

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: October 3, 4, 5, 6 and 7, 2011.</p> <p>Facility Number: 000981 Provider Number: 15G467 AIM Number: 100249390</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/17/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0120	<p>The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation and interview for 1 of 4 clients who attended an outside services day program (#7), the facility failed to ensure there was a communication system in place, staff conducted observations at the day program and the day program staff were included in meetings.</p> <p>Findings include:</p> <p>An observation was conducted on 10/4/11 from 12:25 PM to 1:25 PM at client #7's day program. During the observation, client #7 was not engaged in activities. Client #7 sat at a table holding a doll. At 1:21 PM, client #7 looked through a stack of magazines and then sat down at a table</p>	W0120	<p>W120 Communication log for day services was developed for client #7. Group Home Team will schedule a meeting with client #7 day services team to discuss program needs and implementation. At that meeting, behavior plan data requirements and program goals will be reviewed. In addition, a routine meeting arrangement will be established. QDDP will routinely visit day service provider facilities to ensure that client needs are being met at those facilities. Documentation of these visits will be maintained in the program chart. At those visits, QDDP will establish meeting arrangements for all other individuals. QDDP will review the casemanagement summaries and day service meeting notes in each monthly</p>	11/06/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>with her doll. During the observation, staff interacted with client #7 one time at 12:34 PM.</p> <p>An interview with an administrative staff (AS) at the day program was conducted on 10/4/11 at 12:55 PM. The AS indicated she had not seen anyone from the group home at the site ensuring the services were meeting the needs of client #7. The AS indicated the day program did not have the behavior tracking sheets from the group home to document her behaviors; the AS indicated the day program was tracking behaviors on their paperwork. The AS indicated the day program was not involved in developing training objectives for the day program for client #7. The AS indicated there was no communication system in place for the group home and day program to communicate. The AS indicated she did not know the home manager or the Qualified Mental Retardation Professional (QMRP).</p> <p>An interview with the QMRP was conducted on 10/5/11 at 1:37 PM. The QMRP indicated there was no communication system in place. The QMRP indicated the communication was verbal from group home staff to the day program staff. The QMRP indicated there was not a particular staff identified to</p>		program review.		

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W0149	<p>conduct observations at the day program. The QMRP indicated the staff from the day program should be involved in the team meetings for client #7.</p> <p>9-3-1(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 25 incident/investigative reports reviewed affecting clients #2 and #3, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/3/11 at 1:30 PM.</p> <p>-On 4/29/11 at 6:00 PM, staff #1 "swatted" client #3 on the arm after a shelf fell off the wall with the staff's hat on it. The client attempted to give staff #1 his hat back and staff yelled, "You don't touch my hat!" Abuse was unsubstantiated.</p> <p>-On 7/20/11 (no time), facility-operated day program staff used a loud, "inappropriate" voice and physically pulled client #3.</p> <p>-On 9/15/11 at 12:00 PM at the</p>	W0149	<p>W149</p> <p>Abuse allegation for 4/29/11 was unsubstantiated. The information obtained during the investigation did not support that any abuse or neglect had occurred.</p> <p>Abuse allegation on 7/20/11 was discovered to not have been addressed appropriately at the time of incident. This was discovered during a review of associate files on 9/15/11. Incident was then treated as an allegation of abuse and investigation began. Staff statement was obtained and the allegation was substantiated. In addition, during the initial stages of the investigation, the associate was terminated for other cause unrelated to this investigation. The incident on 9/15/11 in which client had wandered away from his group and was unattended while sitting in a van in the front parking lot was not addressed initially as an investigation to neglect. The incident had been approached as a performance related incident in which the</p>	11/06/2011

