STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015	RECEIVED DHSR MH Licensure Sect	

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QP | 4-24-25

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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	34G227	A. BUILDING _____ B. WING _____	04/15/2025

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the provision of subsistence needs for clients and staff relative to the emergency food and water supply. The finding is: Observation of the facility's emergency food and water supply on 4/14/25 revealed multiple expired food items dating back to 2023. Continued observation revealed four gallons of emergency water. Review of the facility's emergency supply list on 4/14/25 revealed eight gallons of water is required to meet the emergency supply. Interview with qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed the emergency food and water supply should be inspected regularly to ensure all items meet the adequate requirements.	E 015	The group home manager will do monthly checks to ensure that the food and water supplies meet the requirements and make that all food items are not out of date. Qp will follow up with Group home manager quarterly to ensure emergency items are being monitored.	6/1/2025
E 037	EP Training Program CFR(s): 483.475(d)(1)	E 037		

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E 037	Continued From page 2 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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E 037	Continued From page 3 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 4 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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	34G227	A. BUILDING _____ B. WING _____	04/15/2025

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E 037	Continued From page 5 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 6 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness Plan (EPP) at least biennially. The finding is: Review of the facility's EPP on 4/14/25 revealed it was updated on 3/20/25. Continued review revealed no evidence of initial or biennial staff training on the EPP. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed that initial and biennial training for current staff has not been completed.	E 037	Qp will in-service the staff on the Emergency Preparedness Evacuation plan annually. Qp will document training in In-service book for records.	6/1/2025
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at	E 039		

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E 039	Continued From page 7 §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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	34G227	A. BUILDING _____ B. WING _____	04/15/2025

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E 039	Continued From page 9 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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	34G227	A. BUILDING _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 10 facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or	E 039		

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E 039	Continued From page 11	E 039		

man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]

(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an

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E 039	Continued From page 12 actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the	E 039		

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	34G227	A. BUILDING _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

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E 039	Continued From page 13 emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section	E 039		

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E 039	Continued From page 14 is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.	E 039		

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E 039	Continued From page 15 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's Emergency Preparedness Plan (EPP). The finding is: Review of the facility's EPP on 4/14/25 revealed a table top exercise dated 3/6/25. Continued review revealed no evidence of an additional full-scale community/facility-based exercise or mock drill exercise. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed the facility has not conducted an additional full-scale community/facility-based exercise or mock drill exercise.	E 039	The group home manager will initiate a full-scale evacuation exercise to ensure staff and individuals are effectively educated on the process and plans for evacuation. The group home manager will make sure the required calls to authorities and evacuate the home to the safety site. Qp will follow up to review documentation and the team will discuss the results of the evacuation exercise.	6/5/2025
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

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W 104	Continued From page 16 This STANDARD is not met as evidenced by: Based on observations and interview, the governing body failed exercise general policy, budget, and operating direction over the facility relative to hygiene supplies. The finding is: Observations throughout the 4/14-15/25 survey revealed hand soap to be unavailable in the client bathrooms. Continued observations throughout the survey revealed clients to independently use the bathroom without access to hand soap. Further observations at meal time revealed staff to provide body wash to support clients with hand washing before meals. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all clients should have access to hand soap in the bathrooms.	W 104	Qp will do an in-service to re-educate staff of the importance of hygiene supplies for the health and safety of our individuals. Qp will remind staff of the universal importance of hand washing to prevent sickness and the spread of germs. Group home manager will monitor hygiene products in the home to make sure the hygiene items are available and easily accessible.	6/5/2025
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 6 clients (#4). The finding is: During observations in the home on 4/14/25, client #4 was observed to enter a restroom along with one staff and one other client in order to wash her hands prior to dinner. Further observations revealed client #4 to indicate that she needed to use the toilet and staff A to assist client #4 to sit on the toilet with her pants down	W 130		

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W 130	Continued From page 17 while the other client remained in the restroom and the door to the restroom remained open. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all staff should ensure clients' privacy is protected during personal care and treatment.	W 130	Qp will re-educate staff with an in-service on the importance of our clients right to Privacy. The group home manager will monitor staff to ensure privacy policy is being respected at all times.	6/5/2025
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that 1 of 6 clients (#4) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to use of a communication tool and staff implementation of mealtime guidelines. The finding is: During evening observations in the group home on 4/14/25, client #4 was observed to take part in individual activities and to eat dinner which consisted of beef ravioli, green beans, and sugar free pudding. Further observations revealed that during the dinner meal, no staff prompted client #4 to put her fork down after each bite of food and that client #4 consumed her meal rapidly and	W 249		

