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W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: September 6, 7, 8, 12, 2011 Provider Number: 15G095 Facility Number: 000634 AIM Number: 100233980 Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III (September 7, 8, 12, 2011) The following deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/19/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the	W0104	W104 Plan of Correction: The medication policy is being reviewed and will be revised if necessary. The staff in the home will be retrained on the proper	10/12/2011

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	group home had an adequate supply of medication for 1 of 4 sampled clients (client #3). The governing body failed to exercise general policy and operating direction over the facility to ensure appropriate use of client funds for 1 of 4 sampled clients (client #1) and 1 additional client (client #8). Findings include: 1. During observation of medication administration on 09/08/2011 at 5:10 a.m., client #3 did not receive his prescribed eye drops. DSP (Direct Support Professional) #1 indicated a refill for client #3's eye drops had been requested but the medication had not been delivered to the home. She stated, "He has been out of them for four days." Client #3's MAR (Medication Administration Record), dated September 2011 was reviewed on 09/07/11 at 7:05 a.m. The 09/11 MAR indicated, "...Patenol Opth (ophthalmic) solution 5 mg - instill one drop both eyes twice daily...." During an interview on 09/08/2011 at 10:30 a.m., LPN #6 indicated the facility did not have a system in place to ensure medications were obtained, once ordered, to ensure an adequate supply of		steps to follow for ordering medications. The nursing department and QMRP-D will be retrained on monitoring medication supply. All medications will be checked to make sure each consumer has an adequate supply. Clients 1 and 8 will be reimbursed for the purchases they made that KCARC should have made. Group Home staff and financial staff will be retrained on what is appropriate for consumers to purchase with their money and what KCARC has to purchase. Preventive Action: The nurse or QMRP-D will check medications at least once weekly to ensure there is an adequate supply. This will be implemented as procedure and will be ongoing. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted. KCARC Financial Coordinators will be retrained on monitoring consumer purchases to ensure they are not purchasing items that should be purchased by KCARC. The individual responsible for purchasing personal care products will be retrained on purchasing more of a variety. The order form will be changed to allow consumers to make specific requests.	

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	medications were available to administer. 2. Client #8's financial records were reviewed on 9/7/11 at 7:55 AM and at 10:45 AM. Client #8's Register Report from 9/7/2010 to 9/7/2011 and/or Cash Ledgers indicated the following: -11/7/10 client #8 purchased 2 liquid soaps at $2.97 each -2/12/11 Folgers Coffee $8.18 -5/7/11 purchased 2 containers of liquid soap at $2.97 each -6/6/11 purchased 2 containers of bubble bath $2.97 each -7/17/11 purchased 2 containers of mango bubble bath $2.97 each -7/30/11 purchased mango bubble bath $2.97 -8/20/11 purchased Folgers Coffee $9.18 Client #1's financial records were reviewed on 9/7/11 at 7:55 AM and at 10:45 AM. Client #1's Register Report		Monitoring: The nurse or QMRP-D will check medications at least once weekly to ensure there is an adequate supply. This will be implemented as procedure and will be ongoing. The individual responsible for purchasing personal care supplies will monitor the consumer requests and purchase what the consumers ask for when possible. Date to be completed by: October 12, 2011	

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	from 9/7/2010 to 9/7/2011 and/or Cash Ledger sheet indicated client #1 purchased Folger's Instant Coffee on 4/2/11 for $3.98. Interview with finance staff #1 and #2 on 9/7/11 at 11:45 AM stated "They (clients #1 and #8) like a certain brand of coffee." Finance staff #2 stated "[Client #8] liked bubble bath." Finance staff #1 and #2 indicated the facility should be paying for the coffee. Interview with administrative staff #5 on 9/8/11 at 3:10 PM indicated clients should not be purchasing coffee at the group home. Administrative staff #5 also indicated the clients should not be paying for hygiene products as the facility should be buying hygiene supplies for the clients to use.			
W0130	1.1-3-1(a) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, the facility failed to ensure privacy during medication administration for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5, #6, and #7). Findings include:	W0130	W130 Plan of Correction: A wall will be built in the home providing an enclosed private area to administer medications. Staff will be retrained on providing privacy during med administration. Preventive Action: A wall will be built in the	10/12/2011

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	During observations on 09/07/2011 between 5:00 a.m. and 6:45 a.m., DSP (Direct Support Professional #1 passed oral medications to clients #2, #3 and #7 in a large open room divided by furniture into an office space, television area and dining area. Client #7 received a diabetic subcutaneous (under the skin) injection into his right lower abdomen and nasal spray in addition to the oral medications. Client #2 received topical medications in addition to oral medications. Client #3 received nasal spray and eye drops in addition to oral medications. The room did not allow privacy to each client receiving medications since clients who had received medications or were waiting to receive medications were seated at the dining table or in the TV area (clients #3, #5 and #6) which was located less than 5 to 12 feet from the medication area. During an interview on 09/08/2011 between 3:45 p.m. and 5:45.p.m., administrative staff #5 indicated the home did not have a private location for administering the medications. Administrative staff #4 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8's medications should be administered in private as this had been an issue before. During an interview on 09/08/2011 between 3:45 p.m. and 5:45 p.m., administrative staff #8 indicated a request had been submitted to have the maintenance department build a wall or partition to create a private location for administering medications. 1.1-3-2(a)		home providing an enclosed private area to administer medications. Staff will be retrained on providing privacy during med administration. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted. Monitoring: The QMRP-D or nurse will be present to observe a medication pass at least once per week. Date to be completed by: October 12, 2011	
W0140	The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.			