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W0153	<p>facility-operated day program, client #2 "wandered" away from his group during lunch and was found in a van in the parking lot.</p> <p>A review of the facility's policy on Suspected Abuse, dated 9/2011, was conducted on 10/5/11 at 12:03 PM. The policy indicated, "[Facility name] will not condone abuse or violation of individual rights by anyone, including, but not limited to associates, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or any other individuals."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/5/11 at 1:37 PM. The QMRP indicated the facility prohibits abuse and neglect.</p> <p>9-3-2(a)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 14 incident reports reviewed affecting</p>	W0153	<p>person assigned to that group had not adequately monitored her responsibilities. All further instances of unsupervised individuals will be treated as an investigation for neglect of duty. That associate had been disciplined and the group ratio for that client was reduced from 4:1 to 2:1.</p> <p>Staff will be retrained on the change in investigation requirements by Group Home Director.</p> <p>St. Vincent New Hope policy and procedure was reviewed. It</p>	11/06/2011	

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	<p>client #3, the facility failed to immediately notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, of an allegation of abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/3/11 at 1:30 PM. On 7/20/11 (no time), facility-operated day program staff used a loud, "inappropriate" voice and physically pulled client #3. This incident was not reported to administrative staff until 9/26/11 when the day services manager found a coaching form in the alleged perpetrator's employee file for mistreatment of an individual and cited the suspected abuse policy. The facility reported the incident to BDDS on 9/26/11.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/5/11 at 1:37 PM. The QMRP indicated the facility should submit a report of abuse to BDDS within 24 hours.</p> <p>An interview with the Director was conducted on 10/7/11 at 11:58 AM. The Director indicated the administrator</p>		<p>continues to meet regulatory requirements. Group Home Director will retrain Day Services staff on the requirements for reporting, notifying the administrator and investigating the incidents as required. This incident was reported to BDDS on 9/15/11 when the error in reporting was discovered by Day Services Manager. Day Services Manager will monitor all future reports as they are submitted to ensure that notification to administrator and investigation is done appropriately. GH Director and QDDP are also copied on all incident reports and will monitor as they are completed as well.</p>		

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W0154	<p>should be notified of allegations of abuse immediately.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 25 incident/investigative reports reviewed affecting clients #2 and #3, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/3/11 at 1:30 PM. -On 7/20/11 (no time), facility-operated day program staff used a loud, "inappropriate" voice and physically pulled client #3. This incident was not reported to administrative staff until 9/26/11 when the day services manager found a coaching form in the employee's file for mistreatment of an individual and cited the suspected abuse policy. The investigative packet contained two statements from staff and a summary. The documentation reviewed included a statement from the witness and one from the alleged perpetrator. There was no interview with additional staff or clients. There was no interview of client #3. The</p>	W0154	<p>Abuse allegation on 7/20/11 was discovered to not have been addressed appropriately at the time of incident. This was discovered during a review of associate files on 9/15/11. Incident was then treated as an allegation of abuse and investigation began. Staff statement was obtained and the allegation was substantiated. In addition, during the initial stages of the investigation, the associate was terminated for other cause unrelated to this investigation. The incident on 9/15/11 in which client had wandered away from his group and was unattended while sitting in a van in the front parking lot was not addressed initially as an investigation to neglect. The incident had been approached as a performance related incident in which the person assigned to that group had not adequately monitored her responsibilities. All further instances of unsupervised individuals will be treated as an investigation for neglect of duty. That associate had been disciplined and the group ratio for that client was reduced from 4:1 to 2:1. Staff will be retrained on</p>	11/06/2011

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	<p>facility did not indicate whether or not the allegation was substantiated. The investigation did not indicate the reason the investigation was conducted more than 2 months after the incident. The recommendation and follow-up section indicated the alleged perpetrator, "...no longer works for [facility name]." An Associate Disciplinary Action Form, dated 9/27/11, indicated the alleged perpetrator was terminated on 9/28/11. -On 9/15/11 at 12:00 PM at the facility-operated day program, client #2 "wandered" away from his group during lunch and was found in a van in the parking lot. An investigation was not provided during the survey for review.</p> <p>An interview with the Director of group homes was conducted on 10/3/11 at 2:49 PM. The Director indicated an investigation should have been conducted for the incident involving client #2 on 9/15/11. The Director indicated an investigation was not conducted. On 10/7/11 at 11:58 AM, the Director indicated the investigation for the incident on 7/20/11 was not thorough.</p> <p>9-3-2(a)</p>		the change in investigation requirements by Group Home Director.		

