

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2013
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25799 ROLLING HILLS DR SOUTH BEND, IN 46614
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: November 18, 19, 20, 27 and December 6 and 19, 2013.</p> <p>Facility Number: 011297 Provider Number: 15G733 AIM Number: 200842740</p> <p>Surveyor: Christine Colon, QIDP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 31, 2013 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. Based on observation, record review and interview, the governing body failed for 1 of 2 sampled clients (#1), and 2 additional clients (clients #3 and #4), to exercise general operating direction over the facility in a manner to provide oversight to ensure their abuse and</p>	W000104	Refer to plan of correction for W149, W153, W154	01/18/2014

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>neglect policy was implemented.</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 1 of 2 sampled clients (#1), and 2 additional clients (clients #3 and #4), to implement written policy and procedures to prevent alleged abuse and neglect.</p> <p>2. Please refer to W153: The facility failed for 1 of 2 sampled clients (#1), and 2 additional clients (clients #3 and #4), to report injuries of unknown origin and suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>3. Please refer to W154: The facility failed for 1 of 2 sampled clients (#1), and 2 additional clients (#3 and #4), to provide written evidence investigations were conducted.</p> <p>9-3-1(a)</p>						

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W000112	<p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed to keep 3 of 4 clients' (clients #1, #2 and #3) information confidential by having each client's diet order, adaptive equipment information, mealtime goals and staff guidance for each client during mealtimes displayed in the open kitchen/dining/living room area.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:10 P.M. Upon entering into the home of clients #1, #2 and #3, in plain view where visitors to the home had access, were three, 3 1/2" (inch) by 5" plastic frames which indicated:</p> <p>Plastic frame #1: "[Client #2]-Goal: Wipe mouth, physical assist. Diet: Mechanical soft/Nectar thick</p>	W000112	<p>The meal/diet cards provide guidance to staff during meals and will remain available for reference due to the specialized diets. The cards will be kept in the cupboard when not in use. All staff have been re-trained on the location of the meal/diet cards and maintaining client confidentiality. The QDDP and Residential Manager work in the home and will be responsible to monitor the practice on a regular basis. The QDDP and Residential Manager will observe all staff on every shift within a 30 day period to ensure confidentiality of client information. These observations will be documented on a staff observation sheet and turned into the director for review. 1/20/14 update: After the 30 day period, the QDDP or Residential Manager will observe one meal weekly to ensure the absence of the meal cards. These observations will be documented on a dining checklist and turned into the director for review.</p>	01/18/2014			

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	<p>liquids...Adaptive equipment: Divided plate."</p> <p>Plastic frame #2: "[Client #3]-Goal: Take 1 spoonful of food to mouth with hand on hand assist...Diet: Pureed, Double portions at meals...Adaptive equipment: Coated spoon, divided dish, sippy cup."</p> <p>Plastic frame #3: "[Client #1]-10 A.M., 3 P.M. and HS (bedtime) CIB (Carnation Instant Breakfast) and fortified pudding...Diet: Regular with 4 ounces milk, 4 ounces prune juice, 1/2 cup fortified cereal, 4 ounces magic cup (supplement)...Adaptive Equipment: regular utensils, straws or cups with straw, Boost two cal (supplement)."</p> <p>An interview with Group Home Trainer (GHT) #1 was conducted at the group home on 11/18/13 at 5:45 P.M. GHT #1 indicated clients #1, #2 and #3's information was used for guidance for staff during mealtimes and further indicated the information was kept on the countertop in the open kitchen/dining/living room area.</p> <p>A morning observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. At 6:50 A.M., in plain view where visitors to the home</p>						

