help him, but the med tech turned them away when they arrived. She further stated, staff took him to the hospital after EMS left because he "still didn't look right."

Interview on 4/3/25 with the Administrator revealed he was called by the Qualified Professional (QP) on 3/29/25, who stated they were taking dc #2 due to a seizure. He was aware that EMS was called but stated the nurses didn't think he needed to go out.

During an interview with the ASOD (administration staff on duty) for 3/29/25 revealed she received a call from the building charge that dc #2 was being transported to the emergency room due to fever. The ASOD confirmed, she then texted the DON and administrator to notify them.

Interview on 4/3/25 with the Assistant Director of Nursing (ADON) revealed she was not aware that

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dc #2 had not been eating and drinking well, nor did she know he required hand over hand to eat on 3/27/25. The ADON confirmed dc #2 was capable of eating and drinking independently and it would be unusual for him to require assistance. She further state does not believe dc #2 had lost approximately 22 pounds between his last weight at the facility on 3/1/25 (99.1 pounds) and his hospital admission weight on 3/29/25 (77 pounds).

Interview on 4/3/25 with the DON revealed she was unaware that staff refused to allow EMS to assess dc #2 when they arrived to the facility. The DON revealed she was also unaware that facility staff were the ones who transported dc #2 to the emergency room. She was notified via text on 3/29/25 at 6:58pm by the ASOD that dc #2 was being sent out due to a fever.

The DON also stated she was not aware that dc #2 had any issues with eating or drinking. However, she confirmed there were discrepancies between the T-Logs and the Meal/Supplement/Snack Intake sheets for dc #2 on 3/27/25. The DON was unable to provide an explanation for differences and what would be the accurate amount of intake.

Continued interview on 4/3/25 with the DON revealed the PA typically does face to face visits when completing quarterly medication reviews for the clients. The DON confirmed that the documentation written by the PA for dc #2 on 12/23/24 stated that the client was seen by the PA, however no skin abnormalities were noted.

During a subsequent interview on 4/3/25 with the facility administrator revealed he was notified on

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| W 331 | Continued From page 37<br>3/29/25 via text by the ASOD at 6:58pm that dc #2 was being sent out due to a fever. He had no knowledge of any dehydration issues regarding dc #2. The administrator revealed he was unaware that EMS was sent away from the facility by staff and that dc #2 was transported to the emergency room by facility staff. Continued interview with the Administrator revealed he had a concern, if staff called 911 and did not follow the agency protocol of allowing the nurses to handle it.<br>C. The facility failed ensure the emergency/crash cart was up to date with necessary supplies in the event of a code.<br><br>During observations on 3/25/25 of Rise Academy, an emergency/crash cart was noted to be inside the nurses station. Surveyor asked nurse #5 when the crash cart was last checked to ensure the appropriate equipment was located inside. Nurse #5 revealed that the crash cart did not currently contain all equipment that should be there but that the respiratory therapist (RT) was supposed to be coming to check it. Nurse #5 also revealed that there should be a paper located on top of the cart with a checklist of supplies that could be found inside, however it could not be located. Nurse #5 confirmed that in the case of an emergency there was not another crash cart available in that building. Nurse #5 revealed she was unsure when the cart was last checked or who would have checked it.<br><br>Interview on 3/25/25 with staff E revealed respiratory therapist (RT) is responsible for restocking the crash cart. However, he worked part time and was only at the facility twice a week. In the event of an emergency, someone would have to bring necessary equipment from the main | W 331 | | |

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| W 331 | Continued From page 38<br>building.<br><br>Further observation on 3/25/25 revealed, the next available crash cart was located in the main building which is .22 miles (swift walk) from Rise Academy. The crash carts in the main building revealed to have several expired cannula tubings inside, with expiration dates of 2023 and 2024.<br><br>Interview on 3/25/25 with the ADON revealed the crash cart is checked daily for necessary supplies by the RT. When Surveyor verified the RT's schedule of two days a week, she later stated the med techs were responsible for checking it on the other days.<br><br>Interview on 3/25/25 with staff #4 stated there used to be a form located on the crash cart for staff to sign off when the crash cart was checked. However, she had not seen the form since June 2024.<br><br>Interview on 3/25/25 with the RT revealed, he works at the facility 2 days a week part time. He is responsible for ensuring the locks are working on the crash cart, making sure the pump is charged and ensuring necessary supplies are in the cart. He does not check the expiration dates of the supplies in the cart but confirmed that any expired supplies should be replaced. The RT further stated the crash cart should be checked once a week, however, the last time he checked the carts was a month ago. The facility is still working out a schedule for when he should check the cart.<br><br>Interview on 3/25/25 with the DON revealed she was not aware there was expired cannula tubings in the crash cart or that supplies were missing. | W 331 | | |

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The RT sent her an email on 3/10/25 reporting that the carts had been checked. The DON confirmed that expired supplies should be discarded.