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W0189	<p>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. Based on observation, interview and record review for 1 of 4 clients in the sample (#5), the facility failed to ensure the staff received training on the proper positioning of her feet while in the wheelchair.</p> <p>Findings include:</p> <p>An observation was conducted on 10/3/11 from 4:11 PM to 6:27 PM. During the observations, client #5 was sitting in her wheelchair with her feet unsupported. There were no footrests on her wheelchair. At 5:18 PM, staff #2 assisted client #5 to put her footrests on her wheelchair. Client #5's feet did not touch the footrests. Her heels were 4 inches from touching the footrests. At 5:29 PM, staff #2 was interviewed. Staff #2 indicated the footrests could go up and down. She indicated she asked client #5 if she wanted her feet to touch the footrests and client #5 told her no.</p> <p>An observation was conducted at the group home on 10/4/11 from 5:58 AM to 8:15 AM. At 6:50 AM, client #5 entered the dining room. Her footrests were on her chair however her feet did not touch</p>	W0189	<p>Durable Medical Equipment facilitator reviewed client #5 wheelchair foot rests and gave specific guidance to the position of the footrests. Team developed a visual guide for staff to ensure that the foot rests are in the proper position, and how to change the position of the foot rests when needed. Team was retrained on the proper positioning of the footrests. ISP was updated to include information and guidance for proper use of the footrests. All other individuals in the home were reviewed. There is one other wheelchair, however that client has specialized seating and foot rests. He has a positioning schedule in place, but foot rest placement is not relevant for him. All providers will be retrained on the proper positioning of her wheelchair footrests.</p>	11/06/2011			

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	<p>the footrests. Her feet were 4 inches from touching the footrests. At 7:25 AM, client #5's footrests were moved into a horizontal position and her legs and feet were supported.</p> <p>A review of client #5's record was conducted on 10/5/11 at 11:32 AM. Her Individual Support Plan (ISP), dated 2/7/11, indicated she was to use a wheelchair in large, common areas and in the community. There was no documentation regarding the adjustment of her footrests. There was no documentation regarding when her footrests were to be applied. There was no documentation when the footrests should be adjusted into the horizontal position.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/5/11 at 1:37 PM. The QMRP indicated the staff needed to be trained on the appropriate use of the footrests.</p> <p>On 10/6/11 at 1:52 PM, an interview with the nurse was conducted. The nurse indicated she had not noted that client #5's feet did not touch the footrests. She indicated the staff should adjust the footrests to ensure client #5's heels were supported by the footrests every time</p>			

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W0249	<p>client #5 was in her wheelchair.</p> <p>9-3-3(a)</p> <p>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.</p> <p>Based on observation, interview and record review for 2 of 4 clients in the sample (#7), the facility failed to ensure:</p> <p>1) client #7's behavior plan addressing late arrival/refusals to attend the day program was implemented, as written and</p> <p>2) client #2's dining plan was implemented.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 10/4/11 from 5:58 AM to 8:15 AM. During the observation, client #7 was in her room and in bed. She was not observed to take her medications or eat breakfast. Staff #5, #11 and #12 were not observed to prompt client #7 to wake up and follow her schedule.</p> <p>An interview with an administrative staff (AS) at the day program was conducted on 10/4/11 at 12:55 PM. The AS</p>	W0249	<p>All staff will review Client #5 Behavior plan for techniques to approach refusals. Program goal for Client #5 to leave the home on the first van run with other housemates. Cueing and technique to approach this is within the program. All staff will be trained on this goal. Day Services meeting will be arranged to review behavior plan and implementation at their service site as applicable. All dining plans were reviewed and revised as needed. A specific meal schedule and seating arrangement was developed to guide staff on specific time frames and assignments during dining. Team Leader will conduct weekly meal observations to ensure that the home's dining schedule and individual dining plans are being implemented as written. All staff trained on home dining schedule and meal plans for each client.</p>	11/06/2011	