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W000149	<p>had access, were the three, 3 1/2" (inch) by 5" plastic frames with clients #1, #2 and #3's information.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/19/13 at 7:45 A.M. The QIDP indicated the clients' information should not have been in the open area where visitors to the home could see.</p> <p>9-3-1(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 1 of 2 sampled clients (#1), and 2 additional clients (#3 and #4), the facility neglected to implement written policy and procedures to prevent alleged abuse and neglect by failing to report/investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the group home reportable incidents/investigations and client</p>	W000149	The staff including the managers and nurse have received re-training on the requirement for an injury report to be completed anytime an injury is noted. This training also included the timeframe for reporting and the routing instructions. Immediate contact can still be made to the nurse, however an injury report must be initiated which requires the management staff to document follow up and investigation of unknown injuries in addition to requiring the nurse to document the follow up	01/18/2014
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	<p>records was conducted on 11/19/13 at 11:15 A.M. Review of the client records indicated the following logs documented by group home staff for the nurse:</p> <p>1. Client #1-Health Issues/Nursing Notes dated 10/9/13: "[Client #1's] right ear was as red as the couch in the living room. [Nurse] was called and told. Group Home Trainer (GHT) to see if it still persist (sic) in a couple hours and call her back."</p> <p>-Health Issues/Nursing Notes dated 10/15/13: "[Client #1's] nails was (sic) so long he cut his hand. [Nurse] was called and vaseline was put on it."</p> <p>-Health Issues/Nursing Notes dated 10/27/13: "[Client #1] has a red scar on his wrist. Petroleum jelly and a band-aid were applied."</p> <p>-Health Issues/Nursing Notes dated 11/1/13: "[Client #1] fell in his wheelchair on the side walk. He came home and got clean (sic) up. Nurse was called."</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:00 P.M. Review of the record indicated client #1 was non-verbal. Review of his record did not indicate the facility's nursing</p>		<p>assessment and instructions. A post-test was completed to ensure the staffs understanding and ongoing monitoring will be completed by the director who will review the injury reports in addition to the nursing notes. This will be monitored weekly for 6 weeks or longer if needed so compliance can be monitored.</p>				

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	<p>staff assessed him after the documented notes made by the group home staff.</p> <p>2. Client #3-Health Issues/Nursing Notes dated 10/21/13: "[Client #3] has a red scrape on her arm."</p> <p>-Health Issues/Nursing Notes dated 10/24/13: "[Client #3] has a red mark on her upper left hip. [Nurse] was called."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] has red marks on her upper right hip."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] also has 2 long bruises on her upper left thigh. Nurse was called."</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M. Review of the record indicated client #3 was non-verbal. Review of her record did not indicate the facility's nursing staff assessed her after the documented notes made by the group home staff.</p> <p>3. Client #4 Health Issues/Nursing Notes dated 10/18/13: "[Client #4] has a red mark on upper left back, left upper arm, left elbow and across stomach. Nurse notified. Report was filled out."</p>				

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	<p>A review of client #4's record was conducted on 12/6/13 at 5:00 P.M. Review of his record did not indicate the facility's nursing staff assessed client #4.</p> <p>A request for the facility's internal incident reports, BDDS/Bureau of Developmental Disabilities Services reports and investigations was made on 11/20/13 at 11:40 A.M. The Residential Director indicated there were no internal incident reports. There were no BDDS reports or investigations submitted in regards to the mentioned incidents.</p> <p>A review of the facility's abuse and neglect policy dated 8/08 was conducted on 11/20/13 at 3:00 P.M. Review of the policy indicated:</p> <p>"AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse....If any staff witness, observe, or suspect abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities." Further review of the facility's Incident Reporting and Investigation Policy-Indiana dated</p>				

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	<p>6/13/13 indicated: "Reportable incidents are any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. Investigations will take place for the following incidents including, but not limited to: abuse, neglect, exploitation, unknown injury, unexpected death while receiving services."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated staff should follow the facility's abuse/neglect policy. The RD indicated all incidents of abuse and neglect and injuries of unknown origin are to be immediately reported to the administrator and within 24 hours to BDDS. The RD further indicated GHT should document incidents on internal incident reports and contact their immediate supervisor. The RD indicated all incidents of injury of unknown origin should be reported and investigated. When asked if the noted incidents were documented on an internal incident report, she stated "No." When asked if the documented incidents on the Health Issues/Nursing notes would be considered injuries of unknown injury, she stated "Yes."</p>			
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W000153	<p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 2 sampled clients (#1), and 2 additional clients (#3 and #4), to report injuries of unknown origin and suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental</p>	W000153	The staff including the managers and nurse have received re-training on the requirement for an injury report to be completed anytime an injury is noted. This training also included the timeframe for reporting and the routing instructions. Immediate contact can still be made to the	01/18/2014	