D. Nursing services failed to ensure follow up was completed for necessary interventions and/or treatments for client #10 and #12

1. Review on 4/3/25 of client #10's case notes revealed on 1/20/25, the ADON was notified by staff to assess client #10 for a rash. Further review of the case note revealed a rash was noted on client #10's left hand, back and left side, with an open blister noted to the left abdomen. Continued review of the case note revealed the ADON notified the facility's PA, who stated he would "be in around 1:00pm to assess the individual." There was no further information written in client #10's case notes regarding the rash, blister or care he received after the initial assessment by the ADON.

Observations on 4/3/25 with 2 facility nurses of client #10 lying in bed revealed client #10's left side, left arm and hand, back and stomach area to be covered in a rash with red bumps/blisters present.

Interview on 4/3/25 with the facility ADON revealed she was not sure what the rash was, it could possibly be "eczema." Further interview with the facility ADON revealed she was sure that the PA assessed client #10 on 1/20/25, and treatment was discussed. The ADON revealed she would locate the documentation and provide it for review. However, no documentation was provided to show that client #10 was assessed on

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1/20/25 by the PA and what treatment had been provided.

2. Review on 4/3/25 client #12's hospital discharge summary dated 2/22/25 revealed a diagnoses of pneumonia and acute respiratory failure.

Review on 4/3/25 of client #12's hospital discharge summary dated 3/24/25 revealed discharge diagnoses of community acquired pneumonia of left lung, unspecified part of lung. Client #12 was also ordered home oxygen at discharge. Further review on 4/3/25 revealed a case note dated 3/24/25 written by nurse #4 documenting a coordination note: that client #12 was being discharged, client needs to be on 3 more days of antibiotics, for bronchitis, continue chest physiotherapy (CPT) but increase to 4 times a day instead. Further review of client #12 administration history of chest physiotherapy from 3/24/25 to present date revealed client #12 received treatment twice a day 8:00am and 8:00pm.

Interview on 4/3/25 with nurse #2 confirmed that client #12 received CPT twice a day 8:00am and 8:00pm. Nurse #2 also confirmed that was the CPT treatment that client #12 received before being admitted to the hospital and continued the same scheduled when she returned from the hosptial.

Interview on 4/3/25 with nurse #4 revealed she did received a phone call from the discharging doctor for client #12 however a script was not sent back to the facility. Nurse #4 confirmed client #12 had not received treatment per the coordination case note. Nurse #4 confirmed she

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should have followed up with the discharging doctor for a written script.

An immediate jeopardy was identified in the area of Nursing Services due to the failure to ensure staff recognize and respond to signs and symptoms of medical emergencies; failure to ensure staff were completing appropriate checks and seek medical assistance in a timely manner; failure to ensure staff and nurses respond appropriately to medical crisis and not intervene when medical professionals arrive to assess medically ill clients, failure to ensure nurses complete follow ups with health care professionals, so that clients receive the necessary treatments as ordered. The facility's failure in nursing services directly impacted the care and services delivered to the clients and correlated with the deaths of dc #1 and dc #2.

The facility developed the following plan to remove the immediate jeopardy to the clients in the facility which included: (1) Staff to be in-service on completing 30-minute sleep wake data and documentation. Supervisor will check sleep wake data at least twice throughout the night to ensure documentation - completed by Administrator and Program Manager. (2) Staff to be in-service on notify nursing of any medical concerns immediately - completed by Administrator and Program Manager. (3) Nursing staff to be in serviced on monitoring individuals with any medical concerns and documentation in Therap - to be completed by Director of Nursing. (4) Nursing staff will ensure that any order received from PCP (Primary Care Physician) will be precise with direct perimeters and time frame such as check every 2 hours for 24 hours - to be completed by Director of Nursing. (5) All staff will

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be in-serviced to call Code Blue for any individual that isn't breathing or All nursing staff for any individual in distress - completed by Administrator, Program Manager and Director of Nursing. (6) Nursing staff will be in-serviced on checking crash cart daily to ensure items present, in working order and not expired - to be completed by Director of Nursing. This plan was signed and dated by the facility Administrator on 3/25/25.