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	<p>indicated client #7 arrives to the day program, daily, between 11:00 AM and 12:00 PM. The AS indicated she was not aware of a plan to address this on-going issue. The AS indicated client #7 misses several activities each day due to her late arrival.</p> <p>A review of client #7's record was conducted on 10/5/11 at 12:16 PM. Client #7's Individual Support Plan, dated 7/28/11, indicated the following, "Has been refusing to attend frequently." The Behavior Support Plan (BSP), dated 11/1/10, indicated she had a targeted behavior of refusals. The targeted behavior was defined as refusing to follow her schedule, refusing to get up in the morning, refusing to take medications or to do her skills training. The plan indicated the following, "Let [client #7] know what the daily schedule will be to remind her of upcoming activities and tasks. [Client #7] enjoys attending [name of day program], so remind her that her day program staff are looking forward to seeing her... Staff can offer [client #7] an incentive if she agrees to wake up promptly in the morning, such as coffee or hot tea... If [client #7] initially refuses to get out of bed in the morning, leave her alone for about five or ten minutes, and then give her a second prompt. Give her additional prompts every five minutes or</p>				

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	<p>so if necessary. Avoid power struggles."</p> <p>An interview with the Team Leader (TL) was conducted on 10/5/11 at 1:37 PM. The TL indicated the approach staff took was informal (no plan) to get client #7 to the day program.</p> <p>An interview with the Director was conducted on 10/7/11 at 11:58 AM. The Director indicated client #7's BSP should be implemented as written.</p> <p>2) Observations were conducted at the group home on 10/3/11 from 4:11 PM to 6:27 PM and 10/4/11 from 5:58 AM to 8:15 AM. During dinner on 10/3/11 and breakfast on 10/4/11, the staff at the group home did not prompt client #2 to alternate sips of fluids and bites of food during dinner and breakfast.</p> <p>A review of client #2's record was conducted on 10/5/11 at 10:48 AM. An Interdisciplinary Team Meeting form, dated 6/20/11, indicated the team reviewed the dietary recommendations dated 6/20/11. The recommendations included alternating sips of fluid and bites of food.</p> <p>An interview with the nurse was conducted on 10/6/11 at 1:52 PM. The nurse indicated the staff should prompt</p>			

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W0259	<p>client #2 to alternate sips of fluid and bites of food during every meal and after each bite or drink.</p> <p>An interview with the Director was conducted on 10/7/11 at 11:58 AM. The Director indicated the staff should implement his dining plan as written.</p> <p>9-3-4(a)</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 clients in the sample (#2), the facility failed to ensure his comprehensive functional assessment (CFA) was reviewed annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 10/5/11 at 10:48 AM. Client #2's Functional Skills Assessment was dated 5/3/10. There was no documentation in his record or provided during the survey indicating his assessment was reviewed since 5/3/10.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>	W0259	<p>W259 Comprehensive Functional Assessments have all been reviewed and signed. 7 of 8 were observed to be signed in the survey. 1 of the assessments had been reviewed but signature was missed. This has been corrected.</p> <p>A chart audit system is in place to ensure that CFAs are reviewed annually and updated as needed. This system will continue.</p>	11/06/2011			

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W0331	<p>conducted on 10/5/11 at 1:37 PM. The QMRP indicated she did not have documentation indicating client #2's CFA had been reviewed since 5/3/10. She indicated it should be reviewed annually.</p> <p>9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 clients in the sample (#7), the nurse failed to ensure the client returned to the physician due to an eye infection.</p> <p>Findings include:</p> <p>An observation was conducted at client #7's day program on 10/4/11 from 12:25 PM to 1:25 PM. During the observation, client #7's right eye was red, her eyelashes were matted and crusty and the corners of her eye had drainage. On 10/4/11 at 12:40 PM, client #7 indicated her eye was bothering her. Day program staff #1 indicated, on 10/4/11 at 12:48 AM, her eye problem was an on-going issue.</p> <p>A review of client #7's record was conducted on 10/5/11 at 12:16 PM. A physician's note, dated 8/30/11, indicated she was prescribed Tobrex to treat mild</p>	W0331	Client #5 saw her physician, receiving another prescription for eye irritation. Script ended and eye has cleared. Site will complete weekly body checks to ensure eye irritation or symptoms do not return. Nurse will review body checks and observe all clients at routine site visit, no less than monthly.	11/06/2011