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W 249	Continued From page 18 without putting her fork down. Continued observation revealed client #4 to get up from the table and take her dishes to the kitchen. Subsequent observation revealed a Big Mack switch that was placed at client #4's place at the dinner table, but that client #4 never used the switch, nor was she prompted to use the switch by any staff. During morning observations in the group home on 4/15/25, client #4 was observed to indicate non-verbally to staff that she wanted coffee. Further observations revealed staff C to attempt to redirect client #4 to the living room, but client #4 refused. Continued observation revealed staff C to eventually allow client #4 to prepare a cup of coffee, but at no time did staff C prompt client #4 to use a Big Mack switch to request her coffee. Subsequent observation revealed client #4 to take part in the breakfast meal which consisted of Cream of Wheat cereal, prune juice and milk. Further observations revealed client #4 to consume her meal rapidly. At no time during the meal was client #4 prompted to put her spoon down after each bite of food. Additional observation revealed client #4 to get up from the table and take her dishes to the kitchen. Finally, observation revealed a Big Mack switch that was placed at client #4's place at the breakfast table, but that client #4 never used the switch, nor was she prompted to use the switch by any staff. Review of records revealed a PCP for client #4 dated 10/7/24 which lists some of client #4's goals as, "Use a Big Mack switch to indicate 'I'm finished' after eating a meal with no more than 2 verbal prompts," "Use a Big Mack switch to request 'Please' when she would like to make her coffee with no more than 2 verbal prompts," and	W 249		

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W 249	Continued From page 19 "Put down her utensil after each bite of food with no more than 2 verbal prompts." Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed that staff should have prompted client #4 to use the available Big Mack switches and to put her utensil down after each bite of food.	W 249	Qp will re-educate staff with an in-service on implementing the goals as written. Group home manager will monitor staff to ensure goals are being run as written and that all adaptive equipment is used properly.	6/5/2025
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all drugs, including those that are self-administered, were administered without error for 1 of 6 clients (#2). The finding is: Observation in the group home on 4/15/25 at 6:30 AM revealed client #2 to participate in the breakfast meal. Continued observation at 7:45 AM revealed client #2 to enter the medication room for medication administration with Staff B. Observation of client #2's medication pass revealed them to receive the following two medications: Ferrous Sulfate - 15 mL dose poured into medication cup by Staff B and taken orally by the client; Tirosint Solution - administered orally with staff assistance and given one hour and 15 minutes after the breakfast meal. Review of client #2's record on 4/15/25 revealed physician's orders dated 3/19/25. Review of the physician's orders indicated client #2's AM	W 369		

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W 369	Continued From page 20 medications to include: Ferrous Sulfate 15 mg Iron (75mg)/mL Oral Drops - Take 1 mL every day by oral route; Tirosint-SoL 62.5 mcg/mL Oral Solution - Take 1 mL by mouth daily in the morning at least 30 minutes before breakfast. Interview with Staff B on 4/15/25 verified they administered a 15 mL dose of Ferrous Sulfate to client #2. Interview with the facility nurse on 4/15/25 confirmed client #2's AM medication orders are current. Continued interview confirmed client #2 received the incorrect dose of Ferrous Sulfate. Further interview confirmed client #2 should have received the Tirosint Solution 30 minutes before breakfast as prescribed.	W 369	Lifespan Nurse will re-educate the staff with an in-service on the medication administration policy. Group home manager will monitor staff to ensure the policy is being followed daily.	6/5/2025
W 472	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure food was served in the appropriate quantity for 4 of 6 clients (#1, #2, #3 and #5). The findings are: Observations in the group home on 4/14/25 during the evening meal revealed all clients to be served beef ravioli, green beans and sugar free pudding. Further observation revealed the meal to be served family style, with no measuring tools used to assist clients with portioning food on their plates. The serving sizes indicated on the daily menu were 4 oz. of ravioli, ½ cup of green beans, and ½ cup of pudding. Subsequent observation revealed all clients received similarly sized portions of ravioli and green beans and each was served 1 individually packed container of pudding.	W 472		

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W 472	Continued From page 21 Observations in the group home on 4/15/25 during breakfast revealed all clients to be served Cream of Wheat cereal and prune juice. Further observation revealed the meal to again be served family style with clients using a large spoon to serve themselves the Cream of Wheat cereal. Subsequent observations revealed no effort made by staff to measure the food clients served themselves and the servings appeared to be larger or smaller than called for by clients' individually prescribed diets. Review of client #1's record on 4/15/25 revealed a nutritional evaluation dated 2/11/25 which indicates client #1's prescribed diet to be chopped meats, double portions at all meals, no milk. Review of client #2's record on 4/15/25 revealed a nutritional evaluation dated 2/11/25 which indicates client #2's prescribed diet to be chopped meats, double portions at all meals. Review of client #3's record on 4/15/25 revealed a nutritional evaluation dated 2/11/25 which indicates client #3's prescribed diet to be regular, heart healthy, ½ portions of starch and desserts, double portions of vegetables. Review of client #5's record on 4/15/25 revealed a nutritional evaluation dated 3/25/25 which indicates client #5's prescribed diet to be heart healthy, chopped as tolerated, double portions at all meals. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all clients' prescribed diets are current. Further interview with the QIDP confirmed specially modified diets should always be followed as	W 472		

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W 472	Continued From page 22 prescribed.	W 472	Dietician will do an in-service on the importance of following dietary orders for all clients. Staff will be re-educated on the items used to measure quantity and the adaptive equipment needed at mealtimes for some of our individuals. Qp will follow up to observe mealtimes to ensure diet orders are being followed.	6/5/2025