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	<p>Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the group home reportable incidents/ investigations and client records was conducted on 11/19/13 at 11:15 A.M. Review of the records indicated the following logs documented by group home staff for the nurse:</p> <p>1. Client #1-Health Issues/Nursing Notes dated 10/9/13: "[Client #1's] right ear was as red as the couch in the living room. [Nurse] was called and told. Group Home Trainer (GHT) to see if it still persist (sic) in a couple hours and call her back."</p> <p>-Health Issues/Nursing Notes dated 10/15/13: "[Client #1's] nails was (sic) so long he cut his hand. [Nurse] was called and vaseline was put on it."</p> <p>-Health Issues/Nursing Notes dated 10/27/13: "[Client #1] has a red scar on his wrist. Petroleum jelly and a band-aid were applied."</p> <p>-Health Issues/Nursing Notes dated 11/1/13: "[Client #1] fell in his wheelchair on the side walk. He came home and got clean (sic) up. Nurse was</p>		<p>nurse, however an injury report must be initiated which requires the management staff to document follow up and investigation of unknown injuries in addition to requiring the nurse to document the follow up assessment and instructions. The DSP's, management staff and nurse also received re-training on the investigation procedures which indicates their responsibilities for notification of the administrator (director). A post-test was completed to ensure the staffs understanding and ongoing monitoring will be completed by the director who will review the injury reports in addition to the nursing notes. This will be monitored weekly for 6 weeks or longer if needed so compliance can be monitored.</p> <p>Update 1/20/14: Ongoing monitoring after the initial 6 weeks will be completed by the director through a review of all injury reports within 24 hours. This has been specified on the injury report form and was included in the staff training and is the ongoing practice.</p>				

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	<p>called."</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:00 P.M. Review of the record indicated client #1 was non-verbal and not able to self report injury. Review of his record did not indicate the facility's nursing staff assessed him after the documented notes made by the group home staff.</p> <p>2. Client #3-Health Issues/Nursing Notes dated 10/21/13: "[Client #3] has a red scrape on her arm."</p> <p>-Health Issues/Nursing Notes dated 10/24/13: "[Client #3] has a red mark on her upper left hip. [Nurse] was called."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] has red marks on her upper right hip."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] also has 2 long bruises on her upper left thigh. Nurse was called."</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M. Review of the record indicated client #3 was non-verbal and not able to self report injuries. Review of her record did</p>						

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	<p>not indicate the facility's nursing staff assessed her after the documented notes made by the group home staff.</p> <p>3. Client #4 Health Issues/Nursing Notes dated 10/18/13: "[Client #4] has a red mark on upper left back, left upper arm, left elbow and across stomach. Nurse notified. Report was filled out."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated these incidents were not immediately reported to the administrator or BDDS. The RD further indicated the incidents should have been immediately reported to the administrator and within 24 hours to BDDS.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 2 sampled clients (#1), and 2 additional clients (#3 and #4) the facility failed to provide written evidence investigations were conducted of unknown injuries.</p> <p>Findings include:</p> <p>A review of the group home was conducted on 11/19/13 at 11:15 A.M. Review of the records indicated the following logs documented by group home staff for the nurse:</p> <p>1. Client #1-Health Issues/Nursing Notes dated 10/9/13: "[Client #1's] right ear was as red as the couch in the living room. [Nurse] was called and told. Group Home Trainer (GHT) to see if it still persist (sic) in a couple hours and call her back."</p> <p>-Health Issues/Nursing Notes dated 10/15/13: "[Client #1's] nails was (sic) so long he cut his hand. [Nurse] was called and vaseline was put on it."</p> <p>-Health Issues/Nursing Notes dated 10/27/13: "[Client #1] has a red scar on</p>	W000154	<p>The staff including the managers and nurse have received re-training on the requirement for an injury report to be completed anytime an injury is noted. This training also included the timeframe for reporting and the routing instructions. Immediate contact can still be made to the nurse, however an injury report must be initiated which requires the management staff to document follow up and investigation of unknown injuries in addition to requiring the nurse to document the follow up assessment and instructions. The DSP's, management staff and nurse also received re-training on the investigation procedures which indicates their responsibilities for notification of the administrator (director) so that an investigation can be initiated. A post-test was completed to ensure the staffs understanding and ongoing monitoring will be completed by the director who will review the injury reports in addition to the nursing notes. This will be monitored weekly for 6 weeks or longer if needed so compliance can be monitored. Update 1/20/14: All staff have received additional training on their reporting responsibilities. Ongoing monitoring includes</p>	01/18/2014			

