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| E 004 | Develop EP Plan, Review and Update Annually<br>CFR(s): 483.475(a)<br><br>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. | E 004 | | |

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

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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| E 004 | Continued From page 1<br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br><br>.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide an update for the emergency preparedness plan (EPP) manual. The finding is:<br><br>Review of records during the 6/9/25 - 6/10/25 survey revealed no evidence of an update to the home EPP manual. Continued review of records for the same survey period revealed an EPP manual with "Rockwell" name presented for review. Further review of records revealed the "Rockwell" manual returned as it was not the correct home EPP manual.<br><br>Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) confirmed that the facility has no evidence of the homes EPP update or actual manual. | E 004 | | |
| E 015 | Subsistence Needs for Staff and Patients<br>CFR(s): 483.475(b)(1)<br><br>§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)<br><br>[(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 | E 015 | | |

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| E 015 | Continued From page 2 | E 015 | | |

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 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.

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| E 015 | Continued From page 3<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure its provision of subsistence needs for staff and clients specific to evacuation supplies and foods were maintained. The finding is:<br><br>Observations in the group home on 6/9/25 revealed the facilities emergency food supplies to contain a variety of expired products to include the following: canned goods ranging from 09/24, 12/24, 03/25, 05/25, strawberry snack packs - 03/25, chocolate puddings cups - 04/25, 30 count cereal bars - 01/25, cheddar crackers 09/24, and honey graham crackers - 11/24.<br><br>Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed she was not aware of the expired foods in the emergency food container. Further interview with the QIDP confirmed the foods and other items should be kept current and monitored ensuring expired goods are discarded and replaced. | E 015 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>§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).<br><br>*[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 4<br>§491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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 5<br>*[For Hospices at 418.113(d):]<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br><br>(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:<br>(i) Participate in an annual full-scale exercise that | E 039 | | |

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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,

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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

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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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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

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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

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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.

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| E 039 | Continued From page 12<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is:<br><br>Review on 6/10/25 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, a tabletop exercise.<br><br>Interview on 6/10/25 with the qualified intellectual 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 and tabletop exercise in-service. | E 039 | | |
| W 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, | W 104 | | |

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| W 104 | Continued From page 13<br>budget, and operating direction over the facility. This STANDARD is not met as evidenced by:<br>Based on observation, record review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted timely. The finding is:<br><br>Observations in the group home during the survey period from 6/9/25 - 6/10/25 revealed all clients to use two bathrooms for bathing and grooming in the group home. Continued observations revealed both bathrooms to have the toilet seat safety rails rusted. Subsequent observation in the group home revealed walls in the home's dining room and living room that require sanding and paint; a love seat and recliner in the living room with peeling and torn leather; and a dining room table that has several areas where the paint is peeling off the top surface.<br><br>Interview with staff B on 6/9/25 revealed they have made management aware of the items that needed replacing in the home via the placement of work orders, but they were uncertain of the status of the work orders.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 6/10/25 revealed she and management were aware of the furniture and walls needing to be replaced and painted. Further interview the QIDP revealed management to be placing orders for replacement furnishings, but they could not provide invoices for those. | W 104 | | |
| W 195 | ACTIVE TREATMENT SERVICES<br>CFR(s): 483.440 | W 195 | | |

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| W 195 | Continued From page 14<br><br>The facility must ensure that specific active treatment services requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>The team failed to: ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission (W210); and ensure the person-centered plan (PCP) was developed and implemented within 30 days of admission for 1 newly admitted client (W226).<br><br>The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients. | W 195 | | |
| W 196 | ACTIVE TREATMENT<br>CFR(s): 483.440(a)(1)<br><br>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:<br>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and<br>(ii) The prevention or deceleration of regression or loss of current optimal functional status.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and confirmed by interviews with staff, the facility | W 196 | | |

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| W 196 | Continued From page 15<br>failed to provide an aggressive implementation of specialized treatment to 1 of 6 audited clients (#3) in the areas completing preliminary accurate assessments and failing to develop an accurate PCP within 30 days of admission.<br><br>A. Cross reference W210. The interdisciplinary team failed to complete preliminary accurate assessments within 30 days of admission for 1 newly admitted client.<br><br>B. Cross reference W226. The facility failed to ensure the person-centered plan (PCP) was developed and implemented within 30 days of admission for 1 newly admitted client. | W 196 | | |
| W 210 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)<br><br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission. This affected 1 newly admitted audit client (#3). The finding is:<br><br>Review of client #3's record revealed he was admitted to the facility on 4/29/25. Further review of client #3's record revealed his person centered plan (PCP) meeting was held on 5/20/25. Review of client #3's preliminary evaluations revealed he was missing a nutrition evaluation, eye exam, hearing exam, speech, physical therapy, psychological evaluation and an adaptive | W 210 | | |

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| W 210 | Continued From page 16<br>behavior inventory (ABI) assessment.<br><br>Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed a few assessments had been completed. Further interview with the QIDP revealed the facility had not received the assessments from the consultants and were not available for review. Continued interview with the QIDP revealed that all assessments should be completed within 30 days after admission for all clients. | W 210 | | |
| W 226 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(4)<br><br>Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure 1 newly admitted client (#3) received an person-centered plan (PCP) within 30 days after admission. The finding is:<br><br>Review on 6/9/25 - 6/10/25 of client #3's record revealed he was admitted to the facility on 4/29/25 and that his person centered plan meeting was held on 5/20/25.<br><br>Observations during the 6/9/25 - 6/10/25 survey revealed client #3 to participate in leisure activities, breakfast and dinner meals by serving himself, taking his dishes to the sink, rinse then place in the dishwasher as well as wiping his space at the table. Medication administration observations at 7:40 AM revealed, client #3 was able to state his medications and participate in administering. Further observations revealed | W 226 | | |