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	Based on record review and interview for 1 of 4 sampled clients (#1) and for 1 additional client (#6), the facility failed to maintain a complete accounting of the clients' cash on hand at the group home. Findings include: 1. Client #1's financial records were reviewed on 9/7/11 at 7:55 AM. Client #1's 9/11 Finance Ledger indicated the client had $7.46 cash on hand (COH). Client #1 had $7.44 actual COH in his pocket folder. Interview with Qualified Developmental Disabilities Professional (QDDP) #2 on 9/7/11 at 8:00 AM indicated he did not know why client #1's COH was 2 cents off. 2. Client #6's financial records were reviewed on 9/7/11 at 7:55 AM. Client #6's 9/11 Finance Ledger indicated the client had $4.75 COH. Client #6 had $4.74 actual COH in his pocket folder. Interview with Qualified Developmental Disabilities Professional #2 on 9/7/11 at 8:00 AM indicated he did not know why client #6's COH was 1 cent off. 1.1-3-2(a)	W0140	W140 Plan of Correction: KCARC will reimburse the money missing from the consumers' cash on hand. Staff will be retrained on monitoring consumer finances and keeping an accurate ledger, reflecting the actual cash on hand. Preventive Action: The QMRP-D will check the ledgers at least once weekly. The staff will be retrained on monitoring consumer finances and keeping an accurate ledger, reflecting the actual cash on hand. Monitoring: The QMRP-D will check the ledgers at least once weekly. Staff will be trained to check the ledger daily. Date to be completed by: October 12, 2011	10/12/2011

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W0189	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 sampled clients (#1), the facility failed to ensure all direct care staff were trained in regard to the client's diet. Findings include: During the 9/6/11 observation period between 3:50 PM and 6:45 PM, at the group home, Direct Support Professional (DSP) #12 served client #1 the same portion size of food the other clients received at the group home (1 serving of green beans, baked chicken breast, 1 cup of applesauce, 1 baked potato, 1/2 banana, Milk and/or Koolaid). Interview with Direct Support Professional (DSP) #3 on 9/7/11 at 7:35 AM indicated client #1 received a 1500 calorie diet. Client #1's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 9:25 AM. Client #1's 7/11 physician's orders indicated client #1 was on a 1200 calorie sugar free diet due to the client's Prader Willi Syndrome diagnosis (genetic disorder which causes extreme insatiable	W0189	W189 Plan of Correction: Staff will be retrained on all consumer diets and where to locate them if they can't remember the diet at any point in time. Staff will be retrained on portion for specific diets and where to find that information. Preventive Action: Staff will be retrained on all consumer diets and where to locate them if they can't remember the diet at any point in time. Staff will be retrained on portion for specific diets and where to find that information. Monitoring: Dietary Manager or QMRP-D will observe at least one meal weekly for six weeks. QMRP-D will continue to monitor at least one meal weekly. Staff will receive hands-on training when necessary. Date to be completed by: October 12, 2011	10/12/2011

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	appetite resulting in morbid obesity). The facility's staff training records/inservices were reviewed on 9/8/11 at 3:07 PM. The facility's 8/22/11 Employee Training Record indicated DSP #3, #13, #14, #15 and #16 had not been trained in regard to client #1's diet. Interview with Qualified Developmental Disabilities Professional (QDDP) #2, administrative staff #4, #5, and RN #7 on 9/8/11 at 3:40 PM indicated facility staff should follow client #1's diet as ordered. Administrative staff #4 and #5 indicated facility staff were trained in regard to client #1's 1200 calorie diet. Administrative staff #4 and #5 did not provide any additional documentation of training in regard to all staff being trained in regard to client #1's diet. 1.1-3-3(a)			
W0227	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 4 sampled clients (#1 and #3), the clients'	W0227	W227 Plan of Correction: An objective will be added to Client 3' s IPP for slowing his rate of eating. Staff will be trained to run this objective during each meal and snack time. Staff will also be trained to keep Client 3 in	10/12/2011

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	interdisciplinary teams (IDTs) failed to address the clients' identified training needs. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 9/6/11 at 11:45 AM. The facility's 6/7/11 reportable incident report indicated client #3 began coughing while eating shredded chicken for dinner. The 6/7/11 reportable incident report indicated client #3 left the table and went to the bathroom and vomited. The reportable incident report indicated the staff called the facility's nurse who instructed the staff to monitor the client. The 6/7/11 reportable incident report indicated the nurse called back to check on the		constant line of sight while eating. Picking will be added to Client 1's IPP and BSP. Staff will be trained on these additions. Preventive Action: QMRP-D will monitor in the home at least four times per week to ensure new objectives and behavior plans are being utilized when appropriate. QMRP-D will be retrained on adding training objectives, addenda to IPP and behaviors to BSP when appropriate. Monitoring: QMRP-D will monitor in the home at least four times per week to ensure new objectives and behavior plans are being utilized when appropriate. Date to be completed by: October 12, 2011	

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	client 20 minutes later, and client #3 was still coughing in the back ground. The reportable incident report indicated the facility staff were instructed to take the client to a local emergency room for an evaluation. The facility's 6/20/11 follow-up report indicated a Dysphagia study was completed on 6/17/11 where client #3 was diagnosed with Mild Oral Pharyngeal Dysphagia. During the 9/6/11 observation period between 3:50 PM and 6:45 PM and the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, client #3 ate at a fast pace at his 9/6/11 dinner meal and at his 9/7/11 breakfast meal. Facility staff did not prompt and/or encourage the			

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	client to slow down. Client #3 finished both his dinner meal (ground chicken, green beans, baked potato and a banana) and his breakfast meal (cereal, scrambled eggs, coffee, milk and juice) within 4 to 5 minutes of sitting down at the table. Client #3's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 12:34 PM. Client #3's 6/17/11 Dysphagia Study indicated a recommendation to "...slow rate of eating...." Client #3's 8/11/11 Individual Program Plan (IPP) indicated client #3 did not have an objective to address the client's need to slow his rate of eating. Interview with Qualified Developmental Disabilities			

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	Professional (QDDP) #2 on 9/8/11 at 3:40 PM indicated client #3 did not have an IPP training objective to address the client's identified need of eating fast. 2. During the 9/6/11 observation period between 3:50 PM and 6:45 PM, at the group home, client #1 had a sore on his upper right thigh. The open area was about 1/2 inch long with a red area around the open area. At 4:00 PM, LPN #6 was getting ready to leave the group home when the LPN looked over and saw client #1's leg. LPN #6 stated to client #1 "You have been picking." LPN #6 instructed Direct Support Professional (DSP) #9 to place an antibiotic ointment on the area and to cover the area with a band-aid.			

