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W 000	INITIAL COMMENTS A revisit was conducted on July 1, 2025 for all previous deficiencies cited on April 29, 2025. Previous deficiencies were recited and new standard and condition level deficiencies were cited.	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure the rights of 1 of 6 audit clients (#4) had the right to be treated with dignity related to the use of incontinence padding. The finding is: During observations in the home on 7/1/25 from 6:45am through 8:10am, client #4 was sitting in her wheelchair with waterproof incontinence pad positioned underneath her and across the seat of her wheelchair. The pad was visible to anyone in the home. Review on 7/1/25 of client #4's individual program plan (IPP) dated 5/31/24 revealed the client is incontinent and wears adult briefs. Interview on 7/1/25 with the program manager revealed the pad positioned underneath client #4 was placed there because the client soils herself and wets the wheelchair.	W 125		

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

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W 125	Continued From page 1 Interview on 7/1/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should not have had an incontinence pad placed under her.	W 125		
{W 192}	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all staff were sufficiently trained to initiate/complete facility incident reports and ensure clients receive necessary medical assessment/treatment. This affected 1 of 5 audit clients (#3). The finding is: During observations in the home on 4/28/25 at 5:33pm, client #3 could be seen by surveyor through the dining room window where he was outside on a swing with Staff G nearby. At 5:35pm client #3 was seen being assisted up from the ground by Staff G, who had been outside with him. The client and Staff G then returned inside. Immediate interview on 4/29/25 with Staff G revealed the client fell when getting out of the swing too quickly after she told him it was time to eat dinner. Interview on 4/29/25 with the facility nurse revealed she had not been made aware of client #3 falling the previous day nor could she locate an incident report. The nurse revealed that staff should notify nursing immediately following a fall and an incident report should be completed.	{W 192}		

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{W 192}	Continued From page 2 The follow up survey completed on 7/1/25 revealed: Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed the program manager will follow up with staff daily regarding any incidents and will ensure all incidents are documented. Record review revealed client #3 had falls on 5/19/25, 6/22/25 and an injury of unknown origin on 6/24/25. However, there were no incident reports to review for any of those dates. Interview on 7/1/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed there were no incident reports completed.	{W 192}		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: This CONDITION is not met as evidenced by: The facility failed to ensure each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services (W196); ensure clients were provided opportunities for choice and self-management in their environment (W247); ensure each client must receive a continuous active treatment program consisting of needed interventions and	W 195		

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W 195	Continued From page 3 services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan (W249). The cumulative effect of these systemic practices resulted in the facility failure to provide statutorily mandated services of active treatment to it's client.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) 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: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations interview and record review, the facility failed to ensure each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services for 2 of 6 audit clients (#3 and #4). The findings are: A. Cross reference W247. The facility failed to ensure client #4 was provided opportunities for choice and self-management in the environment.	W 196		

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W 196	Continued From page 4 B. Cross reference W249. The facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services. The facility also failed to ensure health and safety for client #3 regarding his falls.	W 196		
{W 247}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4 was provided opportunities for choice and self-management in her environment. This affected 1 of 5 audit clients. The findings are: Observations in the home on 4/28-4/29/25, client #4 was maneuvered throughout the home by staff in her wheelchair. During the observations, various staff locked the wheels of the client #4 wheelchair which prevented her movement. Record review on 4/29/25 of client #4's Individual Program Plan (IPP) dated 5/31/24 revealed she uses wheelchair for mobility, however can walk short distances and transfer with one or two staff with a gait belt Interview on 4/29/25 with Staff C revealed they lock client #4's wheelchair for safety and that was how she was trained. Interview on 4/29/25 with the nurse confirmed the wheelchair wheels should not be locked by staff.	{W 247}		

