

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: August 18, 19, 20 and 21, 2014</p> <p>Facility Number: 000876 Provider Number: 15G362 AIM Number: 100249160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 non-sampled clients (#6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure client #6 did not pay for haircuts.</p> <p>Findings include:</p>	W000104	<p>W 104</p> <p>Planof Correction: Cost of both haircuts that were paid for on 7/2 and 8/6 werereimbursed to client #6 by facility (Attachment A). Planof Prevention: An email was sent out to all Stone Belt SGL coordinators, housemanagers, and staff who are responsible for</p>	08/22/2014

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>A review of client #6's finances was conducted on 8/18/14 at 4:32 PM and indicated the following: On 7/2/14 (check number 348) and 8/6/14 (check number 353), client #6 paid \$14.00 for haircuts. There was no documentation in client #6's check book ledger indicating the facility reimbursed client #6 for the haircuts.</p> <p>An email to the House Manager, Associate Manager, Coordinator and Director of Supervised Group Living from the Fiscal Coordinator (FC), dated 8/19/14 at 1:52 PM, indicated, in part, "Please remember all clients (sic) haircuts are to be paid with the house credit card. When completing the Purchase form and the budget sheet you put this information under client supports. The haircut cost is up to (\$20.00 with a (\$2.00 tip per client. If the cost exceeds (\$20.00 then the client pays the extra. That being said it was brought to my attention that [client #6] paid for a haircut on 7/2/2004 (2014) (sic) I will get this info to [name of fiscal staff] to pay him back, and he also had one he paid for on 8/6/2014 - please send in that receipt to [fiscal staff] with a purchase form so we can get him paid back."</p>		<p>client finances to make certain client hair cuts are paid for by facility and never the client up to \$20(Attachment B). Quality Monitoring: Coordinators have been trained to oversee this and continue to train with their staff what cost are covered in Per Diem Rates and what items are not (Attachment C).</p>	

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W000148	<p>On 8/20/14 at 2:17 PM, the Coordinator indicated the facility should be paying for client #6's haircuts. The Coordinator indicated the staff were sending a blank check with client #6 when he went out with his guardian. The guardian took client #6 to get the haircuts. The Coordinator indicated the facility needed to reimburse client #6 for the two haircuts.</p> <p>On 8/18/14 at 4:44 PM, the Director of Supervised Group Living (DSGL) indicated the group home should pay for client #6's haircuts. The DSGL indicated the group home needed to reimburse client #6's money since he paid for his own haircut.</p> <p>On 8/19/14 at 1:37 PM, the Fiscal Coordinator (FC) indicated client #6 should not pay for his haircuts. The FC indicated client #6 needed to be reimbursed for the two haircuts he paid for.</p> <p>9-3-1(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition</p>						

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	<p>including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 3 non-sampled clients (#5), the facility failed to promptly notify the client's guardian of numerous staffing changes at the group home.</p> <p>Findings include:</p> <p>On 8/20/14 at 1:01 PM, client #5's guardian indicated she had heard from a former staff there had been staffing changes at the group home but no one from the group home called her to notify her of the changes. Client #5's guardian indicated she was not informed the Director of Supervised Group Living, Coordinator, House Manager, Food Management Purchasing Specialist and one weekend staff had all left. Client #5's guardian indicated she was not aware the Coordinator had changed. The guardian indicated she wanted to be informed of significant changes at the group home including staffing changes, especially since many of the staff who left had been there for years.</p> <p>On 8/20/14 at 2:16 PM, a review of client #5's record was conducted and indicated there was no documentation the facility contacted the guardian to inform her of</p>	W000148	<p>W148</p> <p>Planof Correction: Newly appointed facility coordinator, Bruce Murray, hascontacted client #5 guardians via phone. Planof Prevention: Stone Belt SGL Coordinators have been trained to communicateregularly with their guardians to communicate any change in status, planning,schedules or staffing, etc. They were also trained to introduce themselves toall guardians and provide contact information for themselves, DSGL, nurse, and otherrelevant individuals on chain of command. This information is reviewed annuallyas well (Attachment B).</p>	09/12/2014	

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W000149	<p>the numerous staffing changes at the group home.</p> <p>On 8/20/14 at 3:03 PM, the Coordinator indicated he could not locate documentation the guardian(s) were contacted. The Coordinator indicated he had not contacted the guardian to notify her of the changes in the group home staffing.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS 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 5 of 20 incident/investigative reports reviewed affecting clients #1 and #7, the facility neglected to implement its policies and procedures to prevent client to client abuse at the facility-operated day program and verbal abuse of client #1.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/18/14 at 2:26 PM and indicated the following:</p> <p>1) On 7/21/14 at the facility-operated</p>	W000149	<p>Addendum: Policy was followed and staff was immediately suspended then terminated when accusation was founded She is not eligible for rehire W149 Planof correction: Stone Belt policy was followed immediately following the accusation of abuse was made on 8/18/14. Stone Belt has a policy that prohibitsmistreatment, neglect, or abuse of a client. This policy was broken by accused staff therefore she was suspended moments following accusation of abuse ofclient #1 and terminated the next day (Attachment D). Plan ofPrevention: Facility day program staff and Stone Belt SGL staff will be trainedon prevention</p>	09/01/2014

