

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G535	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 W GOLDEN HILLS DR PERU, IN 46970
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 12/9, 12/10, 12/11, 12/12, 12/15, and 12/16/2014.</p> <p>Provider Number: 15G535 Facility Number: 001049 AIM Number: 100245300</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 31, 2014 by Dotty Walton, 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 3 of 4 sampled clients (clients #1, #2, and #4) and four additional clients (clients #5, #6, #7, and #8) who were in the group home on 11/26/14, the governing body failed to exercise operating direction over the facility to ensure clients #1, #2, #4, #5, #6, #7, and</p>	W000104	<p>Toensure proper appropriation and use of client funds, the following correctiveaction(s) will be implemented: 1) Allclients residing at 1901 West Golden Hills Drive (Golden Hills group home) willbe reimbursed from the agency for meals purchased with their own money on 11/26/14. 2) Toprevent a</p>	02/01/2015

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>#8 were not charged for services the facility was to provide.</p> <p>Findings include:</p> <p>On 12/11/14 at 8:45am, client #1, #2, and #4's financial records were reviewed with the RM (Residential Manager) and indicated the following:</p> <p>-Client #1's financial record included a 11/26/14 receipt and entry on client #1's 11/2014 ledger for a local restaurant on 11/26/14 for \$6.42 from client #1's personal funds account.</p> <p>-Client #2's financial record included a 11/26/14 receipt and entry on client #2's 11/2014 ledger for a local restaurant on 11/26/14 for \$6.53 from client #2's personal funds account.</p> <p>-Client #4's financial record included a 11/26/14 receipt and entry on client #4's 11/2014 ledger for a local restaurant on 11/26/14 for \$7.76 from client #4's personal funds account.</p> <p>On 12/11/14 at 8:45am, an interview with the Residential Manager (RM) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RM and QIDP both indicated clients #1, #2, and #4 had went out to eat with clients</p>		<p>reoccurrence of this incident, the Residential House Manager willreview all client receipts on a weekly basis to ensure that client funds werenot spent on services that should be provided by the agency.</p> <p><i>a. Whatwill be done proactively in the planning stages to ensure that the deficientpractice does not reoccur?"</i></p> <p>All staff located at 1901 West GoldenHills Drive (Golden Hills group home) will be counseled and re-trained on whichexpenses clients are responsible for and which expenses in which the agency isresponsible for. Record of training forms will be completed by all staffmembers when trainings are finalized.</p>				

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W000125	<p>#5, #6, #7, and #8 on 11/26/14 and each client paid for their individual dinner meal. The RM stated "No. We did not cook that night" at the group home. The RM indicated clients #1, #2, #4, #5, #6, #7, and #8 should not pay for services which the facility should provide. The RM indicated client #3 had left the group home earlier in the day on a LOA (Leave of Absence) with her family. The RM and the QIDP both stated the facility's rate was "all inclusive."</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure client #3 had a legally sanctioned representative to assist her with her medical and financial needs per her assessments.</p> <p>Findings include:</p> <p>On 12/11/14 at 10:40am, a record review for client #3 was conducted. Client #3's</p>	W000125	<p>Toensure that client #3 has a legally sanctioned representative to assist herwith her medical and financial needs per his assessment, the following correctiveaction(s) will be implemented: 1) TheResidential Director and QIDP will work with existing agencies within ourcommunity and other communities to obtain a valid and qualified advocate forClient #3 to assist her with</p>	02/01/2015			

