DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/12/19 through 02/14/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 026		

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

Acting Clinical Director — 3/1/2019

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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E 026	Continued From page 1 Facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. On 02/14/17 at 11:05 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, acting program manager and ASM # 2, acting clinical director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 2 stated that the facility did not have it. On 02/14/19 at 11:30 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit.	E 026	E026 Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) To correct and insure no individuals and staff are effected in the future the Lake Jackson Drive Group Home Emergency Preparedness Plan will be reviewed and modified for compliance to facility role under a waiver declared by the Secretary, in accordance with 1135 of the Act with care and treatment of Lake Jackson Group Home individuals at an alternate site. A training will occur at the March Lake Jackson Drive Group Home team meeting to review the content of the additional procedures related to care and treatment at an alternative site. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis. The Clinical Director will ensure and monitor all new and existing program staff are trained on the emergency preparedness plan by reviewing the staff training sign in sheets.	3/30/19
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.	E 033		

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E 033	Continued From page 2 (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and	E 033	E033 Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) The program specific communication plan for Lake Jackson Group Home will be further modified to include detailed information with regards to how the Lake Jackson Drive Group Home shares general status and medical information while maintaining confidentiality Program specific information on the portability of medical information in case of evacuation and a means of providing information about the general condition and location of the individuals. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis. Included in this review will be any E tag citations from the previous year from all Intermediate Care Facilities that Community Residences provides services in to provide comprehensive review of Lake Jackson Group Home Emergency Plan	3/30/19

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E 033	Continued From page 3 documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. On 02/14/19 at 11:05 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, acting program manager and ASM # 2, acting clinical director. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 2 stated that the facility did not have it. On 02/14/19 at 11:30 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit.	E 033		
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/ID Health Care Certification survey was conducted 02/12/19 through 02/14/19. The facility was not in compliance with 42 CFR Part 483 Requirements	W 000		

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W 000	Continued From page 4 for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this five bed facility was five at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals #1, #2 and # 3).	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on residential program record reviews, day program record review and staff interview, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the individuals' active treatment programs for three of three individuals in the survey sample, Individuals # 1, # 2, and # 3. 1a. The QIDP failed to ensure Individual # 1's PCP (person-centered plan) outcomes/goals for community integration at (Name of Group Home) was developed in measurable terms. 1b. The QIDP failed to ensure the data collection of Individual # 1's PCP (person-centered plan) outcome/goal of medication management; stress management and community integration at (Name of Group Home) was in measurable terms. 1c. The QIDP failed to ensure Individual # 1's PCP (person-centered plan) outcomes/goals of	W 159	W159: QIDP CFR:483.430 The QIDP will revise Individual # 1's "Community Integration" outcomes into measurable terms The QIDP will revise Individuals #2's "Community Integration and Self Help" outcomes into measurable terms The QIDP will revise Individuals # 3's " Community Integration, Daily Living Skills/ self Help" outcomes into measurable terms The Program Manager will update the PCPs to incorporate these changes for those individuals The Program Manager will complete this process for all the individuals to prevent further deficiencies The Program Manager will continue to monitor to ensure that all service needs of individuals are accurately reflected through the use of weekly operations meetings The Clinical Director will review within supervision with the Program Manager for documentation to support the coordination of services for each individual needs.	3/26/19

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W 159	Continued From page 5 medication management, stress management and community integration were implemented. 2a. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help at (Name of Group Home) were developed in measurable terms. 2b. The QIDP failed to ensure the data collection of Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help, medication management, money management and exercise/recreation at (Name of Group Home) was in measurable terms. 2c. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) was developed in measurable terms. 2d. The QIDP failed to ensure the data collection of Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) was in measurable terms. 2e. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcomes/goals for self-help and medication management, and exercise/recreation at (Name of Group Home) were implemented. 2f. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) were implemented. 3a. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcomes/goals for	W 159	The QIDP will revise Individuals # 1's " Medication Management, Stress Management and Community integration" outcomes into measurable terms to collect appropriate data. The QIDP will revise Individuals # 2's " Community Integration,Self Help, Medication Management, Money Management, and Exercise/Recreation" outcomes into measurable terms to collect appropriate data. The QIDP will revise Individuals # 3's "Community Integration,Sensory stimulation, Activities of Daily Living/Self-Help Skills, and Money Management" outcomes into measurable terms to collect appropriate data. The Program Manager will update the PCPs to incorporate these changes for those individuals The Program Manager will complete this process for all the individuals to prevent further deficiencies The Program Manager will continue to monitor to ensure that all service needs of individuals are accurately reflected through the use of weekly operations meetings The Clinical Director will review within supervision with the Program Manager for documentation to support the coordination of services for each individual needs.	3/26/19

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W 159	Continued From page 6 community integration and activities of daily living/self-help skills at (Name of Group Home) were developed in measurable terms. 3b. The QIDP failed to ensure the data collection of Individual # 3's PCP (person-centered plan) outcomes/goals for community integration, sensory stimulation, activities of daily living/self-help skills and money management at (Name of Group Home) was in measurable terms. 3c. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills at (Name of Day Program) were developed in measurable terms. 3d. The QIDP failed to ensure the data collection of Individual # 3's PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills at (Name of Day Program) was in measurable terms. 3e. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and activities of daily living/self-help skills at (Name of Group Home) were implemented. 3f. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program) was implemented. The findings include:	W 159	The QIDP will revise Individual #1's PCP outcomes that addresses "Medication Management, Stress Management and Community Integration", Individual #2's "Self-Help, Medication Management and Exercise/ Recreation" outcomes and Individual #3's "Sensory Stimulation and Activities of Daily Living/Self-Help Skills" outcomes and update these outcomes to ensure that they accurately reflect the needs of Individuals #1, #2 and # 3. The Program Manager / QIDP will review all individuals outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager will provide the training to all the staff to review all individuals PCPs during the next staff meeting. The Program Manager will provide supervision to all staff and ensure that the PCPs accurately reflect the individuals needs and are implemented appropriately. The QIDP will conduct monthly assessments to ensure that all services and needs are met and are accurately reflect on monthly QIDP notes. The Clinical Director will review within supervision with the Program Manager the documentation to support the coordination of services for each individual.	3/26/19

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W 159	Continued From page 7 1a. The QIDP failed to ensure Individual # 1's PCP (person-centered plan) outcomes/goals for community integration at (Name of Group Home) was developed in measurable terms. Individual # 1 was a 75 year-old female, who was admitted to (Name of Group Home) on 01/24/03. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), cerebral palsy (2), hypertension (3), neurogenic bladder (4) and edema (5). Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented, "Desired Outcome: # 6. It is important for (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019. Support Activity: (Individual #1) chooses activities or places of interest at least two times a month until 02/28/2019. Support Instructions: A) (Individual # 1) is informed of activities out in the community. B) (Individual # 1) is present with options of activities in the community. C) (Individual # 1) participates in the activities when in the community." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked who the QIDP was for (Name of Group Home), ASM # 1 stated that she was one of the QIDPs. When asked to describe the responsibilities of the QIDP, ASM # 1 stated, "They are part of the IDT (interdisciplinary team), assess individuals to determine their wants and	W 159	The Day Program Manager will revise Individual # 2's PCP outcomes of "Community Integration" into measurable terms The Day Program Manager will revise Individual # 3's PCP outcomes of "Communication Skills,Community and Interest, Sensory Stimulation and Activities of Daily Living Skills" into measurable terms The Program Manager and/ or QIDP will review and revise day program PCPs for all the other individuals to ensure that they are in measurable terms The Program Manager/QIDP will conduct monthly observations and record reviews to ensure that outcomes are in measurable terms and report on these in monthly QIDP notes. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

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W 159	Continued From page 8 needs, how to support and implement the PCP (person-centered plan), check documentation including the progress notes and make sure the programs are implemented at the day program and the group home. They write monthly and quarterly reviews and whether the goals were met or not." When asked how often the QIDP visits the day program, ASM # 1 stated, "Once a month and as needed if something comes up." When asked how often the progress notes are reviewed at the day program and the group home, ASM # 1 stated, "At the day program it is done monthly during the visit and at the group home it should be done daily." When asked how often the PCP was reviewed by the QIDP, ASM #1 stated, "Monthly during the visit and as needed and at the group home it is done at the time the PCP is developed." After ASM # 1 reviewed Individual # 1's outcome for community integration, ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult	W 159	The Day Program Manager will revise Individual # 2's PCP outcomes of "Community Integration" into measurable terms to collect appropriate data The Day Program Manager will revise Individual # 3's PCP outcomes of "Communication Skills,Community and Interest, Sensory Stimulation and Activities of Daily Living Skills" into measurable terms to collect appropriate data The Program Manager and/ or QIDP will review and revise day program PCPs for all the other individuals to ensure that data is being collected in measurable terms The Program Manager/QIDP will conduct monthly observations and record reviews to ensure that outcome data are collected in measurable terms and report on these in monthly QIDP notes. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

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W 159	Continued From page 9 responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. (5) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. 1b. The QIDP failed to ensure the data collection of Individual # 1's PCP (person-centered plan) outcome/goal of medication management; stress management and community integration at (Name of Group Home) was in measurable terms. Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented, "Desired Outcome: Need # 4: Medication Management. Goal # 4: It is	W 159	The Day Program Manager will review Individual #2's "Community Integration" outcome and Individual #3's" Activities of Daily Living Skills" outcome and update these outcomes to ensure that they accurately reflect the needs of Individuals #2 and # 3. The Program Manager / QIDP will review all individuals day program outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager /QIDP will complete monthly observations at the day program to ensure that the individuals outcomes are being properly implemented. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

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W 159	Continued From page 10 important for (Individual # 1) to know the use of her thermometer, at least 5 (five) out of 7 (seven) times a week (71.43%) until 02/28/2019." "Desired Outcome: Need # 6: Community Integration. Goal # 6: It is important for (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 failed to evidence data collection of the outcomes of medication management and community integration in measurable terms. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 1's data collection for medication management and community integration, ASM # 1 was asked if the data was in measureable terms. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 1c. The QIDP failed to ensure Individual # 1's PCP (person-centered plan) outcomes/goals of medication management, stress management and community integration were implemented.	W 159		