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{W 247}	Continued From page 5 The follow up survey completed on 7/1/25 revealed: Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed the team will meet to reassess mobility needs and update client #4's IPP as applicable. Review on 7/1/25 of client #4's IPP revealed no updates regarding mobility needs. Interview on 7/1/25 with the facility's Qualified Intellectual Disabilities Professional (QIDP) revealed the team had not met to reassess needs for client #4 as of yet. Therefore, the facility remains out of compliance.	{W 247}		
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 interview, the team failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP). This affected 1 of 6 audited clients (#3). The findings are:	W 249		

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W 249	Continued From page 6 A. Observation in the home on 7/1/25 at 7:00 am revealed client #3 walked to the dining area from the bathroom with staff B holding him by his arm. Client #3 was not wearing his helmet, knee pads or gait belt. Staff B was holding the gait belt and helmet in her hand. Staff B put the helmet and gait belt on client #3 while he sat in the dining room chair. When staff B slid the helmet onto client #3's head, surveyor observed a dime sized bruise on the client's right eye. Further observation on 7/1/25 from 7:15am until 7:40am, client #3 walked around the dining room and living room area unsupervised. Client #3 had an unsteady gait and poor upright posture. He frequently bumped into the walls and chairs, which were in his path. At approximately 7:40am, client #3 got up from the kitchen table and walked into the living room area. There were no staff in the living room and no one assisting him with walking or monitoring him. Interview on 7/1/25 with staff B revealed she was unaware of how client #3's eye was bruised and doesn't remember when she first noticed the bruise. Interview on 7/1/25 with staff E revealed she was unaware of how client #3's eye was bruised and doesn't remember when she first noticed the bruise. Interview on 7/1/25 the qualified intellectual disabilities professional (QIDP) revealed she was unaware of client #3 having a bruise on his right eyelid. Interview on 7/1/25 with nurse #2 revealed, she	W 249		

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W 249	Continued From page 7 was made aware of client #3 having a seizure on 6/22/25 and biting his lip until it bled. Nurse #2 further revealed she saw client #3 on 6/24/25 at a doctor's appointment and saw the black eye and assumed it came from the seizure he had 2 days prior. Nurse #2 also revealed she was unable to document seeing client #3's eye due to being in the middle of moving buildings. Nurse #2 revealed she had not received a call informing her of client #3's eye. Record review on 7/1/25, of client #3's IPP dated 11/10/24 revealed adaptive equipment as knee pads, leg ankle splints, gait belt and helmet for protection during seizure activity. Adaptive equipment should be worn for optimal safety in ambulation and transfers. It should be worn during the day and during out of bed activities. Continued record review revealed client #3 had falls on 1/12/25, 3/19/25, 4/22/25, 4/28/25, 5/19/25, and 6/22/25. No documentation of the interdisciplinary team meeting to discuss client falls. Further record review on 7/1/25 revealed there was no physical therapy or occupational therapy assessment available for review. The facility had not conducted an interim team meeting to discuss client #3's increased falls. The most current gait belt guidelines dated 7/6/09 (16 years ago) revealed "The gait belt is used to sustain the client in an optimal upright position for safety in ambulation and transfers. The gait belt stays on the client's waist during the day, during out of bed activities. Due to the client's poor upright posture, balance and/or spontaneous and frequent falls, a gait belt is needed for safety in ambulation and transfers."	W 249		

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W 249	Continued From page 8	W 249		

B. Observation on the morning on 7/1/25 at 7:00am client #3 was not wearing knee pads or leg and ankle splints throughout the time the surveyors were in the home from 7:00am-8:15am. Client #3 walked with no supervision or assistance from the staff.

Interview on 7/1/25 with the QIDP revealed she was not aware client #3 did not have on his knee pads and she referred to the nurse about client #3's leg and ankle splints. The QIDP confirmed that PT and OT had not been consulted to discuss or implement strategies regarding the use of splints and AFO's to support the client needs.

Interview on 7/1/25 with nurse #2 revealed client #3 should have been wearing his knee pads. However, he was fitted on 6/22/25 for new AFO's and it takes a month for the braces to be made. Nurse #2 further revealed he is not wearing his old splints because they were making sores on his legs and she told the staff that client #3 was not to wear them. Nurse #2 confirmed there was no order to discontinue the use of the splint and no PT consult regarding the use of splints and/or AFO's.