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	<p>5/9/12 "Informed Consent" assessment, 5/13/14 Individual Support Plan (ISP), and 10/2014 BSP (Behavior Support Plan) indicated client #3 was not independent with her finances and/or medical care. Client #3's Informed Consent assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment, ISP, and BSP indicated client #3 required twenty-four hour supervision and assistance to understand to be able to give informed consent in each area. Client #3's record indicated client #3 did not have a legally sanctioned representative and did not have a contact person outside the agency to assist client #3 to understand her rights. Client #3's record indicated she was not able to understand to advocate her rights independently.</p> <p>On 12/11/14 at 12:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) was conducted. The QIDP stated client #3's Informed Consent assessment, ISP, and BSP did indicate she needed an advocate/guardian "to assist her with decision making process" for medications and with her finances. The QIDP and the RM both</p>		<p>decision making in regards to medical care, financial obligations, and any other pertinent decisions relating to her care and well-being. a. "Were any other clients affected by the deficient practice?" Yes. One other client residing in the home does not have a legally sanctioned representative to assist with medical and financial decisions. b. "How will the facility monitor to ensure compliance?" To ensure that all clients residing in the group home setting have appropriate legally sanctioned representatives to assist with medical and financial decisions, the inter-disciplinary team will review each client's status with a guardian or health care representative on an annual basis or as needed if changes in circumstances require that the agency assist in obtaining a new or additional representative to assist individual clients.</p>				

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W000249	<p>indicated client #3 did not have a legally sanctioned representative at this time. The QIDP indicated client #3 did not understand her rights, medications, or money and needed an advocate to assist to explain these to client #3.</p> <p>9-3-2(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, interview, and record review, for 1 of 4 sampled clients (client #4), the facility failed to use formal and informal opportunities to implement ISP (Individual Support Plan) and risk plans when opportunities existed.</p> <p>Findings include:</p> <p>On 12/9/14 from 5:50pm until 6:05pm, observation and interviews were conducted at the group home with client #4. From 5:50pm until 6:05pm, client #4 was seated at the dining room table consuming his supper meal. At 5:50pm,</p>	W000249	<p>Toensure proper execution of individual plans for Client #4, the following corrective action(s) will be implemented:</p> <p>1) Allstaff located at 1901 West Golden Hills Drive (Golden Hills group home) will beretrained on all individual plans for Client #4. Record of training forms willbe completed by all staff members when training is finalized.</p> <p>a. "Wereany other clients affected by the deficient practice?"</p> <p>The agency will assume that allresidences in the home have been affected by the deficient practice thatoccurred.</p>	02/01/2015

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	<p>client #4 was seated at the dining room table and GHS (Group Home Staff) #2, with hand over hand assistance with client #4, served cooked carrot chunks onto client #4's plate. GHS #2 walked away from client #4 and turned her back to him. Client #4 began to consume one after another of the carrot chunks into his mouth and was redirected to wait for the carrot chunks to cool by the Residential Manager (RM). Client #4 did not chew eat bite of the carrot chunks. GHS #2 returned to client #4 from the opposite end of the table with Fish Sticks and assisted client #4 to hand over hand serve himself six Fish Sticks onto his plate. GHS #2 again walked away from client #4 and client #4 consumed four of the six Fish Sticks one after another without chewing and without redirection. At 5:55pm, client #4 was redirected to slow his rate of eating and GHS #2 was instructed by the RM to ensure client #4's Fish Sticks were sliced into small bite size bites of food. The RM indicated client #4 was at risk to choke and his plans stated he "required" his foods be cut up into small bite sizes of food to consume and needed staff supervision while eating his food.</p> <p>On 12/11/14 at 12:30pm, client #4's 6/18/14 ISP (Individual Support Plan) was reviewed and indicated client #4 "has</p>		<p>Therefore, to prevent future deficient practices, all staff located at 1901 West Golden Hills Drive (Golden Hills group home) will be retrained on all individual plans for all clients residing in the home.</p> <p>b. "How will the facility monitor to ensure compliance?"</p> <p>The Qualified Developmental Disabilities Professional (QDDP) and Residential House Manager (RHM) will alternate working various shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by the QDDP and/or RHM, the Director and Vice President of Residential Services will be immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staff working in the home to be counseled and re-trained on agency and departmental policies and procedures as well as individual client plans. All trainings will be documented on agency Record of Training</p>	