An additional Plan of Protection was obtained on 4/3/25 to remove an immediate jeopardy cited after dc #2's death which included: (1) DON/Program Manager will review 100% of weights and inform Dietician/Medical provider of all weight loss that is 5% or greater by Monday 4/7/25. (2) DSP (Direct Support Professional) and medical personnel will be inserviced on signs and symptoms of dehydration and the need to report to the on-call medical provider - to be completed by DON and Program Manager. Corporate team will ensure that all training is completed by making on-site visits and interviewing staff to ensure the training is completed and staff understand process which will be documented on the staff supervision log. (3) A log of communication has been created. the ASOD will log all communications in reference to people supported who require medical attention daily and email to the Administrative Team and corporate team will review log daily and spot check individuals to ensure the required treatment was rendered. (4) All personnel will be trained on calling EMS and communicating with the team about the call - to be completed by Program Manager, DON and Administrator - Corporate Team will ensure the training is completed and staff understand process which

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| W 331 | Continued From page 43<br>will be documented on the staff supervision log.<br><br>Upon reviewing the above plan of protection dated 4/3/25 , the team on site accepted the plan and observed the Administrator and Program manager providing on-site training therefore the immediate jeopardy to the clients in the home was removed, effective 4/3/25. | W 331 | | |
| W 342 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(iii)<br><br>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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in detecting signs and symptoms of illness and changes in client's health. This affected 1 of 1 deceased client (dc #1). The finding is:<br><br>Review of the IRIS (Incident Response Improvement System) revealed, a level III incident report for the death of dc #1 on 3/24/25 at 10:00am due to unknown causes. No other information was provided in the report.<br><br>Record review on 3/25/25 of dc #1's Person Centered Plan (PCP) dated 10/8/24 revealed the client was ambulatory. Dc #1 required 30 minute bed checks during the night to ensure he was sleeping comfortably. The PCP revealed dc #1 was non-verbal but used various modes of | W 342 | | |

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communication to express his emotions, needs and to respond to conversation or questions.

Interview on 3/25/25 with the Administrator revealed, he was contacted by nurse #6 on 3/24/25 at approximately 7:10am and informed that EMS had been called for dc #1. The facility nurse started CPR until EMS arrived. Dc #1 was pronounced deceased at the facility.

Continued interview with the administrator revealed, he was not aware of any recent health concerns regarding dc #1. He was informed that dc #1 had developed a new behavior over the past weekend of putting his finger in his mouth. He was not made aware that dc #1 was sick.

Interview on 3/25/25 with staff E revealed that on 3/21/25, dc #1 appeared to not be feeling well. Staff E reported that dc #1 kept acting as if he was going to vomit and was pale. Staff E reported that while working the weekend from 3/21/25 to 3/23/25, dc #1 was not acting like himself. He had not been eating and had just been lying in bed most of the weekend, which was not like him. He's usually very active.

Review on 3/25/25 of a case note with a service date of 3/21/25 at 6:00pm and was submitted on 3/24/25 at 10:25am by nurse #1, revealed that she was notified that dc #1 had thrown up. Nurse #1 did a fecal check and it was negative, as well as temperature check. Nurse #1 documented that she reported to night shift to monitor client and notify MD if the client vomited again.

Review on 3/25/25 revealed the next note entered had a service date of 3/23/25 at 1:40pm and was submitted on 3/24/25 at 9:40am by medication

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technician (MT). The MT documented that dc #1 vomited at 12:40pm, rectal check was negative and nursing was notified and listened for bowel sounds.

Continued review of case note revealed a note submitted by nurse #2 with a service date of 3/23/25 at 1:10pm and was submitted on 3/24/25 at 10:43am. Nurse #2 documented that the MT reported, dc #1 had thrown up and had a temperature of 100.1 and was given Tylenol. The MT also reported he had checked and dc #1 was negative for impaction. Nurse #2 documented that the client was in his room, in bed with 3 staff present. Dc #1 responded to his name being called. Nurse #2 did an assessment and abdomen is soft, non-distended with bowel sounds present in all 4 quadrants. Nurse #2 instructed staff to notify her if dc #1 vomited again.

Review on 3/25/25 revealed a case note entered and submitted by MT on 3/23/25 at 5:12pm. The t-log revealed that dc #1 "refused breakfast and lunch. Temp of 100.1 rectal. PRN Tylenol given at 0701 ineffective temp was 99.7. PRN Tylenol given again. Went down to 97.9".

Interview on 3/25/25 with MT revealed, on 3/23/25 he was informed by staff that dc #1 wasn't feeling well. MT revealed he monitored dc #1's temperature and monitored for fecal impaction throughout the day, giving Tylenol as needed. MT confirmed dc #1 did not eat breakfast or lunch on 3/23/25, but did eat pudding for a snack. MT confirmed he notified nurse #3 about dc #1's condition as she was taking over for night shift.