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W 159	Continued From page 11 Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented, "Desired Outcome: Need # 4: Medication Management. Goal # 4: It is important for (Individual # 1) to know the use of her thermometer, at least 5 (five) out of 7 (seven) times a week (71.43%) until 02/28/2019." "Desired Outcome: Need # 5: Stress Management. Goal # 5: (Individual # 1) is assisted with calming down herself, every time she has [sic] ran emotional outburst 100% of the time until 02/28/2019." "Desired Outcome: Need # 6: Community Integration. Goal # 6: It is important for (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 4, medication management in 27 of 31 opportunities, outcome # 5, stress management for one of one opportunities and outcome # 6 community integration for two of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 1's data collection for medication management, stress management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No."	W 159		

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W 159	Continued From page 12 On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 2a. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help at (Name of Group Home) were developed in measurable terms. Individual # 2 was a 64 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6). Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented, "Desired Outcome: Need # 1: Community Integration. Goal # 1: (Individual # 2) interacts with others in the community, while engaging in preferred activities or events to increase social skills at 50% of the time at least twice every month until 7/31/2019. Support Activity: (Individual # 2) participates in a variety of social activities or events to increase social skills at 50% of the time at least twice every month until 7/31/2019. Support Instructions: A) Preferred activities can include but are not limited to: the library, museums, bowling, artworks or art shows. B) Research events or activities which may be of interest to (Individual # 2). C) Offer (Individual # 2) different outings to choose from. D) Have	W 159		

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W 159	Continued From page 13 (Individual # 2) choose and identify an activity of interest. E) When in the community support and supervise (Individual # 2) for his safety. F) Praise (Individual # 2) for his participation." "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019. Support Activity: Staff total [sic] supported (Individual # 2) with his activities of daily living 7 (seven) out of 7 days per week 100% of the time until 7/31/2019. Support Instructions: A) (Individual # 2) is reminded when it is time for his ADLs (activities of daily living). B) (Individual # 2). Is supported by staff in completing his activities of daily living. C) (Individual # 2) is given an extended assist (assistance) when needed. D) Have (Individual # 2) is praised for doing a good job." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked who the QIDP was for (Name of Group Home), ASM # 1 stated that she was one of the QIDPs. When asked to describe the responsibilities of the QIDP, ASM #1 stated, "They are part of the IDT (interdisciplinary team), assess individuals to determine their wants and needs, how to support and implement the PCP (person-centered plan), check documentation including the progress notes and make sure the programs are implemented at the day program and the group home. They write monthly and quarterly reviews and whether the goals were met	W 159		

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W 159	Continued From page 14 or not." When asked how often the QIDP visits the day program, ASM # 1 stated, "Once a month and as needed if something comes up." When asked how often the progress notes are reviewed at the day program and the group home, ASM # 1 stated, "At the day program it is done monthly during the visit and at the group home it should be done daily." When asked how often the PCP was reviewed by the QIDP, ASM #1 stated, "Monthly during the visit and as needed and at the group home it is done at the time the PCP is developed." After ASM # 1 reviewed Individual # 2's outcome for community integration, ASM # 1 was asked what skill was being measured. ASM # 1 stated, "It's not very clear. After ASM # 1 reviewed Individual # 2's outcome for self-help, ASM # 1 was asked what skill was being measured, ASM # 1 stated, "It doesn't identify the skill being measured." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactShee	W 159		

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W 159	Continued From page 15 t.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (6) A type of movement disorder. This	W 159		

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W 159	Continued From page 16 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The QIDP failed to ensure the data collection of Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help, medication management, money management and exercise/recreation at (Name of Group Home) were in measurable terms. Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented the following: "Desired Outcome: Need # 1: Community Integration. Goal # 1: (Individual # 2) interacts with others in the community, while engaging in preferred activities or events to increase social skills at 50% of the time at least twice every month until 7/31/2019." "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019." "Desired Outcome: Need # 6: Medication Management. Goal # 6: Staff supported (Individual # 2) to participate in administering his own medication, 7 (seven) out of 7 days a week at the rate [sic] 100% until 7/31/2019." "Desired Outcome: Need # 7: Money Management. Goal # 7: (Individual # 2) is supported in purchasing his own person items at least two times until 7/31/2019." "Desired Outcome: Need # 8: Exercise and	W 159		

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W 159	Continued From page 17 Recreation. Goal # 8B: (Individual # 2) is offered gentle gross motor physical activities 3-4 (three to four) times a week 60% of the time until 7/31/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence data collection of the outcomes of community integration and self-help, medication management, money management and exercise/recreation in measurable terms. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 2's data collection for community integration and self-help, medication management, money management and exercise/recreation from (Name of Group Home), ASM # 1 was asked if the data was in measureable terms. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director, were made aware of the above findings. No further information was provided prior to exit. 2c. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) was developed in measurable terms. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019	W 159		

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W 159	Continued From page 18 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3. Supervised while using wheelchair. Target # 4. Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 2's outcome for community ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 2d. The QIDP failed to ensure the data collection of Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) was in measurable terms. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019	W 159		

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W 159	Continued From page 19 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3: Supervised while using wheelchair. Target # 4: Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." Review of (Name of Day Program) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence data collection of the outcome of community integration in measurable terms. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 1's data collection for community integration from (Name of Day Program), ASM # 1 was asked if the data was in measureable terms. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 2e. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcomes/goals for	W 159		

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W 159	Continued From page 20 self-help and medication management, and exercise/recreation at (Name of Group Home) were implemented. Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented the following: "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019." "Desired Outcome: Need # 6: Medication Management. Goal # 6: Staff supported (Individual # 2) to participate in administering his own medication, 7 (seven) out of 7 days a week at the rate [sic] 100% until 7/31/2019." "Desired Outcome: Need # 8: Exercise and Recreation. Goal # 8B: (Individual # 2) is offered gentle gross motor physical activities 3-4 (three to four) times a week 60% of the time until 7/31/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 2, personal time / self-help in 30 of 31 opportunities, outcome # 6, medication management in 31 of 31 opportunities and outcome # 8 community integration in 30 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After	W 159		

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W 159	Continued From page 21 ASM # 1 reviewed Individual # 2's data collection for personal time/self-help, medication management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 2f. The QIDP failed to ensure Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) were implemented. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3: Supervised while using wheelchair. Target # 4: Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." Review of (Name of Day Program) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 2, community integration in 17 of 17 opportunities.	W 159		

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W 159	Continued From page 22 On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 2's data collection for community integration from (Name of Day Program), ASM # 1 was asked if the program was implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3a. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcomes/goals for community integration and activities of daily living/self-help skills at (Name of Group Home) were developed in measurable terms. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and hyperlipidemia (7). Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented the following: "Desired Outcome: Need # 2: Community Integration. Goal # 1: (Individual # 3) develops new relationships in the community, while engaging in preferred activities or events for at	W 159		

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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 159	Continued From page 23 least two times a month for 50% of the time until 6/30/2019. Support Activity: (Individual # 3) is given options and informed of up coming activities like fairs, festivals, concerts, animal related for at least two times a month 100% of the time until 6/30/2019. Support Instructions: A) (Individual # 3) should be given the opportunity to choose the activities he would like to participate in using his communication chart. B) (Individual # 3) should be supported in the community at all times. C) (Individual # 3) is praised and encouraged." "Desired Outcome: Need # 4: Personal Time / Self-Help. Goal # 4: (Individual # 3) participates in activities of daily living skills to promote independence 10 minutes a day 50% of the time until 6/30/2019. Support Activity: # 1: (Individual # 3) is handed a wet wash cloth and prompted to scrub his body at least 1 (one) time a day for 50% of the time. # 2 (Individual # 2) holds on to the bar while staff supporting him with his brief change every 2 (two) hours at 80% of the time until 6/30/2019. Support Instructions: A) (Individual # 3) should be informed that it is time to do his ADLs. B) (Individual # 3) is assisted with bathing, tooth brushing, hand washing, shaving and grooming. C) (Individual # 3) should be given [sic] a hand over hand technique to assist with his personal hygiene or ADLs. D) (Individual # 2) is encouraged and provided praise." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked who the QIDP was for (Name of Group Home), ASM # 1 stated that she was one	W 159		

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W 159	Continued From page 24 of the QIDPs. When asked to describe the responsibilities of the QIDP, ASM #1 stated, "They are part of the IDT (interdisciplinary team), assess individuals to determine their wants and needs, how to support and implement the PCP (person-centered plan), check documentation including the progress notes and make sure the programs are implemented at the day program and the group home. They write monthly and quarterly reviews and whether the goals were met or not." When asked how often the QIDP visits the day program, ASM # 1 stated, "Once a month and as needed if something comes up." When asked how often the progress notes are reviewed at the day program and the group home, ASM # 1 stated, "At the day program it is done monthly during the visit and at the group home it should be done daily." When asked how often the PCP was reviewed by the QIDP, ASM #1 stated, "Monthly during the visit and as needed and at the group home it is done at the time the PCP is developed." After ASM # 1 reviewed Individual # 3's outcome for community integration and activities of daily living/self-help skills, ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money,	W 159		

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W 159	Continued From page 25	W 159		

schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

(3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

(6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the

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W 159	Continued From page 26 website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 3b. The QIDP failed to ensure the data collection of Individual # 3's PCP (person-centered plan) outcomes/goals for community integration, sensory stimulation, activities of daily living/self-help skills and money management at (Name of Group Home) were in measurable terms. Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented the following: "Desired Outcome: Need # 2: Community Integration. Goal # 2: (Individual # 3) develops new relationships in the community, while engaging in preferred activities or events for at least two times a month for 50% of the time until 6/30/2019." "Desired Outcome: Need # 3: Sensory Stimulation. Goal # 3: (Individual # 3) is offered the opportunity to participate in sensory activities. (Individual # 3) is encouraged to choose preferred sensory activity at least 3 (three) times a week. [sic] 75 of the time until 6/30/2019." "Desired Outcome: Need # 4: Activities of Daily Living. Goal # 7: (Individual # 3) participates in	W 159		

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W 159	Continued From page 27 activities of daily living skills to promote independence 10 minutes a day, 50%^ of the time until 6/30/2019." "Desired Outcome: Need # 7: Money Management. Goal # 7: (Individual # 3) goes to the store and he is supported to choose what he wants, by buying [sic] item of his choice one time out [sic] two times per month for at least 50% of the time until 7/31/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 3 dated 01/01/2019 through 01/31/2019 failed to evidence data collection of the outcome of for community integration, sensory stimulation, activities of daily living/self-help skills and money management in measurable terms. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 3's data collection for community integration, sensory stimulation, activities of daily living/self-help skills and money management from (Name of Group Home), ASM # 1 was asked if the data was in measureable terms. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3c. The QIDP failed to ensure Individual # 3's	W 159		