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	<p>day program, there was an allegation of physical abuse by a group home staff while at the day program. The investigation indicated, in part, "[Staff #10] reported that the incident took place in Room 1 at 3:30 pm yesterday. [Staff #11] came in to pick [client #1] up. She had been sleeping. She (staff #11) shook [client #1's] head back and forth and messed up her hair. She then slipped her arm around [client #1's] neck to give her a hug. [Client #1] was grabbing at her hands trying to get her to stop. [Client #1] appeared startled. [Staff #10] reported that it was hard to know intent. She has sought guidance from her supervisor about whether this is abuse and wasn't sure what to do. [Staff #10] reported that waking [client #1] in an abrupt fashion has happened multiple times in the past. [Staff #10] reported that this incident was particularly 'insidious,' and this was the first time the waking had appeared so harsh. [Staff #10] had asked the supervisor, prior to yesterday, to come to Room 1 at 3:30 pm to witness but when the supervisor showed up, [staff #11] did not do this same behavior described above to wake [client #1] up. [Staff #10] reported that this was 'too rough and abrupt.' She reported that is isn't fair for someone to wake up in this way. [Staff #10] reported when asked that [staff #11] doesn't seem</p>		<p>of mistreatment, neglect, and abuse each month (Attachment B). Quality Monitoring: Facility manager / day program manager will provide daily monitoring. Facility coordinator / day program manager will provide bi-weekly documented monitoring. Facility director will provide monthly documented monitoring at both programs (Attachment B).</p>	

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	<p>mad when this is taking place and didn't seem mad this time."</p> <p>The investigation indicated, in part, "[Staff #9] reported that she has been trying to wake [client #1] before staff come in at 3:30 pm. She reported that she and [staff #10] had been trying to do this to prevent the abrupt awakenings they had observed on multiple occasions at the hands of [staff #11] directed at [client #1]. She reported she went to gently pat her to wake her. [Staff #11] said, 'No, No, I got this.' She then shook [client #1] to the point her head was vigorously moving back and forth. She messed up her hair. She then had a smile on her face and moved her arm down around [client #1's] neck from behind to hug her. [Staff #9] reported that [client #1] was not injured but startled. She was 'roughly awakened,' [staff #9] shared with clinician. [Staff #9] reports also, 'It was brutal.' [Staff #9] indicates that this has happened before with this staff. She says she wakes her roughly about 3-4 times per week when asked to clarify. She reported that this was the first time she had witnessed it to be so rough. She wasn't sure if this was considered abuse or not and has discussed it with [staff #10]. [Staff #9] reported that no other staff treat her like that. She couldn't tell if it was a power struggle or what the</p>			

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	<p>intent was. [Staff #9] reports that she was looking at [staff #11] do this and [staff #11] was smiling the entire time."</p> <p>An interview with client #1's peer at the day program indicated, "[Peer] was asked by this clinician, 'Did you see staff touch [client #1] on the head yesterday?' [Peer] indicated that he did. He was then asked, 'then what happened?' He said that [client #1] said, 'Get away.' He was asked if she swatted at staff, and he said 'yes.' He was asked then what happened. He said staff's hands moved down like they were going to choke her. He made choking sounds. This clinician demonstrated the batting motions and the choking motions and [peer] confirmed this is what he had seen. He was asked if he saw anything else of if the actions would appear to have hurt [client #1] and he indicated that he didn't think anything hurt her."</p> <p>The investigation's Statement of Findings indicated, "Two staff confirmed overly rough and abrupt treatment of [client #1] during the interview process. Two staff confirmed that [client #1's] head was moving back and forth in a worrisome manner. [Client #1's peer] confirmed the hug part of the report and substantiated the touching of [client #1's] head by [staff #11], but was not able to confirm that</p>			

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	[client #1's] head moved back and forth. Two staff as witnesses indicate that there is a report of a history of abrupt and inappropriate awakenings to the point of startling [client #1]. The comments of the behaviorist add concerns in regard to the nature of this staff's interaction with this client." The investigation indicated, "While there is no evidence of physical harm, I feel that there is evidence, confirmed by two witnesses, of emotional/verbal abuse. While [client #1] was not able to relay the incident, she did indicate that it bothered her the way people try to wake her up at the end of her day program day. She indicated when asked that she wants it to stop. It is clear from these reports that [staff #11] is using these tactics to gain control over [client #1's] sleeping behavior. The use of words or actions of this manner is a clear violation of Stone Belt policy and constitutes emotional/verbal abuse when the client feels harassed. The reported 'harsh and abrupt' awakening during the interview process in reference to this incident, and the reports of inappropriate abrupt awakenings on other occasions are cited as evidence. This incident has been substantiated for emotional/verbal abuse. [Client #1] is a 90 year old woman. She has difficulty staying awake and alert at the end of the day. She is wheelchair bound and due to her age is physically			

