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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 interview, the facility failed to ensure that 5 of 5 clients (#1, #2, #3, #4, and #5) were given opportunities for choice and self-management with respect to family-style dining. The finding is: Observations in the group home during the dinner meal on 2/9/26 and during the breakfast meal on 2/10/26 revealed staff to prepare all clients' plates in the kitchen, without input from any of the clients regarding food choice, then to direct each client to take their plate to the dining room table. Continued observation revealed that each client was served the same meal of ground beef, Spanish rice, mixed vegetables and flour tortillas. Further observation revealed all clients to be capable of serving themselves and passing dishes to each other with independence or assistance from staff. Record review on 2/10/26 revealed person-centered plans (PCPs), goals and clinical assessments for each client. Continued record review revealed all clients to have at least some level of independence during self-care, home management and mealtime activities. Review of the record for client #4 revealed a PCP dated 12/18/25 which indicates that client #4 demonstrates food-seeking behaviors which are not conducive to passing common bowls of food at the table. Interview with the qualified intellectual disabilities	W 247		

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

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W 247	Continued From page 1 professional (QIDP) on 2/10/26 revealed that any modifications to a client's opportunity to participate in family-style dining should be incorporated into the client's PCP and that clients who are capable should be allowed to participate in family-style dining and to make choices regarding their meals.	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 reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan for 3 of 5 clients (#3, #4, and #5) relative to implementing training objectives and providing adaptive equipment. The findings are: A. The facility failed to provide necessary training to address an identified need for client #3. For example: Observations in the group home on 2/9/26 at 5:15 PM revealed the dinner meal to be ground beef, Spanish rice, mixed vegetables and flour tortillas.	W 249		

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W 249	Continued From page 2 Continued observations revealed staff to set client #3's place at the table with a regular plate, cup and spoon, but no fork or knife. Further observation revealed client #3 to consume the entire meal independently using the spoon. Observations in the group home on 2/10/26 at 7:30 AM revealed the breakfast meal to be cheese grits, sausage links, fruit and coffee. Continued observations revealed staff to set client #3's place at the table with a regular plate, cup and spoon, but no fork or knife. Further observation revealed client #3 to consume the entire meal independently using the spoon. Record review on 2/10/26 revealed an adaptive behavior inventory (ABI) for client #3 dated 9/30/25 which indicates client #1 is unable to independently the use a fork, knife or spoon and further indicates that these skills represent a need which should be addressed for client #3. Continued record review revealed a person-centered plan (PCP) for client #3 dated 10/2/25 which lists the following goals: identify coins, wipe table, communication skills, work behaviors, put dishes in sink, fold shirt, name/print letters of the alphabet, toileting and washing hands. Interview with the qualified intellectual disabilities professional (QIDP) on 2/10/26 confirmed that client #3's ABI indicates the need for client #3 to have formal training in the independent use of all appropriate eating utensils and that he does not currently have a training goal in that area. Further interview with the QIDP confirmed that the facility should address this identified need with an appropriate training goal.	W 249		

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W 249	Continued From page 3 B. The facility failed to implement training objectives for client # 4 during large amounts of unstructured leisure time. For example: Afternoon observations on 2/9/26 revealed client #4 to spend 135 minutes of unstructured time sitting on a couch in the living room, wandering around the group home, participating in the evening meal and taking his dishes from the dining room to the kitchen. During this interval, staff directed client #4 to sit on the couch at least 6 times, but did not offer client #4 any other interaction or activity. Morning observations on 2/10/26 between 6:30 AM and 8:00 AM revealed client #4 to get out of bed, get dressed, receive medications, participate in the breakfast meal, move his dishes to the sink, and wander around the home. At one point, client #4 entered the kitchen where staff were cleaning up and was immediately redirected out of the kitchen with no direction toward another activity. The only other interaction staff had with client #4 was centered on completing necessary self-care. Record review on 2/10/26 revealed a PCP for client #4 dated 12/18/25. The PCP notes that client #4 enjoys interacting with others, being able to roam while monitored, watching cartoons, listening to music, going for walks and participating in activities. Interview with the QIDP on 2/10/26 confirmed that client #4's PCP is current and that staff should have provided client #4 choices of activities during leisure time. C. The facility failed to provide prescribed	W 249		

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W 249	Continued From page 4	W 249		

adaptive equipment for client #5. For example:

Observations in the home on 2/9/26 and 2/10/26 revealed one shower chair present in the home. Further observations revealed the shower chair has no seat belt attached and no seat belt could be seen in the bathroom where the chair is located.