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W 159	Continued From page 28 PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills at (Name of Day Program) were developed in measurable terms. Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented the following: "# 1. Support Activity: (Individual # 2) will communicate effectively. (Individual # 3) participates in social activities to enhance his social skills. Skill Building: Yes. Support Instructions: (Individual # 3) will be assessed by the speech therapist. When (Individual # 3) is being assessed by the speech therapist, staff will observe speech therapist as she works with (Individual # 3), this will help staff to further understand methods of communicating. Staff will encourage (Individual # 3) to use eye contact, gestures and facial expression to communicate his needs. (Individual # 3) does understand basic verbal cues, staff will continue to communicate with him using verbal prompts. Staff will inform him of the kinds of social activities on the calendar for each day and encourage him to participate. (Individual # 3) enjoys bouncing balls while he's seated in his wheelchair. Staff observe (Individual # 3) with the way in which he responds to the offers. Documentation Instructions: Staff will provide detailed documentation of the manner at which he communicated, the support provided, (Individual # 3's) reaction towards speech therapy, and his preferred way of communicating, the socialization activities participated in, supports provided and skills he used and learned." "#2. Support Activity: (Individual # 3) participates in outings he enjoys. Skill Building: Yes. Support	W 159		

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W 159	Continued From page 29 Instructions: Once a month, support (Individual # 3) with planning an outing activity he enjoys, such as visiting the duck pond. During activities at the center, prompt (Individual # 3) to sit at the table with his staff and peers [sic] him to engage. Encourage him to engage in activities like morning meet and greet, (Name of Day Program) body moves, Arts and crafts sessions, Music, Jam Fridays, reading and group discussions. Encourage him to participate in table top activities such as connect 4 (four), games and using picture cards to teach daily living skills. Documentation Instructions: Staff will provide detailed documentation of the activities that he engaged in, specify and include community outings, his participation, his interaction with peers, and his reaction and duration of the activity." "#3. Support Activity: (Individual # 3) acquires skill sets while participating in various sensory stimulating activities. Skill Building: Yes. Support Instructions: Allow (Individual # 3) to choose a sensory activity he will [sic] to engage in by offering him choices of sensory activities. When offering objects, gently support [sic] (Individual # 3) hand to assist him [sic] point or pick up whatever he will like. As (Individual # 3) participates in his sensory stimulating activities, provide hand over hand support and verbal prompts to engage him in the activity. When (Individual # 3) has had enough, he might remove from the activity or place it to the side. Wait 1-2 min (one to two minutes) and offer him another activity. At least once a week, encourage (Individual # 3) to visit the sensory room. Provide (Individual # 3) with support to turn music on and other devices in the sensory room. Staff will make sure (Individual # 3) is healthy and safe	W 159		

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W 159	Continued From page 30 while he engages in any outing of his choice. Documentation Instructions: Staff will provide detailed documentation about (Individual # 3's) level of engagement during the activity, his response if he enjoyed that preferred activity and any suggestions for improvement." "#4. Support Activity: (Individual # 3) will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview, was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 3's outcomes of communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills from (Name of Day Program), ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings.	W 159		

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W 159	Continued From page 31 No further information was provided prior to exit. 3d. The QIDP failed to ensure the data collection of Individual # 3's PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills at (Name of Day Program) were in measurable terms. Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented the following: "# 1. Support Activity: (Individual # 2) will communicate effectively. (Individual # 3) participates in social activities to enhance his social skills. Skill Building: Yes. Support Instructions: (Individual # 3) will be assessed by the speech therapist. When (Individual # 3) is being assessed by the speech therapist, staff will observe speech therapist as she works with (Individual # 3), this will help staff to further understand methods of communicating. Staff will encourage (Individual # 3) to use eye contact, gestures and facial expression to communicate his needs. (Individual # 3) does understand basic verbal cues, staff will continue to communicate with him using verbal prompts. Staff will inform him of the kinds of social activities on the calendar for each day and encourage him to participate. (Individual # 3) enjoys bouncing balls while he's seated in his wheelchair. Staff observe (Individual # 3) with the way in which he responds to the offers. Documentation Instructions: Staff will provide detailed documentation of the manner at which he communicated, the support provided, (Individual # 3's) reaction towards speech therapy, and his preferred way of communicating, the socialization activities participated in, supports provided and skills he used and learned."	W 159		

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W 159	Continued From page 32 "#2. Support Activity: (Individual # 3) participates in outings he enjoys. Skill Building: Yes. Support Instructions: Once a month, support (Individual # 3) with planning an outing activity he enjoys, such as visiting the duck pond. During activities at the center, prompt (Individual # 3) to sit at the table with his staff and peers [sic] him to engage. Encourage him to engage in activities like morning meet and greet, (Name of Day Program) body moves, Arts and crafts sessions, Music, Jam Fridays, reading and group discussions. Encourage him to participate in table top activities such as connect 4 (four), games and using picture cards to teach daily living skills. Documentation Instructions: Staff will provide detailed documentation of the activities that he engaged in, specify and include community outings, his participation, his interaction with peers, and his reaction and duration of the activity." "#3. Support Activity: (Individual # 3) acquires skill sets while participating in various sensory stimulating activities. Skill Building: Yes. Support Instructions: Allow (Individual # 3) to choose a sensory activity he will [sic] to engage in by offering him choices of sensory activities. When offering objects, gently support [sic] (Individual # 3) hand to assist him [sic] point or pick up whatever he will like. As (Individual # 3) participates in his sensory stimulating activities, provide hand over hand support and verbal prompts to engage him in the activity. When (Individual # 3) has had enough, he might remove from the activity or place it to the side. Wait 1-2 min (one to two minutes) and offer him another activity. At least once a week, encourage (Individual # 3) to visit the sensory room. Provide	W 159		

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W 159	Continued From page 33 (Individual # 3) with support to turn music on and other devices in the sensory room. Staff will make sure (Individual # 3) is healthy and safe while he engages in any outing of his choice. Documentation Instructions: Staff will provide detailed documentation about (Individual # 3's) level of engagement during the activity, his response if he enjoyed that preferred activity and any suggestions for improvement." "#4. Support Activity: (Individual # 3)will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available." Review of (Name of Day Program) "Progress Notes" for Individual # 3 dated 01/01/2019 through 01/31/2019 failed to evidence data collection of the outcomes of communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills in measurable terms. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 1's data collection for communication skills, community and interest,	W 159		

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W 159	Continued From page 34 sensory stimulation and ADL (activities of daily living) skills from (Name of Day Program), ASM # 1 was asked if the data was in measureable terms. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3e. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and activities of daily living/self-help skills at (Name of Group Home) were implemented. Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented the following: "Desired Outcome: Need # 3: Sensory Stimulation. Goal # 3: (Individual # 3) is offered the opportunity to participate in sensory activities. (Individual # 3) is encouraged to choose preferred sensory activity at least 3 (three) times a week, [sic] 75 of the time until 6/30/2019." "Desired Outcome: Need # 4: Activities of Daily Living. Goal # 7: (Individual # 3) participates in activities of daily living skills to promote independence 10 minutes a day, 50%^ of the time until 6/30/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 3 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 3, sensory	W 159		

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W 159	Continued From page 35 stimulation in 31 of 31 opportunities, outcome # 4, activities of daily living in 31 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 3's data collection for sensory stimulation and activities of daily living, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3f. The QIDP failed to ensure Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program) was implemented. On 02/12/19 at approximately 4:25 p.m., an observation of Individual # 3 was conducted at (Name of Group Home). Individual # 3 was sitting in his wheelchair and positioned at the dining room table. DSP (direct support professional) # 3 brought a single serving container of Jell-O to the table for Individual # 3. DSP # 3 sat down in a chair next to Individual # 3, opened the Jell-O, and fed Individual # 3 the complete serving of Jell-O. On 02/13/19 at approximately 10:05 a.m., an observation of Individual # 3 was conducted at	W 159		

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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 159	Continued From page 36 (Name of Day Program). Individual # 3 was sitting in his wheelchair and positioned at a table with another Individual seated at the same table. PSS (program support specialist) # 8 brought a single serving container of Jell-O pudding to the table for Individual # 3. PSS # 8 opened the Jell-O pudding, placed a regular clear plastic spoon in the pudding container and placed in front of Individual # 3. PSS # 8 sat down in a chair next to Individual # 3, took the spoon and the pudding container, held them in her hand and fed Individual # 3. The (Name of Day Program) "PCP (person-centered plan)" for Individual # 3 dated 8/1/18 through 7/31/19 was reviewed. Under the title " Describe support instructions and preference that occur consistently across activities and settings" it documented in part, "During meals he uses adaptive equipment such as plate guard, high raised platform table, bent spoon and nosey cup." Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented, "#4. Support Activity: (Individual # 3) will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available."	W 159		

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W 159	Continued From page 37 The "Nutritional Assessment" for Individual # 3 dated, "6/5/18" documented, "Adaptive Equipment: uses small nosey cup, may use elevated tray, use high sided plate, use built-up right bend spoon." On 02/12/19 at 11:00 a.m., an interview was conducted at Individual # 3's day program site with PSS #8. When asked about the use of adaptive equipment and whether or not Individual # 3 could feed himself, PSS # 8 stated, "He has a platform, a high sided plate, nosey cup, but he uses a drink bottle with a straw, and a bent spoon with a built up handle." He doesn't use the adaptive equipment for snacks only at lunch time." When asked if she provided the bent spoon for Individual # 3 to use for the pudding, PSS # 8 stated, "No. We've tried before and the spoon doesn't work with small containers." When asked if she tried serving the pudding in something else so Individual # 3 could the adaptive spoon, PSS # 8 stated, "Yes, like a bowl but it didn't work so well so we use a regular spoon. He has difficulty with the regular spoon and I have to feed him." On 02/13/19 at 3:55 p.m., an interview was conducted with ASM (administrative staff member) # 2, acting clinical director and RN (registered nurse) # 1. RN #1 was asked how often and when Individual # 3 should use the adaptive spoon to eat. RN # 1 stated, "Every time the individual eats and every time there is something to eat that requires a spoon." On 02/13/19 at 4:15 p.m., an interview was conducted with DSP (direct support professional) # 3 at (Name of Group Home). When asked if	W 159		

