STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD WINSTON SALEM, NC 27107

(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 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 §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

E 039 Wilson Smith Cottage ICF/IDD group home will conduct exercises to test the emergency plan annually. The facility will do all of the following: 07-01-2025

- Participate in a full-scale exercise that is community-based every 2 years and if a community-based exercise is not accessible, the group home will conduct a facility-based functional excercise instead.
-In the event that Wilson Smith Cottage experiences an actual natural or man-made emergency that requires activation of the emergency plan, the group home will document the evacuation as the required community-based or facility-based functional exercise.

-The facility will conduct an additional exercises on the opposite year of the full-scale or functional exercise. The additional exercise may be, but not limited to a second full scale exercise, a mock disaster drill, a tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrative, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. An analysis of the emergency drill's response will be completed and revised as needed with documentation maintained.

Evidence of completed emergency exercises will be documented on an appropriate form. The form shall include:

(1)what type of exercise was practiced, i.e. full scale community-based, functional facility-based, actual natural or man-made emergency, mock disaster drill, or facilitator led tabletop exercise/workshop.
- each type will have a description to aid in staff's understanding of procedure.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	QP Program Director	5/28/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD WINSTON SALEM, NC 27107

(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

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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 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

E 039
(2) date, time, and length of the drill
(3) a list of client and staff participants
(4) the facilitator of the drill
(5) the location of the drill
(6) a detailed narrative of the drill or group discussion
(7) written clinical-related scenerios uses (as appropriate)
(8) written set of problem statement, directive messages, and prepared questions
(8) analysis of participates response
(9) suggestions for improvements

*This form shall be separate from the monthly fire Rehearsal Report.
It will be reviewed and signed by the Program Manager and/or Director upon completion.

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	34C204	_____ BLDG. _____ WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	165 MARTINDALE RD WINSTON SALEM, NC 27107

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)	COMPLETION DATE
E 039	Continued From page 2	E 039		

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 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.

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WILSON SMITH COTTAGE	135 MARTINDALE RD WINSTON SALEM, NC 27107

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*[For PRFTs at §441.184(d), Hospitals at §482.15(c), 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, 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 drill 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(c):]

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WILSON SMITH COTTAGE	185 MARTINDALE RD WINSTON SALEM, NC 27107

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E 039	Continued From page 4	E 039		

(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 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

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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 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

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E 039	Continued From page 6	E 039		

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 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

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(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 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

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E 039	Continued From page 8	E 039		

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.

*[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 on 5/13/25 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or tabletop exercise.

Interview on 5/14/25 with the qualified intellectual

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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 039	Continued From page 9 disabilities professional (QIDP) confirmed that the facility has no evidence of conducting a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or tabletop exercise.	E 039		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to have evidence that the behavior support plans (BSP's) for 4 of 5 audited clients (#1, #2, #3 and #5) were revised and updated at least annually as required. The findings are: A. The facility failed to revise and update the BSP at least annually for client #1. For example: Review of records for client #1 on 5/14/25 revealed a BSP dated 1/16/24. Continued record review revealed client #1 to have no current BSP for the review year of 2025. B. The facility failed to revise and update the BSP at least annually for client #2. For example: Review of records for client #2 on 5/14/25 revealed a BSP dated 11/9/19. Continued record review revealed client #2 to have no current BSP for the review year of 2025. C. The facility failed to revise and update the BSP at least annually for client #3. For example: Review of records for client #3 on 5/14/25	W 260	No less than annually, all clients of Wilson Smith Cottage will have their individual program plan revised, as appropriate. Individual program plans shall include a Behavior Support Plans. The Program Director/Qualified Professional will conduct routine Interdisciplinary Team meetings to allow the consultative review and progress update discussions. Prog Dir/QP will ensure that a licensed psychologist is staffed as a specialized consultant on the IDT. Prog Dir/QP will ensure the annual and as needed revisions to the BSP are completed in a timely fashion by the consulting psychologist. Once submitted, Prog Dir/QP will present the BSP to the Human Rights Committee and guardian of the individuals and obtain signatures of approval and consent.	07-01-2025