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	Client #1's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 9:25 AM. Client #1's 4/6/11 Medical Information Form (MIF) indicated client #1 had "Impetigo of (R) (right) thigh, several pick sites on chest." The 4/6/11 MIF indicated client #1 was started on Keflex (antibiotic) 500 milligrams three times a day for 7 days and Bactroban (antibiotic ointment) was to be applied to the "ulcer" 3 to 4 times a day for 1 week. Client #1's 4/26/11 MIF indicated the client saw his doctor for a "lesion" on the client's upper right leg. The 4/26/11 MIF indicated Keflex 250 milligrams was ordered for 4 times a day for 10 days until the area was healed. The			

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	4/26/11 MIF indicated Bactroban was also to be applied to the area. The 4/26/11 indicated the client was to return in 20 to 14 days to have the area re-evaluated. Client #1's 5/9/11 MIF indicated "Lesion (R) upper leg-Improving." Client #1's 4/11/11 Nurses Physical Examination (quarterly examination) indicated client #1 had areas on his chest and right upper leg that had been picked by the client. Client #1's 7/14/11 Nurses Physical Examination indicated client #1 had an area on his right upper leg. Client #1's 6/1/11 nurse note indicated "...Continue to monitor area that [client #1] picks at on his upper right			

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	thigh...." Client #1's 6/1/11 IPP and/or 7/29/11 Behavior Support Plan (BSP) did not indicate the client's identified behavioral need of picking had been addressed. Interview with DSP #3 on 9/7/11 at 7:35 AM stated "Not doing as much (picking) lately. When I first started, it was really bad." When asked if client #1 had a behavior plan for picking, DSP #3 stated "I don't think so." Interview with QDDP #2, administrative staff #5 and RN #7 on 9/8/11 at 3:40 PM indicated client #1's 6/11 IPP and/or 8/11 BSP did not address the client's identified behavioral need of picking.			

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W0240	1.1-3-4(a) The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the client's Individual Program Plan (IPP) failed to indicate how facility staff were to monitor the client to ensure the client did not sneak food and/or encourage others to obtain food for him. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 9/6/11 at 11:45 AM. The facility's 2/23/11 reportable incident report indicated while client #5 was at the dinner table, client #5 reported to staff he had not been sleeping well "...the last few nights that week as he woke to [client #6] and [client #1] performing sexual acts to each other in exchange for [client #6] giving [client #1] food. [Client #5] said [client #6] has gotten food out of the pantry and hid it in his room until [client #1] came across to get it and sneaking food out of the freezer as well." The facility's 2/23/11 Incident Reporting Worksheet (investigation) indicated client #1 was diagnosed with Prader Willi (genetic	W0240	W240 Plan of Correction: A strategy for monitoring Client 1 so he will not sneak food or have others sneak it for him will be added to his BSP. Client 1 will be checked on every five minutes when awake and every 30 minutes while sleeping to ensure he does not have the opportunity to sneak food or have others sneak it for him. Staff will be trained on the new plan. Preventive Action: A strategy for monitoring Client 1 so he will not sneak food or have others sneak it for him will be added to his BSP. Client 1 will be checked on every five minutes when awake and every 30 minutes while sleeping to ensure he does not have the opportunity to sneak food or have others sneak it for him. Staff will be trained on the new plan. The QMRP-D will be retrained on adding to a BSP and/or IPP when needed. The desk will be moved to the large room outside Client 1's bedroom. Client 1's weight will be monitored daily. Staff and Dietary Manager will be retrained to weigh Client 1 daily. Monitoring: The QMRP-D will observe in the home at least four times per week to ensure	10/12/2011

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	disorder which causes extreme insatiable appetite resulting in morbid obesity). The facility's investigation indicated both clients (#1 and #6) denied any sexual activity. The 2/23/11 investigation indicated one staff reported client #6 admitted client #1 had gone through client #6's room to get food out of the kitchen at night. The 2/23/11 worksheet/investigation indicated "...substantiated [client #1] taking food but could not substantiate sexual activity between [client #1] and [client #6]...." The facility's investigation indicated a recommendation to re-arrange the staff's office "...to allow consistent monitoring of the area in which [client #1] and [client #6's] bedrooms are located...." The 2/23/11 worksheet indicated "Regular bed checks done every 2 hours." During the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, client #1 and client #6's bedrooms were located at the back of the house, at the end of a long hallway. The staffs office area/desk was located at the front of the house in the living room/dining room areas. Client #1 and client #6's bedrooms were across from each other at the back of the house. The kitchen was next to the living room area. Interview with Direct Support Staff (DSP) #1 on 9/7/11 at 7:00 AM indicated client		new strategies are being used when appropriate. Client 1's weight will be monitored daily. Date to be completed by: October 12, 2011	

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	#1 required staff monitoring due to his Prader Willi diagnosis. When asked how client #1 was monitored at night, DSP #1 stated "I check [client #1] every 2 hours and more often if needed. DSP #1 indicated she had to monitor clients #6 and #3 as well as they would get food for client #1 and hide it in the bathroom for client #1 to retrieve. DSP #1 indicated the staff's desk faced the hallway and this allowed DSP #1 to see down the hallway at night. DSP #1 indicated she would also do cleaning and other job duties at the house which would take her away from the desk area. Client #1's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 9:25 AM. Client #1's 6/15/11 Medical Information Form indicated the client saw his doctor due to a headache and a 7 pound weight gain over the weekend (249 pounds to 256.8 pounds). The 6/15/11 contact note indicated "-Weight Gain- pt (patient) has history of Prader-Willi Syndrome and isolated himself w/ (with) food this weekend, would recommend consideration of closer staff supervision to prevent or limit food binges." Client #1's Contact Notes indicated the following: -7/15/11 came out of kitchen supply room			