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	<p>his wrist. Petroleum jelly and a band-aid were applied."</p> <p>-Health Issues/Nursing Notes dated 11/1/13: "[Client #1] fell in his wheelchair on the side walk. He came home and got clean (sic) up. Nurse was called."</p> <p>A request to the Residential Director (RD) for investigations, Bureau of Developmental Disabilities Services (BDDS) and internal incident reports for this group home was made on 11/20/13 at 11:40 A.M. No investigations, BDDS reports and internal incident reports were submitted for review in regard to the mentioned incidents.</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:00 P.M. Review of the record indicated client #1 was non-verbal and unable to report injury. Review of his record did not indicate the facility's nursing staff assessed him after the documented notes made by the group home staff.</p> <p>2. Client #3-Health Issues/Nursing Notes dated 10/21/13: "[Client #3] has a red scrape on her arm."</p> <p>-Health Issues/Nursing Notes dated 10/24/13: "[Client #3] has a red mark</p>		<p>notification of the director and QMRP, verbal or written, which will prompt the initiation of the investigation and reporting. AWS has an investigation policy which provides guidance for the completion of a thorough investigation including staff interview, assessment of injury's and documentation review. AWS has certified investigators to complete the investigation as trained and per policy. Results of the investigation are reported to the director within the mandated timeframe and is reviewed by a multi-level process including the Regional Director, Vice President and Human Resources. Investigations are also reviewed by the AWS Risk Management Committee and the Compliance Department for trends and accuracy.</p>		

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	<p>on her upper left hip. [Nurse] was called."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] has red marks on her upper right hip."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] also has 2 long bruises on her upper left thigh. Nurse was called."</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M. Review of the record indicated client #3 was non-verbal and unable to report injury. Review of her record did not indicate the facility's nursing staff assessed her after the documented notes made by the group home staff.</p> <p>3. Client #4 Health Issues/Nursing Notes dated 10/18/13: "[Client #4] has a red mark on upper left back, left upper arm, left elbow and across stomach. Nurse notified. Report was filled out."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. When asked if there was documentation to indicate investigations were conducted in regards to the mentioned incidents, the RD stated "No." When asked if the</p>						

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W000240	<p>documented injuries should have been investigated, the RD stated "Yes." The RD further indicated the injuries were of unknown origin.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview, the facility failed to develop written instruction related to how 2 of 2 sampled clients (#1 and #2), and 1 additional client (#3), who required assistance with mobility and who used wheelchairs and walkers for mobility, were to be transferred in and out of their wheelchairs.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:30 P.M. During the entire observation period clients #1, #2 and #3 utilized wheelchairs for</p>	W000240	Staff are trained during their initial training on lifting/mobility assist techniques. This is reviewed annually when staff receive training on the updated plan which is inclusive of assessments and recommendations of therapists. Should an assessment or evaluation require any modifications to basic lifting procedures, staff would be trained accordingly and this would prompt the development of mobility/transfer guidelines or positioning guidelines. None of the assessments for clients #1, 2 or 3 indicate any need for specific plans and should assessments indicate that need in the future, the above mentioned process would be initiated. The nurse will review all assessments and	01/18/2014			

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	<p>mobility.</p> <p>A morning observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. During the entire observation period clients #1, #2 and #3 utilized wheelchairs for mobility.</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:15 P.M. Review of client #1's record did not indicate a protocol/guidelines on how to transfer client #1 in and out of his wheelchair for toileting, bathing or into bed safely. Review of his Individual Support Plan (ISP) dated 8/30/13 did not indicate how to transfer client #1 in and out of his wheelchair.</p> <p>A review of client #2's record was conducted on 12/6/13 at 4:18 P.M. Review of client #2's record did not indicate a protocol/guidance on how to transfer client #2 in and out of his wheelchair for toileting, bathing or into bed safely. Review of his ISP dated 2/28/13 did not indicate how to transfer client #2 in and out of his wheelchair.</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M. Review of client #3's record did not indicate a protocol/guidance on how to transfer client #3 in and out of her</p>		<p>recommendations with the IDT to ensure that the plans are developed as needed and staff trained on those plans.</p>				

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W000249	<p>wheelchair for toileting, bathing or into bed safely. Review of her ISP dated 10/18/13 did not indicate how to transfer client #3 in and out of her wheelchair.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. When asked if there was a plan in place to give guidance when and how staff were to transfer clients #1, #2 and #3 in and out of their wheelchairs, the RD stated "No, there aren't plans in place." When asked if clients #1, #2 and #3's ISPs gave written instruction to staff on how to transfer each client, the RD stated "No."</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. Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4), the facility failed to implement the</p>	W000249	All staff have been retrained on the proper implementation of active treatment and goals and objectives identified in the ISP. The QDDP and Residential	01/18/2014			