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	<p>fragile. While there was no injury, this repeated treatment is intimidating for [client #1] and does have the potential to cause psychological harm. If the rubbing of the head with the back and forth motion of the neck, is significantly vigorous, this could cause injury to her neck or spine given her age. It is likely that [staff #11] did not relay the facts of the incident accurately, given that two staff, and one client confirmed on multiple points, the original report of this incident."</p> <p>The Employee Warning Notice, dated 7/24/14, indicated, "[Staff #11] was accused of abuse and neglect. The investigation documented evidence, confirmed by two witnesses, of emotional/verbal abuse towards a client. It is clear from these reports that [staff #11] has used these tactics to gain control over a client's behavior. The use of words or actions of this manner is a clear violation of Stone Belt policy and constitutes emotional/verbal abuse when the client feels harassed." The employee was discharged from employment.</p> <p>2) On 6/25/14 at 9:50 AM at the facility-operated day program, client #7 was sitting in a chair. Client #7 stood up, ran over to a peer, and put his hands on the peer. Staff used a brief physical hold</p>				

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	<p>to remove client #7's hands from the peer. The peer indicated he was hurt on the left, upper shoulder area. Staff checked the peer for injuries and none were found. At 12:15 PM, client #7 ran toward the peer while the peer was exiting the room. Staff blocked client #7 from grabbing the peer.</p> <p>3) On 6/24/14 at 12:15 PM at the facility-operated day program, client #7 grabbed a peer's left forearm. Staff removed client #7's hands. At 1:00 PM, client #7 lunged at a peer when entering the classroom. At 1:01 PM, client #7 lunged and grabbed client #1's right shoulder. Staff removed client #7's hands from client #1's shoulder. At 1:35 PM, client #7 grabbed a peer's right shoulder. Staff removed client #7's hands from the peer's shoulder.</p> <p>4) On 6/23/14 at 12:55 PM at the facility-operated day program, client #7 entered the room. Staff observed a peer swing his lunch box and hit client #7 in the thighs. Client #7 attempted to grab another peer but a brief physical hold was used to block the aggression.</p> <p>5) On 5/12/14 at 12:45 PM at the facility-operated day program, a peer exited the restroom crying, holding his arm. The peer reported client #7 punched</p>			

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	<p>him in the arm and grabbed his face. The peer reported client #7 got close to him, grabbed his arms and bumped heads.</p> <p>On 8/18/14 at 3:09 PM, the Director of Supervised Group Living indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The DSGL indicated the facility should prevent abuse and neglect. The DSGL indicated client to client aggression was abuse.</p> <p>On 8/18/14 at 1:59 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are</p>			

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	<p>detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged</p>			

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W000189	<p>abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 9/14, indicated, in part, "Emotional/Verbal abuse: Consists of the intentional use of actions, words, or activities where an individual suffers emotional/psychological harm or trauma."</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM 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 (#1), the facility failed to provide initial and continuing training to enable</p>	W000189	<p>Addendum: Facility nurse will monitor setting (3) times out of the (5) day lifelong learning schedule The frequency may taper following one quarter</p>	09/08/2014

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	<p>the facility-operated day program staff to perform their job duties effectively, efficiently and competently regarding client #1's risk plan for hypoxia (oxygen saturation levels below 90% at room air).</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 8/19/14 from 12:30 PM to 1:50 PM. At 12:47 PM, client #1's oxygen concentrator was set at 1.5 liters per minute (LPM). An interview with staff #7 indicated she was not sure what client #1's oxygen concentrator was supposed to be set on. On 8/19/14 at 12:48 PM, staff #8 indicated she was not sure what client #1's oxygen concentrator was to be set on. At 12:49 PM, staff #7 indicated she would look at client #1's record. Staff #7 referred to client #1's 1/20/14 Medication Information Sheet (MIS) located in a binder within the classroom. Staff #7 indicated client #1's MIS read client #1 was to receive 2 LPM continuously. Staff #7 indicated client #1's oxygen concentrator was set at 1.5 LPM when she checked it. At 12:51 PM, staff #7 adjusted the concentrator so client #1 received 2 LPM of oxygen. At 12:52 PM, staff #7 indicated she was trained on client #1's MIS and risk plan for hypoxia. At 12:53 PM, a note written on the board</p>		<p>W189 Plan of correction: Day program coordinator and staff have been trained on client #1 oxygen concentrator is to be set at 2 liters (Attachment D and E). Plan of Prevention: Facility manager / day program manager will provide daily monitoring. Facility coordinator / day program manager will provide bi-weekly documented monitoring. Facility director will provide monthly documented monitoring at both programs (Attachment B). Plan of Monitoring: Facility program director and nurse will provide constant monitoring and training to ensure plans are being followed by physician orders.</p>		

