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W 000	INITIAL COMMENTS A revisit was conducted on 9/26/25 for deficienicies cited on 7/21 - 7/22/25. Five deficiencies were corrected, two deficiencies were recited and two new deficiencies were also cited. The facility remains out of compliance.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure sufficient direct care staff were provided to supervise clients in accordance with their Individual Program Plans (IPP). This affected all clients residing in the home, specifically client #13. The finding is: During morning observations in the home on 9/26/25 from 8:31am - 9:01am, two direct care staff and the Habilitation Coordinator (HC) worked in the home with fifteen clients present, including client #13, who required a one-on-one staff person. Another direct care staff did not arrive in the home until 9:45am. At 9:45am, three direct care staff and one HC were working in the home for a total of four direct care personnel. Throughout the observations from 8:31am - 10:00am, client #13 did not have an assigned one-on-one staff person. Various staff provided verbal and physical prompts and/or followed the	W 186		

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

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client throughout the home and outside. No specific staff wore a lanyard to identify their direct responsibility and/or supervision for the client.

Interview on 9/26/25 with Staff F revealed the minimum of direct care staff working in the home should be five. She noted they rarely have five direct care staff working in the home, especially on the weekends. The staff also indicated client #13 requires a one-on-one staff person due to his behaviors. Staff F added, "This is the reality we have to deal with everyday."

Review on 9/26/25 of client #13's IPP dated 8/19/25 revealed, "A one-on-one program was implemented during the past service year to ensure [Client #13's] safety and well-being as well as increase his qualify of life...His behavior goal and one-on-one program will continue for the upcoming year with priority status." Additional review of client #13's Behavior Intervention Program (BIP) implemented 2/23/25 revealed an objective to reduce the frequency of maladaptive behavior episodes to 28 or fewer per month for 10 out of 12 months. Further review of the BIP revealed behaviors of aggression, self-injurious behavior, property destruction and elopement. The plan further noted, "A staff member will be assigned to keep [Client #13] within their sight. The staff member will denoted by wearing a specified lanyard. When staff are wearing this lanyard, they are responsible for being able to see [Client #13] and knowing his whereabouts...The person who has responsibility for keeping [Client #13's] supervision at shift change must communicate with the oncoming shift as to who will be taking over this responsibility and hand over the lanyard. Responsibility of supervision has not changed

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until the lanyard has been handed over to the receiving staff member...Note: [Client #13] has an identified one-on-one staff during all hours. The identified one-on-one staff may only engage with [Client #13] when wearing the lanyard and assigned to work with [Client #13]. Responsibilty of supervision has not changed until the lanyard has been handed over to the receiving staff member"

Interview on 9/26/25 with the HC confirmed the facility requires a minimum of five direct care staff working in the home during awake hours to provide care and supervision of the 15 clients, including client #13 who requires one-on-one supervision per his BIP. Additional interview revealed three staff were scheduled to work first shift but two had called out and one staff had an emergency. The HC acknowledged the three third shift staff should have continued to work into first shift as "hold over" staff; however, they had other jobs to go to.

Review on 9/26/25 of the facility's Staff Coverage policy (#3027) revealed, "There shall be staff coverage adequate to meet minimum licensing requirements at all times...The director of the facility or QP of the caseload or on-call staff of afterhours shall be responsible for assuring adequate staff coverage." Additional review of the policy did not include any information regarding "hold over" staffing or minimum staff to client ratios.

During an interview on 9/26/25, the Vice President of Operations (VPO) acknowledged a minimum of five direct care staff should be working in the home and this job should be the priority for staff who need to continue working in

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W 186	Continued From page 3 the home until a replacement can be obtained. Additional interview confirmed the facility's current Staff Coverage policy does not provide specific information and/or procedures for "hold over" or minimum staffing when a callout occurs. The VPO confirmed client #13 continues to require an assigned one-on-one staff per his BIP.	W 186		
{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 reviews and interviews, the facility 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) in the areas of dining guidelines and adaptive equipment use. This affected 3 of 8 audit clients (#4, #5 and #9). A. During 3 of 3 mealtime observations in the home on 7/21 - 7/22/25, client #4's mealtime guidelines were not followed. For example, during lunch on 7/21/25 at 12:27pm, client #4 consumed his meal using an adaptive built-up handle spoon, elevated plate platform, high-sided plate and regular cups. No non-skid mat was utilized. At the	{W 249}		

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meal, the client was not provided any prompts for drinking or rate of eating. During dinner observations on 7/21/25 at 6:15pm, client #4 utilized the same adaptive dining equipment, including a non-skid mat. During the meal, client #4 was not provided prompts to drink or rest his spoon. Additional breakfast observations on 7/22/25 revealed the same adaptive dining equipment noted at lunch. The client was given his cups of liquid twice, near the middle of the meal and at the end. Staff D was also noted to feed client #4 his food during the latter portion of the meal.