Client #3 has had an increase in falls in the home. Client #3 on 7/1/25 was not using his adaptive equipment as prescribed. Client #3 did not receive continuous active treatment program consisting of needed interventions and services, his gait belt guidelines had not been reviewed or revised since 2009.

There were no assessments for physical therapy

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W 249	Continued From page 9 or occupational therapy to assess client on his needs. Client #3 had 2 head injuries in 2 months that required emergency room visits. There is no way to determine how many other injuries or incidents due to the lack of documentation and reporting from the facility. There has been no interdisciplinary team meetings to discuss how to best address client #3 increase in falls. Nurse #2 discontinued client #3's adaptive equipment (ankle splints) to assist with safety and steady his gait. On 7/1/25 client #3 was not wearing his prescribed adaptive equipment (knee pad) and ankle splints to assist him for safety. Client #3 was walking around unassisted and not being monitored by staff after breakfast unsteady bumping into walls and chairs whatever was in his path. The cumulative effect of these systemic practices resulted in the facility failure to provide statutorily mandated services of active treatment to it's client.	W 249		
{W 340}	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to implement appropriate health and hygiene methods. This affected 2 of 5 audit clients (#1 and #2). The findings are:	{W 340}		

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{W 340}	Continued From page 10 A. During observations in the home throughout the survey on 4/28/25 through 4/29/25, client #1's fingernails were noted to be very long. Interview on 4/29/25 with the facility nurse revealed client #1 is a diabetic and it is nursing's responsibility to cut his nails. The nurse also revealed she was unsure of the date his nails were last cut but thought it had been a few weeks. B. During observations in the home throughout the survey on 4/28/25 through 4/29/24, client #2's fingernails were noted to be very long. Interview on 4/29/25 with the facility nurse revealed staff in the home are responsible for cutting client #2's fingernails weekly on Wednesday after showering. The nurse confirmed she was not sure when client #2's fingernails were last cut. The follow up survey completed on 7/1/25 revealed: Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed a weekly task would be added to the health record for staff to document on nail care for client's every Wednesday. Review on 7/1/25 of the nail care documentation book revealed no documentation for any of the client's nail care since 6/4/25. Interview on 7/1/25 with the facility's Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should have been documenting in	{W 340}		

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{W 340}	Continued From page 11 the book weekly after assessing the need for nail care. Therefore, the facility remains out of compliance. Additionally, during observations on 7/1/25 during the medication pass at 7:20am, staff A brought client #4 into the medication room and administered Levothyroxine 75mcg. At no time did staff A pull up client #4's medication administration record (MAR) to confirm the order. Further observations on 7/1/25 at 8:05am, staff D was observed administering medications to client #5. Staff D administered Lithium, Metformin, Seroquel, Optase and ammonium lactate cream. At no time did staff D reference client #5's MAR during the medication pass. Immediate interview on 7/1/25 with staff D revealed the facility no longer allows staff to use their cell phones to look at clients MAR and stated that they are supposed to use the computer in the medication room instead. However, when staff D attempted to log in she did not have a valid password. Interview on 7/1/25 with the QIDP confirmed staff should always use the MAR when giving any medications.	{W 340}		
{W 341}	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel	{W 341}		

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{W 341}	Continued From page 12 imethods of infection control. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to implement measures to assure staff were trained and followed methods of infection control. The finding is: Observations made throughout the survey on 4/28-4/29/25 revealed client #3 was outside swinging in a chair, client #3 fell to the ground in the dirt when attempting to get out of the swing. Client #3 came from outside on the ground to the kitchen table to eat dinner. Further observation revealed all clients #1, #2,#3,#4,and #5 on the morning of 4/29/25 were doing leisure activities such as blocks, word puzzle books, and sensory toys at the kitchen table. Once breakfast was ready the activities were removed by staff and clients began to serve and eat there breakfast without washing their hands or hands being sanitized. Interview on 4/29/25 with Staff E revealed clients should have washed their hands before beginning to eat breakfast. Interview on 4/29/25 with nurse revealed clients should wash or sanitize their hands before eating a meal. The follow up survey completed on 7/1/25 revealed: Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed nursing will inservice staff on the Infection Control Policy with focus on handwashing. Observations in the home on 7/1/25 at 7:35am,	{W 341}		