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W0436	<p>conjunctivitis after "about 7 days right eye drainage." There was no documentation in client #7's record indicating she had been back to the doctor for her eye since 8/30/11.</p> <p>An interview with the nurse was conducted on 10/5/11 at 1:40 PM. The nurse indicated she was not aware of the on-going issue with client #7's eye. She indicated no one from the group home had contacted her regarding client #7's eye. The nurse indicated she was not sure why client #7 had not been back to the doctor for a follow-up appointment.</p> <p>9-3-6(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 2 of 4 clients in the sample (#2 and #8), the facility failed to ensure their small size spoons were provided/offered during meals.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/3/11 from 4:11 PM to</p>	W0436	<p>All dining plans were reviewed and updated as needed. The site also purchased new equipment as needed. All dining plans were reviewed with staff. A specific meal schedule and seating arrangement was developed to guide staff on specific time frames and assignments during dining. Team Leader will conduct weekly meal observations to ensure that the home's dining</p>	11/06/2011

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	<p>6:27 PM. At 6:03 PM, dinner started. Clients #2 and #8 ate dinner using a regular size spoons; neither were provided or offered a small size spoon during the meal. On 10/4/11 from 5:58 AM to 8:15 AM, an observation was conducted at the group home. Client #2 ate breakfast starting at 6:46 AM. He ate his cereal and pancakes using a regular spoon. He was not prompted to use or offered a small size spoon during breakfast.</p> <p>A review of client #2's record was conducted on 10/5/11 at 10:48 AM. Client #2's Individual Support Plan (ISP), dated 10/28/10, indicated he was to use a "baby/toddler spoon" at meals (no reason given in the plan).</p> <p>A review of client #8's record was conducted on 10/5/11 at 12:51 PM. Client #8's ISP, dated 11/19/10, indicated her adaptive equipment during meals was a "baby" spoon.</p> <p>An interview with the nurse was conducted on 10/6/11 at 1:52 PM. The nurse stated if the use of a "toddler" spoon was part of the clients' ISPs, then the "toddler" spoon should be provided for each meal.</p> <p>An interview with the Director was conducted on 10/7/11 at 11:58 AM. The</p>		<p>schedule and individual dining plans are being implemented as written. All staff trained on home dining schedule and meal plans for each client.</p>		

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W0448	<p>Director indicated staff should provide/offer the clients "toddler" spoons if it was in their plans.</p> <p>9-3-7(a)</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure issues noted during evacuation drills were investigated.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 10/3/11 at 2:20 PM. The drills affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Issues noted during day shift drills (7:00 AM to 3:00 PM):</p> <p>-On 4/14/11 at 9:26 AM, a fire drill was conducted. The documentation did not indicate the elapsed time for the drill. It was reviewed by the Team Leader on 4/18/11 with no note regarding the missing elapsed time.</p> <p>-On 7/27/11 at 10:45 AM, a fire drill was conducted. The duration of the drill was 7 minutes. The comments section indicated, "Will work on timing next time."</p>	W0448	A QDDP external to this team has been assigned to review fire drills, specifically accurate completion of forms, timeliness of evacuation and effectiveness of needed follow up. The evacuation score for that home is reviewed by Life Safety Survey and has been in compliance with LS Code. Staff will be retrained on accurately completing drills.	11/06/2011	

