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	49G005	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN VIRGINIA TRAINING	2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/21/20 through 10/23/20 and 10/26/20. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 10/21/20 through 10/23/20 and 10/26/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 85 certified bed facility was 75 at the time of the survey. The survey sample consisted of 6 Individual reviews (Individuals #1 through #6).	W 000		
W 206	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs.	W 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/23/2020

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This STANDARD is not met as evidenced by:
Based on observations, staff interviews, record reviews, and facility documentation review, the facility staff failed to develop a specific plan with parameters for the use of a soft helmet for 2 of 6 Individuals (Individuals #4 and #3) in the survey sample.

The findings include:

1. The facility staff failed to ensure there was a plan developed that indicated clear parameters for the use of Individual #4's soft helmet.

Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. and seizures.

The following observations were made of Individual #4 in the residential and day program areas:

On 10/21/20 at 7:40 a.m., Individual #4 was observed in his residence positioned in his wheelchair with seat belt at the dining table for the breakfast meal. He was 1:1 supervised during the meal by a Direct Support Professional (DSP). Following his meal, Individual #1 independently

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backed up and wheeled himself away from the table. He wore socks and tennis shoes and was able to propel himself freely in the wheelchair by using both feet. Staff stated that he was only 1:1 supervised for meals, and had to be "in sight supervised" at all times otherwise for safety due to attempts to rise and walk or during his Obsessive Compulsive Disorder (OCD) behaviors with destruction of property, repetitive bathroom use and hand washing. Individual #4 was not wearing his soft helmet.

On 10/22/20, Individual #4 was observed the following four times out of sight of the staff:

At 1:15 p.m., this surveyor was standing in a hallway at a corner wall to the left of the bathroom door and observed Individual #4, unbuckling his wheelchair seat belt and unsteadily transferred himself on the commode, after which he, in the same manner, transferred himself back in his wheelchair, re-buckled his seat belt, washed and dried his hands using approximately 10-15 paper towels.

At 1:25 p.m., Individual #4 wheeled into the same bathroom, remained in his wheelchair, again washed and dried his hands using too numerous to count paper towels.

At 1:28 p.m., Individual #4 repeated the same above behavior.

At 1:30 p.m., Individual #4 wheeled himself into the living room from the hallway, now clearly visible to staff at this point. He proceeded to the screened porch with one sock on. Approximately 1 minute later, Direct Support Professional (DSP) #6 headed into the screened porch to administer

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the individual's medication. The DSP stated that Individual #4 propels himself "very, very fast" in his wheelchair and required "in sight supervision" due to escalation of OCD behaviors, rising out of his wheelchair and destructive tenancies to ensure is safety and safety of others. When asked when he wore the soft helmet, she stated, " We put it on from time to time, if we think he needs it, especially if he starts banging his head against the wall, but no real times otherwise." She stated that Individual #4 could ambulate, but was very unsteady, had a fall history and remained at high risk for falls. She stated all the staff keep eyes on Individual #4 throughout the home to maintain his safety and assist him to manage his OCD and destructive behaviors. She stated when in bed asleep, the staff implemented mandatory every (q)15 minute checks for his safety because he would get out of bed to go to the bathroom and not always to use it, but to constantly wash his hands.

The Data Forms, completed by the assigned DSP dated 10/22/20 for AM and PM did not indicate the OCD behavior that included unbuckling the seat belt of his wheelchair, going to the bathroom and or frequent handwashing events. There was a note in the AM on 10/22/20 that indicated Individual #4 banged his head on the wall and shaking hand while squeezing tightly.

On 10/23/20 at 1:40 p.m., Individual #4 was buckled in his wheelchair propelling himself quickly down a hallway, out of view of staff that were located in the living room area. Once he entered the living room, DSP #8, who was charting, asked him where he came from and asked "What were you up to?"

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On 10/26/20 at 10:30 a.m., Individual #4 was in building #29 for day programing, sitting in his wheelchair at a table with his model trains and watching a movie. He was in the room with along with four other individuals from the same home. DSP #7 stated all staff in the room watch the individuals, but he was regularly assigned Individual #4. The DSP stated could walk, but "speedily" and not safe without assistance from the staff. He stated, he unbuckles his seat belt and heads out of his chair or gets out of bed to go to bathroom. DSP #7 said, "When he is in the bathroom he likes to compulsively wash his hands and could splash water on the floor, slip, fall and possibly hit his head which he has done before. He comes out of bed quick too, also a chance of falls and has injured himself in the past coming out of the bed. We watch him every 15 minutes when he is in bed." The DSP could not specifically give parameters the staff followed that required application of Individual #4's soft helmet. Another DSP#6 added that the soft helmet could be used when the individual started the behavior of banging his head against the wall, but they reserved the right to use it whenever they thought it was necessary for his safety.

There were several documented incidents that involved Individual #4 behaviors to included pacing up and down hallways, pushing and grabbing staff, running back and forth to the bathroom, throwing himself on the bed, running in the living room, aggressively pushing staff. A review of the recent past three months of incident reports presented identified on 8/18/20, the individual was having a bad OCD event when he jumped off his bed to run to the bathroom, slipped and hit his head on the floor. On 10/17/20, while exhibiting OCD behaviors, Individual #4 was

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throwing toys from out of his room, kicking the dresser drawers and knocking three of them out of the structure of the dresser. Two of these dresser drawers were stacked on each other on top of the dresser structure which posed a potential danger of falling on the Individual with or without a behavioral outburst of OCD events. On 10/26/20 at 10:40 a.m., DSP #6 was with Individual #4 in building #29 for activities and movie time. She stated, "He did that about 2 weeks ago and I meant to get (name of the buildings and grounds person) to fix these drawers." She stated one of the drawers was placed in a storage area, but she is calling today to get them fixed. The condition of the broken stacked drawers on top of the dresser was observed throughout all days of the survey.