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	with a mail bag. -4/23/11 "Saltine Crackers - 2 boxes Reg (regular bread) - 5 loaves Brown & (and) Serve Rolls - 1 pkg (package) Hamburger Buns - 2 pkgs ...all empty. All these items were found in [client #1's] room empty and around his bed (sic) one (sic) bread wrapper was actually in his hand when I woke him up." -3/30/11 "As I (DSP #11) was doing bed checks I went into [client #1's] room & found him asleep; with bread crumbs on his mouth, half eaten pieces of bread on his stomach, & side in his hand. As a result I took a picture w/ my phone & sent it to my QMRP (D) (Qualified Mental Retardation Professional-Designee) after that I left the room." -3/29/11 "I (DSP #10) checked [client #1's] room this AM and found several candy wrappers, gum wrappers, zyplock (sic) baggies (empty), an empty bun wrapper, an empty diet bread wrapper, an empty reg. (regular) bread wrapper, and an empty hot roll wrapper. Some were in his bed, some in his shelf, & some under the bed (sic)." -3/14/11 "Searching [client #1's] room this morning one uneaten loaf of bread			

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	was found buried underneath clothes from laundry. Also 3 eaten bags of white bread, cinnamon raisin bread & blueberry bagels were found in his trash can by his bed." -3/14/11 (at 10 PM) "Found empty cinnamon roll pkg-refrig (refrigerator) kind like biscuits that you bake in BR (bathroom) 3 vanity cabinet. Found bread & hot roll wrappers stuffed between shower curtains on edge of tub in BR 1-date looked like 3/13 but wet, so not 100% sure, but pretty sure. Found cookies & snack wrappers & bread wrappers in bottom of BR 1 & 2 trash & laundry room trash had several snack wrappers. Also some graham cracker wrappers & reitz (sic) cracker tubes. Two peel off tops from frozen juice on counter tonite (sic) when I (DSP #10) got here but no juice made up...Also noted 4 boxes of garlic toast gone from freezer, 6 or 8 servings per box." -2/25/11 "After searching [client #1's] room I (Direct Support Professional-DSP #9) found a full package of 12 brown and serve rolls under his bed." -2/22/11 staff noticed food items (2 packages of hamburger buns, 3 or 4 loaves of bread, and rolls) missing from the pantry.			

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	Client #1's 1/13/11 Interdisciplinary Team (IDT) Meeting note indicated "[Client #1] gained 8.6 lbs (pounds) in two days. We are certain that he has a food source, but we aren't sure what it is." Client #1's 6/1/11 IPP indicated client #1's diagnosis included, but was not limited to, Prader Willi Syndrome. Client #1's IPP indicated "[Client #1] has Prader Willi, which affects his self-control when self feeding...." Client #1's 6/1/11 IPP and/or 7/29/11 Behavior Support Plan (BSP) did not specifically indicate how facility staff were to monitor the client to prevent client #1 from sneaking food and/or obtaining food from others. Interview with Qualified Developmental Disabilities Professional (QDDP) #2, Administrative staff #4, #5, and RN #7 on 9/8/11 at 3:40 PM indicated client #1 would attempt to sneak food. When asked how client #1 was monitored to prevent sneaking/obtaining food, QDDP #2 stated "Basically supervise. Overnight staff have good visual sight." QDDP #2 indicated the staff was able to supervise/monitor the client at night from the desk at the front of the house. QDDP #1 and administrative staff #5 indicated client #1's 6/1/11 IPP and/or 7/29/11 BSP did not indicate how facility staff were to			

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	monitor the client to prevent the client from obtaining food. 1.1-3-4(a)			
W0249	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. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the facility failed to implement clients' training objectives/Individual Program Plans (IPPs) when formal and informal training opportunities existed. Findings include: 1. During the 9/6/11 observation period between 3:50 PM and 6:45 PM, at the group home, Direct Support Professional (DSP) #12 ground client #3's chicken up in a food processor. Client #3 had (finely) ground chicken for his dinner meal. During the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, client #3 ate his breakfast meal (cereal, scrambled eggs, coffee, milk and juice) at a fast pace. No staff was at	W0249	W249 Plan of Correction: Staff will be retrained on active treatment/running IPP's during formal and informal opportunities, following consumer diets, independence, consumers being involved in all aspects of meal prep and clean up, encouraging consumers to complete chores and encouraging consumers to complete all objectives when the opportunity exists for them to do so. Preventive Action: Staff will be retrained on active treatment/running IPP's during formal and informal opportunities, following consumer diets, independence, consumers being involved in all aspects of meal prep and clean up, encouraging consumers to complete chores and encouraging consumers to complete all objectives when the opportunity exists for them to do so. Monitoring: The QMRP-D will be in the home to observe/train at least four times weekly. Date to be completed by:	10/12/2011

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	the table when client #3 consumed his breakfast meal in 4 to 5 minutes. Once client #3 finished his breakfast, at 5:55 AM, the client sat down in the living room and watched the other clients eat, walked outside and stood on the porch, and/or sat in the living room without a meaningful activity/training to participate in until the client left for work at 7:05 AM. Client #3's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 12:34 PM. Client #3's 8/11/11 IPP indicated the client had objectives to discuss the proper care of his adaptive equipment (eyeglasses), to identify 10 alphabet cards in order and an objective to identify 20 number cards in order which DSPs #1 and #3 did not implement when opportunities for training existed. Client #3's 8/11/11 IPP indicated client #3 required "...Supervision during all oral intake." Client #3's 6/20/11 physician's order indicated "Clarification: Bite-size meat soft regular food...." DSP #12 did not implement/follow the client's diet as ordered. Interview with Qualified Developmental Disabilities Professional (QDDP) #2, RN #7 and administrative staff #5 on 9/8/11 at 3:40 PM indicated facility staff should		October 12, 2011	