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	<p>in the room indicated, "[Client #1's initials] 2 L (liters) O2 (oxygen)."</p> <p>On 8/19/14 at 2:13 PM, a review of client #1's record indicated her 6/10/14 Physician's Orders included oxygen at 2 liters per minute per nasal cannula continuously. Client #1's current Medication Information Sheet, dated 8/19/14, indicated client #1 was to receive oxygen at two liters per minute per nose cannula continuously. Client #1's risk plan for hypoxia, dated 6/19/14, indicated client #1 was at risk for hypoxia. The risk plan indicated, in part, "Staff will ensure that [client #1] wears her oxygen as ordered via nasal cannula set at 2 L (liters) per minute. Staff will check [client #1's] oxygen tank to ensure it is working and is set properly 4 times a day: AM, Noon, 5p, and right before bedtime... Only Staff who have received training on this plan and understand the plan will work with this consumer to ensure the safety of the consumer. Staff will be informed on risk plan and protocol for hypoxia...".</p> <p>The facility did not provide documentation indicating day program staff #7 and #8 received initial and continuing training enabling the staff to perform their job duties effectively, efficiently and competently.</p>			

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W000248	<p>On 8/19/14 at 3:00 PM, the Coordinator indicated client #1's oxygen concentrator needed to be set correctly and the staff needed to be trained on implementing client #1's plans.</p> <p>On 8/20/14 at 3:25 PM, the day program Coordinator indicated staff #7 was trained on client #1's risk plan however the training documentation did not specifically indicate staff #7 was trained on the client #1's plan. The Coordinator indicated staff #8 was a substitute and had not received training on client #1's plans.</p> <p>9-3-3(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview for 1 of 4 clients in the sample (#1), the facility failed to provide a copy of client #1's current Medication Information Sheet (MIS) to all relevant staff.</p> <p>Findings include:</p>	W000248	<p>W248 Plan of correction:A copy of client #1 MIS sheet was printed and made available to all relevantstaff. These documents are also kept internally and secured on a web basedsystem that is accessible to day program staff. Plan ofprevention: Day program staff have been trained on client</p>	09/08/2014

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	<p>Observations were conducted at the group home on 8/18/14 from 4:08 PM to 5:46 PM and 8/19/14 from 5:00 AM to 7:36 AM. During the observations, client #1's portable oxygen tank was set to 2 Liters Per Minute (LPM).</p> <p>An observation was conducted at the facility-operated day program on 8/19/14 from 12:30 PM to 1:50 PM. At 12:47 PM, client #1's oxygen concentrator was set at 1.5 liters per minute (LPM). An interview with staff #7 indicated she was not sure what client #1's oxygen concentrator was supposed to be set on. On 8/19/14 at 12:48 PM, staff #8 indicated she was not sure what client #1's oxygen concentrator was to be set on. At 12:49 PM, staff #7 indicated she would look at client #1's record. Staff #7 referred to client #1's 1/20/14 Medication Information Sheet (MIS) located in a binder within the classroom. Staff #7 indicated client #1's MIS read client #1 was to receive 2 LPM continuously. Staff #7 indicated client #1's oxygen concentrator was set at 1.5 LPM when she checked it. At 12:51 PM, staff #7 adjusted the concentrator so client #1 received 2 LPM of oxygen. At 12:53 PM, a note written on the board in the room indicated, "[Client #1's initials] 2 L (liters) O2 (oxygen)."</p>		<p>#1 MIS sheet alongwith how to access other relevant documents (Attachment E). Plan of monitoring: Facility manager / day program manager will provide daily monitoring. Facility coordinator / day program manager will provide bi-weekly documented monitoring. Facility director will provide monthly documented monitoring at both programs (Attachment B). Plan of Monitoring: Facility program director and nurse will provide constant monitoring and training to ensure plans are being followed by physician orders</p>	

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W000249	<p>A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1's current MIS was dated 8/19/14. Client #1's MIS had been updated eight times since 1/20/14.</p> <p>On 8/20/14 at 2:17 PM, the Coordinator indicated the staff should have the current MIS available to the day program staff.</p> <p>On 8/19/14 at 1:24 PM, a Day Program Coordinator indicated the day program staff should have the current MIS available for review. The Day Program Coordinator indicated she was unsure why the MIS available in the room was not current.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, record review and interview for 2 of 4 clients in the sample (#1 and #7), the facility failed to ensure staff implemented the clients' program</p>	W000249	<p>Addendum: Facility nurse will monitor setting (3) times out of the (5) day lifelong learning schedule The frequency may taper</p>	09/09/2014

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	<p>plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the facility-operated day program on 8/19/14 from 12:30 PM to 1:50 PM. At 12:47 PM, client #1's oxygen concentrator was set at 1.5 liters per minute (LPM). An interview with staff #7 indicated she was not sure what client #1's oxygen concentrator was supposed to be set on. On 8/19/14 at 12:48 PM, staff #8 indicated she was not sure what client #1's oxygen concentrator was to be set on. At 12:49 PM, staff #7 indicated she would look at client #1's record. Staff #7 referred to client #1's 1/20/14 Medication Information Sheet (MIS) located in a binder within the classroom. Staff #7 indicated client #1's MIS read client #1 was to receive 2 LPM continuously. Staff #7 indicated client #1's oxygen concentrator was set at 1.5 LPM when she checked it. At 12:51 PM, staff #7 adjusted the concentrator so client #1 received 2 LPM of oxygen. At 12:52 PM, staff #7 indicated the day program staff did not adjust or check client #1's oxygen throughout the day. Staff #7 indicated when the group home staff dropped off client #1, the group home staff switch the source of oxygen from her portable tank to the oxygen</p>		<p>following one quarter W249</p> <p>1. Plan of correction: Day program coordinator and staff have been trained on client #1 oxygen concentrator is to be set at 2 liters per minute per nasal cannula continually (Attachment D and E). Plan of Prevention: Facility manager / day program manager will provide daily monitoring. Facility coordinator / day program manager will provide bi-weekly documented monitoring. Facility director will provide monthly documented monitoring at both programs (Attachment B). Plan of Monitoring: Facility program director and nurse will provide constant monitoring and training to ensure plans are being followed by physician orders.</p> <p>2. Plan of correction: Day program coordinator and staff have been trained in following client #7 active treatment schedule (Attachment E and F). Plan of prevention: Plan of Prevention: Facility manager / day program manager will provide daily monitoring. Facility coordinator / day program manager will provide bi-weekly documented monitoring. Facility director will provide monthly documented monitoring at both programs (Attachment B). Plan of Monitoring: Facility program director and nurse will provide constant monitoring and training to ensure plans are being</p>	