On 10/26/20 at 1:25 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) assigned to Individual #4. She stated the individual remains at high risk for falls at each annual assessment and after the assessment of each of his falls. She stated based on the issues with his spine, if he fell again, he could be paralyzed. She continued to say he has had injuries from running with a tendency to fall. She the individual preferred to use his wheelchair because he could get around quickly, but when he was cycling he moves even quicker sometimes escalating his behaviors with sweating, repetitively squeezing others hands too tightly and agitating other individuals. When asked what parameters were in place that the staff used to apply the individual's soft helmet, she stated there was a consent and physician's order in place for the use of the helmet, but no parameters were addressed with the Specially Constituted Committee SCC. She stated the soft

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helmet was used when the individual starts to bang head on wall, and should probably wear the helmet when other OCD, cycling, agitated and destructive behaviors start to escalate to prevent injury. She stated the individual at times refused the soft helmet, but did not present the refusal documentation. She stated she plans to address the use of the soft helmet with the interdisciplinary team followed by a presentation at Individual #4's upcoming SCC review. The QIDP stated she expected the staff to have kept Individual #4 in sight for his safety and to monitor OCD behaviors in accordance with his Behavioral Support Plan (BSP) (dated as reviewed on 5/20/20) and his Individual Support Plan (IPP) (dated 5/20/20 through 5/19/21).

On 10/26/20 at approximately 3:30 p.m., the aforementioned observations, staff interviews were shared with the facility Administrator and the Director of Compliance. They stated there was clear understanding of the presented issues. No further information provided prior to survey exit.

The Individual Support Plan (ISP) dated 5/20/20 through 5/19/21 identified adaptive equipment and assistive technology supports to include soft helmet, but no clear parameters for its use. The ISP notes Individual #4 was prone to falls due to axonal myopathy, ataxic gait and other chronic conditions that affect his balance and coordination. There were physician's orders dated 9/6/18, "Encourage use of helmet." The Physical Management Plan dated 5/14/20 soft helmet that the individual could remove. There was an informed consent dated 3/12/20 for the soft helmet with straps to ensure safety and protection during falls and there were no alternatives with similar benefits identified at the time of the signed

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consent. There was no SCC review presented to this surveyor for the soft helmet.

The Behavioral Support Plan (BSP) dated 5/20/20 indicated, "(Individual #4's name) helmet will be used in accordance with physician orders." The BSP identified Self Injurious Behavior (SIB) that included using his head to hit objects, windows or walls with such force to potentially cause injury.

2. The facility's staff failed to develop a program which defined parameters including why, when, and for how long to use a soft helmet for Individual #3.

Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) facility on 5/8/19 with diagnoses that included profound Intellectual Disability, epilepsy, legal blindness, hypercholesterolemia, and hypothyroidism.

On 10/21/20 at approximately 3:45 p.m. Individual #3 was observed under the pavilion with another Individual and two Direct Service Personnel (DSP). Individual #3 was seated in a wheel chair with his head down as if asleep. He was wearing a black soft helmet on his head.
Individual #3 was observed again on 10/22/20 at approximately 3:30 p.m., in the living room area. He was seated in a wheel chair with his head down. A neck napkin was donned around his neck and covering his chest area and a soft black helmet was on his head. A staff came over to the Individual and assisted him to stand utilizing a gait belt. The staff member instructed the individual to walk with him to the bathroom. Individual #3 unsteadily walked with the staff member's assistance into the bathroom. Upon

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Individual #3's return to the living room, he was assisted to sit in the wheel chair and the helmet remained on his head.

On 10/23/20 at approximately 11:00 a.m., Individual #3 was again observed under the pavilion. He had a neck napkin donned around his neck and a soft black on his head. An interview was conducted Activity staff #1. Activity staff #1 stated Individual #3 reads braille therefore, activity programming for him was developed around the use of braille and music. At approximately 12:07 p.m., Individual #3 was observed seated in a wheel chair at the dining table for the midday meal. He was wearing a neck napkin and a soft black helmet. An interview was conducted with DSP #4 at approximately 12:13 p.m., on 10/23/20, regarding removal of the helmet during meal time. DSP #4 stated the helmet is not removed for meals.

The Individual Support Plan (ISP) dated 4/8/20 through 4/7/21 listed the following adaptive equipment for use; floor mats, wheel chair with seat belt, bed alarm, Therarest mattress with blocks to elevate the head of the bed, shower chair with safety straps, soft shell helmet, built up handle coated spoon, nosey cup, high side sectional plate, dycem mat, Vagus Nerve Stimulation (VNS) magnet, and a gait belt. Also the ISP revealed under; "what others need to know to support me", (name of individual) has a soft shell helmet.

The October 2020, physician order summary contained an order dated 9/27/19 which read; soft helmet. No information could be located in the clinical record specifying when or when not to wear the soft shell helmet.

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W 206	Continued From page 9 On 10/26/20 at approximately 2:40 p.m. an interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated Individual #3 was to wear the soft helmet when walking but he couldn't recall other parameters for use but he would follow-up and ensure specifics were documented and available to all staff. On 10/26/20 at approximately 2:40 p.m., the above information was shared with the Administrator and the Director of Compliance. The Administrator stated she understood what was absent from the record and she would ensure the necessary information was acquired and made available for staff.	W 206		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility documentation review, the facility staff failed to implement the Individual Support Plan (ISP) for 1 of 4 individuals (Individual #4) in the survey sample. The facility staff failed to consistently provide insight	W 242		

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supervision for Individual #4 to maintain his safety and deter any inappropriate behaviors.

The findings include:

Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. and seizures.

The following observations were made of Individual #4 in the residential and day program areas:

On 10/21/20 at 7:40 a.m., Individual #4 was observed in his residence positioned in his wheelchair with seat belt at the dining table for the breakfast meal. He was 1:1 supervised during the meal by a Direct Support Professional (DSP). Following his meal, Individual #1 independently backed up and wheeled himself away from the table. He wore socks and tennis shoes and was able to propel himself freely in the wheelchair by using both feet. Staff stated that he was only 1:1 supervised for meals, and had to be "in sight supervised" at all times otherwise for safety due to attempts to rise and walk or during his Obsessive Compulsive Disorder (OCD) behaviors with destruction of property, repetitive bathroom

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use and hand washing. Individual #4 was not wearing his soft helmet.

On 10/22/20, Individual #4 was observed the following four times out of sight of the staff:

At 1:15 p.m., this surveyor was standing in a hallway at a corner wall to the left of the bathroom door and observed Individual #4, unbuckling his wheelchair seat belt and unsteadily transferred himself on the commode, after which he, in the same manner, transferred himself back in his wheelchair, re-buckled his seat belt, washed and dried his hands using approximately 10-15 paper towels.