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W 260	Continued From page 10 revealed a BSP dated 10/13/19. Continued record review revealed client #3 to have no current BSP for the review year of 2025. D. The facility failed to revise and update the BSP at least annually for client #5. For example: Review of records for client #5 on 5/14/25 revealed a BSP dated 2/5/19. Continued record review revealed client #5 to have no current BSP for the review year of 2025. Interview on 5/14/25 with the qualified intellectual disabilities professional (QIDP) confirmed the BSP's for client #1, #2, #3 and #5 have not been updated due to the facility's vacant psychologist position. Further interview with the QIDP confirmed all clients should have an updated BSP at least annually.	W 260		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on review of records and interviews, the facility failed to obtain written consent from the human rights committee (HRC) at least annually for 4 of 5 audited clients (#1, #2, #3 and #5). The finding are: A. The facility failed to obtain an annual HRC consent for client #1. For example: Review of records for client #1 on 5/14/25	W 262	No less than annually, all clients of Wilson Smith Cottage will have their individual program plan revised as appropriate. Individual program plans shall include a Behavior Support Plans that is designed to manage inappropriate behavior. The individual program plan's BSP (and other programs that involve risks to client protection and rights) shall be reviewed, approved and monitored. The Prog Director/Qualified Professional will conduct routine Interdisciplinary Team meetings to allow the consultative review and progress update discussions. Prog Dir/QP will ensure that a licensed psychologist is staffed as a specialized consultant on the IDT. Prog Dir/QP will ensure the annual and as needed revisions to the BSP are completed in a timely fashion by the consulting psychologist. Once submitted, Prog Dir/QP will present the BSP to the Human Rights Committee	07-01-2025

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W 262	Continued From page 11	W 262	and guardian of the individual and obtain signatures of approval and consent. Further measures will be taken by LSC's Extended Reach data base system. When LSC personnel uploads a BSP document, the E-Reach system will request if both the HRC's and guardian's signature have been obtained.	

revealed an HRC consent dated 5/15/24. Continued record review revealed client #1 to have no current HRC consent for the review year of 2025.

B. The facility failed to obtain an annual HRC consent for client #2. For example:

Review of records for client #2 on 5/14/25 revealed an HRC consent dated 11/19/19. Continued record review revealed client #2 to have no current HRC consent for the review year of 2025.

C. The facility failed to obtain an annual HRC consent for client #3. For example:

Review of records for client #3 on 5/14/25 revealed an HRC consent dated 10/13/19. Continued record review revealed client #3 to have no current HRC consent for the review year of 2025.

D. The facility failed to obtain an annual HRC consent for client #5. For example:

Review of records for client #5 on 5/14/25 revealed an HRC consent dated 2/5/19. Continued record review revealed client #5 to have no current HRC consent for the review year of 2025.

Interview on 5/14/25 with the qualified intellectual disabilities professional (QIDP) confirmed the HRC consents for client #1, #2, #3 and #5 have not been updated due to the facility's vacant psychologist position. Further interview with the QIDP confirmed all clients should have an updated HRC consent at least annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD WINSTON SALEM, NC 27107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on review of records and interviews, the facility failed to obtain written consent from the guardians at least annually for 4 of 5 audited clients (#1, #2, #3 and #5). The finding are: A. The facility failed to obtain an annual guardian consent for client #1. For example: Review of records for client #1 on 5/14/25 revealed a guardian consent dated 5/15/24. Continued record review revealed client #1 to have no current guardian consent for the review year of 2025. B. The facility failed to obtain a annual guardian consent for client #2. For example: Review of records for client #2 on 5/14/25 revealed a guardian consent dated 11/19/19. Continued record review revealed client #2 to have no current guardian consent for the review year of 2025. C. The facility failed to obtain a annual guardian consent for client #3. For example: Review of records for client #3 on 5/14/25 revealed a guardian consent dated 10/13/19. Continued record review revealed client #3 to have no current guardian consent for the review year of 2025.	W 263	No less than annually, all clients of Wilson Smith Cottage will have their individual program plan revised, as appropriate. The Program Director/Qualified Professional will conduct an annual and/or as needed treatment team / committee meetings to review, and report client's progress. Prog Dir/QP will ensure that the client, guardian, and staffed licensed professionals / specialized consultants attend the treatment team / committee meeting. Prog Dir/QP will ensure the annual and/or as needed revisions to the individual program plan are completed. All attendees to the treatment team / committee meeting will sign the plan's signature page.	07-01-2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	165 MARTINDALE RD WINSTON SALEM, NC 27107