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| W 226 | Continued From page 17<br>client to have his glucose level checked and the reading was "166" following the breakfast meal.<br><br>Review of client #3's physician order on 6/10/25 lists client's diet as regular diabetic, however in the group home, his diet is listed as whole consistency, regular 2,000 calorie diet.<br><br>Interview on 6/9/25 with the program manager (PM) revealed no PCP has been developed. Further interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed no PCP has been developed, and only a few assessments have been developed. Continued interview with the QIDP right before the survey exit on 6/10/25 revealed the QIDP to provide the surveyors a PCP based on a previous admission. | W 226 | | |
| W 472 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(i)<br><br>Food must be served in appropriate quantity.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure food was served in the appropriate quantity as prescribed for 3 of 6 audit clients (#2, #3 and #6). The findings are:<br><br>A. The facility failed to assure food was served in the appropriate quantity for client #2 as prescribed. For example:<br><br>During observation in the home on 6/10/25 at 5:30 PM, client #2 was observed eating dinner which consisted of one 4 oz baked pork chop, ½ cup of mashed potatoes, ½ cup of mixed vegetables, 1 biscuit, sugar free cool aid and | W 472 | | |

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| W 472 | Continued From page 18 | W 472 | | |

lemonade, almond milk, 2% milk and water. Continued observation revealed client #2 to serve himself more than the ½ cup of mashed potatoes with hand over hand assistance. Further observation revealed client #2 to eat the pork chop, mashed potatoes and biscuit in its entirety.

Review of client #2's records revealed a person-centered plan (PCP) dated 6/4/24 revealed a weight loss ¼ consistency diet due to excessive weigh gain.

B. The facility failed to assure food was served in the appropriate quantity for client #3 as prescribed. For example:

During observations in the home on 6/9/25 at 5:30 PM, client #3 was observed eating dinner which consisted of one 4 oz baked pork chop, ½ cup of mashed potatoes, ½ cup of mixed vegetables, 1 biscuit, sugar free punch and lemonade, almond milk, 2% milk and water. Continued observation revealed client #3 to serve himself at least 1 cup or more of the mashed potatoes. Further observation revealed client #3 to consume his dinner meal in its entirety.

During observations in the home on 6/10/25 at 7:00 AM, client #3 was observed eating breakfast which consisted of 1 cup of oatmeal, 1 serving of scrambled egg, orange juice, 2% milk, water and a bowl of peaches. Continued observation revealed client #3 to serve himself double the portion of scrambled eggs; the oatmeal was already in the bowl. Further observation revealed client #3 to eat all of his breakfast in its entirety.

Review of client #3's records revealed a physicians order (PO) dated 5/14/25 that revealed

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| W 472 | Continued From page 19<br>a regular diabetic diet.<br><br>C. The facility failed to assure food was served in the appropriate quantity for client #6 as prescribed. For example:<br><br>During observations in the home on 6/10/25 at 5:30 PM, client #6 was observed eating dinner which consisted of a one 4 oz baked pork chop, ½ cup of mashed potatoes, ½ cup of mixed vegetables, 1 biscuit, sugar free punch and lemonade, almond milk, 2% milk and water. Continued observation revealed client #6 to serve himself at least 1 cup or more of the mashed potatoes. Further observation revealed client #3 to consume his dinner meal in its entirety.<br><br>Review of client #6's records revealed a nutritional assessment (NA) dated 4/15/25 that revealed a 1/2 consistency ground meats, weight loss (1500 calories) Heart Healthy, thin liquids, Diabetes Mellitus (DM), diet.<br><br>Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) confirmed the diets for client's #2, #3 and #6' are current. Further interview with the QIDP confirmed that all clients should have been served the amount of food indicated on the menu and as prescribed per their respective diet orders. Continued interview with the QIDP revealed staff should follow the clients' prescribed diets during mealtimes. | W 472 | | |
| W 474 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iii)<br><br>Food must be served in a form consistent with the developmental level of the client.<br>This STANDARD is not met as evidenced by: | W 474 | | |

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| W 474 | Continued From page 20<br>Based on observation, record review, and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 1 of 6 audit clients (#4). The findings is:<br><br>During observations in the home on 6/10/24 at 7:00 AM, client #4 was observed eating breakfast which consisted of oatmeal, scrambled eggs, orange juice, 2% milk, water and a bowl of peaches. The scrambled eggs and peaches were served in whole form, with client #4 eating all in whole form.<br><br>Review on 6/10/25 of client 4#'s nutritional assessment (NA) dated 4/15/25 revealed a diet order consisting of puree diet, regular calorie snacks, alternate bites/liquids, meds crushed in applesauce/pudding/yogurt.<br><br>Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) confirmed client #4's NA is current. Further interview with the QIDP confirmed client #4's scrambled eggs and peaches should have been served in a puree consistency. | W 474 | | |