STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G017	A. BUILDING _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE HOMES	5945 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

(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 000	INITIAL COMMENTS As a result of the annual health survey, standard-level deficiencies were cited at W130, W237, W249, W250 and W323. The investigation of #98944-I resulted in determination of Immediate Jeopardy (IJ) with deficiency cited at W189. On 9/13/21 at 3:00 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff checked on clients as directed by the individual program plan to ensure their health and safety. The facility was notified of the IJ on 9/13/21 at 3:20 p.m. The facility developed a plan to remove the IJ, which included the retraining staff on policies/procedures for checking clients well-being as required for their health and safety. The IJ was removed on 9/14/21 at 2:30 p.m. The facility was found to be out of compliance with the Condition of Participation (COP) Facility Staffing. The condition-level deficiency was cited at W158 and a standard-level deficiency was cited at W189. The investigation of 98941-I was completed from 8/10/21 to 9/13/21. As a result of the investigation a Standard Level deficiency was cited at W154. A focused infection control survey was also completed at this time. No concerns were identified.	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients.	W 130		

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

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W 130	Continued From page 1 Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the rights of all clients by ensuring each client was provided with privacy during personal cares. This affected one client added to the sample (Client #5). Findings follow: Observations on 8/3/21 at 8:25 a.m. revealed Rehabilitation Living Assistant (RLA) B prepared to assist Clients #5 with personal hygiene in her room. Continued observation revealed RLA B exited the room as Client #5 sat on her bed topless with a brief pulled around her ankles. Client #5 remained in this position with her door open for approximately five to seven minutes before RLA B returned to assist her. Record review revealed a Facility's Policy for Consumer and Staff Guidelines (CSG) last revised 11/4/13 which communicated the client's right to privacy during personal cares. The document specifically indicated doors needed to be shut during personal cares. When interviewed on 8/4/21 at 4:45 p.m. the Administrator confirmed staff failed to protect the privacy of the resident by leaving the door open while the client was undressed during personal cares.	W 130		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)	W 154		

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W 154	Continued From page 2 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure all client injuries were thoroughly investigated to include the identification and determination of failed safeguards put in place to prevent injury. This affected 1 of 1 clients (Client #13) involved in incident 98941-I. Record review revealed two separate incident reports were filled out regarding Client #13 on 7/25/21. One incident report from 8:45 a.m. revealed the client purposely dropped to the floor and hit her head on the floor in her bedroom when she discovered staff wanted her to take a shower. The report indicated staff should monitor for injury to buttocks and/or forehead as a result. The second incident report was filled out at 7:20 p.m. when the client was found in her bedroom on the floor with scratches on her head. Further record review revealed a facility investigation report indicated the client initially refused to get out of bed and was limping once she did on the next morning on 7/26/21. She was taken to Mercy ER for x-rays of her left hip indicating no fracture and she returned home. Continued observations over the next couple days revealed no swelling, but worsening pain and the client refused to stand or walk. On 7/30/21 the facility took her back to Mercy for more x-rays and a CT scan. The facility was told the scans came back normal but the hospital wanted to admit her for observations and PT due to facility reports of her lack of normal desire to	W 154		

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ambulate. On 8/2/21 Mercy nurses stated she was still not walking and another CT scan and x-ray were ordered. The 8/2/21 the x-ray showed a fracture to the right hip without the need for surgery.

When interviewed on 8/10/21 at 2:46 p.m. the LPN confirmed she found Client #13 on the floor in her room on 7/25/21 around 7:20 p.m. She stated she went to get the client for medications when she found her. Eventually she helped her off of the floor and noticed a slight limp which she hadn't noticed earlier in the day. She also remembered the client pointed to her hip which potentially signified pain or a problem. She also stated she was aware the client needed assistance when she walked and had an alarm on her chair and monitor in her room. She stated she was so concerned with the client's potential injuries (being a nurse) she didn't even think about the alarm at the time. She stated she did not know whether it was set, whether the client had disconnected it herself or what happened as she forgot to look. She mentioned the client had on occasion figured out how to get the alarm off. As far as she knew no one looked to see about the condition of the alarm.