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Review on 3/25/25 revealed a case note with a service date of 3/23/25 at 2:30pm and was submitted by nurse #2 on 3/24/25 at 3:50pm stating that the physician assistant (PA) had been in the facility and was informed that dc #1 had thrown up, negative for impaction, abdomen soft, non-distended with active bowel sounds. Also informed the PA that dc #1 was not eating. The PA informed to continue to watch and call if he continues to throw up or needs anything.

Interview on 3/25/25 with the PA revealed he had been present at the facility on 3/23/25 and was made aware dc #1 had not been feeling well and had vomited twice. The PA revealed that he was unsure if he assessed dc #1 at that time. The PA also revealed he gave a verbal order to nursing to put dc #1 on a clear liquid diet for 24 hours, nursing to check frequently and call him with any concerns. The PA confirmed that no specific parameters were set for times the client should be checked.

Review on 3/25/25 of the time tracking sleep log for dc #1 revealed no data was documented after 10:30pm on 3/23/25.

Review on 3/25/25 revealed the next note was submitted by nurse #6 on 3/24/25 at 12:06pm with a service date of 3/24/25 at 5:55am. Nurse #6 documented that staff had informed him dc #1 was "making noises and kept attempting to stick his hand in his mouth. Staff attempted to redirect. Upon assessment noted abdomen hard and tight. Check BM (bowel movement) book and noted individual had 2 BM's on 3/23/25. Bowel sounds present but sluggish. Staff stated hadn't been eating. Upon talking with staff, indicated it was a behavior for him".

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| W 342 | Continued From page 47<br><br>Interview on 3/25/25 with nurse #4 revealed, she worked the morning of 3/24/25. She was at the nurses station for the 6:40am meeting. During the meeting, nothing was mentioned about dc #1 being sick over the weekend. As she was sitting at the desk, staff A asked her to step down the hallway to dc #1's room. She went into the room and noticed dc #1 had vomited on the bed and was grayish in color. Dc #1 was unresponsive. Nurse #8 called 911. Staff began checking dc #1's vitals and started CPR.<br><br>Record review on 3/25/25 revealed the next nursing note was submitted on 3/24/25 at 11:53am with a service date of 3/24/25 at 7:55am. The note stated, "Code for individual was called at 7:53am by EMS staff as individual does not have any respirations or pulse".<br><br>Interview on 3/25/25 with the Director of Nursing (DON) revealed no verbal order for a clear liquid diet could be located for dc #1. She further stated that it was the responsibility of direct support staff to check on the clients every 30 minutes throughout the night and report concerns to nursing.<br><br>Interview on 3/25/25 with the Administrator revealed dc #1 should have been checked every 30 minutes throughout the night on 3/23/25 through 3/24/25.<br><br>The facility failed to ensure staff were trained to monitor, document and verbally share needed information regarding dc #1's required care, to assure the client was monitored appropriately prior to the clients death on 3/24/25. | W 342 | | |

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| W 368 | Continued From page 48 | W 368 | | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 2 deceased clients (dc #2). The findings is:<br><br>Review on 4/3/25 of dc #2's physician orders written on 11/18/24 revealed Hydrocortisone 2.5% topical cream apply to AA (affected area) of the face BID 2 days on 2 days off and Triamcinolone acetonide 0.1% topical cream apply BID from the neck down to eczema 2 days on 2 days off. This was a verbal order given by the physician assistant (PA).<br><br>Review on 4/3/25 of the medication administration record (MAR) for dc #2 from November 1, 2024 through December 10, 2024 revealed the client received Hydrocortisone cream on the following dates: 11/24/24; 11/26/24; 11/28/24; 11/30/24; 12/2/24; 12/4/24; 12/6/24; 12/8/24 and 12/10/24.<br><br>Further review of the MAR revealed, dc #2 received Triamcinolone acetonide cream on the following dates: 11/21/24; 11/23/24; 11/25/24; 11/27/24; 11/29/24; 12/1/24; 12/3/24; 12/5/24; 12/7/24 and 12/9/24.<br><br>Interview on 4/3/25 with the director of nursing (DON) confirmed that the order written for hydrocortisone cream and triamcinolone acetonide was not given as ordered by the | W 368 | | |