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	have implemented client #3's diet as ordered. QDDP #2 indicated during the morning, clients' objectives were not implemented as the staff did not have time to do the training. QDDP #2 indicated client's objectives were implemented in the evening. 2. During the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, client #4 came out of his bedroom at 5:30 AM. Client #4 sat in the back room without an activity laid back in a lounge chair with his eyes closed, walked around and/or stayed in his bedroom except to take his morning medications. DSPs #1 and #3 did not offer and/or provide client #4 any activity and/or training. At 7:17 AM, client #4's bedroom was observed, client #4's bed had not been made as the covers were hanging to one side of the bed. Client #4's record was reviewed on 9/7/11 at 7:15 AM. Client #4's 5/8/11 IPP indicated the client had objectives to make his bed before starting daily activities and to complete a card matching game which DSPs did not implement when formal and/or informal training opportunities existed. Interview with QDDP #2 and administrative staff #5 on 9/8/11 at 3:40			

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	PM indicated facility staff should have implemented client #4's objective to make his bed and redirected client #4 to complete a chore. QDDP #2 indicated during the morning, clients' objectives were not implemented as the staff did not have time to do the training. QDDP #2 indicated client's objectives were implemented in the evening. 3. During the 9/6/11 observation period between 3:50 PM and 6:45 PM, at the group home, client #2 sat in a lounge chair in the living room area with his eyes closed from 5:10 PM until 5:50 PM, when the client opened his eyes, stood and walked to the back of the house. DSPs #9 and #12 did not prompt and/or redirect the client to participate in an activity and/or training. During the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, after client #2 finished eating his breakfast at 6:15 AM, client #2 received his morning medications. DSP #1 gave the client his ordered mouth rinse and stated to the client to "rinse and spit." Client #2 walked to the bathroom placed the mouth rinse in his mouth and immediately spit the mouthwash out into the sink. DSP #1 did not monitor and/or supervise the client during the oral hygiene activity. DSP #1 and/or #3 did			

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	not encourage the client to brush his teeth. At 6:58 AM, DSP #3 was in the bathroom shaving client #2 with the client's electric razor. DSP #2 did not encourage the client to shave himself and/or allow the client to shave himself with hand over hand training. Client #2's record was reviewed on 9/7/11 at 7:20 AM. Client #2's 5/8/11 IPP indicated the client had objectives to brush his teeth, when given an electric razor, the client was to shave his entire face and neck, to identify a function of an objective and an objective to select an exercise and/or physical activity to participate in. DSPs did not implement the client's training objectives when formal and/or informal training opportunities existed. Interview with QDDP #2 on 9/8/11 at 3:40 PM indicated during the morning, clients' objectives were not implemented as the staff did not have time to do the training. QDDP #2 indicated client's objectives were implemented in the evening. 1.1-3-4(a)			

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W0262	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. Based on record review and interview, the facility failed to ensure its Human Rights Committee (HRC) deliberated and discussed plans that included restrictive interventions prior to approving the use of the medication for 1 of 2 sampled clients (client #4) reviewed for restrictive program plans. Findings include: Client #4's record was reviewed on 09/08/2011 at 9:46 a.m. A "MEDICAL INFORMATION FORM," dated 08/02/2011, indicated, "...Trilafon (a medication used to treat symptoms of schizophrenia) 4 mg (milligrams) hs (at bedtime) for 1 week then 2 mg am (in the morning) 4 mg hs...." There was no documentation to indicate the HRC discussed and approved use of the medication. During an interview on 09/08/2011 between 3:45 p.m. and 5:45 p.m., Administrative staff #5 indicated HRC members were contacted via telephone	W0262	W262Plan of Correction: Emergency meetings will now be called rather than calling HRC members for approval. During these emergency meetings, KCARC staff will present the information to at least 3 HRC members. The HRC members will have the opportunity to discuss the information prior to approving it. The Admin Assistants will be contacted by other KCARC staff to assist in the scheduling of emergency HRC meetings. Preventive Action: All QMRP-D's, QMRP's and nurses will be trained on the new procedure. Monitoring: The Admin Assistants will assist in the scheduling of emergency HRC meetings and will monitor to ensure the correct process is being followed. Date to be completed by: October 12, 2011	10/12/2011

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	individually for verbal approval of the medication. She indicated the committee did not meet or have group discussion of the risks versus benefits of the medication. Administrative staff #5 indicated the medication order had been implemented. 1.1-3-4(a)			
W0268	These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to protect and/or encourage clients to promote their own dignity when posting clients' pictures in the group home. Findings include: During the 9/6/11 observation period between 3:50 PM and 6:45 PM, at the group home, clients #1, #2, #3, #4, #5, #6, #7 and #8 each had an eight by ten picture posted on a living room wall above the kitchen doorway of the group home. At the bottom of each client's picture was a large white piece of notebook paper with the client's first name printed in large black letters. Client #1, #2, #3, #4, #5, #6, #7 and #8's pictures were posted on	W0268	W268 Plan of Correction: The Recreation Coordinator will assist the consumers in purchasing/making appropriate picture frames. The consumer photos will be placed in the new frames and will be placed appropriately in the home. Preventive Action: Staff will be retrained on promoting dignity. Monitoring: The QMRP-D will observe in the home at least 4 times per week and redirect/retrain when necessary. Date to be completed by: October 12, 2011	10/12/2011

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	the wall in a single line going from left to right above the door way. The 8 individual pictures with each client's name could be seen upon entering the front door of the group home. Interview with Direct Support Professional (DSP) #3 on 9/7/11 at 7:35 AM indicated she did not know why client #1, #2, #3, #4, #5, #6, #7 and #8's pictures were posted on the wall in the living room with the clients' names at the bottom. DSP #3 stated "I guess so the clients can see what their names look like." Interview with administrative staff #5 and Qualified Developmental Disabilities Professional (QDDP) #2 on 9/8/11 at 3:40 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 wanted their pictures with their names posted on the wall in the group home. Administrative staff #5 stated "It was the guys' idea. They did not want to take them down." Administrative staff #5 stated she was aware the pictures of clients #1, #2, #3, #4, #5, #6, #7 and #8 looked like "mug shots." 1.1-3-5(a)			
W0331	The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for	W0331	W331 Plan of Correction: The	10/12/2011