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	<p>clients' training objectives when formal and/or informal opportunities existed at the group home.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:30 P.M. During the entire observation period client #4 sat in his bedroom with no interaction and/or meaningful activity. Clients #1, #2 and #3 sat in the living and dining room area with no meaningful activity. Group Home Trainer (GHT) #1 would walk into the rooms and check on clients #1, #2, #3 and #4, but did not offer any meaningful activity. Clients #1, #2 and #3 did not communicate in their home in that they were non-verbal.</p> <p>A morning observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. During the entire observation period client #4 stayed in his bedroom with no interaction and/or meaningful activity. Clients #1, #2 and #3 sat in the living room area with no meaningful activity. Group Home Trainers (GHT) #3, #4 and #5 would walk into the rooms and check on clients #1, #2, #3 and #4, but did not offer any meaningful activity. Clients #1, #2 and #3 did not communicate in their home in</p>		<p>Manager will monitor all staff three times on each shift to ensure that continuous active treatment and ISP goals are implemented. Monthly spot checks at various times will be completed thereafter. These observations will be documented on a staff observation form and turned into the director so compliance can be monitored. Update 1/20/14: For 30 days, unannounced spot checks will be completed three times on first shift, three times on second shift and three times on third shift. Once competency is ensured through those checks, AWS management staff will conduct weekly checks at various times to ensure that continuous active treatment and ISP goals are implemented. These will be documented on a staff observation form which will be turned into the director monthly so compliance can be monitored. Spot checks include routine visits to the home. These are completed to monitoring various tasks such as meals, medication administration and active treatment. Monthly quality assurance checks are also completed to document overall monitoring of the home, programming and treatments.</p>		

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	<p>that they were non-verbal. At 7:12 A.M., DSP #3 began administering clients #1, #2 and #4's prescribed medications. DSP #3 popped out each of the clients' medications and fed them in applesauce to each client. No medication, training and communication objectives were implemented during the observation period.</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:15 P.M. A review of client #1's Individual Support Plan (ISP) dated 8/30/13 indicated the following objectives could have been implemented during both observations: "Will complete ROM (Range of Motion) exercises...Will reach for the medication box to get a medication card...Will participate in money management activity...Will count up to 3...Will take his plate to the sink after dinner."</p> <p>A review of client #2's record was conducted on 12/6/13 at 4:18 P.M. The ISP dated 2/28/13 indicated the following objectives could have been implemented during both observations: "Will complete ROM exercises...Will punch medication into the medication cup...Will say 'Thank you'...Will wipe the table after breakfast."</p> <p>A review of client #3's record was</p>						

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	<p>conducted on 12/6/13 at 4:40 P.M. The ISP dated 10/18/13 indicated the following objectives could have been implemented during both observations: "Will complete ROM exercises... Will give staff a high five... Will stir up Magic cup given hand over hand assistance."</p> <p>A review of client #4's record was conducted on 12/6/13 at 5:00 P.M. The ISP dated 12/27/12 indicated the following objectives could have been implemented during both observations: "Will do a kind deed for another individual... Will vacuum his room... Will take out the medication box from cupboard for staff to pass medications... Will take all fluid items to the table... Will follow a simple command."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4), the facility's nursing services failed to meet the needs of the clients in regard to monitoring the client's health needs, assessing clients after being notified of injuries of unknown origin and injury and putting in place specific risk plans to meet the health care needs of clients. The facility's nursing services failed to ensure staff were adequately trained to provide care/treatment of a hand wound. The facility's nursing services failed to ensure a client had a follow up medical appointment as recommended by the optometrist.</p> <p>Findings include:</p> <p>1. A review of the group home records was conducted on 11/19/13 at 11:15 A.M. Review of the client records indicated the following logs documented by group home staff for the nurse:</p>	W000331	<p>The nurse has received additional training to include documentation of her assessment related to client illness or injuries and her responsibility to notify the administrator (director) of even minor injuries if the origin is unknown. The staff including the managers and nurse have received re-training on the requirement for an injury report to be completed anytime an injury is noted. This training also included the timeframe for reporting and the routing instructions. Immediate contact can still be made to the nurse, however an injury report must be initiated which requires the management staff to document follow up and investigation of unknown injuries in addition to requiring the nurse to document the follow up assessment and instructions. The DSP's, management staff and nurse also received re-training on the investigation procedures which indicates their responsibilities for notification of the administrator (director) so that an investigation can be initiated. A post-test was completed to</p>	01/18/2014	