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| W 368 | Continued From page 49<br>physician from 11/18/24 through 12/10/24. The DON confirmed the medication should have been given two days on and two days off and not every other day. | W 368 | | |
| W 455 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to assure an aggressive active program for the prevention, control and investigation of infection and communicable diseases was in place to ensure clients in the facility were protected adequately. The findings are:<br><br>Observations on 4/9/25, substantiated by interview with administrative staff, revealed the clients on the Yellow unit to be quarantined as a precaution due to suspected scabies. Further observations of the unit from the hallway revealed the client on this unit to be confined to their rooms with staff going between the rooms to assist the clients with any needs, meals and medications. Continued observations revealed staff to not wear personal protective equipment (PPE) on any kind when going between the rooms. Subsequent observations revealed staff to also travel to other locations around the facility to work on adjacent units or other areas.<br><br>Review of client records verified the facility has had an ongoing issue with scabies. For example:<br><br>A. Review on 4/3/25 of deceased client (dc) #2's | W 455 | | |

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Person Centered Plan (PCP) dated 6/26/24 revealed, on 10/12/23 dc #2 was treated with Permethrin 5% cream due to possibly exposure to scabies. Placed in contact isolation. On 10/16/23 contact isolation was discontinued. On 6/18/24 they were placed on contact isolation for possibly exposure to scabies. On 6/19/24 1st treatment of Permethrin cream 5% was applied to body from neck down.

Review on 4/3/25 of dc #2's medical records dated 3/29/25 revealed, Psoriasis and similar disorder: Severe plaque-like rash over almost entire body. Mother reports it has been labeled as psoriasis. Certainly some concern for ichthyosis type syndrome. Unclear if congential. Currently on Dupixent and multiple creams. Has been on steroids recently for this.

Continued review of dc #2's medical records dated 3/29/25 also revealed a wound care consultation documenting dc #2 "has some type of an ichthyotic dermatitis...As there is some question as to what the diagnosis truly is and if there is potentially some other superimposed process including but not limited to scabies...He has had no biopsies performed."

B. Review on 4/3/25 of client #10's case notes revealed on 1/20/25, staff alerted nursing that client #10 had a rash to his abdomen, back and left arm. The case note revealed nursing to reach out to the medical provider on 1/20/25, who stated he would be into the facility after 1:00pm on that same day to assess the client. Observations on 4/3/25 of client #10 while lying in his bed revealed a rash with red spots/blisters on his abdomen, back, left side, left arm and left hand. Continued review of case notes revealed

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no further documentation since 1/20/25 to address the rash was noted until a case note was written on 4/4/25 by the qualified intellectual disabilities professional (QIDP) to inform the guardian that client #10 was on isolation for scabies treatment due to potential exposure, as well as a case note written by the facility nurse on 4/4/25 to begin medication for the treatment of scabies.

C. Review on 4/9/25 of client #16's PCP dated 9/26/24 revealed in the client's health summary that the client was possibly exposed to scabies on 6/18/24 and was placed on contact isolation while being treated with Permethrin 5% Cream from the neck down. Further review of the PCP revealed clinical case notes located in the client's record dated 4/4/25. Review of the note revealed the QIDP contacted the client's guardian to inform them of the current scabies outbreak, that the client would be on a 7-day isolation for scabies treatment due to potential exposure, and that the client does have bumps on both hands. Further review of the is note revealed the "Guardian expressed concerns about the recurring issue on the unit."

Interview on 4/9/25 with administrative staff revealed, 6 staff were currently out claiming to be infected with scabies. She further stated that all of the clients currently quarantined on the unit are receiving Permethrin 5% Cream as a precaution but none of the clients have been assessed with skin scrapes which is used to verify the presence of scabies. In addition, interviews with staff verified that the facility has not been deep cleaned when an outbreak has been suspected and clients' personal clothing and linens have not been properly cleaned when an outbreak has

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| W 455 | Continued From page 52<br>occurred outside of the normal laundry routine.<br><br>Interview on 4/9/25 with staff K revealed the facility had been battling a scabies outbreak for approximately 2 and half years. Staff K revealed that the facility was notified on 4/3/25 at approximately 4pm that a staff member had tested positive for scabies. The facility did not quarantine the clients until the following day due to surveyors being present on 4/3/25. Staff K revealed that numerous clients in quarantine currently have skin issues and have not been tested but are currently being treated for scabies anyway.<br><br>In that the facility has had ongoing outbreaks of scabies without an aggressive, coordinated, and active program to prevent, control and eliminate this communicable infestation as of the 4/9/25 survey, the facility was neglectful of it's clients.<br><br>It should be noted that the facility submitted a corrective plan on 4/9/25 which included properly assessing the client's in quarantine the next day and testing any referred by the doctor, contracting cleaning companies to deep clean the facility as well as client linen and training all staff on scabies and the prevention of transmission. | W 455 | | |