Record review on 2/10/26 revealed a PCP for client #5 dated 9/4/25 which states that client #5 is diagnosed with a seizure disorder and details all precautions needed to keep him safe in the event of a seizure. One required precaution is that client #5 utilizes a shower chair with belt to ensure his health and safety in the shower.

Interview with the direct care supervisor (DCS) on 2/10/26 revealed she has not used a belt while assisting client #5 with showering and she is not aware that a belt has ever been present in the home while she has been employed there.

Interview with the QIDP on 2/10/26 confirmed that client #5's PCP indicates the need for a shower chair with belt to ensure his safety while showering and that the facility should provide an appropriate belt.

D. The facility failed to implement needed safety precautions for client #5 relative to ambulation. For example:

Observations in the home on 2/9/26 and 2/10/26 revealed client #5 to be wearing a drop harness. Further observation on 2/9/26 revealed staff to accompany client #5 while he was out of his chair by standing within arms reach and holding onto the harness. Continued observation on 2/10/26

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W 249	Continued From page 5 revealed staff to instruct client #5 to walk to the dining room and when he had finished his breakfast, to take his dishes to the kitchen, but staff did not walk with client #5 or offer an stand-by assistance. Subsequent observations revealed client #5 to walk from the living room to the dining room, then to the kitchen and back to the living room without assistance from staff. Record review on 2/10/26 revealed a physical therapy evaluation dated 8/8/25 which recommends, "Continue assistance PRN for ADL's, daily wear drop harness contact guard +1 staff during standing activities (ie, standing, transfers, ambulation, etc.) Interview with the QIDP on 2/10/26 confirmed that client #5's plan indicates the need for contact guard assistance while client #5 is engaged in standing activities and that client #5 should have been provided with appropriate assistance to ensure his health and safety.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 5 of 5 audited clients (#1, #2, #3 #4 and #5). The findings are:	W 262		

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W 262	Continued From page 6 A. The facility failed to ensure restrictive techniques were monitored and reviewed annually. For example: Observations throughout the recertification survey period from 2/9/26 - 2/10/26 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by one client. Review of client records on 2/10/26 revealed no evidence that the Human Rights Committee (HRC) had reviewed, consented to, or monitored the locked refrigerator and pantry for any of the 5 clients. Interview with the qualified intellectual disabilities professional (QIDP) on 2/10/26 revealed that signed consent forms regarding the locked refrigerator and pantry could not be located during the survey. Continued interview with the (QIDP) verified HRC rights limitation consent forms for all clients should be updated and signed by the HRC annually. B. The facility failed to ensure that client #3's restrictive techniques were monitored and reviewed annually. For example: Observations throughout the recertification survey period from 2/9/26 - 2/10/26 revealed an audio-visual monitor to be present and turned on in client 3#'s bedroom. The monitor receiver was located in the living room of the home and visible by anyone in the room. Review of client #3's record on 2/10/26 revealed a person-centered plan (PCP) dated 10/2/25 which states the video monitor is necessary for client #3's safety due to the risk of client #3 falling	W 262		

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W 262	Continued From page 7 while getting in and out of bed. Continued record review revealed no evidence that the HRC had reviewed, consented to, or monitored the use of the video monitor annually, as required. Interview with the QIDP on 2/10/26 revealed that signed consent forms could not be located during the survey. Continued interview with the QIDP verified HRC rights limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the court appointed guardians for 4 of 5 surveyed clients (#1, #2, #3 and #5). The findings are: A. Observations throughout the recertification survey period from 2/9/26 - 2/10/26 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by one client. Review of client records on 2/10/26 revealed no evidence that the duly appointed guardians of clients #1, #2, #3 or #5 had been advised of or consented to the locked refrigerator and pantry. Interview with the qualified intellectual disabilities professional (QIDP) on 2/10/26 revealed that	W 263		