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	<p>previously completed therapy for swallowing. [Client #4] needs constant monitoring while he eats to ensure he is taking appropriate sized bites, chewing his food completely, and swallowing with no difficulties. [Client #4] does take medication for GERD (Gastro Esophageal Reflux Disease) symptoms due to vomiting after eating." Client #4's record indicated he had a choking incident on 3/10/14 which required the Heimlich Maneuver and he was seen at the hospital following the incident on 3/10/14. Client #4's 6/18/14 "Dysphagia Risk Plan" indicated "...Staff will be near [client #4] when he is at the table and prompt him to eat slowly, and chew food properly. Direct Support Professionals will assist [client #4] in cutting his food into bite size pieces."</p> <p>On 12/11/14 at 10:00am, an interview was conducted with the LPN (Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional). The LPN and QIDP both indicated client #4 had the identified need for staff to supervise client #4 while he was around food and/or eating food. The LPN indicated the facility staff failed to implement client #4's ISP and Dysphagia Plan for dining correctly when staff walked away from client #4 during serving foods at the meal. The QIDP</p>		<p>forms and retained by the Residential Services Coordinator.</p> <p><i>c. "How is this training different than the original training that occurred?"</i></p> <p>The training will consist of materials used in the original training that occurred, however the monitoring for compliance will be increased to ensure comprehension and effective execution of the plans by direct care staff.</p>				

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W000331	<p>indicated client #4 did not understand the risk of choking when eating quickly uncut foods.</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 interview, for 2 of 4 sample clients (clients #1 and #4), the facility's nursing services failed to provide oversight of client #1 and #4's use of pain medication, failed to develop pain assessments, and failed to develop protocols to manage client #1 and #4's pain.</p> <p>Findings include:</p> <p>1. On 12/9/14 at 4:04pm, GHS (Group Home Staff) #1 asked client #4 to come to the medication room for medication administration. GHS #1 compared client #4's "Tramadol HCL (Hydrochloride) 50mg (milligrams), take 1 tablet by mouth 2 times a day" for knee discomfort and Ibuprofen 200mg, take 1 tablet 2 times a day" for pain to client #4's 12/2014 MAR (Medication Administration Record). GHS #1 dispensed client #4's medications into a medication cup and handed the</p>	W000331	<p>Toensure proper pain assessment and the appropriate use of pain medications, thefollowing corrective action(s) will be implemented: 1) TheResidential Nurse has implemented a pain assessment form to assess and monitorclient pain as well monitor PRN pain medication use. <i>Refer to Appendix A to see the pain assessment form currently beingused by staff.</i> The pain assessmentform will be used in the following manner: prior to administering the PRN forpain, all PRNs will be reviewed and administered if available. Once the PRN isadministered it will be recorded in the MAR and the staff will then complete thepain assessment form. The completed pain assessment form will be placed in thedesignated folder within the respective client's records. 1) Allstaff located at 1901 West Golden Hills Drive (Golden Hills group home) will beretrained on the new pain</p>	02/01/2015			

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	<p>medications to client #4. Client #4 consumed the medication. GHS #1 did not ask regarding client #4's pain.</p> <p>Client #4's record was reviewed on 12/11/14 at 12:30pm. Client #4's 11/14, 8/14, 5/14, and 11/13 nursing reviews did not address client #4's pain and client #4's use of pain medication. Client #4's diagnoses included, but were not limited to: Aortic Aneurysm Repair and Arthritis of both Knees. Client #4's 10/31/14 "Physician's Order" indicated "Tramadol HCL 50mg (milligrams), take 1 tablet by mouth 2 times a day" for knee discomfort and Ibuprofen 200mg, take 1 tablet 2 times a day" for pain. Client #4's record did not include a plan for client #4's pain.</p> <p>On 12/11/14 at 10:00am, an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated no plan had been developed and no assessment had been completed to manage client #4's pain. The LPN stated client #4 was "receiving routine" pain medications every day.</p> <p>2. On 12/9/14 at 4:12pm, GHS (Group Home Staff) #1 asked client #1 to come to the medication room for medication administration. GHS #1 compared client #1's "Prednisone 10mg, take 1/2 tablet by mouth daily with food" for Rheumatoid</p>		<p>assessment procedure. Record of training forms will be completed by all staff members when training is finalized. 2) To ensure proper monitoring and compliance, the Residential Nurse will review all MARs on a weekly basis. If per the MAR, a PRN has been administered, the Residential Nurse will verify that a pain assessment form has been completed. If staff have failed to complete pain assessment forms as previously trained, the respective staff will be retrained on the pain assessment process and if warranted receive appropriate disciplinary action as outlined in the agency personnel policies and procedures. <i>a.</i></p> <p><i>"Is the nurse contacted prior to administering the PRN?"</i></p> <p>If the PRN is for routine use (i.e. headache, common cold, or cough), the nurse is not notified. The direct care staff are trained to follow the process listed above in which they are to review the MAR prior to administering the medication. If however, if there is a PRN medication that is to be used prior to a medical procedure or for behavioral needs, then either the nurse or QIDP is contacted prior to administration for approval.</p>				