At 1:25 p.m., Individual #4 wheeled into the same bathroom, remained in his wheelchair, again washed and dried his hands using too numerous to count paper towels.

At 1:28 p.m., Individual #4 repeated the same above behavior.

At 1:30 p.m., Individual #4 wheeled himself into the living room from the hallway, now clearly visible to staff at this point. He proceeded to the screened porch with one sock on. Approximately 1 minute later, Direct Support Professional (DSP) #6 headed into the screened porch to administer the individual's medication. The DSP stated that Individual #4 propels himself "Very, very fast" in his wheelchair and required "In sight supervision" due to escalation of OCD behaviors, rising out of his wheelchair and destructive tenancies to ensure is safety and safety of others. She stated that Individual #4 could ambulate, but was very unsteady, had a fall history and remained at high risk for falls. She stated all the staff keep eyes on

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Individual #4 throughout the home to maintain his safety and assist him to manage his OCD and destructive behaviors. She stated when in bed asleep, the staff implemented mandatory every (q)15 minute checks for his safety because he would get out of bed to go to the bathroom and not always to use it, but to constantly wash his hands.

The Data Forms, completed by the assigned DSP dated 10/22/20 for AM and PM did not indicate the OCD behavior that included unbuckling the seat belt of his wheelchair, going to the bathroom and or frequent handwashing events. There was a note in the AM on 10/22/20 that indicated Individual #4 banged his head on the wall and shaking hand while squeezing tightly.

On 10/23/20 at 1:40 p.m., Individual #4 was buckled in his wheelchair propelling himself quickly down a hallway, out of view of staff that were located in the living room area. Once he entered the living room, DSP #8, who was charting, asked him where he came from and "what were you up to?"

On 10/26/20 at 10:30 a.m., Individual #4 was in building #29 for day programing, sitting in his wheelchair at a table with his model trains and watching a movie. He was in the room with along with four other individuals from the same home. DSP #7 stated all staff in the room watch the individuals, but he was regularly assigned Individual #4. The DSP stated he could walk, but "speedily" and not safe without assistance from the staff. He stated, he unbuckles his seat belt and heads out of his chair or gets out of bed to go to bathroom. DSP #7 said, "When he is in the bathroom he likes to compulsively wash his

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hands and could splash water on the floor, slip, fall and possibly hit his head which he has done before. He comes out of bed quick too, also a chance of falls and has injured himself in the past coming out of the bed. We watch him every 15 minutes when he is in bed."

There were several documented incidents that involved Individual #4 behaviors to included pacing up and down hallways, pushing and grabbing staff, running back and forth to the bathroom, throwing himself on the bed, running in the living room, aggressively pushing staff. A review of the recent past three months of incident reports presented to this surveyor identified on 8/18/20, the individual was having a bad OCD event when he jumped off his bed to run to the bathroom, slipped and hit his head on the floor. On 10/17/20, while exhibiting OCD behaviors, Individual #4 was throwing toys from out of his room, kicking the dresser drawers and knocking three of them out of the structure of the dresser. Two of these dresser drawers were stacked on each other on top of the dresser structure which posed a potential danger of falling on the Individual with or without a behavioral outburst of OCD events. On 10/26/20 at 10:40 a.m., DSP #6 was with Individual #4 in building #29 for activities and movie time. She stated, "He did that about 2 weeks ago and I meant to get (name of the buildings and grounds person) to fix these drawers." She stated one of the drawers was placed in a storage area, but she is calling today to get them fixed. The condition of the broken stacked drawers on top of the dresser was observed throughout all days of the survey.

On 10/26/20 at 1:25 p.m., an interview was conducted with the Qualified Intellectual Disability

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Professional (QIDP) assigned to Individual #4. She stated the individual remains at high risk for falls at each annual assessment and after the assessment of each of his falls. She stated based on the issues with his spine, if he fell again, he could be paralyzed. She continued to say he has had injuries from running with a tendency to fall. She the individual preferred to use his wheelchair because he could get around quickly, but when he was cycling he moves even quicker sometimes escalating his behaviors with sweating, repetitively squeezing others hands too tightly and agitating other individuals. The QIDP stated she expected the staff to have kept Individual #4 in sight for his safety and to monitor OCD behaviors in accordance with his Behavioral Support Plan (BSP) (dated as reviewed on 5/20/20) and his Individual Support Plan (IPP) (dated 5/20/20 through 5/19/21).

On 10/26/20 at approximately 3:30 p.m., the aforementioned observations, staff interviews were shared with the facility Administrator and the Director of Compliance. They stated there was clear understanding of the presented issues. No further information provided prior to survey exit.

The Individual Support Plan (ISP) dated 5/20/20 through 5/19/21 indicated Individual #4 was at increased risk for falls and required in-sight supervision when out of his room to remain engaged and possibly deter any inappropriate behaviors. He required visual checks in his bedroom. The ISP notes Individual #4 was prone to falls due to axonal myopathy, ataxic gait and other chronic conditions that affect his balance and coordination.

The policy and procedures titled Guidelines for

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W 242	Continued From page 15 the Supervision dated 10/19/17 indicated that individuals and groups are to receive staff supervision and support consistent with individual needs and within parameters determined by the Individual Support plan (IPP). In-sight supervision: Visual observation of an individual by a minimum of one staff member. The staff member may be engaged in other activities simultaneously, including supervision of other individuals.	W 242		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the Specially Constituted Committee (SCC) failed to ensure well-defined parameters for a restrictive device (a soft helmet) were obtained prior to granting approval for the use of the helmet for 2 (Individual #3 and #4) of 6 Individuals in the survey sample. The findings included; 1. Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) on 5/8/19 with diagnoses that included profound Intellectual Disability, epilepsy, legal blindness, hypercholesterolemia, and hypothyroidism.	W 262		