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	<p>concentrator. Staff #7 indicated at the end of the day, the group home staff switch the source from the oxygen concentrator to the portable unit. Staff #7 indicated the day program staff did not do any of the switching of sources of oxygen. At 12:53 PM, a note written on the board in the room indicated, "[Client #1's initials] 2 L (liters) O2 (oxygen)."</p> <p>On 8/19/14 at 2:13 PM, a review of client #1's record indicated her 6/10/14 Physician's Orders included oxygen at 2 liters per minute per nasal cannula continuously. Client #1's current Medication Information Sheet, dated 8/19/14, indicated client #1 was to receive oxygen at two liters per minute per nose cannula continuously. Client #1's risk plan for hypoxia, dated 6/19/14, indicated client #1 was at risk for hypoxia. The risk plan indicated, in part, "Staff will ensure that [client #1] wears her oxygen as ordered via nasal cannula set at 2 L (liters) per minute. Staff will check [client #1's] oxygen tank to ensure it is working and is set properly 4 times a day: AM, Noon, 5p, and right before bedtime... Only Staff who have received training on this plan and understand the plan will work with this consumer to ensure the safety of the consumer. Staff will be informed on risk plan and protocol for hypoxia..."</p>		<p>followed by physician orders. W252</p> <p>1. Plan of correction: Nurse Lauren Koen consulted pcp and it was determined that client #1 did not require 2 hour position. New risk plan has been developed and trained with staff (Attachment G). Plan of prevention: Nurse Lauren has been trained on reviewing all high risk plans and MIS and ensuring there accuracy (Attachment H). Plan of monitoring: Director will complete internal inspection and review MIS and high risk plans to confirm that plans are being reviewed for accuracy monthly by nurses and QIDP.</p> <p>2. Plan of correction: Day program and facility staff have been trained on client #1 MIS and new oral hygiene goal which states: "oral care after meals" (Attachment E and I). Plan of prevention: Facility coordinators have been trained on reviewing MIS and goal progress monthly and that documentation is occurring (Attachment Plan of monitoring: Director will complete internal inspection and review MIS ,high risk plans, IPPs to confirm that plans are being reviewed for accuracy monthly by nurses and QIDP.</p>	

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	<p>On 8/19/14 at 3:00 PM, the Coordinator indicated the facility-operated day program staff should ensure client #1's oxygen concentrator was set correctly based on physician's orders and the risk plan for hypoxia. The Coordinator indicated the staff should have implemented client #1's plan to ensure she received 2 LPM of oxygen.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated client #1's risk plan for hypoxia should be implemented as written.</p> <p>2) An observation was conducted at the facility-operated day program on 8/19/14 from 12:30 PM to 1:50 PM. From 12:30 PM to 1:16 PM, client #7 sat in a chair at the facility-operated day program. He was not engaged or prompted to engage in an activity. At 1:11 PM, a day program staff from another room walked through the room, said hello to client #7, shook his hand and continued out the door. At 1:14 PM when client #7 was falling asleep, staff #8 said to him, "Hey [client #7]." Client #7 opened his eyes and no further interaction was observed. Client #7 sat in a chair with no activity during the observation.</p> <p>A review of client #7's record was</p>			

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W000252	<p>conducted on 8/20/14 at 11:52 AM. Client #7's Individual Support Plan, dated 6/18/14, indicated he had training objectives to increase his pedestrian safety skills, make a purchase, launder his clothes, increase his medication administration training, demonstrate appropriate table manners and shower himself.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated client #7 should be prompted to engaged in activities during the day program. The Coordinator indicated there had been a recent, large turnover of day program staff. The Coordinator indicated the day program staff should prompt client #7 to participate in activities.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 1 of 4 clients in the sample (#1), the facility failed to ensure staff documented the implementation of the client's program plans.</p>	W000252	<p>W252 1. Plan of correction: Nurse Lauren Koen consulted pcp and it was determined that client #1 did not require 2 hour position. New risk plan has been developed and trained with staff (Attachment G).</p>	09/09/2014			