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	<p>Arthritis to client #1's 12/2014 MAR (Medication Administration Record). GHS #1 dispensed client #1's Prednisone medication into a medication cup and handed the medication to client #1. Client #1 consumed the medication. GHS #1 did not ask regarding client #1's pain.</p> <p>On 12/9/14 at 4:19pm, client #1's 12/2014 MAR indicated "Prednisone 10mg, take 1/2 tablet by mouth daily with food" for Rheumatoid Arthritis.</p> <p>On 12/11/14 at 9:15am, client #1's record was reviewed. Client #1's 11/14, 8/14, 5/14, and 11/13 nursing reviews did not address client #1's pain and client #1's use of pain medication. Client #1's diagnoses included, but were not limited to: Arthritis, Chronic Pain, and Osteoporosis. Client #1's 10/31/14 "Physician's Order" indicated "Prednisone 10mg (milligrams), take 1/2 tablet by mouth daily with food" for Rheumatoid Arthritis, "Evista 60mg, 1 tablet by mouth daily" for Osteoporosis, and "Hydroxchloroquine 200mg, take 1 tablet by mouth twice a day" for Rheumatoid Arthritis. Client #1's record did not include a plan for client #1's pain.</p> <p>On 12/11/14 at 10:00am, an interview with the LPN (Licensed Practical Nurse)</p>			

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W000369	<p>was conducted. The LPN indicated no plan had been developed and no assessment had been completed to manage client #1's pain. The LPN stated client #1 was "receiving routine" pain medications every day.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION 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, record review, and interview, for 3 of 12 medication doses administered during the evening medication administration (clients #1 and #3), the facility failed to ensure client #1 and #3's medications were given without error.</p> <p>Findings include:</p> <p>1. On 12/9/14 at 4:00pm, GHS (Group Home Staff) #1 asked client #3 to come to the medication room for medication administration. GHS #1 compared client #3's "Metformin 1000mg (milligrams), take 1 tablet by mouth twice a day with meals" for Diabetes Mellitus to client #3's 12/2014 MAR (Medication Administration Record). GHS #1</p>	W000369	<p>To ensure that all medications are administered as prescribed by physicians' orders and without error, the following corrective action(s) will be implemented: 1) All staff located at 1901 West Golden Hills Drive (Golden Hills group home) will receive re-training on the agency medication administration policy. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix B for Record of Training forms to be used.</i> It is the intent that this training will prevent future medication errors for the clients affected as well as all other clients residing in the home.</p> <p>1. "How did the facility monitor the particular staff that made the med error the</p>	02/01/2015
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	<p>dispensed client #3's Metformin tablet into a medication cup and handed the medication to client #3. Client #3 consumed the medication and no food was provided. At 5:50pm, client #3 consumed her first bite of food at the evening meal. At 5:50pm, client #3 indicated she had her last bite of food at lunch at the workshop around 11:00am.</p> <p>On 12/9/14 at 4:04pm, client #3's 12/2014 MAR indicated "Metformin 1000mg (milligrams), take 1 tablet by mouth twice a day with meals" for Diabetes Mellitus.</p> <p>On 12/11/14 at 10:40am, client #3's record was reviewed. Client #3's 10/31/14 "Physician's Order" indicated "Metformin 1000mg (milligrams), take 1 tablet by mouth twice a day with meals" for Diabetes Mellitus.</p> <p>2. On 12/9/14 at 4:12pm, GHS (Group Home Staff) #1 asked client #1 to come to the medication room for medication administration. GHS #1 compared client #1's "Prednisone 10mg, take 1/2 tablet by mouth daily with food" for Rheumatoid Arthritis and Oyster -D 250mg, take 2 tablets by mouth twice a day with food" for Osteoporosis to client #1's 12/2014 MAR (Medication Administration Record). GHS #1 dispensed client #1's</p>		<p><i>next time that the staff person passed meds?"</i></p> <p>The Residential Nurse will re-train all staff located at 1901 West Golden Hills Drive (Golden Hills group home) on the agency medication administration policy. To ensure staff competency to successfully administer medications as directed per physician orders, the Residential Nurse will observe a medication pass by the staff member.</p> <p><i>1. "How will the facility consistently monitor the medication pass to ensure competency and compliance?"</i></p> <p>All Residential Nurses will be required to develop systems in which they a) conduct weekly reviews of all medication records for all clients residing in the home b) observe staff on a routinely basis to ensure that all medications are administered according to physician's orders and agency policy. In the event of a medication error, the Residential Nurse will immediately review all medication records for</p>				