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W 159	Continued From page 38 individual # 3 had, the capability to feed himself, DSP # 3 stated, "Yes." When asked if she recalled serving Individual # 3 his snack of Jell-O on 02/12/19 at approximately 4:25 p.m., DSP # 3 stated, "Yes." When asked if she allowed Individual # 3 to feed himself the snack, DSP # 3 stated, "No, because it is difficult to use the adaptive spoon with the small container." When asked if there was something else she could have done to allow Individual # 3 to feed himself, DSP # 3 stated, "I could have put it in the high sided plate." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what adaptive equipment should be provided at (Name of Day Program) for Individual # 3 to use when eating, ASM # 1 stated, "When he is eating he is to use a raised platform, high sided plate, adaptive spoon with the curve and a nosey cup." When asked how often Individual # 3 should use the adaptive equipment at (Name of Day Program), ASM # 1 stated, "Every time he is having a meal and when having a snack." When asked if the active treatment program for Individual # 3's use of adaptive equipment and self-help skill was implemented at (Name of Group Home and Name of Day Program), ASM #1 stated, "No." On 02/13/19 at 5:00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit.	W 159		

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W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop objectives in measurable terms for three of three individuals in the survey sample, Individual # 1, # 2 and # 3. 1a. The facility staff failed to develop Individual # 1's PCP (person-centered plan) outcome/goal for community integration at (Name of Group Home) in measurable terms. 2a. The facility staff failed to develop Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help at (Name of Group Home) in measurable terms. 2b. The facility staff failed to develop Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) in measurable terms. 3a. The facility staff failed to develop Individual # 3's PCP (person-centered plan) outcomes/goals for community integration and activities of daily living/self-help skills at (Name of Group Home) in measurable terms. 3b. The facility staff failed to develop Individual # 3's PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily	W 231	W 231 INDIVIDUAL PROGRAM Plan: CFR: 483.440(c)(4) The QIDP will revise Individual # 1's "Community Integration" outcomes into measurable terms The QIDP will revise Individuals #2's Community Integration and Self Help" outcomes into measurable terms The QIDP will revise Individuals # 3's " Community Integration,Activities of Daily Living/Self Help Skills" outcomes into measurable terms The Program Manager will update the PCPs to incorporate these changes for those individuals The Program Manager will complete this process for all the individuals to prevent further deficiencies The Program Manager will continue to monitor to ensure that all service needs of individuals are accurately reflected through the use of weekly operations meetings The Clinical Director will review within supervision with the Program Manager for documentation to support the coordination of services for each individual needs.	3/26/19

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W 231	Continued From page 40 living) skills at (Name of Day Program) in measurable terms. The findings include: 1. The facility staff failed to develop Individual # 1's PCP (person centered plan) outcome/goal for community integration in measurable terms. Individual # 1 was a 75 year-old female, who was admitted to (Name of Group Home) on 01/24/03. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), cerebral palsy (2), hypertension (3), neurogenic bladder (4) and edema (5). Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented, "Desired Outcome: # 6. It is important for (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019. Support Activity: (Individual #1) chooses activities or places of interest at least two times a month until 02/28/2019. Support Instructions: A) (Individual # 1) is informed of activities out in the community. B) (Individual # 1) is present with options of activities in the community. C) (Individual # 1) participates in the activities when in the community." On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked to describe the purpose of the CPC ASM #1 stated, "It is directed to a specific individual. It assist them to meet their needs and	W 231	The Day Program Manager will revise Individual # 2's PCP outcomes of "Community Integration" into measurable terms The Day Program Manager will revise Individual # 3's PCP outcomes of "Communication Skills,Community and Interest, Sensory Stimulation and Activities of Daily Living Skills" into measurable terms The Program Manager and/ or QIDP will review and revise day program PCPs for all the other individuals to ensure that they are in measurable terms The Program Manager/QIDP will conduct monthly observations and record reviews to ensure that outcomes are in measurable terms and report on these in monthly QIDP notes. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

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W 231	Continued From page 41 wants, teach them new skills and help them maintain or improve skills they already have." After ASM # 1 reviewed Individual # 1's outcome for community integration, ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." When asked what was intended to be measured, ASM # 1 stated, "How many relationships she develops in the community." The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.3 Procedures: C. (Name of Corporation) ensures that an ISP will contain at a minimum: 4. Goals / outcomes and measurable objectives / desired outcomes for addressing each identified need. 4.1.4 Individual Service Plan (ISP) Development. E. Goals / Outcomes and Objectives/Desired Outcomes: The objectives / desired outcomes will be expressed in terms that are behavioral and provide measurable indexes of progress." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained	W 231		

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W 231	Continued From page 42 from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. (5) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. 2a. The facility staff failed to develop Individual # 2's PCP (person-centered plan) outcomes/goals for community integration and self-help in measurable terms. Individual # 2 was a 64 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6).	W 231		

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W 231	Continued From page 43 Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented, "Desired Outcome: Need # 1: Community Integration. Goal # 1: (Individual # 2) interacts with others in the community, while engaging in preferred activities or events to increase social skills at 50% of the time at least twice every month until 7/31/2019. Support Activity: (Individual # 2) participates in a variety of social activities or events to increase social skills at 50% of the time at least twice every month until 7/31/2019. Support Instructions: A) Preferred activities can include but are not limited to: the library, museums, bowling, artworks or art shows. B) Research events or activities which may be of interest to (Individual # 2). C) Offer (Individual # 2) different outings to choose from. D) Have (Individual # 2) choose and identify an activity of interest. E) When in the community support and supervise (Individual # 2) for his safety. F) Praise (Individual # 2) for his participation." "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019. Support Activity: Staff total [sic] supported (Individual # 2) with his activities of daily living 7 (seven) out of 7 days per week 100% of the time until 7/31/2019. Support Instructions: A) (Individual # 2) is reminded when it is time for his ADLs (activities of daily living). B) (Individual # 2). Is supported by staff in completing his activities of daily living. C) (Individual # 2) is given an extended assist (assistance) when needed. D) Have (Individual # 2) is praised for doing a good job."	W 231		

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W 231	Continued From page 44 On 02/14/19 at 9:30 a.m., a review of Individual # 1's PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 2's outcome for community integration, ASM # 1 was asked what skill was being measured. ASM # 1 stated, "It's not very clear. After ASM # 1 reviewed Individual # 2's outcome for self-help, ASM # 1 was asked what skill was being measured, ASM # 1 stated, "It doesn't identify the skill being measured." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website:	W 231		

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W 231	Continued From page 45 https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (6) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The facility staff failed to develop Individual # 2's PCP (person-centered plan) outcome/goal for	W 231		

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W 231	Continued From page 46 community integration at (Name of Day Program) in measurable terms. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3: Supervised while using wheelchair. Target # 4: Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." On 02/14/19 at 9:30 a.m., a review of Individual # 2's PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 2's outcome for community, ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3a. The facility staff failed to develop Individual # 3's PCP (person-centered plan) outcomes/goals	W 231		

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W 231	Continued From page 47 for community integration and activities of daily living/self-help skills in measurable terms. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and hyperlipidemia (7). Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented, "Desired Outcome: Need # 2: Community Integration. Goal # 1: (Individual # 3) develops new relationships in the community, while engaging in preferred activities or events for at least two times a month for 50% of the time until 6/30/2019. Support Activity: (Individual # 3) is given options and informed of up coming activities like fairs, festivals, concerts, animal related for at least two times a month 100% of the time until 6/30/2019. Support Instructions: A) (Individual # 3) should be given the opportunity to choose the activities he would like to participate in using his communication chart. B) (Individual # 3) should be supported in the community at all times. C) (Individual # 3) is praised and encouraged." "Desired Outcome: Need # 4: Personal Time / Self-Help. Goal # 4: (Individual # 3) participates in activities of daily living skills to promote independence 10 minutes a day 50% of the time until 6/30/2019. Support Activity: # 1: (Individual # 3) is handed a wet wash cloth and prompted to scrub his body at least 1 (one) time a day for 50% of the time. # 2 (Individual # 2) holds on to the	W 231		

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W 231	Continued From page 48 bar while staff supporting him with his brief change every 2 (two) hours at 80% of the time until 6/30/2019. Support Instructions: A) (Individual # 3) should be informed that it is time to do his ADLs. B) (Individual # 3) is assisted with bathing, tooth brushing, hand washing, shaving and grooming. C) (Individual # 3) should be given [sic] a hand over hand technique to assist with his personal hygiene or ADLs. D) (Individual # 2) is encouraged and provided praise." On 02/14/19 at 9:30 a.m., a review of Individual # 3's PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 3's outcome for community integration and activities of daily living/self-help skills, ASM # 1 was asked what was being measured. ASM # 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult	W 231		

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W 231	Continued From page 49 responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad	W 231		

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W 231	Continued From page 50 cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 3b. The facility staff failed to develop Individual # 3's PCP (person-centered plan) outcome/goal for communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills at (Name of Day Program) in measurable terms. Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented, "# 1. Support Activity: (Individual # 2) will communicate effectively. (Individual # 3) participates in social activities to enhance his social skills. Skill Building: Yes. Support Instructions: (Individual # 3) will be assessed by the speech therapist. When (Individual # 3) is being assessed by the speech therapist, staff will observe speech therapist as she works with (Individual # 3), this will help staff to further understand methods of communicating. Staff will encourage (Individual # 3) to use eye contact, gestures and facial expression to communicate his needs. (Individual # 3) does understand basic verbal cues, staff will continue to communicate with him using verbal prompts. Staff will inform him of the kinds of social activities on the calendar for each day and encourage him to participate. (Individual # 3) enjoys bouncing balls while he's seated in his wheelchair. Staff observe (Individual # 3) with the way in which he responds to the offers. Documentation Instructions: Staff will provide detailed documentation of the manner	W 231		