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	<p>Findings include:</p> <p>1) A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1 had a risk plan for Skin Breakdown, dated 7/15/14. The risk plan indicated, "[Client #1] is at risk for skin break down due to the decreased mobility and use of wheelchair for the majority of each day." The plan indicated, "Staff will encourage and assist, if needed, frequent (at least every 2 hrs (hours)) shifts in position, even if they are only slight, this is effective to relieve pressure points." The facility did not provide documentation client #1's risk plan was being implemented.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated he was not sure if there was documentation but the facility should have documentation of the positioning schedule being implemented.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated he was unsure if the positioning schedule was being implemented. The Coordinator indicated if there was no documentation, then it didn't happen.</p> <p>2) A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1's Medication Information Sheet (MIS),</p>		<p>Plan of prevention: Nurse Lauren has been trained on reviewing all highrisk plans and MIS and ensuring there accuracy (Attachment H). Plan of monitoring: Director will complete internal inspection andreview MIS and high risk plans to confirm that plans are being reviewed foraccuracy monthly by nurses and QIDP. 2. Plan of correction: Day program and facility staff have been trained onclient #1 MIS and new oral hygiene goal which states: "oral care after meals"(Attachment E and I). Plan of prevention: Facility coordinators have been trained on reviewingMIS and goal progress monthly and that documentation is occurring (AttachmentPlan of monitoring: Director will complete internal inspection and review MIS ,highrisk plans, IPPs to confirm that plans are being reviewed for accuracy monthlyby nurses and QIDP.</p>				

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W000331	<p>dated 8/19/14, indicated she was to receive oral care after each meal with assistance. The MIS indicated, "Oral care after each meal with assist. Track on IHP (Individual Habilitation Plan)."</p> <p>There was no documentation the oral care was being provided three times a day to client #1. Client #1 had a swallow study completed on 8/30/13. The Outside Services Report, dated 8/30/13, indicated, in part, "Recommend: oral care after meals."</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated the facility should have documentation of the oral care after meals as recommended by the speech therapist.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated he would look for the documentation of client #1's oral care being provided to her. The Coordinator did not provide documentation the oral care was being provided to client #1.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and</p>	W000331		09/09/2014

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	<p>interview for 2 of 4 clients in the sample (#1 and #2) and one additional client (#4), the facility's nursing services failed to ensure: 1) staff administered client #1 and #4's medication as ordered by the physician, 2) documentation of client #1's positioning schedule, 3) client #1's plan for oral care after meals was implemented, 4) client #1's hypoxia (oxygen saturation levels below 90% at room air) risk plan was implemented at the facility-operated day program, and 5) client #2's risk plan for skin break down was in her electronic record for review.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 8/19/14 from 5:00 AM to 7:36 AM. At 5:04 AM, client #1 received her ten oral medications, including Levothyroxin, from staff #5. The August 2014 Medication Administration Record indicated for Levothyroxin, "1 hr (hour) before other meds." The package the Levothyroxin was removed from indicated, "1 hr before other meds."</p> <p>On 8/19/14 at 5:18 AM, staff #5 stated the staff "never" pass client #1's Levothyroxin prior to her other medications. Staff #5 stated Levothyroxin "always" passed with her</p>		<p>Addendum: Facility nurse will monitor setting (3) times weekly The frequency may taper following one quarter W331 1. Plan of Correction: Facility staff trained on administrating prescribed Levothyroxin to client #1 and #4 prior to other medications (Attachment J). Plan of prevention: House manager will provide daily monitoring and teaching of staff on correctly administrating medications per MAR and physician's order. Plan of Monitoring: House coordinator and nurse will document semi-weekly medication observation and immediate training then submit them to director for review (Attachment B). 2. Plan of correction: Nurse Lauren Koen consulted pcp and it was determined that client #1 did not require 2 hour position. New risk plan has been developed and trained with staff (Attachment G). Plan of prevention: Nurse Lauren has been trained on reviewing all high risk plans and MIS and ensuring there accuracy (Attachment H). 3) Plan of correction: Day program and facility staff have been trained on client #1 MIS and new oral hygiene goal which states: "oral care after meals" (Attachment E and I). Plan of prevention: Facility coordinators have been</p>		

