STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G123	A. BUILDING _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 observations and interviews, the facility failed to ensure the right to dignity and respect relative to providing personal care affecting 1 of 6 audited clients (#20) on the B wing. The finding is: Observations in the facility on 9/16/25 from 5:15PM-6:00PM revealed client #20 to be seated in the day room on the B wing with her pants soiled. Further observations revealed client #20 to have soiled herself covering from the clients' waist to her thigh area on both legs. Continued observation at 6:00PM revealed staff to place a shirt protector around client #20's neck on top of the soiled pants. At no point during the observation did staff remove client #20 from the day room to provide personal care and change her pants. Interview with the nursing manager on 9/17/25 revealed that client #20 has a g-tube which will leak at times. Further interview with the nurse manager revealed staff should not have allowed client #20 to remain in the day room with their peers with soiled clothes for a long period of time. Continued interview verified that staff should have made nursing aware and taken client #20 to her room for personal care and putting on clean clothes.	W 125		

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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W 125	Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on 9/17/25 revealed staff have been trained to honor the dignity and respect of the clients at all times.	W 125		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, document review, and interview, the facility failed to ensure clients were afforded privacy during medication administration. This affected 2 of 6 audited clients (#9 and #17). The finding is: A. The facility failed to ensure privacy was given during the medication administration for client #9. Observation during the medication administration (C-Wing) on 9/17/25 revealed Med Tech #1 to prepare client #9's medication on top of the medication cart while standing in the hallway. Continued observation revealed the Med Teach #1 to transport client #9 to the hallway from the dayroom to administer his medications through his g-tube. Further observation revealed at no time did Med Tech #1 utilize a private screen or client #9's bedroom. Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures " to promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents	W 130		

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W 130	Continued From page 2	W 130		

should be in the most private setting allowable at the time of medication administration to allow for drug education."

Interview with the nursing manager and the qualified intellectual disabilities professional (QIDP) on 9/17/25 revealed client #9 should have been offered privacy during his medication pass.

B. The facility failed to ensure privacy was given during the medication administration for client #17.

Observation during the medication administration(B-Wing) on 9/17/25 revealed Med Tech #2 to prepare client #17's medication on top of the medication cart while standing in the hallway. Continued observation revealed Med Tech #2 to administer client #17's medication through his g-tube in the hallway while staff and other residents were passing by. Further observation revealed at no time did Med Tech #2 utilize a private screen or client #17's bedroom.

Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures " to promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."

Interview with the nursing manager and the QIDP on 9/17/25 revealed client #17 should have been offered privacy during his medication pass.

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W 340	Continued From page 3	W 340		
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, document review, and interview, the facility failed to provide nursing services in accordance with the clients' needs relative to addressing the clients' medical needs and providing drug education with the nurse/med tech for 4 of 6 audited clients (#9, #17, #20 and #24). The findings are: A. The facility failed to notify nursing of concerns with client #20's g-tube. For example: Afternoon observations in the facility on 9/16/25 from 5:15PM-6:00PM revealed client #20 to be seated in the day room on B-Wing with her pants soiled. Continued observation revealed the soiled area to cover from client #20's waist area to her thighs on both legs. Further observation revealed that at no point during the observation did staff alert nursing services to check client #20's g-tube for signs of leakage. Interview with the nursing manager on 9/17/25 revealed staff should have alerted nursing of the client's soiled pants covering from her waist to her thighs as it could have been leakage or blockage in the g-tube. Further interview with the nursing manager verified staff have been trained to alert nursing when a client's g-tube needs to be checked.	W 340		

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W 340	Continued From page 4 B. The facility failed to provide drug education during the medication administration for client #17. Observations during the medication administration(B-Wing) on 9/17/25 at 6:54 AM revealed Med Tech #2 to prepare client #17's medication on top of the medication cart while standing in the hallway with her back turned away from client #17. Continued observation revealed a staff member to transport client #17 from the hallway to the dayroom while Med Tech #2 continued to prepare the medications. Further observation revealed Med Tech #2 to transport client #17 from the dayroom back to the hallway and administered the medications through his g-tube. Additional observation revealed that at no time did Med Tech #2 inform client #17 what medications he was taking, its purpose, and by which route. Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR. Explain that the medication is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education." Interview on 9/17/25 with the nursing manager	W 340		

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W 340	Continued From page 5	W 340		

confirmed that Med Tech #2 should have provided drug education to client #17 by stating what the medication is, its purpose, and which route.