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	1 of 4 sampled clients (#1), the facility's nursing services failed to ensure the facility obtained daily weights for the client as ordered, and/or ensured the client's Individual Program Plan (IPP) addressed how/when the client should be weighed to ensure accuracy. Findings include: Client #1's record was reviewed on 9/7/11 at 7:06 AM and on 9/8/11 at 9:25 AM. Client #1's 7/11 physician's order indicated client #1's diagnosis included, but was not limited to Prader Willi Syndrome (genetic disorder which causes extreme insatiable appetite resulting in morbid obesity). Client #1's 7/11 physician's orders indicated client #1 had an order "weight every day." Client #1's Blood Pressure/Pulse/Weight Record (kept at the Baker Center-office for the group home) for 9/2011 indicated client #1 was not weighed on 9/3, 9/4 and/or 9/5/11. Client #1's 8/2011 weight record indicated no documented weights for 8/6, 8/7, 8/13, 8/14, 8/19, 8/20, 8/21, 8/27 and 8/28/11. Client #1's 7/2011 weight record indicated no documented weights for 7/2, 7/3, 7/4, 7/9, 7/10, 7/16, 7/17, 7/23, 7/24, 7/26, 7/27, 7/28 and 7/29/11.		Director of Health Services will develop a protocol to follow for how and when to weigh Client 1 and when to contact the dr. Staff and QMRP-D will be trained on the protocol and when they need to alert a nurse. The information will be added to Client 1's Risk Plan. Preventive Action: Staff will be trained on how and when to weigh Client 1 and when to report a weight gain to the nurse. Monitoring: The Director of Health Services, another nurse or the QMRP-D will check the weights at least weekly. Staff will be trained to alert the nurse when Client 1 gains more weight than the physician thinks he should in a period of time. Date to be completed by: October 12, 2011	

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	Client #1's Blood Pressure/Pulse/Weight Record indicated the client's blood pressure and pulse were completed on 7/26, 7/27, 7/28 and 7/29/11, but the area to chart the client's weight was left blank. Client #1's 9/2011 weight record indicated the following (not all inclusive): -9/1/11 238.2 -9/2/11 238 -9/6/11 235.8 -9/7/11 238.6 -8/4/11 247 -8/5/11 243.8 -7/12/11 246.6 -7/13/11 246 -7/14/11 244 -7/15/11 246.8 Client #1's record/nursing notes did not indicate why there was a discrepancy with the above mentioned client's weight (actual weight gain/loss or scale/condition). Client #1's 6/1/11 IPP and/or high risk plan did not indicate how and/or when client #1 should be weighed daily to ensure the accuracy of the client's weight. Interview with RN #7, administrative staff #4 and #5 on 9/8/11 at 3:40 PM indicated client #1 was weighed daily due to the			

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	client's diagnosis of Prader Willi. RN #7, administrative staff #4 and #5 indicated client #1 was weighed at the Baker Center Monday through Friday. Administrative staff #5 indicated the blanks on the weight record probably indicated the weights did not get done. RN #7 indicated the client should be weighed as ordered. Administrative staff #4 and #5 indicated the facility staff should be weighing the client at the group home on weekends and holidays/other days the client did not come to the Baker Center. RN #7 stated "He (client #1) has been declining to be weighed at home." Interview with LPN #1 on 9/8/11 at 5:30 PM indicated she monitored client #1's daily weights and the client's doctor monitored the client's weights. LPN #1 indicated client #1 should be weighed at the group home as well at the Baker Center to ensure daily weights were being obtained as ordered. 1.1-3-6(a)			
W0341	Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.	W0341	W341 Plan of Correction: Staff	10/12/2011

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	Based on observation and interview, the facility failed to ensure measures to prevent potential infection by disposing of lancets used to obtain a blood sample from client #1 and 7's fingers into a regular trash container. The facility failed to ensure measures to prevent contamination of medication or potential spread of infection by administering topical medication, nasal spray and eye drops with ungloved hands for 3 of 4 sampled clients (#1, #2 and #3) plus 1 additional client (#7). Findings include: 1. During observations on 09/07/2011 at 5:55 a.m., DSP (Direct Support Professional) #1 was observed using a lancet to prick client #7's finger to		will be retrained on the proper disposal of lancets and proper administration of treatments/medications. Preventi ve Action: Staff will be retrained on the proper disposal of lancets and proper administration of treatments/medications. New staff will also be trained on proper procedure. Monitoring: The QMRP-D will be in the home at least 4 times weekly and will redirect/retrain as necessary. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted. Date to be completed by: October 12, 2011	

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	obtain a blood sugar. The DSP disposed of the lancet in regular trash. 2. During observations on 09/07/2011 at 6:35 a.m., DSP #1 was observed using a lancet to prick client #1's finger to obtain a blood sugar. The DSP disposed of the lancet in regular trash. During an interview on 09/07/2011 at 7:35 a.m., DSP #1 indicated the nurse told her it wasn't necessary to dispose of lancets in a sharps container. During an interview on 09/07/2011 at 1:30 p.m., LPN #6 indicated the lancets should have been disposed of in a sharps container. 3. During observation on			

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	09/07/2011 at 6:20 a.m., DSP #1 reached into client #2's topical medication with an ungloved hand and applied the cream to client #2's hands and forearms. During an interview on 09/07/2011 at 6:22 a.m., DSP #1 indicated she used hand sanitizer before reaching into the container of medication. She stated she "probably should have worn gloves." 4. During observation on 09/07/2011 at 5:05 a.m., DSP #1 administered nasal spray to client #3 with an ungloved hand. She then instilled eye drops into client #3's eyes with ungloved hands. The DSP returned to dispensing oral medications to client #3 without sanitizing her hands.			