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W 231	Continued From page 51 at which he communicated, the support provided, (Individual # 3's) reaction towards speech therapy, and his preferred way of communicating, the socialization activities participated in, supports provided and skills he used and learned." "#2. Support Activity: (Individual # 3) participates in outings he enjoys. Skill Building: Yes. Support Instructions: Once a month, support (Individual # 3) with planning an outing activity he enjoys, such as visiting the duck pond. During activities at the center, prompt (Individual # 3) to sit at the table with his staff and peers [sic] him to engage. Encourage him to engage in activities like morning meet and greet, (Name of Day Program) body moves, Arts and crafts sessions, Music, Jam Fridays, reading and group discussions. Encourage him to participate in table top activities such as connect 4 (four), games and using picture cards to teach daily living skills. Documentation Instructions: Staff will provide detailed documentation of the activities that he engaged in, specify and include community outings, his participation, his interaction with peers, and his reaction and duration of the activity." "#3. Support Activity: (Individual # 3) acquires skill sets while participating in various sensory stimulating activities. Skill Building: Yes. Support Instructions: Allow (Individual # 3) to choose a sensory activity he will [sic] to engage in by offering him choices of sensory activities. When offering objects, gently support [sic] (Individual # 3) hand to assist him [sic] point or pick up whatever he will like. As (Individual # 3) participates in his sensory stimulating activities, provide hand over hand support and verbal prompts to engage him in the activity. When	W 231		

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W 231	Continued From page 52 (Individual # 3) has had enough, he might remove from the activity or place it to the side. Wait 1-2 min (one to two minutes) and offer him another activity. At least once a week, encourage (Individual # 3) to visit the sensory room. Provide (Individual # 3) with support to turn music on and other devices in the sensory room. Staff will make sure (Individual # 3) is healthy and safe while he engages in any outing of his choice. Documentation Instructions: Staff will provide detailed documentation about (Individual # 3's) level of engagement during the activity, his response if he enjoyed that preferred activity and any suggestions for improvement." "#4. Support Activity: (Individual # 3)will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available." On 02/14/19 at 9:30 a.m., a review of Individual # 3's PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. After ASM # 1 reviewed Individual # 3's outcomes of communication skills, community and interest, sensory stimulation and ADL (activities of daily living) skills from (Name of Day Program), ASM # 1 was asked what was being measured. ASM #	W 231		

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W 231	Continued From page 53 1 stated, "It's not in measurable terms of how it is written and supported." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit.	W 231		
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 and staff interview, it was determined that the facility staff failed to provide an opportunity for individual choice and self-management for one of three individuals in the survey sample, Individual # 3. Facility staff failed to offer Individual # 3 the opportunity to feed himself a snack at (Name of Group Home) and at (Name of Day Program). The findings include: Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), clubfeet (6) and hyperlipidemia (7). On 02/12/19 at approximately 4:25 p.m., an observation of Individual # 3 was conducted at	W 247		

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W 247	Continued From page 54 (Name of Group Home). Individual # 3 was sitting in his wheelchair and positioned at the dining room table. DSP (direct support professional) # 3 brought a single serving container of Jell-O to the table for Individual # 3. DSP # 3 sat down in a chair next to Individual # 3, opened the Jell-O, and fed Individual # 3 the complete serving of Jell-O. Further observation of Individual # 3 receiving his snack failed to evidence Individual # 3 was provided the opportunity to feed himself. On 02/13/19 at approximately 10:05 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was sitting in his wheelchair and positioned at a table with another Individual seated at the same table. PSS (program support specialist) # 8 brought a single serving container of Jell-O pudding to the table for Individual # 3. PSS # 8 opened the Jell-O pudding, placed a regular clear plastic spoon in the pudding container and placed in front of Individual # 3. PSS # 8 sat down in a chair next to Individual # 3, took the spoon and the pudding container, held them in her hand and fed Individual # 3. Further observation of Individual # 3 receiving his snack failed to evidence Individual # 3 was provided the opportunity to feed himself. On 02/12/19 at approximately 4:50 p.m., an observation of Individual # 3 was conducted during his dinner at (Name of Group Home). Individual # 3 was in his wheelchair, positioned at the dining room table with the other Individuals who reside at (Name of Group Home). Individual # 3 was provide with a raised platform, high sided plate, built up bent spoon and nosey cup. Observations during the meal revealed Individual	W 247	W 247 INDIVIDUAL PLAN CFR(s):483.440(c)(6)(vi) Program Manager /QIDP will review individual #3's mealtime guidelines with emphasis on choice and independence during meals in the next staff meeting. The Program Manager and QIDP will review Individual #3's mealtime guidelines with emphasis on choice and independence during meals during an interdisciplinary meeting with the day program The QIDP will review the other individuals mealtime guideline both at home and at the day program to ensure that they are being offered the opportunity to feed themselves The QIDP will conduct random/ unannounced mealtime checks at home and at the day program to ensure that the meal time guideline are been adhered. The Program Manager/Clinical director will perform quarterly visits during mealtimes at the home and at the day program to ensure compliance.	3/26/19

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W 247	Continued From page 55 # 3 was able to feed himself the entire meal. The (Name of Day Program) "ISP (individual service plan)" or Individual # 3 dated 8/1/18 through 7/31/19 documented in part, "During meals he uses adaptive equipment such as plate guard, high raised platform table, bent spoon and nosey cup." The "Nutritional Assessment" for Individual # 3 dated, "6/5/18" documented, "Dining Skills: Dines with some assistance; Uses his left hand to eat using built up right bend spoon. Staff holds his cup otherwise he gulps and spills much of the liquid in it; staff gently touch his hand or move his plate away momentarily to help him slow down while eating. Adaptive Equipment: uses small nosey cup, may use elevated tray, use high sided plate, use built-up right bend spoon." On 02/12/19 at 11:00 a.m., an interview was conducted at Individual # 3's day program site with PSS #8. When PSS #8 was asked about the use of adaptive equipment for Individual #3 and whether or not he could feed himself. PSS # 8 stated, "He has a platform, a high sided plate, nosey cup, but he uses a drink bottle with a straw, and a bent spoon with a built up handle." He doesn't use the adaptive equipment for snacks only at lunch time." When asked if she provided the bent spoon for Individual # 3 to use for the pudding, PSS # 8 stated, "No. We've tried before and the spoon doesn't work with small containers." When asked if she tried serving the pudding in something else so Individual # 3 could use the adaptive spoon, PSS # 8 stated, "Yes, like a bowl but it didn't work so well so we use a regular spoon. He has difficulty with the regular spoon and I have to feed him."	W 247		

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W 247	Continued From page 56 On 02/13/19 at 3:55 p.m., an interview was conducted with ASM (administrative staff member) # 2, acting clinical director and RN (registered nurse) # 1. When RN #1 was asked how often and when Individual # 3 should use the adaptive spoon to eat independently. RN # 1 stated, "Every time the individual eats and every time there is something to eat that requires a spoon." On 02/13/19 at 4:15 p.m., an interview was conducted with DSP (direct support professional) # 3 at (Name of Group Home). When asked if individual # 3 had, the capability to feed himself, DSP # 3 stated, "Yes." When asked if she recalled serving Individual # 3 his snack of Jell-O on 02/12/19 at approximately 4:25 p.m., DSP # 3 stated, "Yes." When asked if she allowed Individual # 3 to feed himself the snack, DSP # 3 stated, "No, because it is difficult to use the adaptive spoon with the small container." When asked if there was something else she could have done to allow Individual # 3 to feed himself, DSP # 3 stated, "I could have put it in the high sided plate." When asked if she thought that by doing something for Individual # 3 that he can do himself was supporting independence, DSP # 3 stated, "No, that's not right." On 02/14/19 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked why it was important to allow an Individual to do things they are able to do instead of the staff doing it for them, ASM # 1 stated, "So they don't lose the skills they already have and make them more independent."	W 247		

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W 247	Continued From page 57 On 02/13/19 at 5:00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	W 247		

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W 247	Continued From page 58 (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	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	W 249		

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W 249	Continued From page 59 Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement the active treatment program for three of three individuals in the survey sample, Individuals # 1, # 2, and # 3. 1. The facility staff failed to implement Individual # 1's PCP (person-centered plan) outcomes/goals of medication management, stress management and community integration. 2a. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcomes/goals for self-help and medication management, and exercise/recreation at (Name of Group Home). 2b. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program). 3a. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and activities of daily living/self-help skills at (Name of Group Home). 3b. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program). The findings include: 1. The facility staff failed to implement Individual # 1's PCP (person-centered plan) outcomes/goals of medication management, stress management and community integration.	W 249	W 249 PROGRAM IMPLEMENTATION CFR(s) 483.440 (d)(1) The QIDP will revise individual #1's PCP outcomes that addresses "Medication Management, Stress Management and Community Integration", Individual #2's "Self-Help, Medication Management and Exercise/ Recreation" outcomes and Individual #3's "Sensory Stimulation and Activities of Daily Living/Self-Help Skills" outcomes and update these outcomes to ensure that they accurately reflect the needs of Individuals #1, #2 and # 3. The Program Manager / QIDP will review all individuals outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager will provide the training to all the staff to review all individuals PCPs during the next staff meeting. The Program Manager will provide supervision to all staff and ensure that the PCPs accurately reflect the individuals needs and are implemented appropriately. The QIDP will conduct monthly assessments to ensure that all services and needs are met and are accurately reflect on monthly QIDP notes. The Clinical Director will review within supervision with the Program Manager the documentation to support the coordination of services for each individual.	3/26/19

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W 249	Continued From page 60 Individual # 1 was a 75 year-old female, who was admitted to (Name of Group Home) on 01/24/03. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), cerebral palsy (2), hypertension (3), neurogenic bladder (4) and edema (5). Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented the following: "Desired Outcome: Need # 4: Medication Management. Goal # 4: It is important for (Individual # 1) to know the use of her thermometer, at least 5 (five) out of 7 (seven) times a week (71.43%) until 02/28/2019." "Desired Outcome: Need # 5: Stress Management. Goal # 5: (Individual # 1) is assisted with calming down herself, every time she has [sic] ran emotional outburst 100% of the time until 02/28/2019." "Desired Outcome: Need # 6: Community Integration. Goal # 6: It is important for (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 4, medication management in 27 of 31 opportunities, outcome # 5, stress management in one of one opportunities and outcome # 6 community integration in two of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual #	W 249	The Day Program Manager will review Individual #2's "Community Integration" outcome and Individual #3's" Activities of Daily Living Skills" outcome and update these outcomes to ensure that they accurately reflect the needs of Individuals #2 and # 3. The Program Manager / QIDP will review all individuals day program outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager /QIDP will complete monthly observations at the day program to ensure that the individuals outcomes are being properly implemented. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 249	Continued From page 61 1's "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 1's data collection for medication management, stress management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:	W 249		

