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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure routine cleaning, routine extermination, and maintenance repairs at the group home were completed in a timely manner. The finding is: Observations throughout the 6/9 - 6/10/25 survey revealed repairs inside the group home to include a large hole in the wood laminate floor located in the living room and dining room with debris still present in and around the hole. Continued observations in the living room revealed a large glue trap containing numerous bugs to include dead spiders' and centipedes, a large glue trap beside a recliner chair with peanut butter in the center, and a large easy set mouse trap behind the couch. Further observations revealed a large easy set mouse trap in the pantry. Subsequent observations revealed the floors throughout the home in the kitchen, dining room, hallways and living room to contain dirt, dried substances, and debris. Additionally, the front door has a broken doorbell with wires exposed. Review of maintenance records on 6/10/25 revealed a work order (WO) completed by the qualified intellectual disabilities professional (QIDP) on 6/10/25 to fix the doorbell after records indicated that maintenance did not complete a WO during walk through completed on 6/5/25. Continued review of records revealed a WO dated 6/5/25 for holes in the dining room and	W 104		

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

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W 104	Continued From page 1 living room floor. The facility did not provide surveyor with requested extermination records for the home. Interview on 6/10/25 with the QIDP verified that the facility had a mouse and maintenance put traps throughout the home. Continued interview with the QIDP revealed that maintenance had WO's to repair the holes in the living room and dining room; however, it is unknown when repairs will take place. Further interview with the QIDP verified that the floors throughout the home had not been cleaned for some time and meetings have taken place with the home manager (HM) to ensure cleaning takes place.	W 104		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record reviews and interviews, Nursing services failed to meet the needs of 1 of 5 clients (#5) by failing to monitor diet and excessive weight gain. The finding is: Review of records on 6/10/25 for client #5 revealed a person-centered plan (PCP) dated 6/6/25. Continued review of the PCP revealed a diagnosis of Mild Intellectual Developmental Disabilities, Down Syndrome, Diabetes Mellitus Type 1, and seasonal allergies. Further review of records revealed a nutritional evaluation dated 6/4/25 for client #5 to be prescribed a regular diabetic diet with carbohydrate counting by staff. Subsequent review of weight records for client #5 for 12 months revealed the following weights:	W 331		

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7/24-161 lbs.; 8/24-0; 9/24-164 lbs.; 10/24-175 lbs.; 11/24-175 lbs.; 12/24-178 lbs.; 1/25-0; 2/25-185 lbs.; 3/25-184 lbs.; 4/25-192 lbs.; 5/25-19 lbs. 7; 6/25-196 lbs. Additionally, the client has had a 33 pound increase in the last 12 months with a current weight of 196 pounds which is in the obesity category.

Review of the facility's menu on 6/10/25 revealed a set menu for all individuals in the group home not indicating a regular diet or a diabetic diet. Continued review of the menu revealed that there are no guidelines specific to a diabetic diet and client #5 has no diet restrictions.

Review of client #5's Diabetes protocol on 6/10/25 revealed that the client is insulin-dependent (Type 1) diabetic. Continued review revealed that the client's insulin, food intake, and the amount of exercise need to be balanced. Further review revealed that client #5 has a Dexcom system that measures her glucose levels and ensures the delivery of needed insulin. The client has had 6 hospital visits over the past year relative to her blood sugar levels.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/10/25 revealed that client #5 does better with following a menu and the client's behaviors are food driven. Continued interview with the QIDP revealed that the client will take snacks from the pantry and will eat large amounts of foods while on home visits. Further interview with the QIDP revealed that client #5 will not participate with exercise.