An interview with the Program Coordinator (PC) on 8/11/21 between 9:47 a.m. and 10:15 a.m. revealed the client had poor balance, seizures, osteopenia and needed staff to hold onto her as she walked. The PC stated when the client was in her bedroom she had an alarm attached to her as well as a monitor to pick up sound from her room. She reported when staff heard the alarm they ran to her room to help her. The PC further explained the client liked to walk a lot and needed 1 to 2 staff's assistance when she did. She

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W 154	Continued From page 4 stated even though they don't know exactly when the injury occurred on 7/25/21 or whether the alarm was not attached correctly at the time of the second fall on 7/25/21 they retrained staff on the alarm and the importance of it. The Program Coordinator confirmed they had found on some occasions the client disconnected the alarm, but it had not resulted in injury in the past. She stated they also adjusted the alarm to make it more difficult for the client to disconnect just in case she had disconnected it on 7/25/21 before she was found on the floor. When interviewed on 9/8/21 at 4:00 p.m. the Administrator reported the facility investigated why the alarm never went off, but were not able to find anyone who had checked on the alarm and could tell of its condition after the client was found on the floor at 7:20 p.m. on 7/25/21. She stated they talked to multiple staff and provided documentation no one checked the alarm status after the client was found. The Administrator reported since the incident staff had been retrained to ensure they knew how to put the alarm on the client and why it was important.	W 154		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to comply with the Condition of Participation (CoP) - Facility Staffing. The facility failed to ensure staff were adequately trained on agency procedures to consistently check on the	W 158		

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W 158	Continued From page 5 well-being of clients on each shift as required. Cross reference W189: Based on observations, interviews and record reviews, the facility failed to ensure staff were trained to consistently evaluate and respond to client needs as outlined in agency policies. The investigation of #98944-I resulted in determination of Immediate Jeopardy (IJ) with deficiency cited at W189. On 9/13/21 at 3:00 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff checked on clients as directed by the individual program plan to ensure their health and safety. The facility was notified of the IJ on 9/13/21 at 3:20 p.m. The facility developed a plan to remove the IJ, which included the retraining staff on policies/procedures for checking clients well-being as required for their health and safety. The IJ was removed on 9/14/21 at 2:30 p.m.	W 158		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff were trained to consistently evaluate and respond to client needs as outlined in agency policies. This affected 1 of 2 sample clients in House #3 (Client #3) and 1 of 1 clients involved in 98944-I (Client #12).	W 189		

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Findings follow:

1. Record review revealed Courage Homes reported the 7/29/21 death of Client #12 to the Department of Inspections and Appeals on 7/30/21. Review of a facility investigation dated 7/30/21 revealed Client #12 had a significant medical history which included being on Hospice from 2018 to 2020. In March 2020 after being diagnosed with Covid-19 it was determined the client needed 3L of oxygen per day to prevent his oxygen from dropping. The investigation further revealed the client battled bronchial congestion, a wound on his ankle and bleeding around his colostomy site in June 2021. Review of the investigation along with nursing notes indicated the client showed improvement during July 2021 when his lungs sounded clear. The report further revealed on 7/27/21 Client #12 was found in bed with a temperature of 100 degrees, lungs sounded rhonchi bilaterally with O2 between 72-78%. The facility took the client to the emergency room on 7/27/21 and on 7/28/21 the facility nurse was informed the client had pneumonia and a UTI which was causing septic shock. The report concluded the client was placed on Hospice again and returned to Courage Homes on 7/29/21 at 5:00 p.m. before he passed away later in the evening.

Record review of a facility bed check log for the south side of the home (which included Client #12) was left blank
for the entire shift. The document indicated the client needed to be check every 30 minutes from 9:30 p.m. on 7/26/21 to 5:30 p.m. on 7/27/21, but the log was blank. Review of an accountability sheet revealed at 5:30 a.m. the checks were

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changed from every 30 minutes to every 15 minutes. Further record review of staff schedules revealed Residential Living Assistant (RLA) G was assigned to the Client#12's care for the overnight shift.