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	<p>Issues noted during evening shift (3:00 PM to 11:00 PM):</p> <p>-On 11/29/10 at 8:30 PM, a fire drill was conducted. The duration of the drill was 5 minutes. The comments section indicated, "It was raining during fire drill."</p> <p>-On 5/3/11 at 5:30 PM and 5/10/11 at 3:00 PM, fire drills were conducted. The evacuation form did not indicate the evacuation times on the forms. Both were signed by the Team Leader with no documentation noting the omission of the evacuation time.</p> <p>-On 8/27/11 at 7:00 PM, a fire drill was conducted. The drill took 6 minutes to complete. The comments section indicated, "[Client #6] refuse (sic) to get out of room, I redirected her to get out of her room and she did." There was no documentation an investigation was conducted.</p> <p>Issues noted during night shift (11:00 PM to 7:00 AM):</p> <p>-On 12/12/10 at 12:30 AM, a fire drill was conducted. The duration of the drill was 18 minutes. The comments section indicated, "Took awhile due to one on one with [client #8] and getting [client #4] out of bed. [Client #7] very slow to evacuate, but did." The Qualified Mental Retardation Professional (QMRP) signed the form but did not document</p>				

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	<p>information regarding investigating the issues.</p> <p>-On 3/23/11 at 1:00 AM, a fire drill was conducted. The duration of the drill was 17 minutes. The comments section indicated, "[Client #3] wanted to get bear, [client #2] wanted his shoes. I got everyone out (sic) ran back got [clients #2 and #3]." The Team Leader signed the form but did not document information regarding investigating the issues.</p> <p>-On 6/30/11 at 12:00 AM, a fire drill was conducted. The duration of the drill was 19 minutes. The comments section indicated, "Had some that didn't want to get up. Some wanted to put clothes on." There was no documentation from the Team Leader who signed the form an investigation was conducted.</p> <p>-On 9/30/11 at 3:15 AM, a fire drill was conducted. The duration of the drill was 20 minutes. The comments section indicated, "[Client #3] was a little slow wanted to get robe and bear." There was no documentation from the Team Leader who signed the form an investigation was conducted.</p> <p>An interview with the Team Leader (TL) was conducted on 10/4/11 at 11:15 AM. The TL indicated he was not aware of a targeted time for completing drills. The TL indicated he did not investigate issues noted during evacuation drills.</p>						

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W0484	<p>An interview with the QMRP was conducted on 10/3/11 at 2:31 PM. The QMRP indicated the targeted time for completing drills was 3 to 5 minutes. The QMRP indicated the evacuation drill forms did not include an investigation of the issues noted during drills. The QMRP indicated the evacuation times were too long and needed to be looked into.</p> <p>9-3-7(a)</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 6 of 6 clients who were observed eating dinner (#1, #2, #3, #4, #6, and #8), the facility failed to ensure the clients were provided or offered: 1) condiments and 2) utensils (forks and knives).</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/3/11 from 4:11 PM to 6:27 PM. At 6:03 PM, clients #1, #2, #3, #4, #6 and #8 were at the table for dinner. The clients were served tuna salad, bread or crackers, mashed potatoes, and green beans. On 10/3/11 at 5:08 PM, a review of the menu, dated Week 1 Spring/Summer, indicated the following</p>	W0484	<p>All dining plans were reviewed and revised as needed. A specific meal schedule and seating arrangement was developed to guide staff on specific time frames and assignments during dining. Team Leader will conduct weekly meal observations to ensure that the home's dining schedule and individual dining plans are being implemented as written. All staff trained on home dining schedule and meal plans for each client.</p>	11/06/2011

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	<p>were to be served: 1 tablespoon ketchup, 1 teaspoon margarine and 2 tablespoons of jelly. The ketchup, margarine and jelly were not served. There was no salt or pepper on the table. The clients were not provided or offered knives or forks for the meal; everyone ate with a spoon.</p> <p>An observation was conducted at the group home on 10/4/11 from 5:58 AM to 8:15 AM. At 6:40 AM, breakfast started for clients #1, #2, #3, #6 and #8. The clients were served pancakes, syrup and cereal. The clients were not provided/offered forks or knives. At 6:43 AM, client #3 was assisted by staff using hand over hand assistance to cut up her pancakes with a spoon. There was no margarine on the table. On 10/4/11 at 6:10 AM, a review of the menu, dated Week 1 Spring/Summer, indicated 1 teaspoon of margarine was to be served.</p> <p>On 10/5/11 at 1:37 PM, an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated the clients should be provided condiments and a knife, spoon and fork for all meals.</p> <p>9-3-8(a)</p>				