C. The facility failed to provide drug education during the medication administration for client #24.

Observations during the medication administration(B-Wing) on 9/17/25 at 7:25 AM revealed Med Tech #2 to prepare client #24's medication on top of the medication cart while standing in the hallway. Continued observation revealed client #24 was in her bedroom lying in bed. Further observation revealed Med Tech #2 to enter into client #24's bedroom and administered the medications through her g-tube. Additional observation revealed that at no time did Med Tech #2 informed client #24 what medications she was taking, its purpose, and by which route.

Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR. Explain that the medication is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."

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W 340	Continued From page 6	W 340		

Interview on 9/17/25 with the nursing manager confirmed that Med Tech #2 should have provided drug education to client #24 by stating what the medication is, its purpose, and which route.

D. The facility failed to provide drug education during the medication administration for client #9.

Observations during the medication administration(C-Wing) on 9/17/25 at 7:44 AM revealed Med Tech #1 to prepare client #9's medication on top of the medication cart while standing in the hallway. Continued observation revealed client #9 was participating in activities in the dayroom. Further observation revealed Med Tech #1 to transport client #9 from the dayroom to the hallway and administered the medications through his g-tube. Additional observation revealed that at no time did Med Tech #1 informed client #9 what medications he was taking, its purpose, and by which route.

Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR. Explain that medications is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."

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W 340	Continued From page 7 Interview on 9/17/25 with the nursing manager confirmed that Med Tech #1 should have provided drug education to client #9 by stating what the medication is, its purpose, and which route.	W 340		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review, and interview, the facility failed to ensure all drugs remained locked except when being administered on the C-Wing. The findings are: A. The facility failed to ensure medications were locked when not being administered for client #17. Observations during the medication administration (B-Wing) on 9/17/25 at 6:54 AM revealed the medication technician (Med Tech) #2 to prepare client #17's medications on top of the medication cart while standing in the hallway. Continued observation revealed Med Tech #2 to walk away leaving client #17's medications in a syringe on top of the cart while transporting client #17 from the day room back to the hallway. Further observation revealed medications to be unlocked and accessible to anyone at the facility. Interview on 9/17/25 with the nursing manager confirmed the medications and drug storage should be locked before the Med Tech leaves the area during medication administration. B. The facility failed to keep topicals and	W 382		

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W 382	Continued From page 8	W 382		

biologicals locked when not in use for client #21 on the D wing. For example:

Afternoon observations in the facility on 9/16/25 from 4:30PM-6:00PM revealed several topicals with prescription labels on the nightstand in client #21's room. Further observations at 6:00PM revealed this surveyor to alert the nursing manager that the topicals have been in client #21's room for approximately 75 minutes. Continued observations revealed the nursing manager to remove the topicals from client #21's room and secure them in the medication cart.

Interview with the nursing manager on 9/17/25 verified that topicals should be locked in the medication cart or nurses' station when they are not in use. Further interview with the nursing manager revealed staff have been trained to not allow topicals with prescription labels to remain in clients' rooms unsecured.

C. The facility failed to keep the medication cart locked when not in use on the C wing. For example:

Afternoon observations from 4:30PM-5:58PM revealed an unlocked medication cart in the hallway on the C-wing. Further observations at 6:00 PM revealed a surveyor to alert the qualified intellectual disabilities professional (QIDP) that the medication cart has remained unlocked for a significant period of time.

Interview with the nursing manager and QIDP on 9/17/25 revealed med tech staff should have ensured the medication cart was secured as soon as they stepped away from the cart. Further interview with the nursing manager verified

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W 382	Continued From page 9 medication technician staff have been trained to keep the medication cart double locked when it is not in use.	W 382		