Record review revealed a facility policy which outlined the responsibility of staff regarding the accountability checks. Point #3 on the document indicated "The staff who is assuming responsibility for the member is to visibly check on the well-being of the member and initial the card with the time".

When interviewed on 8/10/21 at 10:35 a.m. RLA F stated she entered Client #12's bedroom around 8:00 a.m. on 7/27/21 to get him up for the day. She stated the client barely responded to her and did not look well. She stated she noticed his color was not good and he was clammy/sweaty so she called the LPN right away to make an assessment. She stated this was the first time she had seen the client that day and felt none of the other staff had likely looked him over very closely since they came on shift at 5:30 a.m. or they would have likely noticed his poor condition.

When interviewed on 8/10/21 at 9:33 a.m. the LPN indicated she was asked by RLA F to come look at Client #12 around 8:00 a.m. on 7/27/21. The LPN reported she was told by RLA F the client did not look well. The LPN reported when she saw the client she noticed his color was bad, his O2 was very low and he had a temperature of 100 degrees. The LPN stated she called the DON who came and observed the client and a decision was made to take him to the hospital.

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When interviewed on 8/11/21 at 8:37 a.m. RLA E confirmed her signature on the accountability card for Client #12 on the morning of 7/27/21 from 5:30 a.m. to 9:15 a.m. She stated most of the time she just initialed the box without making an assessment of the client as they were short staffed and she was just trying to fill in the box as required. When asked if she remembered how the client looked that morning she stated he looked like usual. She stated she did not notice him sweating or that his color was not good.

When interviewed on 9/9/21 RLA G confirmed she had worked with Client #12 in the past, but could not confirm she worked with him on 7/26/21 without looking at the records. Client #12 stated she usually worked in House #1, but occasionally worked in House #2. She stated she is usually very good about documenting her 30 minute checks, but admitted there may be a few nights she forgot to document her checks. RLA G stated she was aware every 30 minutes each client needed to be checked. The RLA stated Client #12 needed his oxegen checked (as sometimes he knocked it off), his catheter checked for kinks in the line, his ostomy bag checked and his overall well-being to make sure he was okay.

When interviewed on 8/11/21 at 8:49 a.m. the Qualified Intellectual Disabilities Professional (QIDP) stated the accountability policy had been in place for a long time and staff had been trained on it many times. When asked for a copy of RLA E's signed training she stated she could not find one. She confirmed the policy indicated when staff initialed the accountability box they were saying they saw the client and checked on their "well-being" and found them to be in satisfactory

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condition. She verified staff were not to check the box without seeing the client. When interviewed again on 9/9/21 the QIDP told the surveyor and showed on the schedule RLA G was assigned to Client #12's care on the overnight shift from 7/26/21 to 7/27/21 until 5:30 a.m. The QIDP provided a copy of the blank check sheet and confirmed RLA G failed to document any checks all night for the client. Further review revealed she worked in House #2 again on 8/21/21 and failed to document any checks. The QIDP stated the overnight supervisor had been home sick and recently passed away so she was supposed to check the overnight logs in her place, but only did so occasionally and missed the failed checks on 7/26/21 and 8/21/21 by RLA G. The QIDP confirmed facility staff failed to document check for Client #12 from 9:30 p.m. to 5:30 a.m. on 7/27/21 and by the admission RLA E failed to check the client as required from 5:30 a.m. to 8:00 a.m. when he was discovered very ill by RLA F.

When interviewed on 8/11/21 at 10:05 a.m. the Administrator confirmed staff failed to check on Client #12 as required on the morning of 7/27/21 between 5:30 a.m. and 8:00 a.m. but just initialed the box. She confirmed the policy was long standing and staff had recently been trained they needed to see and assess the client's well-being before they checked the box on the accountability sheet.