Interview on 7/22/25 with Staff D revealed client #4 can feed himself; however, he needs help getting food from the corners of his plate at times. The staff indicated there were no specific guidelines for client #4 at meals. Additional interview noted he also requires adaptive equipment at meals such as his elevated platform, built-up spoon and non-skid mat.

Review on 7/21/25 of client #4's IPP dated 11/19/24 revealed Mealtime Guidelines (revised 2/8/21). The guidelines noted, "[Client #4] eats independently with some spillage using adaptive feeding equipment...Staff will monitor the amount of food placed on his spoon to prevent over heaping his spoon. [Client #4] will be prompted to rest his spoon on the table between bites to provide him with adequate time to chew his food thoroughly...[Client #4] will be encouraged to take sips of his beverage spaced evenly throughout the meal." Additional review of the IPP indicated the client uses a built-up handle spoon, high walled plate, elevated plate platform and dycem or non-skid mat at meals.

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Interview on 7/22/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's mealtime guidelines are current and should be followed at meals as indicated.

B. During observations in the home throughout the survey on 7/21 - 7/22/25, client #9 intermittently wore a gait belt secured around her waist. During evening observations on 7/21/25, Staff E applied the client's gait belt, stood her up and transferred her from her wheelchair to a chair or walked with the client short distances in the room. Additional observations revealed the staff did not utilize client #9's gait belt while transferring and walking. During morning observations in the home on 7/22/25, Staff C walked client #9 from the dining room table to a rocking chair approximately 15 - 20 away. During this time, client #9 did not wear a gait belt.

During an interview on 7/21/25, when asked about client #9's gait belt and it's use, Staff E stated, "They say she has to have it on" to get her from "seat to seat". Additional interview indicated she did not think the gait belt was used when client #9 is walking.

Review on 7/22/25 of client #9's IPP dated 5/20/25 indicated client #9 is unable to ambulate independently. The IPP noted, "[Client #9] ambulates safely with hand-held assistance using a gait belt for short distances...[Client #9] has identified as a mild to moderate fall risk." Additional review of the client's Ambulation Guidelines (implemented 7/31/24) revealed, "...1)When [Client #9] gets up to ambulate short distances a staff will apply a gait belt...2) Staff should assist [Client #9] by allowing her to hold onto their hand when walking 3) Staff should also

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{W 249}	Continued From page 6 hold onto her gait belt when walking to provide extra support..." Interview on 7/22/25 with the QIDP confirmed client #9's Ambulation Guidelines should continue to be followed as written. C. During breakfast observations in the home on 7/22/25 at 8:32am, client #5 picked up her sausage patty with her fingers and took a bite. Staff B stated, "Do you want to use your rocker knife?" Client #5 continued to bite the sausage patty using her fingers. Further observations revealed the rocker knife was at client #5's place setting. At no time was client #5 given any other cues to use her rocker knife. During an interview on 7/22/25, Staff B stated staff are to use verbal cues to instruct client #5 to use her rocker knife for cutting. Review on 7/21/25 of client #5's IPP dated 10/29/24 revealed she uses a rocker knife for cutting. Review on 7/22/25 of client #5's meal time guidelines revised 5/10/11 stated, "...will use a rocker knife during meals to cut up her food...any meat or food item that is too large for a single bite size should be cut with her rocker knife. If she needs assistance, staff will use training techniques - gesture, prompt or manipulation to get her to cut her food item with the rocker knife...." During an interview on 7/22/25, the QIDP stated staff are to use teaching cues with client #5 to assist her to use her rocker knife. to cut her food.	{W 249}		

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D. During the follow-up on 9/26/25 at 9:30am, client #5 assisted to serve herself whole toast sliced in half, cereal and a whole boiled egg. The client utilized a spoon to break apart the boiled egg as no rocker knife was available for use at the breakfast meal.

Interview on 9/26/25 with the Habilitation Coordinator confirmed client #5 continues to utilize a rocker knife at meals.

E. During the follow-up on 9/26/25 from 8:31am - 10:00am, client #13 did not have an assisgned one-on-one staff. Various staff provided verbal and physical prompts and/or followed the client throughout the home and outside. No specific staff wore a lanyard to identify their repsonsibility and supervision for the client.

Interview on 9/26/25 with Staff F revealed client #13 requires a one-on-one staff during the day.