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{W 341}	Continued From page 13 client #3, client #5 and client #6 sat at the table and begin eating breakfast. At 7:40am, client #1 and client #2 sat at the table and began eating. At 7:41am, staff A asked the clients if they had sanitized their hands and passed out sanitizer at that time. Interview on 7/1/25 with the facility's Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should have ensured client's hands were sanitized prior to eating. Therefore, the facility remains out of compliance. Additionally, observations in the living room on 7/1/25 at 7:15, client #2 reached behind the curtain on the windowsill next to him and pulled a fast food cup out. The cup was full of liquid and appeared to be watered down. The client asked if he could have it and immediately began drinking from the straw. Surveyor brought it to staff C's attention and staff took the cup from the client. Interview on 7/1/25 with the QIDP revealed that client's should never have access to staff's food or drinks or any food or beverages that have been sitting out for an undetermined amount of time.	{W 341}		
{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 review and interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 5 audit clients (#2 and #4)	{W 369}		

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{W 369}	Continued From page 14 observed receiving medications. The findings are: A. During observations of medication administration in the home on 4/28/25 at 4:08pm Staff C administered the following medication to client #2: Lorazepam 1mg; Olanzapine 5mg and Refresh Relieva 0.5 - 0.9% 1 drop per eye. Review on 4/29/25 of client #2's physician's orders dated 2/27/25 revealed an order for Refresh Relieva 0.5 - 0.9% instill 1 drop in each eye three times daily at 8am, 2pm, and 8pm. B. During observations of the medication administration pass in the home on 4/29/25 at 7:10am Staff C administered the following medication to client #4: Levothyroxine 75mcg. Staff C mixed the medication in a pudding cup and fed the cup to the client. Further observations on 4/29/25 revealed client #4 began eating breakfast at 7:33am. Review on 4/29/25 of client #4's physician's orders dated 2/12/25 revealed an order for Levothyroxine 75mcg take 1 tablet by mouth daily 1 hour before breakfast. Interview on 4/29/25 with the facility nurse confirmed client #2 should have received Refresh eye drops at 2pm. The nurse confirmed medications can be given 1 hour before or 1 hour after scheduled administration time. The nurse also confirmed client #4 should not have consumed any food within 1 hour after taking Levothyroxine. The follow up survey completed on 7/1/25 revealed:	{W 369}		

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{W 369}	Continued From page 15 Observations in the home on 7/1/25 at 7:20am, staff A administered Levothyroxine 75mcg to client #4. Client #4 was observed eating breakfast at 7:45am. Review on 7/1/25 of the physician orders dated 5/14/25 revealed an order for Levothyroxine 75mcg, Take 1 tablet by mouth daily one hour before breakfast. Further review revealed a line drawn through 1 hour and someone had written 1/2 over it. Interview on 7/1/25 with nurse #1 confirmed no order given by the physician to change the medication time could be located. Therefore, the facility remains out of compliance.	{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 interview, the facility failed to teach clients to make informed choices about the use of eyeglasses 2 of 5 client (#2 and #4). The findings are: A. Observations in the home on 4/28-4/29/25, client #2 was observed without wearing his glasses while writing and drawing on paper. Record review on 4/29/25 of client #2's vision	{W 436}		

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{W 436}	Continued From page 16	{W 436}		

consultation dated 4/15/25 revealed reading glasses needed.

B. Observation in the home on 4/28-4/29/25, client #4 was observed without wearing glasses.

Record review on 4/29/25 of client #4's Individual Program Plan (IPP) dated 5/31/24 revealed a vision exam on 7/19/24 and a prescription for glasses.