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W 249	Continued From page 62 https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. (5) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html 2a. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcomes/goals for self-help and medication management, and exercise/recreation at (Name of Group Home). Individual # 2 was a 64 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6).	W 249		

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W 249	Continued From page 63 Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented, "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019." "Desired Outcome: Need # 6: Medication Management. Goal # 6: Staff supported (Individual # 2) to participate in administering his own medication, 7 (seven) out of 7 days a week at the rate [sic] 100% until 7/31/2019." "Desired Outcome: Need # 8: Exercise and Recreation. Goal # 8B: (Individual # 2) is offered gentle gross motor physical activities 3-4 (three to four) times a week 60% of the time until 7/31/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 2, personal time / self-help in 30 of 31 opportunities, outcome # 6, medication management in 31 of 31 opportunities and outcome # 8 community integration in 30 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes	W 249		

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W 249	Continued From page 64 under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 2's data collection for personal time/self-help, medication management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in	W 249		

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W 249	Continued From page 65 the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (6) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	W 249		

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W 249	Continued From page 66 2b. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) in measurable terms. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3: Supervised while using wheelchair. Target # 4: Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." Review of (Name of Day Program) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 2, community integration in 17 of 17 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 2's "Progress Notes" for 01/01/2019 through 01/31/2019 from (Name of Day Program) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress	W 249		

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W 249	Continued From page 67 notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 2's data collection for community integration from (Name of Day Program), ASM # 1 was asked if the program was implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3a. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and activities of daily living/self-help skills at (Name of Group Home). Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and hyperlipidemia (7). Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented, "Desired Outcome: Need # 3: Sensory Stimulation. Goal # 3: (Individual # 3) is offered the opportunity to participate in sensory activities. (Individual # 3) is encouraged to choose preferred sensory activity at least 3 (three) times a week, [sic] 75 of the time until 6/30/2019."	W 249		

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W 249	Continued From page 68 "Desired Outcome: Need # 4: Activities of Daily Living. Goal # 7: (Individual # 3) participates in activities of daily living skills to promote independence 10 minutes a day, 50%^ of the time until 6/30/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 3 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 3, sensory stimulation in 31 of 31 opportunities, outcome # 4, activities of daily living in 31 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 3's "Progress Notes" dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 3's data collection for sensory stimulation and activities of daily living, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings.	W 249		

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W 249	Continued From page 69 No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.	W 249		

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W 249	Continued From page 70 (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 3b. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program). On 02/12/19 at approximately 4:25 p.m., an observation of Individual # 3 was conducted at (Name of Group Home). Individual # 3 was sitting in his wheelchair and positioned at the dining room table. DSP (direct support professional) # 3 brought a single serving container of Jell-O to the table for Individual # 3. DSP # 3 sat down in a chair next to Individual # 3, opened the Jell-O, and fed Individual # 3 the complete serving of Jell-O. On 02/13/19 at approximately 10:05 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was	W 249		

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W 249	Continued From page 71 sitting in his wheelchair and positioned at a table with another Individual seated at the same table. PSS (program support specialist) # 8 brought a single serving container of Jell-O pudding to the table for Individual # 3. PSS # 8 opened the Jell-O pudding, placed a regular clear plastic spoon in the pudding container and placed in front of Individual # 3. PSS # 8 sat down in a chair next to Individual # 3, took the spoon and the pudding container, held them in her hand and fed Individual # 3. The (Name of Day Program) "PCP (person-centered plan)" for Individual # 3 dated 8/1/18 through 7/31/19 was reviewed. Under the title " Describe support instructions and preference that occur consistently across activities and settings" it documented in part, "During meals he uses adaptive equipment such as plate guard, high raised platform table, bent spoon and nosey cup." Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented, "#4. Support Activity: (Individual # 3) will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available."	W 249		

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W 249	Continued From page 72 The "Nutritional Assessment" for Individual # 3 dated, "6/5/18" documented, "Adaptive Equipment: uses small nosey cup, may use elevated tray, use high sided plate, use built-up right bend spoon." On 02/12/19 at 11:00 a.m., an interview was conducted at Individual # 3's day program site with PSS #8. When asked about the use of adaptive equipment and whether or not Individual # 3 could feed himself PSS # 8 stated, "He has a platform, a high sided plate, nosey cup, but he uses a drink bottle with a straw, and a bent spoon with a built up handle." He doesn't use the adaptive equipment for snacks only at lunch time." When asked if she provided the bent spoon for Individual # 3 to use for the pudding PSS # 8 stated, "No. We've tried before and the spoon doesn't work with small containers." When asked if she tried serving the pudding in something else so Individual # 3 could the adaptive spoon PSS # 8 stated, "Yes, like a bowl but it didn't work so well so we use a regular spoon. He has difficulty with the regular spoon and I have to feed him." On 02/13/19 at 3:55 p.m., an interview was conducted with ASM (administrative staff member) # 2, acting clinical director and RN (registered nurse) # 1. RN #1 was asked how often and when Individual # 3 should use the adaptive spoon to eat. RN # 1 stated, "Every time the individual eats and every time there is something to eat that requires a spoon." On 02/13/19 at 4:15 p.m., an interview was conducted with DSP (direct support professional) # 3 at (Name of Group Home). When asked if individual # 3 had the capability to feed himself	W 249		

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W 249	Continued From page 73 DSP # 3 stated, "Yes." When asked if she recalled serving Individual # 3 his snack of Jell-O on 02/12/19 at approximately 4:25 p.m., DSP # 3 stated, "Yes." When asked if she allowed Individual # 3 to feed himself the snack DSP # 3 stated, "No, because it is difficult to use the adaptive spoon with the small container." When asked if there was something else she could have done to allow Individual # 3 to feed himself, DSP # 3 stated, "I could have put it in the high sided plate." On 02/14/19 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked why it was important to ensure an Individual has and uses the necessary and appropriate adaptive equipment ASM # 1 stated, "Those are the thing the Individual has been assessed for and it helps them do things for themselves and maintains their skills." When asked what adaptive equipment should be provided at (Name of Day Program) for Individual # 3 to use when eating ASM # 1 stated, "When he is eating he is to use a raised platform, high sided plate, adaptive spoon with the curve and a nosey cup." When asked how often Individual # 3 should use the adaptive equipment at (Name of Day Program), ASM # 1 stated, "Every time he is having a meal and when having a snack." When asked if the active treatment program for Individual # 3's use of adaptive equipment and self-help skill was implemented at (Name of Group Home and Name of Day Program), ASM #1 stated, "No." On 02/13/19 at 5.00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were	W 249		

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W 249	Continued From page 74 made aware of the above findings.No further information was provided prior to exit.	W 249	W 252 PROGRAM DOCUMENTATION CFR(s):483.440(e)(1) The QIDP will revise individual #1's PCP outcomes that addresses "Medication Management, Stress Management and Community Integration", Individual #2's "Self-Help, Medication Management and Exercise/ Recreation" outcomes and Individual #3's "Sensory Stimulation and Activities of Daily Living/Self-Help Skills" outcomes and update these outcomes to ensure that they accurately reflect the needs of Individuals #1, #2 and # 3. The Program Manager / QIDP will review all individuals outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager will provide the training to all the staff to review all individuals PCPs during the next staff meeting. The Program Manager will provide supervision to all staff and ensure that the PCPs accurately reflect the individuals needs and are implemented appropriately. The QIDP will conduct monthly assessments to ensure that all services and needs are met and are accurately reflect on monthly QIDP notes. The Clinical Director will review within supervision with the Program Manager the documentation to support the coordination of services for each individual.	3/26/19
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement the active treatment program for three of three individuals in the survey sample, Individuals # 1, # 2, and # 3. 1. The facility staff failed to implement Individual # 1's PCP (person-centered plan) outcomes/goals of medication management, stress management and community integration. 2a. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcomes/goals for self-help and medication management, and exercise/recreation at (Name of Group Home). 2b. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program). 3a. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and	W 252		

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W 252	Continued From page 75 activities of daily living/self-help skills at (Name of Group Home). 3b. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program). The findings include: 1. The facility staff failed to implement Individual # 1's PCP (person-centered plan) outcomes/goals of medication management, stress management and community integration. Individual # 1 was a 75 year-old female, who was admitted to (Name of Group Home) on 01/24/03. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), cerebral palsy (2), hypertension (3), neurogenic bladder (4) and edema (5). Individual # 1's current PCP from (Name of Group Home) dated 03/01/2018 through 02/28/2019 documented the following: "Desired Outcome: Need # 4: Medication Management. Goal # 4: It is important for (Individual # 1) to know the use of her thermometer, at least 5 (five) out of 7 (seven) times a week (71.43%) until 02/28/2019." "Desired Outcome: Need # 5: Stress Management. Goal # 5: (Individual # 1) is assisted with calming down herself, every time she has [sic] ran emotional outburst 100% of the time until 02/28/2019." "Desired Outcome: Need # 6: Community Integration. Goal # 6: It is important for	W 252	The Day Program Manager will review Individual #2's "Community Integration" outcome and Individual #3's" Activities of Daily Living Skills" outcome and update these outcomes to ensure that they accurately reflect the needs of Individuals #2 and # 3. The Program Manager / QIDP will review all individuals day program outcomes to ensure that they accurately reflect their needs and that they are incorporated within the PCPs. The Program Manager /QIDP will complete monthly observations at the day program to ensure that the individuals outcomes are being properly implemented. The Day Program Monitor/ Clinical Director will also conduct quarterly observations and record reviews for compliance.	3/26/19

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W 252	Continued From page 76 (Individual # 1) to develop new relationships in the community at least one time out of two times a month for 50% of the time until 02/28/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 4, medication management in 27 of 31 opportunities, outcome # 5, stress management in one of one opportunities and outcome # 6 community integration in two of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's "Progress Notes" for Individual # 1 dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 1's data collection for medication management, stress management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings.	W 252		

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W 252	Continued From page 77 No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. (5) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.	W 252		