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	She did not sanitize her hands between the different routes of medication administration. During an interview on 09/07/2011 at 7:35 a.m., the DSP stated she was "nervous" and should have sanitized her hands. She did not indicate she should have worn gloves when administering nasal spray or eye drops. During an interview on 09/07/2011 at 1:30 p.m., LPN #6 indicated she was not sure if DSP was trained to wear gloves when applying topical medications. She indicated the DSP should have worn gloves during administration of topical medications, nasal sprays, and eye drops. 1.1-3-6(a)			

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W0342	Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review, the facility failed to ensure staff were trained to recognize signs and symptoms of abnormal blood sugars for 1 additional client (client #7). Findings include: During observation on 09/07/2011 at 5:45 a.m., client #7 ate 2 handfuls of dry cereal prior to receiving medication and blood glucose monitoring. DSP (Direct Support Professional) #1 asked client #7 to "come get his medicine"	W0342	W342 Plan of Correction: Staff will be retrained on hyper/hypoglycemia, where to find the quick reference and what signs/symptoms to watch for. Staff will also be retrained on the proper procedure to follow when testing a consumer's blood sugar and giving injections. Preventive Action: The QMRP-D will observe at least one med pass per week to ensure proper procedures are being followed. The quick reference will be placed in the front of the MAR for staff to refer to when needed to know signs/symptoms of hyper/hypoglycemia. Monitoring: The QMRP-D will observe at least on med pass per week. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted.Date to be completed by: October 12, 2011	10/12/2011

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	at 5:55 a.m. Client #7 was asked if he wanted his "shot first (antidiabetic medication) or finger stick (blood sugar)." Client #7 stated, "shot." DSP #1 administered the subcutaneous antidiabetic injection into client #7's right lower abdomen, then checked his blood sugar. The blood sugar was 130 (normal fasting blood sugar is 70-130). Client #7's MAR (Medication Administration Record), dated September 2011 was reviewed on 09/07/2011 at 7:05 a.m. Client #7's 09/11 MAR indicated, "ACCU-CHECK (blood sugar) SAFE -T-PRO LANCE TEST THREE TIMES PER WEEK AS DIRECTED...VICTOZA 2-PAK 18 MG(milligrams)/3 ML(milliliters) INJECT			

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	SUBCUTANEOUSLY 1.2 MG DAILY...." During an interview on 09/08/2011 at 7:35 a.m., DSP #1 indicated she was unaware client #7 had eaten cereal prior to checking the blood sugar. The DSP indicated she was unaware of any guidelines in regard to sequence for checking blood sugar, giving the injection, and the meal. She stated, "both (blood sugar and antidiabetic medication) are ordered in the morning." The DSP indicated she was not aware of any diabetic protocols being in the home and did not know signs and symptoms of hypo/hyperglycemia. During an interview on 09/07/2011 at 1:30 p.m., LPN #6 indicated DSP #1 was			

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	trained in diabetic protocols. The LPN provided a copy of a training record, dated 10/18/2010 and titled, "MEDICATION ADMINISTRATION CHECKLIST." The training record indicated DSP #1 had satisfactory skills for insulin administration and "finger sticks." During an interview on 09/08/2011 between 3:45 p.m. and 5:45 p.m., RN #7 indicated staff should have ensured client #7 had not eaten prior to checking his blood sugar and should not have given the antidiabetic injection prior to checking the blood sugar. During an interview on 09/08/2011 between 3:45 p.m. and 5:45 p.m., Administrative			

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	staff #5 indicated a copy of the diabetic protocol was in client #7's record. RN #7 provided an undated document, titled, "Diabetes Overview" on 09/08/2011 at 5:10 p.m. The document indicated symptoms of hyper and hypoglycemia and indicated actions to treat symptoms. 1.1-3-6(a)			
W0362	A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed to ensure a pharmacist reviewed each client's drug regimen at least quarterly (clients #1, #2, #3 #4, #5 #6, #7 and #8). Findings include: Client #1, #2, #3, #4, #5, #6, #7 and #8's pharmacy recommendations were reviewed on 09/08/2011 at 10:00 a.m.	W0362	W362 Plan of Correction: Pharmacy reviews will be completed quarterly. They pharmacy has been contacted concerning the situation. The nurses will be retrained to monitor the completion of pharmacy reviews. Preventive Action: The nurses will be retrained to monitor the completion of pharmacy reviews. Monitoring: The nurses will monitor	10/12/2011

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	The pharmacist reviewed drug regimens on 07/10/2010, 01/10/2011, 04/15/2011, and 07/15/2011. There was no documentation to indicate a review was completed in October 2010. During an interview on 09/08/2011 at 5:20 p.m., Administrative staff #5 indicated a pharmacy review had not been completed in October 2010. 1.1-3-6(a)		the completion of quarterly pharmacy reviews Date to be completed by: October 12, 2011	
W0369	The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review, the facility failed to ensure clients' medications were administered without error for 1 of 4 sampled clients (client #3) and 1 additional client (client #7). Findings include: 1. During observation of medication administration on 09/07/2011 at 5:05 a.m., DSP (Direct Support Professional) #1 did not administer Patanol Ophthalmic Solution to client #3. The DSP stated the client had been "out of the medication for 4 days." The DSP administered 1 spray of	W0369	W369 Plan of Correction: Staff will be retrained on med administration and the procedure for ordering medications. Preventive Action: The nurse or QMRP-D will check medications at least once weekly to ensure there is an adequate supply. This will be implemented as procedure and will be ongoing. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted. Staff will be retrained on med administration. Monitoring: The nurse or QMRP-D will check medications at least once weekly	10/12/2011