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W 262	Continued From page 16 On 10/21/20 at approximately 3:45 p.m. Individual #3 was observed under the pavilion with another Individual and two Direct Service Personnel (DSP). Individual #3 was seated in a wheel chair with his head down as if asleep. He was wearing a black soft helmet on his head. Individual #3 was observed again on 10/22/20 at approximately 3:30 p.m., in the living room area. He was seated in a wheel chair with his head down. A neck napkin was donned around his neck and covering his chest area and a soft black helmet was on his head. A staff came over to the Individual and assisted him to stand utilizing a gait belt. The staff member instructed the individual to walk with him to the bathroom. Individual #3 unsteadily walked with the staff member's assistance into the bathroom. Upon Individual #3's return to the living room, he was assisted to sit in the wheel chair and the helmet remained on his head. On 10/23/20 at approximately 11:00 a.m., Individual #3 was again observed under the pavilion. He had a neck napkin donned around his neck and a soft black on his head. At approximately 12:07 p.m., Individual #3 was observed seated in a wheel chair at the dining table for the midday meal. He was wearing a neck napkin and a soft black helmet. An interview was conducted with DSP #4 at approximately 12:13 p.m., on 10/23/20, regarding removal of the helmet during meal time. DSP #4 stated the helmet is not removed for meals. An SCC review signed and dated 4/29/20, revealed the plan was approved for the following safety and specialized equipment: a soft shell helmet, gait belt, shower/commode chair, head of the bed elevation, bed side floor mat, shower	W 262		

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chair secured to the wall, bed alarm and an audio alarm...

The informed consent for medical and protective restraint form was signed and dated 10/22/20 by the facility's staff with a verbal consent from the authorized representative on 10/22/20. The form stated the soft helmet was to ensure safety and the Individual was unable to independently remove the soft helmet and the facility's staff hadn't identified an alternative to the helmet with similar benefits.

The Individual Support Plan (ISP) dated 4/8/20 through 4/7/21 listed the following adaptive equipment for use; floor mats, wheel chair with seat belt, bed alarm, Therarest mattress with blocks to elevate the head of the bed, shower chair with safety straps, soft shell helmet, built up handle coated spoon, nosey cup, high side sectional plate, dycem mat, Vagus Nerve Stimulation (VNS) magnet, and a gait belt. Also the ISP revealed under; "what others need to know to support me", (name of individual) has a soft shell helmet.

The October 2020, physician order summary contained an order dated 9/27/19 which read; soft helmet. No information could be located in the clinical record specifying when or when not to wear the soft shell helmet.

On 10/26/20 at approximately 2:40 p.m. an interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated Individual #3 was to wear the soft helmet when walking but he couldn't recall other parameters for use but he would follow-up and ensure specifics were documented and available

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to all staff.

The facility's policy dated 6/29/20, on the SCC read at procedure 3B; the SCC will review, approve and monitor Individual Behavior Support Plans and other plans that involve risks to Individual protection and rights restrictions, prior to plan implementing. At a minimum, such plans will include those which involve restraints, psychoactive medications, time out, restrictions on community access, or freedom at home and restrictions on other individual rights as determined by the committee. At procedure 3D it read; review and approve medical and protective restraint devices, physical management plans that involve protective restraints (for example, bed rails, safety straps, mitts or helmets) and similar restrictions will be reviewed at least annually.

On 10/26/20 at approximately 2:40 p.m., the above information was shared with the Administrator and the Director of Compliance. The Administrator stated she understood what was absent from the record and she would ensure the necessary information was acquired and made available for staff.

2. Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and

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objects, high blood pressure and seizures. and seizures.

On 10/21/20 at 7:40 a.m., Individual #4 was observed in his residence positioned in his wheelchair with seat belt at the dining table for the breakfast meal. He was 1:1 supervised during the meal by a Direct Support Professional (DSP). Following his meal, Individual #1 independently backed up and wheeled himself away from the table. Individual #4 was not wearing his soft helmet.

At 1:30 p.m., Individual #4 wheeled himself into the living room from the hallway, now clearly visible to staff at this point. He proceeded to the screened porch with one sock on. Approximately 1 minute later, Direct Support Professional (DSP) #6 headed into the screened porch to administer the individual's medication. The DSP stated that Individual #4 propels himself "very, very fast" in his wheelchair and required "in sight supervision" due to escalation of OCD behaviors, rising out of his wheelchair and destructive tenancies to ensure is safety and safety of others. When asked when he wore the soft helmet, she stated, " We put it on from time to time, if we think he needs it, especially if he starts banging his head against the wall, but no real times otherwise." She stated that Individual #4 could ambulate, but was very unsteady, had a fall history and remained at high risk for falls. She stated all the staff keep eyes on Individual #4 throughout the home to maintain his safety and assist him to manage his OCD and destructive behaviors. She stated when in bed asleep, the staff implemented mandatory every (q)15 minute checks for his safety because he would get out of bed to go to the bathroom and not always to use it, but to

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constantly wash his hands.

The Data Forms, completed by the assigned DSP dated 10/22/20 for AM and PM did not indicated the OCD behavior that included unbuckling the seat belt of his wheelchair, going to the bathroom and or frequent handwashing events. There was a note in the AM on 10/22/20 that indicated Individual #4 banged his head on the wall and shaking hand while squeezing tightly.

On 10/26/20 at 10:30 a.m., Individual #4 was in building #29 for day programing, sitting in his wheelchair at a table with his model trains and watching a movie. He was in the room with along with four other individuals from the same home. DSP #7 stated all staff in the room watch the individuals, but he was regularly assigned Individual #4. The DSP stated could walk, but "speedily" and not safe without assistance from the staff. He stated, he unbuckles his seat belt and heads out of his chair or gets out of bed to go to bathroom. DSP #7 said, "When he is in the bathroom he likes to compulsively wash his hands and could splash water on the floor, slip, fall and possibly hit his head which he has done before. He comes out of bed quick too, also a chance of falls and has injured himself in the past coming out of the bed. We watch him every 15 minutes when he is in bed." The DSP could not specifically give parameters the staff followed that required application of Individual #4's soft helmet. Another DSP#6 added that the soft helmet could be used when the individual started the behavior of banging his head against the wall, but they reserved the right to use it whenever they thought it was necessary for his safety.