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W 252	Continued From page 78 2a. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcomes/goals for self-help and medication management, and exercise/recreation at (Name of Group Home). Individual # 2 was a 64 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6). Individual # 2's current PCP from (Name of Group Home) dated 08/01/2018 through 07/31/2019 documented, "Desired Outcome: Need # 2: Personal Time / Self-Help. Goal # 2B: (Individual # 2) is encouraged by staff to participate in his activities of daily living skills 7 (seven) out of 7 days for the week 100% of the time until 7/31/2019." "Desired Outcome: Need # 6: Medication Management. Goal # 6: Staff supported (Individual # 2) to participate in administering his own medication, 7 (seven) out of 7 days a week at the rate [sic] 100% until 7/31/2019." "Desired Outcome: Need # 8: Exercise and Recreation. Goal # 8B: (Individual # 2) is offered gentle gross motor physical activities 3-4 (three to four) times a week 60% of the time until 7/31/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 2 dated 01/01/2019	W 252		

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W 252	Continued From page 79 through 01/31/2019 failed to evidence the implementation of outcome # 2, personal time / self-help in 30 of 31 opportunities, outcome # 6, medication management in 31 of 31 opportunities and outcome # 8 community integration in 30 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 1's "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 2's data collection for personal time/self-help, medication management and community integration, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized	W 252		

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W 252	Continued From page 80 by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some	W 252		

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W 252	Continued From page 81 granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (6) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The facility staff failed to implement Individual # 2's PCP (person-centered plan) outcome/goal for community integration at (Name of Day Program) in measurable terms. Individual # 2's current PCP from (Name of Day Program) dated 06/28/2018 through 07/31/2019 documented, "Outcome #: 2/A. (Individual # 2) spends time in the community. Documentation: What and Where: Use narrative notes to document how (Individual # 2) participated in the outing. Document when he declines and attempt to determine why. Focus on what staff did for (Individual # 2), not the outing he participated in. Target # 1: Offered choices of community outing. Target # 2: Encourage interactions with community members. Target # 3: Supervised while using wheelchair. Target # 4: Ensure seat belts/restraints are secured. Target # 5: Assisted to make minor purchases." Review of (Name of Day Program) "Progress Notes" for Individual # 2 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 2, community	W 252		

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W 252	Continued From page 82 integration in 17 of 17 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 2's "Progress Notes" for 01/01/2019 through 01/31/2019 from (Name of Day Program) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When asked about the documentation in the progress notes not reflecting the outcomes/goals, ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 2's data collection for community integration from (Name of Day Program), ASM # 1 was asked if the program was implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. 3a. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcomes/goals for sensory stimulation and activities of daily living/self-help skills at (Name of Group Home). Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were	W 252		

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W 252	Continued From page 83 not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and hyperlipidemia (7). Individual # 3's current PCP from (Name of Group Home) dated 07/01/2018 through 06/30/2019 documented, "Desired Outcome: Need # 3: Sensory Stimulation. Goal # 3: (Individual # 3) is offered the opportunity to participate in sensory activities. (Individual # 3) is encouraged to choose preferred sensory activity at least 3 (three) times a week, [sic] 75 of the time until 6/30/2019." "Desired Outcome: Need # 4: Activities of Daily Living. Goal # 7: (Individual # 3) participates in activities of daily living skills to promote independence 10 minutes a day, 50%^ of the time until 6/30/2019." Review of (Name of Group Home) "Progress Notes" for Individual # 3 dated 01/01/2019 through 01/31/2019 failed to evidence the implementation of outcome # 3, sensory stimulation in 31 of 31 opportunities, outcome # 4, activities of daily living in 31 of 31 opportunities. On 02/14/19 at 9:30 a.m., a review of Individual # 3's "Progress Notes" dated 01/01/2019 through 01/31/2019 from (Name of Group Home) and interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked what the staff should document on the daily progress notes under the statement, "Please describe barriers and participation level." ASM # 1 stated, "The manner in which how the staff helped the individual and it should reflect how the individual met the outcome." When	W 252		

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W 252	Continued From page 84 asked about the documentation in the progress notes not reflecting the outcomes/goals ASM # 1 stated, "If it doesn't reflect the outcome I can't say that the outcomes was implemented as it was supposed to be." After ASM # 1 reviewed Individual # 3's data collection for sensory stimulation and activities of daily living, ASM # 1 was asked if those programs were implemented. ASM # 1 stated, "No." On 02/14/19 at 11:00 a.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the	W 252		

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W 252	Continued From page 85 conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 3b. The facility staff failed to implement Individual # 3's PCP (person-centered plan) outcome/goal for ADL (activities of daily living) skills at (Name of Group Home and Name of Day Program).	W 252		

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W 252	Continued From page 86 On 02/12/19 at approximately 4:25 p.m., an observation of Individual # 3 was conducted at (Name of Group Home). Individual # 3 was sitting in his wheelchair and positioned at the dining room table. DSP (direct support professional) # 3 brought a single serving container of Jell-O to the table for Individual # 3. DSP # 3 sat down in a chair next to Individual # 3, opened the Jell-O, and fed Individual # 3 the complete serving of Jell-O. On 02/13/19 at approximately 10:05 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was sitting in his wheelchair and positioned at a table with another Individual seated at the same table. PSS (program support specialist) # 8 brought a single serving container of Jell-O pudding to the table for Individual # 3. PSS # 8 opened the Jell-O pudding, placed a regular clear plastic spoon in the pudding container and placed in front of Individual # 3. PSS # 8 sat down in a chair next to Individual # 3, took the spoon and the pudding container, held them in her hand and fed Individual # 3. The (Name of Day Program) "PCP (person-centered plan)" for Individual # 3 dated 8/1/18 through 7/31/19 was reviewed. Under the title " Describe support instructions and preference that occur consistently across activities and settings" it documented in part, "During meals he uses adaptive equipment such as plate guard, high raised platform table, bent spoon and nosey cup." Individual # 3's current PCP from (Name of Day Program) dated 08/01/2018 through 07/31/2019 documented, "#4. Support Activity: (Individual #	W 252		

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W 252	Continued From page 87 3) will learn how to improve his self-help skills. Skill Building: Yes. Support Instructions: Allow (Individual # 3) is taught how to undress and redress when he uses the restroom. Staff teaches (Individual # 3) how to use proper handwashing techniques, such as pouring soap onto his hands, turning the faucet on to wash his hands and use the paper towel to dry his hands. At meal time while (Individual # 3) is at his program, staff will set up and make his adaptive eating utensils such as guard plate, high raised platform table, bent spoon and [sic] nose cup available." The "Nutritional Assessment" for Individual # 3 dated, "6/5/18" documented, "Adaptive Equipment: uses small nosey cup, may use elevated tray, use high sided plate, use built-up right bend spoon." On 02/12/19 at 11:00 a.m., an interview was conducted at Individual # 3's day program site with PSS #8. When asked about the use of adaptive equipment and whether or not Individual # 3 could feed himself PSS # 8 stated, "He has a platform, a high sided plate, nosey cup, but he uses a drink bottle with a straw, and a bent spoon with a built up handle." He doesn't use the adaptive equipment for snacks only at lunch time." When asked if she provided the bent spoon for Individual # 3 to use for the pudding PSS # 8 stated, "No. We've tried before and the spoon doesn't work with small containers." When asked if she tried serving the pudding in something else so Individual # 3 could the adaptive spoon PSS # 8 stated, "Yes, like a bowl but it didn't work so well so we use a regular spoon. He has difficulty with the regular spoon and I have to feed him."	W 252		

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W 252	Continued From page 88 On 02/13/19 at 3:55 p.m., an interview was conducted with ASM (administrative staff member) # 2, acting clinical director and RN (registered nurse) # 1. RN #1 was asked how often and when Individual # 3 should use the adaptive spoon to eat. RN # 1 stated, "Every time the individual eats and every time there is something to eat that requires a spoon." On 02/13/19 at 4:15 p.m., an interview was conducted with DSP (direct support professional) # 3 at (Name of Group Home). When asked if individual # 3 had the capability to feed himself DSP # 3 stated, "Yes." When asked if she recalled serving Individual # 3 his snack of Jell-O on 02/12/19 at approximately 4:25 p.m., DSP # 3 stated, "Yes." When asked if she allowed Individual # 3 to feed himself the snack DSP # 3 stated, "No, because it is difficult to use the adaptive spoon with the small container." When asked if there was something else she could have done to allow Individual # 3 to feed himself, DSP # 3 stated, "I could have put it in the high sided plate." On 02/14/19 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked why it was important to ensure an Individual has and uses the necessary and appropriate adaptive equipment ASM # 1 stated, "Those are the thing the Individual has been assessed for and it helps them do things for themselves and maintains their skills." When asked what adaptive equipment should be provided at (Name of Day Program) for Individual # 3 to use when eating ASM # 1 stated, "When he is eating he is to use a raised platform, high sided	W 252		

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W 252	Continued From page 89 plate, adaptive spoon with the curve and a nosey cup." When asked how often Individual # 3 should use the adaptive equipment at (Name of Day Program), ASM # 1 stated, "Every time he is having a meal and when having a snack." When asked if the active treatment program for Individual # 3's use of adaptive equipment and self-help skill was implemented at (Name of Group Home and Name of Day Program), ASM #1 stated, "No." On 02/13/19 at 5:00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit.	W 252		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to maintain the environment in good repair. The facility staff failed to maintain the dividing wall between the dining room and the stairs, four of five Individual's bedroom and one of two individual's bathrooms in good repair. The findings include: On 02/12/19 at approximately 9:20 a.m. and 3:25 p.m., and on 12/13/19 at 7:00 a.m., and at 4:10	W 420	W420 Client Bedrooms - 483.470(b)(4)(iv) A work order was submitted and completed on 2/14/19 for installation of electrical and phone jack plates cited in W420. The plates were removed during a painting volunteer project and should have been replaced during the project or the following day if paint was not dry. A new procedure will be implemented in which the Facilities Manager and/or Volunteer Coordinator will visit the volunteer project sites the following day if they are not present during the project. If any additional work is needed to complete a project they will complete a work order request using current urgency guidelines to completed the project. The Property Manager will review and issue the work order task to maintenance staff. Maintenance staff will complete the work order. Property Manager will close the work order once completed. Facility Manager will review closed work order for promptness and conduct random quality assurance reviews on a quarterly basis.	3/15/19