Interview on 4/29/25 with the nurse revealed that client #2 should be wearing his glasses when doing activities. The nurse also revealed client #4 should be wearing her glasses's at all times.

The follow up survey completed on 7/1/25 revealed:

Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed the Qualified Intellectual Disabilities Professional (QIDP) or Program Manager would inservice staff on client #4's need to wear glasses at all times.

Observations in the home on 7/1/25 from 6:45am through 7:45am, client #4 did not have glasses on and was not prompted by staff at any time to wear her glasses.

Interview on 7/1/25 at 7:45am with staff C revealed he was unaware client #4 had glasses. During the interview, staff A went and obtained client #4's glasses and assisted her to put them on.

Interview on 7/1/25 with the facility's QIDP revealed client #4 should have been wearing her glasses. Therefore, the facility remains out of

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{W 436}	Continued From page 17 compliance.	{W 436}		
{W 460}	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations. record review and interviews, the facility failed to ensure 3 or 4 audit clients (#1, #2 and #4) received their specially prescribed diet as indicated. The findings are: A. Observations in the home on 4/28/25 at 5:35pm, the clients were at the table to begin dinner. Client #1 received pureed lasagna, corn and bread with nectar thick liquids. The lasagna had chunks in the noodles and the corn was not a smooth consistency. Further observation on 4/29/25 client #1 received pureed oatmeal, turkey sausage and toast with pre made nectar thick liquids. The oatmeal had chunks of oatmeal and the turkey sausage was a ground consistency not a smooth puree consistency. Record review on 4/29/25 of client #1's nutritional evaluation dated 3/4/25 revealed pudding thick liquids with all meals and snacks. B. Observations in the home on 4/28/25 at 5:35pm, the clients were at the table to begin dinner. Client #2 received whole lasagna, salad and bread.	{W 460}		

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{W 460}	Continued From page 18	{W 460}		

Further observation on 4/29/25 client #2 oatmeal, whole turkey sausage patties and whole toast.

Record review pm 4/29/25 of client #2's nutritional evaluation dated 12/10/24 revealed regular diet food cut into bite size pieces.

C. Observations in the home on 4/28/25 at 5:35pm the clients were at the table to begin dinner. Client #4 received pureed lasagna, corn and bread with nectar thick liquids. The lasagna had chunks in the noodles and the corn was not a smooth consistency.

Further observation on 4/29/25 client #4 received pureed oatmeal, turkey sausage and toast with nectar thick liquids. The oatmeal had chunks of oatmeal and the turkey sausage was a ground consistency not a smooth puree consistency.

Record review on 4/29/25 of client #4's nutritional evaluation dated 9/18/24 revealed nectar thick liquids with all meals and snacks.

Interview on 4/29/25 Staff C revealed the diets are posted in the kitchen and they were feeding by the diets that were posted.

Interview on 4/29/25 the nurse revealed client #2 should have received his correct diet of bite size. Client #1 and client #4's diet consistency was trained by the dietitian. A puree consistency should be smooth and without chunks of food.

The follow up survey completed on 7/1/25 revealed:

Review on 7/1/25 of the facility's Plan Of Correction (POC) dated 6/25/25 revealed the

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{W 460}	Continued From page 19 dietician would inservice staff with a focus on nectar thick liquids, bite size and pureed foods. Observations in the home on 7/1/25 at 7:40am, client #1 and client #2 began eating breakfast. Client #2 received oatmeal and a whole muffin. Staff A prepared client #1's beverages in the kitchen by pouring bottled prethickened containers of milk and water into cups and took them to the table. Surveyor observed the bottles and the label indicated nectar thick consistency for the milk and water. Immediate interview on 7/1/25 with staff A about client #1's prescribed diet revealed he should receive pudding thick liquids. Surveyor asked if she added more thickener to the liquids she prepared for him for since they were only nectar thick and staff A retrieved the cups from the table to add more thickener. However, client #4 had already consumed the cup of water. Interview on 7/1/25 with the facility's Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should have received pudding thickened liquids and client #2's muffin should have been cut into bite size pieces.	{W 460}		