Although there were several incidents that

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involved Individual #4 behaviors to included pacing up and down hallways, pushing and grabbing staff, running back and forth to the bathroom, throwing himself on the bed, running in the living room, aggressively pushing staff. A review of the recent past three months of incident reports presented to this surveyor identified on 8/18/20, the individual was having a bad OCD event when he jumped off his bed to run to the bathroom, slipped and hit his head on the floor. On 10/17/20, while exhibiting OCD behaviors, Individual #4 was throwing toys from out of his room, kicking the dresser drawers and knocking three of them out of the structure of the dresser. Two of these dresser drawers were stacked on each other on top of the dresser structure which posed a potential danger of falling on the Individual with or without a behavioral outburst of OCD events. On 10/26/20 at 10:40 a.m., DSP #6 was with Individual #4 in building #29 for activities and movie time. She stated, "He did that about 2 weeks ago and I meant to get (name of the buildings and grounds person) to fix these drawers." She stated one of the drawers was placed in a storage area, but she is calling today to get them fixed. The condition of the broken stacked drawers on top of the dresser was observed throughout all days of the survey.

On 10/26/20 at 1:25 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) assigned to Individual #4. She stated the individual remains at high risk for falls at each annual assessment and after the assessment of each of his falls. She stated based on the issues with his spine, if he fell again, he could be paralyzed. She continued to say he has had injuries from running with a tendency to fall. She the individual preferred to use his wheelchair

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because he could get around quickly, but when he was cycling he moves even quicker sometimes escalating his behaviors with sweating, repetitively squeezing others hands too tightly and agitating other individuals. When asked what parameters were in place that the staff used to apply the individual's soft helmet, she stated there was a consent and physician's order in place for the use of the helmet, but no parameters were addressed with the SCC. She stated the soft helmet was used when the individual starts to bang head on wall, and should probably wear the helmet when other OCD, cycling, agitated and destructive behaviors start to escalate to prevent injury. She stated the individual at times refused the soft helmet, but did not present the refusal documentation. She stated she plans to address the use of the soft helmet with the interdisciplinary team followed by a presentation at Individual #4's upcoming SCC review. The QIDP stated she expected the staff to have kept Individual #4 in sight for his safety and to monitor OCD behaviors in accordance with his Behavioral Support Plan (BSP) (dated as reviewed on 5/20/20) and his Individual Support Plan (IPP) (dated 5/20/20 through 5/19/21).

On 10/26/20 at approximately 3:30 p.m., the aforementioned observations, staff interviews were shared with the facility Administrator and the Director of Compliance. They stated there was clear understanding of the presented issues and that the SCC should have approved and reviewed use of the soft helmet for Individual #4. No further information provided prior to survey exit.

The Individual Support Plan (ISP) dated 5/20/20 through 5/19/21 identified adaptive equipment and assistive technology supports to include soft

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W 262	Continued From page 23 helmet, but no clear parameters for its use. The ISP notes Individual #4 was prone to falls due to axonal myopathy, ataxic gait and other chronic conditions that affect his balance and coordination. There were physician's orders dated 9/6/18, "Encourage use of helmet." The Physical Management Plan dated 5/14/20 soft helmet that the individual could remove. There was an informed consent dated 3/12/20 for the soft helmet with straps to ensure safety and protection during falls and there were no alternatives with similar benefits identified at the time of the signed consent. There was no SCC review presented to this surveyor for the soft helmet. The Behavioral Support Plan (BSP) dated 5/20/20 indicated, "(Individual #4's name) helmet will be used in accordance with physician orders." The BSP identified Self Injurious Behavior (SIB) that included using his head to hit objects, windows or walls with such force to potentially cause injury.	W 262		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility documentation review, the facility staff failed to provide 1 of 4 Individuals (Individual #4) with treatment as ordered by the physician. Specifically the facility staff failed to apply Individual #4's right leg TED (Thrombo-Embolic-Deterrent) hose. The findings include:	W 331		

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Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures.

The following observations were made of Individual #4 in residential and day program areas:

On 10/21/20 at 7:40 a.m., Individual #4 was observed in his residence positioned in his wheelchair with seat belt at the dining table for the breakfast meal. He was not wearing his physician ordered TED hose to the right leg. On 10/21/20 at 1:30 p.m., the Individual was not wearing his TED hose.

On 10/22/20, at 1:15 p.m., Individual #4 was not wearing his right leg TED hose.

On 10/22/20 at 1:30 p.m., Individual #4 wheeled himself into the living room from the hallway, now clearly visible to staff at this point. He proceeded to the screened porch with one sock on the right foot. Approximately 1 minute later, Direct Support Professional (DSP) #6 headed into the screened porch to administer the Individual's medication. The DSP took the Individual to his room and he returned with socks on each foot as

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well as tennis shoes, but no TED hose.

On 10/22/20 at 4:30 p.m., Individual #4 was not wearing his right leg TED hose.

On 10/23/20 at 1:40 p.m., the Individual had on white socks and tennis shoe, but was not wearing a TED hose. DSP #6 stated Individual #4 often removed his right leg TED hose.

On 10/26/20 at 10:30 p.m., Individual #4 was observed wearing his black right leg TED hose and a tennis shoe.

On 10/26/20 at 1:25 p.m., an interview was conducted with Individual #4's assigned Qualified Intellectual Disabilities Professional (QIDP). She was not able to confirm that nursing or the physician was made aware that Individual #4 was not consistently wearing the TED hose. She stated she knew he sometimes took the TED hose off, but expected the staff to re-apply the TED hose or tell her he consistently refused so she would ensure she addressed the issue with nursing and the physician.

Individual #4 had physician orders dated 1/18/17 to apply compression hose (TED) to right lower leg during the daytime and take off at bedtime-(facility staff to apply). The Treatment Administration Record (TAR) indicated the TED hose was applied in the AM and removed at bedtime. No notes were written on the back of the TAR that indicated Individual #4 refused or removed the right TED hose.