2. Observations on 8/3/21 at 11:41 a.m. revealed Client #3 finished eating and was moved to the living room in his wheelchair. The client yelled out "Baa" to staff shortly after being parked in the living room. Residential Living Associate (RLA) C responded to the client and asked him if he

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needed to use the restroom, to which he shook his head yes. RLA C then told him to wait until his staff was free to take him. At 11:45 a.m. Client #3 continued to yell out "Baa" to staff and appeared frustrated with no response from staff. Six minutes after his initial request at 11:47 a.m. RLA C told RLA D Client #3 needed to use the restroom despite both being in the dining room since the initial request. The client continued to make a groaning noise as well as say "Baa" off and on until 11:56 a.m. when RLA D took him down the hall towards the restroom. At 11:58 a.m. the client was found seated in his wheelchair in the hallway down by his bedroom. At 11:59 a.m. RLA D came out of another client's bedroom and took Client #3 to the restroom.

Record review revealed a Mid-Step policy for consumer and staff guidelines which revealed clients were always to be treated with dignity and respect and should be encouraged to make choices. The policy further stated clients who experienced toileting accidents were to be cleaned up as soon as possible as staff were responsible for the physical appearance and cleanliness of the clients they are assigned to.

When interviewed on 8/4/21 at 4:30 p.m. the Administrator and Program Coordinator confirmed Client #3 had toileting accidents, but could tell staff he needed use the restroom by saying "Baa". When told he repeated "Baa" numerous times for almost 18 minutes while staff were aware of his need she agreed staff failed to get him to the restroom in a timely manner. They also confirmed it didn't have to be his assigned staff who took him to the restroom as anyone of several staff in the area could have taken him. They were also aware the client had a higher risk

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W 189	Continued From page 11 than most for skin breakdown. On 9/13/21 at 3:00 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff checked on clients as directed by the individual program plan to ensure their health and safety. The facility was notified of the IJ on 9/13/21 at 3:20 p.m. The facility developed a plan to remove the IJ, which included the retraining staff on policies/procedures for checking clients well-being as required for their health and safety. The IJ was removed on 9/14/21 at 2:30 p.m.	W 189		
W 237	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(iv) Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure staff documented program data as outlined in the clients individual programs. This affected 4 of 4 sample clients (Client #1, Client #2, Client #3 and Client #4). Findings follow: Record review revealed a program for Client #1 where she needed to identify which medications were to be taken once per day during medication administration. Record review of program data revealed staff failed to record data for 13 of 30 scheduled trials in June 2021 and failed to record	W 237		

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data for 12 of 31 trials in July 2021. Continued review revealed a program where the client needed to participate in tooth brushing twice a day. Review of program data revealed staff failed to document 21 of 62 scheduled trials for May 2021 and failed to document 16 of 62 program trials in July 2021.

Record review revealed a program for Client #2 where the client needed to assist with clearing the table after meals three times a day (once at each meal). Record review of program data revealed staff failed to record data for 7 of 31 scheduled trials after breakfast in July 2021 and failed to document any data trials after lunch and dinner missing an additional 62 training opportunities. Continued review revealed Client #2 need to participate in an activity for a short time at least twice per day. Review of program data for July 2021 revealed staff failed to report 25 of 62 scheduled trials.

Record review revealed a program for Client #3 where the client needed to identify which medications were to be taken. The program indicated it would be run once per day during the morning medication pass. Record review of program data revealed staff failed to document data for 18 of 30 scheduled trials in May 2021 and staff failed to document 13 of 31 trials in July 2021. Record review also revealed a program for the client where he needed to dust an area of the house for 5 minutes once per day. Review of the program data for July 2021 revealed staff failed to record data for 14 of 31 scheduled trials. Continued record review for Client #3 revealed a program where the client participated in tooth brushing twice a day. Review of program data revealed staff failed to document 13 of 58