Interview with the facility nurse on 6/10/25 verified that client #5 is prescribed a regular diabetic with carbohydrate counting by staff. Continued

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W 331	Continued From page 3 interview with the nurse confirmed that the client has gained excessive weight over the last 12 months and the team agreed to follow the diet guidelines put in place by the dietician.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 1 of 5 clients in the group home (#1). The finding is: Observations in the home on 6/10/25 at 7:05 AM revealed client #1 to enter the medication administration room and pour a cup of water. Staff C removed client #1's medications from the med closet and placed them on the desk. Continued observation revealed staff C picked up a medicine bottle and removed a container that contained drops. Further observations revealed the staff to prompt client #1 to shake the drops and staff C placed 4 drops into each of the clients' ears. Subsequent observations revealed that staff C had administered Fluorometholone 0.1 suspension into the client's ears. Additionally, the surveyor informed staff C that she had administered eye drops into client #1's ears. Review of records on 6/10/25 for client #1 revealed a physician's order dated 2/21/25. Continued review of the physician orders revealed client #1 to be prescribed Fluorometholone 0.1% suspension 5 milliliters	W 368		

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W 368	Continued From page 4 place one drop in both eyes every morning. Interview with the home manager (HM) on 6/10/25 confirmed that client #1 is prescribed Fluorometholone 0.1% suspension and has been prescribed eye drops ongoing. Continued interview with the HM revealed that client #1 had an eye appointment on 6/10/25 at 9:30 AM and the physician will continue eye drops due to dry eyes. Interview with the facility nurse on 6/10/25 confirmed that client #1 is prescribed Fluorometholone 0.1% suspension 5 milliliters place one drop in both eyes every morning. Continued interview with the facility nurse revealed that staff C did not call and notify the nurse that eye drops were placed in client #1's ears. Further interview with the facility nurse revealed that staff did not follow notification protocol so that the physician can be notified of medication not being administered as prescribed.	W 368		
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 observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 1 of 6 clients (#2) observed during medication administration. The finding is: Observations in the home on 6/10/25 at 7:05 AM revealed client #1 to enter the medication administration room and pour a cup of water. Continued observations revealed that staff C	W 369		

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administered Fluorometholone 0.1 suspension 4 drops into each of the client's ears. Further observations revealed that staff C punched all pills into medicine cup and client took whole with water. Subsequent observation revealed that staff C took out the ear drops to place in client #1's eyes and the surveyor informed staff C to please verify prior to placing drops in eyes. Staff C verified that she had picked up the wrong drops and located the correct eye drops and administered them to the client. At no time during the medication observation was staff observed to administer client #1's prescribed ear drops.

Review of records for client #1 on 6/10/25 revealed physician's orders dated 3/30-6/30/25. Review of the physician orders revealed medications prescribed at 8:00 AM to be Amlodipine tab 10 mg, Fish oil cap 1000 mg, Hydrochlorothiazide tab 25 mg, Lisinopril tab 40 mg, Metformin tab 500 MG ER, Pot Chloride tab 10MEQ ER, Propranolol cap 60 mg ER, Vitamin D3 25 MCG, Spironolactone 25 mg, Fluorometholone 0.1% suspension 5 milliliters place one drop in both eyes every morning, and Neo/Poly/HC solution 1% to instill 4 drops in both ears twice daily at 8:00 AM and 8:00 PM.

Interview with the facility nurse on 6/10/25 confirmed client #1's physician's orders. Continued interview with the facility nurse revealed that staff C did not call and notify the nurse that eye drops were placed in client #1's ears nor was the nurse informed that the prescribed ear drops were not administered. Further interview with the facility nurse revealed that staff did not follow notification protocol so that the physician can be notified of medication not being administered as prescribed.

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W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all appropriate utensils were provided to 4 of 5 clients (#1, #2, #3, and #5). The findings are: A. The facility failed to ensure all appropriate utensils were provided for client #1. For example, Observations in the home on 6/9/25 at 5:42 PM revealed client #1 to participate in the dinner meal with a place setting that consisted of a plate, spoon, napkin, and 2 cups. Continued observation revealed the dinner meal included hamburger on bun, sweet potato fries, and applesauce. At no time during observations was staff observed to provide client #1 with a fork and knife for the dinner meal. Observation in the home on 6/10/25 at 7:44 AM revealed client #1 to participate in the breakfast meal with a place setting that consisted of a plate, spoon, knife, napkin, and 2 cups. Continued observation revealed the breakfast meal included 2 slices of toast, jelly, and scrambled eggs. At no time during observations was staff observed to provide client #1 with a fork. Review of records for client #1 on 6/10/25 revealed a person-centered plan (PCP) dated 3/31/25. Continued review of the PCP for client #1 revealed a dietary evaluation dated 3/19/25 to note that client #1 can use his silverware (fork, spoon, and knife) correctly, but may need some assistance when using a knife.	W 475		