The Annual Nursing Summary dated 5/20/20 and the Individual Support Plan (ISP) dated 5/20/20 through 5/19/21 indicated the knee high TED

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W 331	Continued From page 26 hose was a treatment for dependent edema to the right lower leg. There were no notes from either of the aforementioned assessments/documents that indicated Individual #4 removed or refused to wear the TED hose. The ISP also set a desired outcome that included the individual would maintain an optimal level of health and that nursing was responsible for implementing, monitoring and making the necessary changes that would impact this outcome. On 10/26/20 at approximately 3:30 p.m., the aforementioned observations and staff interviews were shared with the facility Administrator and the Director of Compliance. They stated there was clear understanding of the presented issues. No further information provided prior to survey exit. The policy titled Personal Support Team (PST) dated 8/12/20 indicted the PST composed of many core members meet to determined the specialized needs through assessments and program planning that promotes a wider sharing of programming responsibilities. Nursing and DSPs are two of the many team members with shared participation in the PST discussion and decision-making regarding the individual.	W 331		
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, staff interviews, record	W 420		

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reviews, and facility documentation review, the facility staff failed to ensure 1 of 4 Individuals (Individual #4) in the survey summary was provided safe functional furniture. Individual #4's dresser drawers were broken and stacked on top of the dresser structure.

The findings include:

Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. and seizures.

On 10/21/20 at 8:00 a.m., upon observation into Individual #4's room, two dresser drawers were observed stacked on top of the dresser structure.

On 10/22/20 at 1:45 p.m., 4:30 p.m. and on 10/23/20 at 1:40 p.m., the condition of the dresser drawers remained unchanged.

There were several incidents documented that involved Individual #4's behaviors to included pacing up and down hallways, pushing and grabbing staff, running back and forth to the bathroom, throwing himself on the bed, running in the living room, aggressively pushing staff. A review of the recent past three months of incident

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reports presented to this surveyor identified on 8/18/20, the individual was having a bad OCD (obsessive-compulsive disorder) event when he jumped off his bed to run to the bathroom, slipped and hit his head on the floor. On 10/17/20, while exhibiting OCD behaviors, Individual #4 was throwing toys from out of his room, kicking the dresser drawers and knocking three of them out of the structure of the dresser. Two of these dresser drawers were stacked on each other on top of the dresser structure which posed a potential danger of falling on the Individual with or without a behavioral outburst of OCD events.

On 10/26/20 at 10:40 a.m., DSP #6 was with Individual #4 in building #29 for activities and movie time. She stated, "He did that about 2 weeks ago and I meant to get (name of the buildings and grounds person) to fix these drawers." She stated one of the drawers was placed in a storage area, but she is calling today to get them fixed. The condition of the broken stacked drawers on top of the dresser was observed throughout all days of the survey.

On 10/26/20 at 1:25 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) assigned to Individual #4. The QIDP stated Individual #4 displayed OCD behaviors that included destruction of property and forcefully kicking the dresser, breaking three drawers. She said she called the buildings and ground director to repair the dresser and drawers after this surveyor inquired about them earlier in the day with the DSP's in building #29.

On 10/26/20 at approximately 3:30 p.m., the aforementioned observations, staff interviews were shared with the facility Administrator and the

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W 420	Continued From page 29 Director of Compliance. No further information provided prior to survey exit. The facility's policy and procedures titled Request for Buildings and Grounds Department Services dated 2/28/19 indicated each area supervisor and their respective staff are responsible for frequent checks of their areas to identify and reports and safety hazards and maintenance deficiencies to the Building and Grounds Department.	W 420		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to assist Individual #1 with hand hygiene prior to her meal on 10/22/20; And failed to appropriately wear PPE (personal protective equipment) to include a face mask in a manner that covered both the nose and mouth; And failed to utilize surgical masks as directed by Administration when caring for individuals to prevent the development and/or transmission of a communicable disease (COVID-19) for 4 out of 15 facility homes. The findings included: 1a. Facility staff failed to assist Individual #1 with hand hygiene prior to dinner on 10/22/20. Individual # 1 was admitted to the facility on 12/16/75 with diagnoses that included but were	W 454		

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not limited to Scleroderma, Bipolar disorder, and unspecified neurocognitive disorder. Individual #1 was documented as having moderate intellectual disabilities.

On 10/22/20 observation was conducted from 3:26 p.m. until 6:04 p.m. of Individual #1.

On 10/22/20 at 5:19 p.m., OSM (Other Staff Member) #1, the Residential Manager, offered to take Individual #1 to the bathroom with a DSP (Direct Support Staff) member. Individual #1 declined stating that her brief was dry. Individual #1 was sitting in her wheelchair in the lounge area watching the news.

On 10/22/20 at 5:37 p.m., Individual #1 propelled herself from the lounge to the dining room table. DSP staff were observed to do hand hygiene on themselves prior to preparing meals.

On 10/22/20 at 5:42 p.m., Individual #1 was served her meal. Individual #1 was able to feed herself with set up help from staff. There was no evidence of staff assisting Individual #1 with hand hygiene prior to starting her meal.

On 10/23/20 at 12:30 p.m., an interview was conducted with DSP (Direct Support Staff) #5. When asked if Individuals were supposed to have hand hygiene performed prior to meals; DSP #5 stated, "Normally we try to wipe them down before meals." When asked what staff used to wipe Individuals hands, DSP #5 showed this writer a package of "Stay Dry Disposable Wipes" that were kept in the same cabinet as the clothing protectors.

On 10/23/20 at 12:37 p.m., DSP #5 showed this

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writer Individual #1's PMP (Program Management Plan) Schedule and stated, "It doesn't say in the PMP schedule to clean hands prior to eating, but we will clean hands after meals if they have food on them."

Review of Individual #1's Program Management Plan did not address hand hygiene anywhere in her daily schedule.

Review of Individual #1's ISP (Individual Support Plan) did not address hand hygiene.

On 10/26/20 at 10:38 a.m., an interview was conducted with (Other Staff Member) #1 , the Residential Manager of house 103. When asked how Individual #1 performed hand hygiene, OSM #1 stated that staff pull her wheelchair right up to the sink and that sometimes she can turn on the faucet herself and that other times the staff will assist with turning on the faucet. OSM #1 stated that Individual #1 can independently use the soap dispenser. OSM #1 stated Individual #1 can also use hand sanitizer when it is squeezed into her hand by staff. OSM #1 stated that Individual #1 can wipe the sanitizer into her hands independently. When asked what a hand hygiene program looked like, OSM #1 stated that a hand hygiene program usually provided step by step instructions on how the individual was to perform hand hygiene. When asked why Individual #1 did not have a hand hygiene program; OSM #1 stated that not all Individuals had a hand hygiene program; especially if they were not trainable. When asked if Individual #1 was trainable, OSM #1 stated that she was. OSM #1 stated that she wasn't sure why it was decided for Individual #1 to not have a hand hygiene program. When asked when she expected her staff to perform hand

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hygiene on Individuals, OSM #1 stated that she expected staff to perform or assist with hand hygiene before and after meals.