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	<p>Prednisone and Oyster-D tablets into a medication cup and handed the medication to client #1. Client #1 consumed the medications and no food was provided. At 5:50pm, client #1 consumed her first bite of food at the evening meal. At 5:50pm, client #1 indicated she had her last bite of food at lunch at the workshop around 11:00am.</p> <p>On 12/9/14 at 4:19pm, client #1's 12/2014 MAR indicated "Prednisone 10mg, take 1/2 tablet by mouth daily with food" for Rheumatoid Arthritis and Oyster -D 250mg, take 2 tablets by mouth twice a day with food" for Osteoporosis.</p> <p>On 12/11/14 at 9:15am, client #1's record was reviewed. Client #1's 10/31/14 "Physician's Order" indicated "Prednisone 10mg, take 1/2 tablet by mouth daily with food" for Rheumatoid Arthritis (and) Oyster -D 250mg, take 2 tablets by mouth twice a day with food" for Osteoporosis.</p> <p>On 12/11/14 at 10:00am, an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #1 and #3's medications should have been administered according to their Physician's orders. The LPN indicated the facility staff should administer medications according to Core A/Core B</p>		<p>allclients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being administeredaccording to physician's orders and agency policy.</p>	

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W000455	<p>medication administration training. The LPN indicated client #1 and #3's medications were given in error when food was not provided at the time of the medication administration or if the client did not eat within one hour of consuming the medication.</p> <p>On 12/11/14 at 1:00pm, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to teach and encourage clients #1, #2, #3, #4, #5, #6, #7, and #8 to wash their hands when opportunities existed.</p> <p>Findings include:</p>	W000455	<p>Toensure hygiene and cleanliness in regards to proper hand-washing techniques,the following corrective action(s) will be implemented: 1) Allstaff located at 1901 West Golden Hills Drive (Golden Hills group home) willreceive re-training on the agency hand-washing policy and procedures. CompletedRecord of Trainings will be obtained and submitted upon completion of training. <i>Referto Appendix C for</i></p>	02/01/2015			

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	<p>On 12/10/14 from 6:00am until 7:45am, observation and interview were conducted at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 6:00am until 7:00am, clients #1, #2, #3, #4, #5, #6, #7, and #8 swept the floor, cooked in the kitchen with Group Home Staff (GHS) #2, sorted laundry, set the table, collected trash from the trash cans in the rooms, took out the trash, petted the facility animals, combed/brushed their hair, wrote and colored in books, and no handwashing was observed taught or encouraged. From 7:00am until 7:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 with GHS #2 set the table, stirred eggs in a skillet, client #6 made toast and handled bread, sat down at the dining room table to eat, and no handwashing was taught or encouraged. At 7:40am, clients #1, #2, #3, #4, #5, #6, #7, and #8 all indicated they had not washed their hands before eating breakfast at the dining room table. At 7:45am, the RM (Residential Manager) indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should have been taught and encouraged to wash their hands before the meal. The RM indicated the clients and the staff did not follow the facility's handwashing policy and procedure.</p> <p>On 12/11/14 at 9:00am the facility's undated policy and procedures for</p>		<p><i>Record of Training forms to be used.</i></p> <p>a. "How will the facility monitor to ensure compliance?"</p> <p>The Qualified Developmental Disabilities Professional (QDDP) and Residential House Manager (RHM) will alternate working various shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by the QDDP and/or RHM, the Director and Vice President of Residential Services will be immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staff working in the home to be counseled and re-trained on agency and departmental policies and procedures as well as individual client plans. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.</p>				