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W 237	Continued From page 13 scheduled trials in May 2021, 10 of 30 trials on the p.m. shift in June 2021 and 13 of 58 possible trials during July 2021. Record review revealed a program for Client #4 where the client needed to participate in medication administration twice per day. Record review of data revealed staff failed to record program data for 37 of 62 scheduled trials in May 2021, 16 of 60 scheduled trials in June 2021 and 41 of 62 scheduled trials in July 2021. Further review of Client #4's record revealed a tooth brushing program where staff needed to document client participation twice a day. Review of data for July 2021 revealed staff failed to document for 14 of 62 scheduled trials. When interviewed on 8/4/21 at the Program Coordinator (PC) confirmed staff failed to document programs as they were required to. The PC indicated due to staff shortages some staff worked doubles and were often allowed to go home before the end of second shift once the clients were in bed. She believed it was these staff who likely failed to document program data as it was often done after the clients were in bed and those staff had been allowed to leave. When interviewed on 8/4/21 at 4:00 p.m. the Administrator and the PC confirmed staff failed to record program data as scheduled. She confirmed the importance of program data for determining client progression towards learning new skills and stated staff needed to be retrained on the expectation of recording program data.	W 237		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure client programs were followed as written while being provided with consistent opportunities for active treatment throughout each day as outlined in the agency policy. This affected 1 of 2 sample clients in House #3 (Client #3) and 6 clients added to the sample (Client #6, Client #7, Client #8, Client #9, Client #10 and Client #11).

Findings follow:

1. Observations on 8/2/21 from 3:10 p.m. to 6:00 p.m. revealed Client #3 primarily in his wheelchair in the living room area or in his bedroom in bed. Continued observations on 8/3/21 from 7:00 a.m. to 10:45 a.m. revealed Client #3 primarily in the living room area or the den in his wheelchair. During the observations the client was seen yelling/groaning out loud on multiple occasions and occasionally asked by staff about what he needed. During none of the observations was the client offered a picture boards to assist with communication of his need.

Record review revealed a program for Client #3 which indicated he would display appropriate

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social responses throughout the day. The goal of the program was for the client to exhibit less than 5 instances of attention seeking behavior per month. The behavior was defined as vocalizing a loud series of yelling or screaming. The program indicated the client would have his "communication pictures with him at all times". The program further indicated staff would allow the client to make a choice of the activity or group he would like to join by showing him the picture card. The program further noted the client needed to be encouraged to use the picture cards anytime he would like assistance or had a request. The program noted if the client pointed to a picture staff needed to honor the request as soon as possible or explain why they could not.

When interviewed on 8/3/21 at 10:45 a.m. Residential Living Assistant (RLA) C stated she was aware Client #3 had a picture card he needed to use throughout the day, but she did not know where it was. The RLA looked and stated they were not in his data book or his bag on the back of his wheelchair.

Additional interviews with the Administrator on 8/3/21 at 10:50 a.m. confirmed the picture cards were part of Client #3's program and needed to be with him at all times and used by staff to communicate with the client. The Administrator asked the Program Coordinator (PC) to get the cards to show the surveyor. At 10:55 a.m. the PC came back and reported she could not find the program cards in any of the usual spots. At 11:05 a.m. the PC reported she found the card and would put it in the clients bag on the back of his chair where it belonged. She confirmed it was often taken out at appointments and someone likely forgot to put it back. She confirmed staff

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should have noticed the card was missing as was to be used regularly as part of the client's programming and that it may have been absent from his bag since a recent off campus appointment.

2. Observations in House #3 on 8/2/21 from 3:10 p.m. to 6:00 p.m. revealed Client #9 spent most of his time in a recliner in the small living room. The client received little to no attention from staff and was not observed engaged in any activities outside of eating meals. Observations during the same time frame revealed Client #10 was seated mostly in the dining room with a piece of string in her hands which she often put in her mouth and pulled back out. Client #10 also received little to no attention from staff outside of meal times. During the same observations Client #11 spent almost all of his time in a recliner in the living room. Client #11 also received very little attention from staff and was not observed to participate in any activities during the observations outside of meal times.

Record review revealed an active treatment schedule for Client #10, but failed to find one for Client #9 or Client #11. Further record review revealed the Facility's policy Consumer and Staff Guidelines (CSG), last revised 11/4/13, recommended "As a general rule, consumers are to be engaged in activities as specified in their schedules." The CSG also communicated "Those who do not wish to engage in the general schedule should be provided alternative activities and/or prompted to join the group(s) at least every 10 minutes."