On 10/26/20 at 1:25 p.m., an interview was conducted with OSM #6 , the QIDP (Qualified Intellectual Disabilities Professional) for house #103. When asked how Individual #1 performed hand hygiene; OSM #6 stated that Individual #1 needed staff assistance with hand hygiene. OSM #6 stated that Individual #1 could propel to the sink but that she sometimes needed assistance with the faucet and maybe applying the soap. OSM #6 could not say for sure if Individual #1 needed assistance with applying soap. When asked if she expected staff to assist with hand hygiene prior to meals, OSM #6 stated that she would expect staff to clean all individuals hands prior to meals. When asked why she would expect this, OSM #6 stated to prevent infection. OSM #6 also stated that it was "No different between you and I before we eat." When asked if Individual #1 had a program in place for hand hygiene, OSM #6 stated that she didn't see one. When asked if every individual needed a hand hygiene program in place, OSM #6 stated, "Not necessarily." OSM #6 stated that hand hygiene was a strength of Individual #1 that did not need training. OSM #6 stated that hand hygiene was coded as a strength on her comprehensive assessment.

Review of Individual #1's comprehensive assessment dated 3/18/18 revealed that hand washing was one of her strengths and that no training was required.

On 10/26/20 at 2:54 p.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2,

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the Director of Compliance were made aware of the above concerns.

Facility policy titled, "Personal Hygiene" documented in part, the following: "Hand hygiene for individuals is the same as hand hygiene for employees! Hands must be washed:...Before eating food..."

No further information was presented prior to exit.

1b. Facility staff failed to wear surgical masks in a manner to prevent the spread of infection in home #103.

On 10/22/20 at 3:26 p.m., an observation was made of the housekeeper (OSM #5) in house #103. OSM #5 was observed in the dining area sweeping the floor. OSM #5 had her surgical mask right underneath her nostrils.

On 10/22/20 at 3:31 p.m., OSM #5 had her surgical mask down by her mouth area. OSM #5 was still in the dining area at this time in close proximity to an individual who was using the dining room table to color.

On 10/22/20 at 3:35 p.m., OSM #5 was still observed to have her surgical mask down by her mouth; at this time she was mopping the kitchen.

On 10/22/20 at 3:41 p.m., OSM #5 was observed placing her surgical mask back to covering her nose.

On 10/26/20 at 10:38 a.m., an interview was conducted with OSM #1, the Residential Manager for house #103. When asked how she expected her staff to wear their surgical masks while in the

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house, OSM #1 stated that she expected staff to cover their entire nose. OSM #1 was told about the above observations. OSM #1 stated that she knows some of the surgical masks slide down the face, and it was hard to keep the mask on the bridge of the nose.

On 10/26/20 at 1:05 p.m., an interview was conducted with OSM #4, the Director of Housekeeping. When asked what he expected his housekeeping staff to don while working in house 103, OSM #4 stated that he expected staff to wear a surgical mask covering the entire mouth and nose. OSM #4 stated he would expect staff to wear other PPE if a house was under quarantine or isolation for a suspected/actual COVID case. When asked the purpose of wearing PPE correctly while in the houses, OSM #4 stated the purpose of wearing the appropriate PPE was to prevent the spread of the contagion from one person to another. When asked if OSM #5 had been trained in how to wear PPE; OSM #4 stated that she was but could not recall the exact date.

On 10/26/20 at approximately 1:30 p.m., ASM (Administrative Staff Member) #1, the Administrator, presented this writer a copy of staff signature sheets showing that education regarding PPE use was conducted on 4/24/20. OSM #5 had signed that she received this education.

On 10/26/20 at 2:54 p.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Compliance were made aware of the above concerns. No further information was provided prior to exit.

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2. On 10/23/20 at approximately 12:07 p.m., during an observation of the midday meal in the #204 Residence. Direct Service Personnel (DSP) #2 was observed seated at the dining table cueing an Individual with the surgical mask below the nose. At this time a conversation was started with DSP #3; DSP #3 lowered the surgical mask to make talking easier, immediately after jogging DSP #3's memory to keep the mask in place, the surgical mask was repositioned and the conversation was completed without further removal of the surgical mask. As DSP #3 adjusted the mask, DSP #2 was also observed adjusting her surgical mask but it continued to fall below her nose each time she cued the individual with the meal.

An interview was conducted with DSP #2 at approximately 12:25 p.m. on 10/23/20. DSP #2 stated the mask was donned appropriately with the metal clip on the bridge of her nose but the mask just wouldn't stay in place. DSP #2 wasn't observed attempting to don a new mask or notifying anyone of the concern. At approximately 12:40 p.m., DSP #2 was still in the residential living room with an individual with the surgical mask below the nose.

On 10/26/20 at approximately 2:40 p.m., the above information was shared with the Administrator and the Director of Compliance. The Director of Compliance stated all staff had been educated on how to don and doff all personal protective equipment (PPE) including the surgical mask and how to utilize PPE when on duty. The Director of Compliance also stated they have random compliance rounds for such purposes.

3. On 3/21/20 at 6:45 a.m., upon entry into

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residence #303, one DSP was observed with wearing a personal facemask positioned under their chin. A second DSP wore a surgical mask positioned below their nose.

The following observations were made in #305:

On 3/22/20 at 7:40 a.m., DSP #10 wore his surgical facemask below his nose and did not attempt to reposition the facemask. The DSP was less than 6 feet physical distance during his interactions with the facility's individuals and staff.

On 10/22/20 at 1:00 p.m., DSP #10 continued to wear his surgical facemask below his nose. DSP #6 repeatedly told him to pull his surgical facemask over his nose.

On 10/22/20 at 1:35 p.m., DSP #10 entered the home without a face mask, walked in and out of the staff office twice passing other individuals and staff without a facemask. At 1:50 p.m., DSP #10 came out of the staff office wearing a surgical facemask. The DSP stated he actually started his shift at 2:00 p.m., but often came early for his shift.