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W 263	Continued From page 13 D. The facility failed to obtain a annual guardian consent for client #5. For example: Review of records for client #5 on 5/14/25 revealed a guardian consent dated 2/5/19. Continued record review revealed client #5 to have no current guardian consent for the review year of 2025. Interview on 5/14/25 with the qualified intellectual disabilities professional (QIDP) confirmed the guardian consent for client #1, #2, #3 and #5 has not been updated due to the facility's vacant psychologist position. Further interview with the QIDP confirmed all clients should have an updated guardian consent at least annually.	W 263		
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 assure all drugs were administered without error for 1 of 5 clients (#5) observed during medication administration. The finding is: Observation in the group home on 5/14/25 at 7:46 AM revealed staff D to assist client #5 to punch medications into a medicine cup during medication administration. Continued observation revealed the client to take all medications whole with water. Further observations revealed client #5 to take prescribed mouth rinse to bathroom and brush on his teeth. Subsequent observations in the bedroom	W 369	Wilson Smith Cottage shall have in place a system for drug administration that will assure that all drugs, including those that are self-administered are administered without error. Wilson Smith Cottage's identified system utilizes the assistance of a buddy.The Buddy system will require a co-worker, to verify that all medications have been administer and documented. Daily, immediatly after each and all medication passes (AM,PM) a second staff member on shift will inspect all medication bubble packs to ensure each day's med is no longer present. (Note that tablets are popped out of numbered bubbles that correspond with the current day's date.) Additionally, the buddy will inspect the MAR to ensure all documentation (initials,PRN descriptions, etc.) is present. Wilson Smith Cottage will provide trainings to staff members administering medications annually and when a need for corrective action is identified.	07-01-2025

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W 369	Continued From page 14 revealed the staff to apply the client's medicated cream to his back and stomach. Review of records for client #5 on 5/14/25 revealed physician orders dated 5/1/2025. Review of the 5/1/2025 physician orders revealed medications to administer at 8:00 AM to be Chlorhexidine 0.12% rinse, Hydrocortisone 2.5% cream, Qc multi Vite tab 130, Risperidone 0.5 Mg, Risperidone 1 Mg, Sertraline Hcl 100 Mg, Sertraline Hcl 50 Mg, and Tamsulosin Hcl 0.4 Mg. During the medication administration observation staff D was not observed to administer, Qc multi Vite tab 130, Risperidone 1 Mg, Sertraline Hcl 100 Mg, and Sertraline Hcl 50 Mg. Interview with the qualified intellectual disabilities professional (QIDP) on 5/14/25 verified the physician orders dated 5/1/2025 to be current. Continued Interview with the QIDP revealed that the facility was in the process of changing pharmacies due to the discrepancies with the physician orders and the medication administration records.	W 369		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure that prescribed adaptive equipment was furnished for 1 of 5 audited clients (#5). The finding is:	W 436	Wilson Smith Cottage shall furnish, maintain in good repair, and teach its clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the IDT as needed by the client. In such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMART (specific, measurable, attainable, relevant and time-based) with interventions supporting the its achivement. Staff members will document the clients daily progress and Prog Dir/QP will monitor and report its quarterly outcome. Materials needed for goal will continuously be available for client's use.	07-01-2025