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	Fluticasone Nasal Spray into each of client #3's nostrils. During an interview on 09/07/2011 at 5:10 a.m., DSP #1 stated the client had been "out of the eye drops for 4 days." The DSP stated she "thought the order was 1 spray" for the nasal spray. Client #3's MAR (Medication Administration Record) was reviewed on 09/07/2011 at 7:05 a.m. The MAR indicated, "...PANTANOL OPTH (Ophthalmic) SOLN (solution) - INSTILL 2 DROPS BOTH EYES TWICE DAILY...FLUTICASONE PRO 50 MCG (microgram) SPRAY -2 SPRAYS EACH NOSTRIL DAILY...." 2. During observation of medication administration on 09/07/2011 at 5:55 a.m., DSP #1 did not administer Nasonex nasal spray to client #7. Client #7 self-administered Ocean Nasal Spray. Client #7 sprayed 3 sprays into his left nostril and 2 sprays into the right nostril. Client #7's 9/11 MAR was reviewed on 09/07/2011 at 7:50 a.m. The MAR indicated client #7 received Nasonex 50 mcg (micrograms) nasal spray 2 sprays in each nostril daily. The 09/2011 MAR indicated client #7 received Ocean Spray 45 milliliters one spray in each nostril 4		to ensure there is an adequate supply. This will be implemented as procedure and will be ongoing. A Nurse Trainer position has been created for the Residential Department. The purpose of this position will be to provide ongoing training to staff. The Nurse Trainer will be in the homes in the evenings. This position has been posted. The QMRP-D will observe at least one med pass per week to ensure staff are following proper procedure during medication administration. Date to be completed by: October 12, 2011	

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	times a day. During an interview on 09/07/2011 at 5:55 a.m., DSP #1 stated she was "waiting for [client #7's] Nasonex to be refilled." She stated client #7 "just recently began administering his Ocean Spray." She indicated she should have redirected him to use the correct dose. During an interview on 09/09/2011 at 10:30 a.m., LPN #6 indicated the clients' medications should be in the group home to administer. 1.1-3-6(a)			
W0436	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. Based on observation, interview and record review for 1 of 4 sampled clients with adaptive equipment (#2), the facility failed to encourage and/or teach the client to wear/care for his eye glasses. Findings include: During observations in the group home on 09/06/2011 between 3:50 p.m. and 6:45	W0436	W436Plan of Correction: An objective will be added to Client 2' s IPP for wearing/caring for his glasses. Preventive Action: Staff will be trained on the new objective. Monitoring: The QMRP-D will be in the home at least 4 days per week and will redirect/retrain as necessary. Date to be completed by: October 12, 2011	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/12/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC		STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	p.m., client #2 wore prescription eye glasses. During observations in the group home on 09/07/2011 between 5:00 a.m. and 7:10 a.m., client #2 was not wearing eye glasses. During observations at day services on 09/07/2011 between 1:30 p.m. and 2:45 p.m., client #2 was not wearing glasses. He leaned over a magazine until his face was only a few inches from the magazine to see the pictures. Client #2's record was reviewed on 09/08/2011 at 12:44 p.m. An Individual Program Plan, revised 05/08/2011, indicated client #2 had eyeglasses. There was no documentation to indicate client #2 had active treatment goals for wearing his glasses or caring for his glasses. During an interview on 09/08/2011 between 3:45 p.m. and 5:45 p.m., QDDP-D #2 (Qualified Developmental Disabilities Professional-Designee), indicated client #2 was supposed to wear his eyeglasses full time. The QDDP-D indicated client #2 had a history of misplacing his eyeglasses for a few days at a time, then finding them in the sofa			

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	cushions or other unusual places. 1.1-3-7(a)			
W0488	The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4) and for 3 additional clients (#5, #6 and #7), the facility failed to ensure clients participated in all aspects of meal preparation when they demonstrated the skills to do so. Findings include: During the 9/6/11 observation period between 4:50 PM and 6:45 PM, at the group home, Direct Support Professional (DSP) #12 placed client #2's chicken in the food processor and ground the client's chicken up without involving/encouraging the client to participate in the activity as client #2 walked through the kitchen to the back room. During the 9/7/11 observation period between 5:00 AM and 7:05 AM, at the group home, DSP #3 cracked the eggs into a bowl, stirred, placed into a skillet, turned the stove on and scrambled client #2, #3, #4, #5, #6 and #7's eggs without	W0488	W488 Plan of Correction: Staff will be retrained on ensuring consumers are involved in all aspects of meal preparation. Preventive Action: Staff will be retrained on ensuring consumers are involved in all aspects of meal preparation. Monitoring: The QMRP-D will be in the home at least 4 days per week and will redirect/retrain as necessary. Date to be completed by: October 12, 2011	10/12/2011

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	involving any client. Client #7, who was in the kitchen making toast, walked over to the stove area to assist. DSP #3 waved her hand at the client to stop the client from helping. Client #7 stood and watched DSP #3 crack the eggs into the bowl. Client #3, who was in the kitchen/living room area was not prompted to help as well. At 5:30 AM, DSP #3 cracked more eggs and placed them in a second skillet. DSP #3 did not involve client #2 who was standing in the kitchen watching the coffee percolate, client #7 who was sitting in the back room watching TV, and/or client #5 who was setting the dining room table. At one point QDDP (Qualified Developmental Disabilities Professional) #2 entered the kitchen and asked DSP #3 which client was to cook the eggs, QDDP #2 then stated " [Client #8] cooks the eggs." Client #8 was not in the group home as the client was on a home visit. Once the eggs were done, DSP #3 placed the eggs into a serving bowl and carried the eggs to the table. DSP #3 got the cereal out and carried the cereal to the table without involving clients #2, #3, #5, #6 and #7. DSP #3 placed client #2's eggs on his plate, buttered the client's toast and placed it on the client's plate without allowing the client to serve to himself. Client #2 independently placed jelly on his bread, poured his own cereal into his bowl and			

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	fed himself during the breakfast meal. Client #2's record was reviewed on 9/7/11 at 7:20 AM. Client #2's 5/8/11 Individual Program plan (IPP) indicated the client had an objective to prepare 1 item for dinner. Interview with QDDP #2, administrative staff #4 and #5 on 9/7/11 at 3:40 PM indicated clients should be involved in all aspects of the meal/food preparation. 1.1-3-8(a)			