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	<p>other medications. Staff #5 indicated client #4's Levothyroxin was administered the same way.</p> <p>On 8/19/14 at 5:32 AM, client #4 received two medications, including Levothyroxin, from staff #5. The August 2014 Medication Administration Record indicated for Levothyroxin, "Before other meds." The package the Levothyroxin was removed from indicated, "Before other meds."</p> <p>A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1's current Physician's Orders, dated 6/10/14, indicated Levothyroxin was to be administered "1 hr before other meds."</p> <p>On 8/19/14 at 2:04 PM, a review of client #4's Physician's Orders, dated 6/10/14, indicated Levothyroxin was to be administered, "Before other meds."</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated client #1 and #4's Levothyroxin should be administered as ordered prior to their other medications. On 8/20/14 at 2:17 PM, the Coordinator indicated he spoke to the nurse and the clients' medication should be administered as ordered. The Coordinator indicated the staff thought they received permission to give the clients' medications at the same</p>		<p>trained on reviewing MIS and goalprogress monthly and that documentation is occurring (Attachment Plan of monitoring: Director will complete internal inspection and review MIS ,highrisk plans, IPPs to confirm that plans are being reviewed for accuracy monthlyby nurses and QIDP. 4) Plan ofcorrection: Day program coordinator and staff have been trained on client #1oxygen concentrator is to be set at 2 liters per minute per nasal cannulacontinually (Attachment D and E). Planof Prevention: Facility manager / day program manager will provide dailymonitoring. Facility coordinator / day program manager will provide bi-weeklydocumented monitoring. Facility director will provide monthly documentedmonitoring at both programs (Attachment B). Planof Monitoring: Facility program director and nurse will provide constantmonitoring and training to ensure plans are being followed by physician orders. 5) Plan ofcorrection: Client #2 risk plan was placed where it is accessible to relevantstaff. Plan ofprevention: Facility manager / day program manager will provide dailymonitoring. Facility coordinator / day program manager will provide bi-weeklydocumented monitoring. Facility director will provide monthly documentedmonitoring at both programs (Attachment B). Plan of monitoring:Facility</p>				

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	<p>time by a previous nurse.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager (NM) indicated client #1 and #4's Levothyroxin order be followed as written. The NM indicated it was a medication error due to the staff not implementing the order as written.</p> <p>2) A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1 had a risk plan for Skin Breakdown, dated 7/15/14. The risk plan indicated, "[Client #1] is at risk for skin break down due to the decreased mobility and use of wheelchair for the majority of each day." The plan indicated, "Staff will encourage and assist, if needed, frequent (at least every 2 hrs (hours)) shifts in position, even if they are only slight, this is effective to relieve pressure points." The facility did not provide documentation client #1's risk plan was being implemented.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated he was not sure if there was documentation but the facility should have documentation of the positioning schedule being implemented.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated he was unsure if the positioning schedule was being implemented. The</p>		<p>coordinators will complete monthly checklist to confirm staff have access to needed information (Attachment K).</p>				

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	<p>Coordinator indicated if there was no documentation, then it didn't happen.</p> <p>3) A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1's Medication Information Sheet (MIS), dated 8/19/14, indicated she was to receive oral care after each meal with assistance. The MIS indicated, "Oral care after each meal with assist. Track on IHP (Individual Habilitation Plan)." There was no documentation the oral care was being provided three times a day to client #1. Client #1 had a swallow study completed on 8/30/13. The Outside Services Report, dated 8/30/13, indicated, in part, "Recommend: oral care after meals."</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated the facility should have documentation of the oral care after meals as recommended by the speech therapist.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated he would look for the documentation of client #1's oral care being provided to her. The Coordinator did not provide documentation the oral care was being provided to client #1.</p> <p>4) An observation was conducted at the facility-operated day program on 8/19/14</p>						

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	<p>from 12:30 PM to 1:50 PM. At 12:47 PM, client #1's oxygen concentrator was set at 1.5 liters per minute (LPM). An interview with staff #7 indicated she was not sure what client #1's oxygen concentrator was supposed to be set on. On 8/19/14 at 12:48 PM, staff #8 indicated she was not sure what client #1's oxygen concentrator was to be set on. At 12:49 PM, staff #7 indicated she would look at client #1's record. Staff #7 referred to client #1's 1/20/14 Medication Information Sheet (MIS) located in a binder within the classroom. Staff #7 indicated client #1's MIS read client #1 was to receive 2 LPM continuously. Staff #7 indicated client #1's oxygen concentrator was set at 1.5 LPM when she checked it. At 12:51 PM, staff #7 adjusted the concentrator so client #1 received 2 LPM of oxygen. At 12:52 PM, staff #7 indicated the day program staff did not adjust or check client #1's oxygen throughout the day. Staff #7 indicated when the group home staff dropped off client #1, the group home staff switch the source of oxygen from her portable tank to the oxygen concentrator. Staff #7 indicated at the end of the day, the group home staff switch the source from the oxygen concentrator to the portable unit. Staff #7 indicated the day program staff did not do any of the switching of sources of</p>			

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	<p>oxygen. At 12:53 PM, a note written on the board in the room indicated, "[Client #1's initials] 2 L (liters) O2 (oxygen)."</p> <p>On 8/19/14 at 2:13 PM, a review of client #1's record indicated her 6/10/14 Physician's Orders included oxygen at 2 liters per minute per nasal cannula continuously. Client #1's current Medication Information Sheet, dated 8/19/14, indicated client #1 was to receive oxygen at two liters per minute per nose cannula continuously. Client #1's risk plan for hypoxia, dated 6/19/14, indicated client #1 was at risk for hypoxia. The risk plan indicated, in part, "Staff will ensure that [client #1] wears her oxygen as ordered via nasal cannula set at 2 L (liters) per minute. Staff will check [client #1's oxygen tank to ensure it is working and is set properly 4 times a day: AM, Noon, 5p, and right before bedtime... Only Staff who have received training on this plan and understand the plan will work with this consumer to ensure the safety of the consumer. Staff will be informed on risk plan and protocol for hypoxia...".</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated the facility-operated day program staff should ensure client #1's oxygen concentrator was set correctly based on physician's orders and the risk</p>			