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W 420	Continued From page 90 p.m., observations of (Name of Group Home's) environment was observed. Observation of the first bedroom on the left side of the hallway on the bottom floor of the group home revealed a bedside table containing three drawers, a dresser with ten drawers. Observation of the bedside table revealed each of the three drawers were missing a drawer pull and the top drawer was observed to be off the track and loosely fit inside the bedside table. Observation of the dresser revealed two of the ten drawers were missing drawer pulls. Further observation of the bedroom revealed two electrical outlets mounted in the wall. One electrical outlet was on the right side of the bed, the other electrical outlet was on the wall near the foot of the bed. Observation of the two electrical outlets revealed the cover plates were missing, and the wiring was visible. Observation of the bedroom at the end of the hallway on the bottom floor of the group home revealed an electrical outlet mounted in the wall on the left side of the bed and at the foot of the bed. Observation of the electrical outlet revealed the cover plate was missing and the wiring was visible. Observation of the resident bathroom on the right side of the hallway on the upper floor of the group home revealed a towel bar approximately 24 inches long mounted on the wall inside the shower stall. Observation of the towel bar revealed it was covered with reddish-brown rust. Observation of the first bedroom on the right side of the hallway on the upper floor of the group home revealed a telephone jack outlet mounted in the wall on the right side of the bed. Observation of the telephone jack outlet revealed	W 420		

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W 420	Continued From page 91 the cover plate was missing and the wiring was visible. Observation of the second bedroom on the left side of the hallway on the upper floor of the group home revealed and bedside table with a broken top drawer. The drawer was observed to be off the track and loosely fit inside the bedside table. Observation of the wall on the upper floor of the group home, separating the dining room and the door leading to the stairs to access the bottom floor revealed tears in the dry wall on the right and left ends of the wall. Facing the wall from the dining room, observation of the right end of the wall revealed torn dry wall consisting of two areas. One area measuring approximately five and a half inches high and three and a half inches wide and the other area measuring approximately three inches high and three and two inches wide. Observation of the left end of the wall revealed torn dry wall consisting of an area measuring approximately six inches high and three inches wide. On 02/13/19 at 4:30 p.m., an observation of (Name of Group Home) was conducted with ASM (administrative staff member) # 1, the acting program manager. Observations were conduct of the bedside table, the dresser and the electrical outlets in first bedroom on the left side of the hallway on the bottom floor, and the electrical outlet in the bedroom at the end of the hallway on the bottom floor. The towel bar in the resident bathroom on the right side of the hallway on the upper floor, the telephone jack in the first bedroom on the right side of the hallway on the upper floor, the bedside table in the second bedroom on the left side of the hallway on the	W 420		

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W 420	Continued From page 92 upper floor were also observed. The wall on the upper floor, separating the dining room and the door leading to the stairs to access the bottom floor, was observed. During the observation of the wall, a standard six inch ruler was used to measure the torn dry wall areas at the right and left ends of the wall separating the dining room and stairs. The torn dry wall, at the rights end of the wall measured five and a half inches high and three and a half inches wide, the other area measured approximately three inches high and three and two inches wide and the torn dry wall on the left side measured six inches high and three inches wide. ASM # 1 verbally agreed, with the measurements. When asked if the observations convey a safe, comfortable homelike atmosphere ASM # 1 stated, "No." When asked if she was aware of the repairs for the Individual's rooms and the condition of the towel bar, ASM # 1 stated, "No." When asked to describe the procedure for maintaining the residents furniture and environment in good repair, ASM # 1 stated, "I do a walk through every day and if I see something that needs to be fixed or repaired I submit a work order. The things you pointed out are things I didn't notice." On 02/13/19 at 5:00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings.No further information was provided prior to exit.	W 420		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 93 This STANDARD is not met as evidenced by: Based on facility document review and staff interview, it was determined that the facility failed to conduct fire drills for each shift quarterly. The finding include: Review of the facility's "Fire Drill Forms" dated 04/2017 through 01/2019 failed to evidence that a fire drill was conducted on the 11:00 p.m. to 7:00 a.m. shift between July 2018 and August 2018. On 02/12/19 at approximately 11:30 a.m. ASM (administrative staff member) # 1, (Name of Group Home) acting program manager was asked to provide evidence of the fire drills conducted on the 11:00 p.m. to 7:00 a.m. shift between July 2018 and August 2018. On 12/13/19 at 4:40 p.m. ASM # 1 stated, "That month (August 2018) our overnight staff was suppose to do the fire drill. I don't know why they didn't do it at that time. We don't have it." On 12/13/19 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the findings. No further information was provided.	W 440	W 440 EVACUATION DRILLS CFR(s) 483.470(i)(1) The program manager will discuss with staff during the next staff meeting, the fire drill expectation with emphasis on rotating the drills for each shift every quarter. A schedule of evacuation drills will be posted with drills rotating per shift each quarter (morning/ afternoon/overnight). Drills will be scheduled between the first and the 15th of the month such as to give enough time in remaining days in the month to conduct the drills, if they are conducted during the scheduled time. 4. Program manager will review drills during monthly documentation review of environmental checks Clinical Director will include environmental reviews on their periodic audits of program operations.	3/26/19
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:	W 475		

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W 475	Continued From page 94 Based on observations and staff interview, it was determined that the facility staff failed to provide one of three individuals in the survey sample, Individual # 3, the proper utensil for eating. Facility staff failed to provide Individual # 3 with an nosey cup, adaptive spoon with a right hand bend and built up handle during his snack at (Name of Group Home) and at (Name of Day Program). The findings include: Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), clubfeet (6) and hyperlipidemia (7). On 02/12/19 at approximately 4:25 p.m., an observation of Individual # 3 was conducted at (Name of Group Home). Individual # 3 was sitting in his wheelchair and positioned at the dining room table. DSP (direct support professional) # 3 brought a single serving container of Jell-O to the table for Individual # 3. DSP # 3 sat down in a chair next to Individual # 3, opened the Jell-O, and fed Individual # 3 the complete serving of Jell-O. On 02/13/19 at approximately 10:05 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was sitting in his wheelchair and positioned at a table with another Individual seated at the same table. PSS (program support specialist) # 8 brought a single serving container of Jell-O pudding to the	W 475	W 475 MEAL SERVICES CFR(s) 483.480(b)(2)(iv) Program Manager /QIDP will review individual #3's necessary dining equipment during the next staff meeting. The Program Manager and QIDP will review Individual #3's necessary dining equipment during an interdisciplinary meeting with the day program, QIDP will review dining utensils needed by all other individuals both at home and at the day support including those with need for modified utensils. The Program Manager/QIDP will provide additional training to the program and day program staff on the the use of dining utensils and individual's choice and independence The QIDP will conduct unannounced checks at day support to ensure that meal time guidelines are been adhered to and dining utensils are being utilized. The Program manager/Clinical director will periodically perform meal time observations to ensure that all applicable meal guidelines are being adhered both at their home and at day program.	3/26/19

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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 475	Continued From page 95 table for Individual # 3. PSS # 8 opened the Jell-O pudding, placed a regular clear plastic spoon in the pudding container and placed in front of Individual # 3. PSS # 8 sat down in a chair next to Individual # 3, took the spoon and the pudding container, held them in her hand and fed Individual # 3. The (Name of Day Program) "ISP (individual service plan)" or Individual # 3 dated 8/1/18 through 7/31/19 documented in part, "During meals he uses adaptive equipment such as plate guard, high raised platform table, bent spoon and nosey cup." The "Nutritional Assessment" for Individual # 3 dated, "6/5/18" documented, "Adaptive Equipment: uses small nosey cup, may use elevated tray, use high sided plate, use built-up right bend spoon." On 02/12/19 at 11:00 a.m., an interview was conducted at Individual # 3 ' s day program site with PSS #8. When asked about the use of adaptive equipment and whether or not Individual # 3 could feed himself PSS # 8 stated, "He has a platform, a high sided plate, nosey cup, but he uses a drink bottle with a straw, and a bent spoon with a built up handle." He doesn ' t use the adaptive equipment for snacks only at lunch time." PSS # 8 then removed a drink bottle from Individual # 3 ' s backpack that was hanging on the back of Individual # 3 ' s wheelchair. Observation of the drink bottle revealed it contain a preferred drink and a straw attached to the inside of the bottle and emerged from the top of the bottle when the cap was removed. Individual #3 was not observed being provided the small nosy cup adaptive equipment. When asked if she	W 475		

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	49G027	A. BUILDING _____ B. WING _____	02/14/2019

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W 475	Continued From page 96 provided the bent spoon for Individual # 3 to use for the pudding PSS # 8 stated, "No. We ' ve tried before and the spoon doesn ' t work with small containers." When asked if she tried serving the pudding in something else so Individual # 3 could the adaptive spoon PSS # 8 stated, "Yes, like a bowl but it didn ' t work so well so we use a regular spoon. He has difficulty with the regular spoon and I have to feed him." On 02/13/19 at 3:55 p.m., an interview was conducted with ASM (administrative staff member) # 2, acting clinical director and RN (registered nurse) # 1. RN #1 was asked how often and when Individual # 3 should use the adaptive spoon to eat. RN # 1 stated, "Every time the individual eats and every time there is something to eat that requires a spoon." On 02/13/19 at 4:15 p.m., an interview was conducted with DSP (direct support professional) # 3 at (Name of Group Home). When asked if individual # 3 had the capability to feed himself, DSP # 3 stated, "Yes." When asked if she recalled serving Individual # 3 his snack of Jell-O on 02/12/19 at approximately 4:25 p.m., DSP # 3 stated, "Yes." When asked if she allowed Individual # 3 to feed himself the snack, DSP # 3 stated, "No, because it is difficult to use the adaptive spoon with the small container." When asked if there was something else she could have done to allow Individual # 3 to feed himself, DSP # 3 stated, "I could have put it in the high sided plate." On 02/14/19 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the acting program manager. When asked why it was important to ensure an	W 475		

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W 475	Continued From page 97 Individual has and uses the necessary and appropriate adaptive equipment, ASM # 1 stated, "Those are the thing the Individual has been assessed for and it helps them do things for themselves and maintains their skills." When asked what adaptive equipment should be provided at (Name of Day Program) for Individual # 3 to use when eating, ASM # 1 stated, "When he is eating he is to use a raised platform, high sided plate, adaptive spoon with the curve and a nosey cup." When asked how often Individual # 3 should use the adaptive equipment at (Name of Day Program), ASM # 1 stated, "Every time he is having a meal and when having a snack." On 02/13/19 at 5:00 p.m., ASM (administrative staff member) # 1, the acting program manager and ASM # 2, the acting clinical director were made aware of the above findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the	W 475		

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W 475	Continued From page 98 website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye.This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	W 475		