When interviewed on 8/4/21 at 4:35 p.m. the Program Coordinator (PC) and the Administrator

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confirmed the schedule for Client #10 was old and out of date. They also confirmed Client's #9 and #11 didn't have active treatment schedules at all. The PC confirmed she had not updated or created any active treatment schedules since she started in House #3 a little over 6 months earlier. The Administrator confirmed staff needed to provide clients #9, #10 and #11 with consistent interactions and activities throughout the day by staff as part of their active treatment.

3. Observations in House #2 on 8/2/21 from 3:50 p.m. to 5:15 p.m. revealed Client #6 seated in a recliner in his bedroom with minimal interactions with staff. During the same time period Client #7 and Client #8 were in their rooms in bed with minimal interactions with staff. Additional observations on 8/3/21 from 1:00 p.m. to 3:00 p.m. revealed Client #6, Client #7 and Client #8 in their bedrooms either in bed or in a recliner with very minimal interactions with staff. The only activity for any of the clients during the observations was Client #6 provided with 5 minutes of exercise (walking) by RLA A from 2:25 p.m. to 2:30 p.m. on 8/3/21.

Record review revealed all Client #6, Client #7 and Client #8 all had active treatment schedules which indicated they were supposed to be consistently provided with activities all throughout the day. Further record review revealed the Facility's policy Consumer and Staff Guidelines (CSG), last revised 11/4/13, recommended "As a general rule, consumers are to be engaged in activities as specified in their schedules." The CSG also communicated "Those who do not wish to engage in the general schedule should be provided alternative activities and/or prompted to join the group(s) at least every 10 minutes."

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W 249	Continued From page 18 When interviewed on 8/4/21 at 4:35 p.m. the Administrator confirmed staff needed to provide all clients with consistent interactions and opportunities for active treatment throughout the day as outlined in their policy on active treatment and their individual active treatment schedules.	W 249		
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to consistently ensure each client was provided with an active treatment schedule which reflected current programming and to ensure the schedule was readily available to staff who worked with the clients. This affected 2 of 2 sample clients in House #3 (Client #3 and Client #4) and 3 clients added to the sample (Client #9, Client #10 and Client #11). Findings follow: Observations on 8/2/21 from 3:10 p.m. through 6:00 p.m. revealed Client #9 spent most of his time in a recliner in the small living room. The client received little to no attention from staff and was not observed engaged in any activities outside of eating meals. Observations during the same time frame revealed Client #10 was seated mostly in the dining room with a piece of string in	W 250		

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her hands which she often put in her mouth and pulled back out. Client #10 also received little to no attention from staff outside of meal times. During the same observations Client #11 spent almost all of his time in a recliner in the living room. Client #11 also received very little attention from staff and was not observed to participate in any activities during the observations outside of meal times.

Record review revealed active treatment schedules for Client #3 and Client #10. Both schedules appeared to be very old and not relevant to current activities. Client #3's schedule appeared to have been typed with a typewriter. The review failed to find any schedules Client #4, Client #9 or Client #11.

When interviewed on 8/4/21 at 4:35 p.m. the Program Coordinator (PC) and the Administrator confirmed the schedules for Client #3 and Client #10 were both old and out of date. The Administrator pointed out language and programming they no longer used such the reference to door pulley exercises in Client #3's schedule. The PC confirmed she had not updated the schedules since she started in House #3 a little over 6 months earlier. The Administrator confirmed of the 5 clients reviewed none of them had current active treatment schedules and 3 of them didn't have one at all. She also confirmed the two out of date schedules found were on the computer and not in program books readily available for staff to review. The Administrator confirmed the schedules needed to be current and in each client's charting book so staff could refer to it throughout the day. She also confirmed staff needed to provide clients #9, #10 and #11 with consistent interactions and

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W 250	Continued From page 20 activities throughout the day by staff as part of their active treatment.	W 250		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure each client received an annual physical at least annually. This affected 1 of 3 sample clients (Client #4) who lived in the facility more than one year. Findings follow: Record review on 8/4/21 revealed a physical for Client #4 dated 2/5/20. When interviewed on 8/4/21 at 2:48 p.m. the Director of Nursing (DON) confirmed the 2/5/20 physical for Client #4 was the most recent. The DON stated she was aware some clients were behind and they were working hard to get them caught up as soon as possible.	W 323		