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	<p>plan for hypoxia. The Coordinator indicated the staff should have implemented client #1's plan to ensure she received 2 LPM of oxygen.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated client #1's risk plan for hypoxia should be implemented as written.</p> <p>5) A review of client #2's record was conducted on 8/20/14 at 10:46 AM. Client #2's Medication Information Sheet, dated 8/19/14, indicated client #2 had a risk plan for skin break down. There was no documentation in client #2's record of a risk plan for skin break down.</p> <p>On 8/20/14 at 1:21 PM, the Nurse Manager indicated there was a risk plan for skin break down. The NM indicated the risk plan should be in the client's record for review. The NM indicated he located the plan in another file on the computer (not accessible to the surveyor). The NM indicated he would send the risk plan by email. The risk plan was not received.</p> <p>9-3-6(a)</p>			

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 2 of 2 clients (#1 and #4) who were administered Levothyroxin (thyroid hormone), the facility failed to ensure staff administered the medication as ordered by the physician.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/19/14 from 5:00 AM to 7:36 AM. At 5:04 AM, client #1 received her ten oral medications, including Levothyroxin, from staff #5. The August 2014 Medication Administration Record indicated for Levothyroxin, "1 hr (hour) before other meds." The package the Levothyroxin was removed from indicated, "1 hr before other meds."</p> <p>On 8/19/14 at 5:18 AM, staff #5 stated the staff "never" pass client #1's Levothyroxin prior to her other medications. Staff #5 stated Levothyroxin "always" passed with her other medications. Staff #5 indicated client #4's Levothyroxin was administered the same way.</p>	W000369	<p>Addendum: Facility nurse will monitor setting (3) times out of the (5) day lifelong learning schedule The frequency may taper following one quarter W369 Plan of Correction: Staff trained on administrating prescribed Levothyroxinto client #1 and #4 prior to other medications (Attachment J). Plan ofprevention: House manager will provide daily monitoring and teaching of staffon correctly administrating medications per MAR and physician's order. Plan ofMonitoring: House coordinator and nurse will document semi-weekly medicationobservation and immediate training then submit them to director for review(Attachment B).</p>	09/09/2014

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	<p>On 8/19/14 at 5:32 AM, client #4 received two medications, including Levothyroxin, from staff #5. The August 2014 Medication Administration Record indicated for Levothyroxin, "Before other meds." The package the Levothyroxin was removed from indicated, "Before other meds."</p> <p>A review of client #1's record was conducted on 8/19/14 at 2:13 PM. Client #1's current Physician's Orders, dated 6/10/14, indicated Levothyroxin was to be administered "1 hr before other meds."</p> <p>On 8/19/14 at 2:04 PM, a review of client #4's Physician's Orders, dated 6/10/14, indicated Levothyroxin was to be administered, "Before other meds."</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated client #1 and #4's Levothyroxin should be administered as ordered prior to their other medications. On 8/20/14 at 2:17 PM, the Coordinator indicated he spoke to the nurse and the clients' medication should be administered as ordered. The Coordinator indicated the staff thought they received permission to give the clients' medications at the same time by a previous nurse.</p> <p>On 8/20/14 at 1:21 PM, the Nurse</p>			

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W000488	<p>Manager (NM) indicated client #1 and #4's Levothyroxin order be followed as written. The NM indicated it was a medication error due to the staff not implementing the order as written.</p> <p>9-3-6(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 of 4 clients in the sample (#1 and #7), the facility failed to ensure the clients were involved with preparing their lunches.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/19/14 from 5:00 AM to 7:36 AM. At 6:17 AM, client #7 starting packing his lunch but walked away. At 6:23 AM, client #7 was sitting in a recliner as staff #1 continued to pack client #7's lunch. Staff #1 got out 4 pieces of bread and cheese and started making two sandwiches. Client #7 was not prompted to assist with the packing of his lunch after walking away. Client #1 was finishing her breakfast while staff #1 packed her lunch. Client #1 was not prompted to assist with packing her</p>	W000488	<p>W488 Plan of correction: Facility staff trained on providing active treatment including client #7 and lunch preparation (Attachment F). Plan of prevention: House manager will provide daily oversight of active treatment provided to clients that follow their assessed needs and IPPs. Plan of monitoring: Facility coordinator will provide bi-weekly active treatment observations that are documented and submitted to director for review.</p>	09/08/2014

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	<p>lunch. At 6:25 AM, staff #1 placed turkey on the two sandwiches. At 6:28 AM, staff #1 used a rocker knife to cut the sandwiches into quarters. Staff #1 indicated to staff #5 the lunches she was packing were for clients #1 and #7. Staff #1 asked client #1 what she wanted to take with her sandwich. Client #1 indicated she wanted to take a cereal bar.</p> <p>On 8/19/14 at 6:28 AM, staff #1 indicated client #7 would get agitated if asked to do too much.</p> <p>On 8/19/14 at 3:00 PM, the Coordinator indicated the clients needed to be involved with preparing their lunches. The Coordinator stated this was an "area for improvement."</p> <p>9-3-8(a)</p>			