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W 475	Continued From page 7 Interview with the qualified intellectual disabilities professional (QIDP) on 6/10/25 revealed that client #1's PCP is current. Continued interview with the QIDP confirmed that all meals for client #1 should be provided with a full place setting consisting of the following utensils (spoon, fork, and knife). B. The facility failed to ensure all appropriate utensils were provided for client #2. For example, Observations in the home on 6/9/25 at 5:42 PM revealed client #2 to participate in the dinner meal with a place setting that consisted of a plate, spoon, napkin, and 2 cups. Continued observation revealed the dinner meal included hamburger on bun, sweet potato fries, and pineapple. At no time during the observation was staff observed to provide client #2 with a fork and knife for the dinner meal. Observation in the home on 6/10/25 at 8:07 AM revealed client #2 to participate in the breakfast meal with a place setting that consisted of a plate, spoon, knife, napkin, and 2 cups. Continued observation revealed the breakfast meal included 2 slices of toast, jelly, cereal, milk and scrambled eggs. At no time during observation was staff observed to provide client #2 with a fork and knife. Review of records for client #2 on 6/10/25 revealed a PCP dated 3/1/25. Continued review of the PCP for client #2 revealed a dietary evaluation dated 2/20/25 to note that client #2 can use his silverware (fork, spoon, and knife) correctly, but may need some assistance when using a knife.	W 475		

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Interview with on 6/10/25 with the QIDP revealed that client #2's PCP is current. Continued interview with the QIDP confirmed that all meals for client #2 should be provided with a full place setting consisting of the following utensils (spoon, fork, and knife).

C. The facility failed to ensure all appropriate utensils were provided for client #3. For example,

Observations in the home on 6/9/25 at 5:42 PM revealed client #3 to participate in the dinner meal with a place setting that consisted of a plate, small spoon, napkin, and 2 cups. Continued observation revealed the dinner meal included hamburger on bun, sweet potato fries, and applesauce. At no time during the observation was staff observed to provide client #3 with a small fork for the dinner meal.

Observation in the home on 6/10/25 at 7:55 AM revealed client #3 to participate in the breakfast meal with a place setting that consisted of a plate, spoon, knife, napkin, and 2 cups. Continued observation revealed the breakfast meal included 2 slices of toast, cereal, milk and scrambled eggs. At no time during observation was staff observed to provide client #3 with a small fork.

Review of records for client #3 on 6/10/25 revealed a PCP dated 4/30/25. Continued review of the PCP for client #3 revealed a dietary evaluation dated 4/18/25 to note that client #3 can use a spoon and fork (small ones to decrease the amount of food eaten in a bite) but is not able to use her knife.

Interview with on 6/10/25 with the QIDP revealed that client #3's PCP is current. Continued

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interview with the QIDP confirmed that all meals for client #3 should be provided with a full place setting consisting of the following utensils (small spoon and small fork).

D. The facility failed to ensure all appropriate utensils were provided for client #5. For example,

Observations in the home on 6/9/25 at 5:42 PM revealed client #5 to participate in the dinner meal with a place setting that consisted of a plate, spoon, napkin, and 2 cups. Continued observation revealed the dinner meal included hamburger on bun, sweet potato fries, and applesauce. At no time during the observation was staff observed to provide client #5 with a fork and knife for the dinner meal.

Review of records for client #5 on 6/10/25 revealed a PCP dated 6/6/25. Continued review of the PCP for client #3 revealed a nutritional evaluation dated 6/4/25 to note that client #5 can use silverware (fork, spoon, and knife) correctly, along with beverage ware.

Interview with on 6/10/25 with the QIDP revealed that client #5's PCP is current. Continued interview with the QIDP confirmed that all meals for client #5 should be provided with a full place setting consisting of the following utensils (fork, spoon, and knife).