Review on 9/26/25 of client #13's Behavior Intervention Program (BIP) implemented 2/23/25 revealed an objective to reduce the frequency of maladaptive behavior episodes to 28 or fewer per month for 10 out of 12 months. Additional review of the BIP revealed behaviors of aggression, self-injurious behavior, property destruction and elopement. The plan further noted, "A staff member will be assigned to keep [Client #13] within their sight. The staff member will denoted by wearing a specified lanyard. When staff are wearing this lanyard, they are responsible for being able to see [Client #13] and knowing his whereabouts...The person who has responsibility for keeping [Client #13's] supervision at shift change must commuicate with the oncoming shift as to who will be taking over this responsibility

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{W 249}	Continued From page 8 and hand over the lanyard. Responisibility of supervision has not changed until the lanyard has been handed over to the receiving staff member...Note: [Client #13] has an identified one-on-one staff during all hours. The identified one-on-one staff may only engage with [Client #13] when wearing the lanyard and assigned to work with [Client #13]. Responsibilty of supervision has not changed until the lanyard has been handed over to the receiving staff member." Interview on 9/26/25 with the Habilitation Coordinator (HC) confirmed client #13 should have an assisgned one-on-one staff person who should be wearing a specific lanyard to identify their responsibility for him. Interview on 9/26/25 with the Vice President of Operations (VPO) confirmed client #13 continues to require a one-on-one staff person per his BIP.	{W 249}		
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 are administered without error. This affected 1 of 2 clients (#1 and #2) observed receiving medications. The finding is: During observations of medication administration in the home on 9/26/25 at 7:39am, client #2 ingested thirteen medications in pill form as dispensed by the Medication Technician (MT). The client consumed the pills in applesauce	W 369		

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W 369	Continued From page 9 followed by a glass of juice. No other medications were administered during this time. Review on 9/26/25 of client #2's physician's orders (dated 8/1/25 - 10/31/25) signed 8/1/25 revealed an order for Peg 3350 powder, mix 17 gms, 1 capful in 8 oz of suitable liquid and take by mouth three times weekly Monday, Wednesday, Friday at 8am. Interview on 9/26/25 with the MT and the Regional Nursing Director confirmed client #2 should have received the Peg 3350 powder or Miralax at the 8:00 medication pass as indicated.	W 369		
{W 454}	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure a sanitary environment was maintained. The finding is: During observations in the home on 7/21/25 at 11:41am, client #1's shorts were noted to be wet. Staff B took the client out of the day room to be changed. As the client left the area, the chair he was sitting in was visibly wet with urine. At 11:44am, another staff noticed the urine on the seat and verbalized that client #1 must have had a toileting accident. At 11:48am, client #1 returned to the day room with Staff B and proceeded to sit on the urine soaked chair. At 11:53am, client #1 pushed the urine soaked chair to the dining room table and left it there. The	{W 454}		

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{W 454}	Continued From page 10	{W 454}		

client then sat in a different chair in the day room while wearing the same pants, now with urine on them. Throughout the observations, the urine soaked chairs were not cleaned and/or sanitized.

Interview on 7/22/25 with Staff B revealed they generally do cleaning tasks after meals and third shift does heavy cleaning. Additional interview with the staff indicated if something gets soiled or dirty during the shift, they clean it immediately.

Review on 7/22/25 of the facility's policy for Environmental Cleaning and Disinfection (Revised 8/9/23) revealed, "When visibly soiled by a client's body fluids, all surfaces (chairs, tabletops, floors or whatever applicable) will be cleaned and disinfected immediately."

Interview on 7/22/25 with the Qualified Intellectual Disabilites Professional (QIDP) confirmed the urine soaked chairs should have been cleaned immediately by staff.

During the follow-up on 9/26/25 at 7:12am, client #1's pants were noted to be wet as Staff A took him out of the day room and to his bedroom to be changed. Closer observation of the chair the client was seated in revealed it was wet with urine. At 7:17am, client #1 was returned to the day room and seated in the same chair urine soaked chair. During additional observations in the day room at 8:36am, client #1 left the room undetected and proceeded to his bedroom. The client's pants were noted to be wet with urine. After changing his pants on his own, at 8:39am, client #1 returned to the day room and sat in the same urine soaked chair. During both observations, the chairs containing urine were not cleaned or sanitized after the toileting accidents

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{W 454}	Continued From page 11 occurred. Interview on 9/26/25 with Staff A revealed chairs should be cleaned after accidents happen on them. Interview on 9/26/25 with the Vice President of Operations (VPO) confirmed the facility's Environmental Cleaning and Disinfection Policy remains unchanged and should continue to be followed.	{W 454}		