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W000460	<p>"Handwashing" and infection control were reviewed and indicated "All persons who are served...are to wash hands before and after providing personal care to an individual and before preparing, serving, or eating food."</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #4), the facility failed to ensure and client #4's evening meal was cut up into bite sized portions.</p> <p>Findings include: On 12/9/14 from 5:50pm until 6:05pm, observation and interviews were conducted at the group home with client #4. From 5:50pm until 6:05pm, client #4 was seated at the dining room table consuming his supper meal. At 5:50pm, client #4 was seated at the dining room table and GHS (Group Home Staff) #2 with hand over hand assistance with client #4 serve cooked carrot chunks onto client #4's plate. GHS #2 walked away from client #4 and turned her back to</p>	W000460	<p>Toensure proper execution of the dining plan for Client #4, the followingcorrective action(s) will be implemented:</p> <p>1) Allstaff located at 1901 West Golden Hills Drive (Golden Hills group home) will receive-re-training on the dining plan for Client #4. Completed Record of Trainingswill be obtained and submitted upon completion of training.</p> <p>a. "Howwill the facility monitor to ensure compliance?"</p> <p>The Qualified DevelopmentalDisabilities Professional (QDDP) and Residential House Manager (RHM) willalternate working various shifts in the home alongside direct support staff.</p>	02/01/2015

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	<p>him. Client #4 began to consume one after another of the carrot chunks into his mouth and was redirected to wait for the carrot chunks to cool by the Residential Manager (RM). Client #4 did not chew eat bite of the carrot chunks. GHS #2 returned to client #4 from the opposite end of the table with Fish Sticks and assisted client #4 to hand over hand serve himself six Fish Sticks onto his plate. GHS #2 again walked away from client #4 and client #4 consumed four of the six Fish Sticks one after another without chewing and without redirection. At 5:55pm, client #4 was redirected to slow his rate of eating and GHS #2 was instructed by the RM to ensure client #4's Fish Sticks were sliced into small bite size bites of food. The RM indicated client #4 was at risk to choke and his plans stated he "required" his foods be cut up into small bite sizes of food to consume and needed staff supervision while eating his food.</p> <p>On 12/11/14 at 12:30pm, client #4's 6/18/14 ISP (Individual Support Plan) was reviewed and indicated client #4 "has previously completed therapy for swallowing. [Client #4] needs constant monitoring while he eats to ensure he is taking appropriate sized bites, chewing his food completely, and swallowing with no difficulties. [Client #4] does take</p>		<p>If insufficiencies in level of care bystaff are noted by the QDDP and/or RHM, the Director and Vice President of Residential Services will be immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staffworking in the home to be counseled and re-trained on agency and departmental policies and procedures as well as individual client plans. All trainings willbe documented on agency Record of Training forms and retained by the Residential Services Coordinator.</p>				

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	<p>medication for GERD symptoms due to vomiting after eating." Client #4's record indicated he had a choking incident on 3/10/14 which required the Heimlich Maneuver and he was seen at the hospital following the incident on 3/10/14. Client #4's 6/18/14 "Dysphagia Risk Plan" indicated "...Staff will be near [client #4] when he is at the table and prompt him to eat slowly, and chew food properly. Direct Support Professionals will assist [client #4] in cutting his food into bite size pieces."</p> <p>On 12/11/14 at 10:00am, an interview was conducted with the LPN (Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional). The LPN and QIDP both indicated client #4 had the identified need for staff to supervise client #4 while he was around food and/or eating food. The LPN indicated the facility staff failed to implement client #4's ISP and Dysphagia Plan for dining correctly when staff walked away from client #4 during serving foods at the meal. The QIDP indicated client #4 did not understand the risk of choking when eating quickly uncut foods.</p> <p>9-3-8(a)</p>			
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