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W 436	Continued From page 15 Observations during survey 5/13 - 5/14/25 revealed client #5 to consume the dinner meal and breakfast meal except for an egg omelette at breakfast. Continued observations revealed client #5 was provided with the following utensils: fork, spoon, and butter knife. At no time during the mealtime observations was client #5 provided with a rocker knife. Review of the record on 5/14/25 for client #5 revealed an individual habilitation plan (IHP) dated 2/3/25. Review of the IHP revealed a dietary evaluation dated 2/10/25 that revealed that the client has an adaptive knife that he uses with assistance, and he can feed himself with a spoon and fork. Interview on 5/13/25 with the qualified intellectual disabilities professional (QIDP) verified that client #5's IHP was current. Continued interview with the QIDP revealed that the staff should have provided the client with his prescribed rocker knife.	W 436		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to investigate any problems with fire drills, including the reason for extended times for evacuation. The finding is: Review of facility fire drill reports revealed the following dates that exceeded five minutes: 5/01/25-10 minutes, 2/12/25-6 minutes.	W 448	Wilson Smith Cottage will investigate all problems with evacuation drills, including accidents. Evidence of investigations will be documented on the group home's Fire Rehearsal Report. After each fire / evacuation drill, the Program Manager will review the date, time, participants, evacuation length, narrative, and clients' response. Upon the assessment, if a problem is apparent, an investiation will be conducted by the Prog Man. Investigation questions, conclusions, and corrections will be documented on the report. All Fire Rehearsal reports will be signed by the Prog Man as evidence of review.	07-01-2025

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W 448	Continued From page 16 6/15/24-10 minutes and, 9/16/24-6 minutes. Interview with the qualified intellectual disabilities professional (QIDP) on 5/14/25 revealed the facility fire drill form had been updated but did not include a section for staff to provide an explanation for extended evacuation times. Continued interview with the QIDP revealed the update fire drill form also did not include a section to record the total number of clients and staff participating in the drill.	W 448		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 5 audited clients (#5) received their specialty diet as prescribed. The finding is: Observation in the group home on 5/13/25 at 4:32 PM revealed client #5 to participate in the dinner meal which consisted of lima beans, fried chicken nuggets, roll, and juice. Continued observations revealed client #5 to consume the dinner meal and exit the dining area. At no time during the observations were staff observed to provide the client with his prescribed supplement. Observation in the group home on 5/14/25 at 7:16 AM revealed client #5 to participate in the breakfast meal which consisted of oatmeal, egg omelette, juice, and milk. Continued observations revealed client #5 to consume the breakfast meal without eating the egg omelette. At no time during	W 463	Wilson Smith Cottage IDT, shall include a qualified dietitian and physician shall prescribe all modified and special diets. The Prog Dir/QP will conduct routine Interdisciplinary Team meetings to allow for consultative review and progress update discussions. Prog Dir/QP will ensure that there is a physician's order for special diets to include but not limited to a dietary supplement. The Prog Dir/QP will ensure that the consultant dietitian monitors the client's overall nutritional health and provide quarterly progress. The Prog Director will ensure the training of direct care staffs of individuals' special dietary needs at least annually. Prog Dir/QP will ensure that the dietitian does routine in-person meal observations no less than quarterly. Documentation of such observations will be maintained. Prog Manager will complete periodic impromptu checks during meals to ensure diet adherence.	07-01-25

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W 463	Continued From page 17 the observations were staff observed to provide the client with his prescribed supplement. Review of records on 5/14/25 for client #5 revealed a dietary evaluation dated 2/10/25. Continued review of the dietary evaluation revealed that client #5 is prescribed a regular diet with two supplements a day for additional calories. The client's supplement is Ovaltine mixed with whole milk. Interview on 5/14/25 with the qualified intellectual disabilities professional (QIDP) confirmed client #5's diet as prescribed. Continued interview with the QIDP confirmed that staff should have provided client #5 with his prescribed diet which includes the supplement Ovaltine.	W 463		