On 10/22/20 from 4:00 p.m. to 4:30 p.m., DSP #9 wore his personal facemask below his nose. It appeared that the facemask was too small which made it difficult to maintain over both mouth and nose.

On 10/23/20 from 1:40 p.m. to 2:10 p.m., DSP #8 was sitting in a chair in the living room area charting where other individuals were located. He specifically attended to several individuals with his mask positioned under his chin and less than 6 feet physical distance.

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W 454	Continued From page 37 The House Manager/Qualified Individual for Intellectual Disabilities (QIDP) for #305 was also observed during the aforementioned observations with a personal one layer facemask that touched slightly under the tip of her nose. On 10/26/20 at 1:25 p.m., the House Manager/QIDP was interviewed wearing another personal facemask that adequately covered both mouth and nose. She stated she recognized the facemask she previously wore during the above observations was not adequate and threw it away. On 10/26/20 at approximately 3:30 p.m., the aforementioned observations and staff interviews were shared with the facility Administrator and Director of Compliance. The Director of Compliance stated she instructed and educated all staff to wear a surgical facemask when in contact and attending to the facility's individuals. She provided inservice records with originals staff signatures on the Coronavirus/Pandemic Plan that addressed proper wearing of facemask and that surgical facemask were to be worn during the care and in the presence of the facility's individuals, other wise personal facemask were acceptable. No further information was provided to survey exit.	W 454		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455		

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W 455	Continued From page 38 This STANDARD is not met as evidenced by: Based on observations and staff interviews the facility's staff failed to ensure infection control measures were implemented to prevent the development and/or transmission of infectious diseases during the medication pour and pass observation on 10/21/20. The findings included: On 10/21/20 at approximately 1:00 p.m., through 2:10 p.m., medication pour and pass observations were observed. Direct Service Personnel (DSP) #1 was observed placing pudding, apple sauce, water, medication cups and a glass measuring cup on a round plastic blue plate. The plate held an extension tubing for a low profile feeding tube (medical device used to provide nutrition to an individual), a 60 cubic centimeter syringe and a liquid white substance was observed around the rim of the plate at all time. At no point did DSP #1 clean the blue plate or apply a barrier. At approximately 2:23 p.m., an interview was conducted with DSP #1, who stated the plate, tubing and syringe all belonged to another specific individual since sometimes they have to take medications to him instead of him coming into the medication room as most residents are required to do. DSP #1 stated she was extremely nervous and it was a mistake to use the plate especially containing used products from another individual. On 10/26/20 at approximately 2:40 p.m., the above information was shared with the Administrator and the Director of Compliance. The facility staff offered no additional information.	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G005	A. BUILDING _____ B. WING _____	10/26/2020

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W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to ensure the Individual Support Plan (ISP) and physician orders were implemented for thickened liquids to achieve adequate hydration for 1 of 6 individuals (Individual #3), in the survey sample. The findings included; Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) facility on 5/8/19 with diagnoses that included profound Intellectual Disability, epilepsy, legal blindness, hypercholesterolemia, and hypothyroidism. On 10/23/20 at approximately 12:07 p.m., Individual #3 was observed seated in a wheel chair at the dining table for the midday meal. He was wearing a neck napkin and a soft black helmet and kept his head lowered. Individual #3 had a high rimmed sectional plate holding his meal but staff fed him with no attempted interaction from the individual. After all the food was consumed Direct Service Personnel (DSP) #4 introduced a red thin liquid in a nosy cup to Individual #3's mouth. Individual #3 quickly and repeatedly lifted his head, and pushed the cup away each time the liquid touched his lips without ingesting the drink. On 10/23/20 at approximately 12:12 p.m., an	W 474		

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W 474	Continued From page 40	W 474		

interview was conducted with DSP #4 to determine if use of extremely thick liquids would be implemented to encourage Individual #3 to accept the red liquid in the nosey cup. DSP #4 stated another Individual consumed thickened liquids but Individual #3 didn't consume thickened liquids. DSP #3 overheard the interview and provided a beverage thickened but not to the point it required a spoon to scoop up. The beverage was still a thinner drinkable consistency and Individual #3 still wouldn't consume it. Individual #3's fluids were left at the table and discarded by the staff.

A nursing summary dated 4/8/20 read: dehydration risk assessment summary 3/18/20, lacks understanding about fluid needs and causes of dehydration, fluids calculated in diet plan. The diet plan included thin liquids unless refused, then thicken liquids to pudding consistency, Serve 4 ounces of prune juice at breakfast, skim milk at breakfast, lunch and dinner. May add chocolate syrup to milk with lunch and dinner, one serving of jell-o for a.m., and p.m., snacks and shaved ice with flavored syrup by spoon to increase fluid intake.

The physician's order summary for October 2020 revealed the following undated diet orders: if food arrives too runny/thin staff may thicken with potato flakes as needed. Minced and moist texture for all foods. No added salt, 2500 calorie meal plan - large/double portions, offer thin liquids but may thicken to extremely thick if refused and consume with a spoon.

The Registered Dietitian summary dated 10/1/20 also stated if thin liquids are refused by cup to offer liquids thickened to "extremely thick" and

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W 474	Continued From page 41 allow him to spoon from a bowl. Serve 4 ounces of prune juice at breakfast, skim milk at all meals, may add chocolate syrup to milk given with meals, plain milk with cereal. Additional 8 ounces of clear fluids (not Gatorade due to its sodium contents) should be offered twice daily at 10:00 a.m., and 3:00 p.m., daily. Individual #3 likes chocolate milk served cold but other beverages are to served at room temperature. The Individual Support Plan (ISP) dated 4/8/20 through 4/7/21 included problem #28 Maintain optimal nutritional status which was partially met. The interventions included: if thin liquids are refused by cup, offer liquids thickened to pudding-like consistency and allow him to spoon it from a bowl because drinking fluids are challenging for Individual #3. On 10/26/20 at approximately 2:40 p.m., the above information was shared with the Administrator and the Director of Compliance. The Director of Compliance stated the ISP and physician's orders should have been followed to encourage Individual #3 to consume the fluids.	W 474		