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W 263	Continued From page 8 signed consent forms for clients #1, #2, #3 and #5 regarding the locked refrigerator and pantry could not be located during the survey. Continued interview with the (QIDP) verified that guardians must be advised of and consent to all restrictions of rights prior to the restrictions being implemented. B. Observations throughout the recertification survey period from 2/9/26 - 2/10/26 revealed an audio-visual monitor to be present and turned on in client 3#'s bedroom. The monitor receiver was located in the living room of the home and visible by anyone in the room. Review of client #3's record on 2/10/26 revealed a person-centered plan (PCP) dated 10/2/25 which states the video monitor is necessary for client #3's safety due to the risk of client #3 falling while getting in and out of bed. Continued record review revealed no evidence that client #3's guardian had been advised of nor consented to the use of the video monitor, as required. Interview with the QIDP on 2/10/26 revealed that a signed consent form could not be located during the survey. Continued interview with the QIDP verified that guardians must be advised of and consent in writing to all restrictions of clients' rights.	W 263		
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	W 368		

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W 368	Continued From page 9 interviews, the facility failed to ensure that all medications were administered in accordance with physicians' orders. The finding is: Morning observations in the group home revealed client #1 to enter the medication room at 7:15 AM along with staff A. Continued observations revealed staff A to prepare the following medications for client #1: Escitalopram 10mg, Benztropine .5mg, Quetiapine 400mg, Lithium carb 150mg, Senna-Time 17.2mg, Citracal, Levothyroxine 125mcg, PEG 3350 powder, Ensure, Ciclopirox, ammonium lactate. Further observation revealed all pills and capsules, including the Levothyroxine, to be placed in a single cup and swallowed by the client at 7:25 AM. Continued observation revealed client #1 to leave the medication room and go directly to the dining room table, where she began eating her breakfast at 7:38 AM. Review of records revealed a physician's order dated 7/2/24 which states, "LEVOTHYROXIN TAB 125mcg - TAKE 1 TABLET EVERY MORNING FOR HYPOTHYROIDISM (TAKE 30 MINUTES BEFORE BREAKFAST OR OTHER MEDICATIONS) Schedule: DAILY AT 07:30." Interview with the facility nurse on 2/10/26 confirmed the physician's order is current and that the Levothyroxine should have been administered to client #1 at least 30 minutes prior to administering her other medications and breakfast and that it was a medication error to administer it along with the other medications and 13 minutes before breakfast.	W 368		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 440		

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W 440	Continued From page 10 at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: Review of the facility's fire drill reports on 2/9/26 revealed a total of five missing fire drills on various shifts and quarters, to include: 1st quarter: 1st shift and 3rd shift 2nd quarter: 1st shift, 2nd shift and 3rd shift Interview with the qualified intellectual disabilities professional (QIDP) on 2/10/26 confirmed that the facility did not conduct fire drills during the months of March, April, May, June and July, 2025. Continued interview with the QIDP confirmed that fire drills should have been conducted quarterly for each shift of personnel.	W 440		
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 review, and interview, the facility failed to ensure that meals were served with appropriate utensils for 2 of 5 clients (#1, #5) to eat as independently as possible according to their highest functioning level. The findings are: Observations in the group home on 2/9/26 at 5:15 PM revealed the dinner meal to be ground beef, Spanish rice, mixed vegetables and flour tortillas. Continued observations revealed staff to set	W 475		

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W 475	Continued From page 11 client #1's place and client #5's place at the table with a regular plate, cup and spoon, but no fork or knife. Observations in the group home on 2/10/26 at 7:30 AM revealed the breakfast meal to be cheese grits, sausage links, fruit and coffee. Continued observations revealed staff to set client #1's place and client #5's place at the table with a regular plate, cup and spoon, but no fork or knife. Record review on 2/10/26 revealed an adaptive behavior inventory (ABI) for client #1 dated 10/9/24 which indicates client #1 is fully independent in the use of a fork, knife and spoon. Record review on 2/10/26 revealed an ABI for client #5 dated 11/16/15 which indicates client #5 is fully independent in the use of a fork, knife and spoon. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that the ABIs reviewed are the most current available and that, based on the information contained therein, the clients should have been provided with a full set of regular utensils during mealtimes.	W 475		