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	<p>A. Client #1-Health Issues/Nursing Notes dated 10/9/13: "[Client #1's] right ear was as red as the couch in the living room. [Nurse] was called and told. Group Home Trainer (GHT) to see if it still persist (sic) in a couple hours and call her back."</p> <p>-Health Issues/Nursing Notes dated 10/15/13: "[Client #1's] nails was (sic) so long he cut his hand. [Nurse] was called and vaseline was put on it."</p> <p>-Health Issues/Nursing Notes dated 10/27/13: "[Client #1] has a red scar on his wrist. Petroleum jelly and a band-aid were applied."</p> <p>-Health Issues/Nursing Notes dated 11/1/13: "[Client #1] fell in his wheelchair on the side walk. He came home and got clean (sic) up. Nurse was called."</p> <p>A review of client #1's record was conducted on 12/6/13 at 5:00 P.M.. Review of the record indicted client #1 was non-verbal. Review of his record did not indicate the facility's nursing staff assessed him after the documented notes made by the group home staff.</p> <p>B. Client #3-Health Issues/Nursing Notes dated 10/21/13: "[Client #3] has a</p>		<p>ensure the staffs understanding and ongoing monitoring will be completed by the director who will review the injury reports in addition to the nursing notes. This will be monitored weekly for 6 weeks or longer if needed so compliance can be monitored. The nurse did provide instruction for the staff related to client #1's wound care. Client #1 was seen by the physician on 7/23/13 and he received an order for antibiotics and standard hygiene for the hand. He had another appointment with his physician on 7/24/13 with no order changes (continuation of the antibiotic and standard hygiene). The area was assessed by the nurse on 7/27/13 to be clean and dry with no bleeding noted. Client #1 then experienced a change on 7/29/13 and the hand was wrapped and no wound care was ordered as the area stayed wrapped. The nurse has been trained on implementing plans in accordance with recommendations provided by OT/PT/SLP assessments (See W218 and W220). The management staff will review annual appointments monthly and ensure that upcoming appointments are scheduled. All appointments were current at the time of this survey and remain current at this time. Managers complete monthly quality assurance checks at the home which include appointments being</p>		

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	<p>red scrape on her arm."</p> <p>-Health Issues/Nursing Notes dated 10/24/13: "[Client #3] has a red mark on her upper left hip. [Nurse] was called."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] has red marks on her upper right hip."</p> <p>-Health Issues/Nursing Notes dated 11/15/13: "[Client #3] also has 2 long bruises on her upper left thigh. Nurse was called."</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M. Review of the record indicated client #3 was non-verbal and unable to report injuries. Review of her record did not indicate the facility's nursing staff assessed her after the documented notes made by the group home staff.</p> <p>C. Client #4 Health Issues/Nursing Notes dated 10/18/13: "[Client #4] has a red mark on upper left back, left upper arm, left elbow and across stomach. Nurse notified. Report was filled out."</p> <p>A review of client #4's record was conducted on 12/6/13 at 5:00 P.M. Review of his record did not indicate the</p>		<p>completed. These are documented on a CQA form and reviewed by the director for compliance. Action plans are completed if applicable and are monitored by the compliance specialist. The nurse has also received re-training on ensuring appointments are completed within the appropriate timeframe (See W323). The management staff will review annual appointments monthly and ensure that upcoming appointments are scheduled. All appointments were current at the time of this survey and remain current at this time. Managers complete monthly quality assurance checks at the home which include appointments being completed. These are documented on a CQA form and reviewed by the director for compliance. Action plans are completed if applicable and are monitored by the compliance specialist.</p>		

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	<p>facility's nursing staff assessed client #4.</p> <p>2. A review of client #1's "ER (Emergency Room) Physician Report" dated 7/29/13 indicated: "The patient is a 59 year old who presents with the staff from his group home with complaints of left finger wound that is bleeding. He was evaluated on Wednesday of this week, so 5 days ago, with a wound to the volar aspect of the left third finger. He was seen at a [Clinic name], was started on Augmentin. Staff reports this started bleeding, oozing blood today and presents with those complaints...The staff that (sic) with him does not really know how he obtain (sic) this wound. He does have some very sharp finger nails as we discovered. My guess would (sic) that this is probably self-inflicted, nonintentional."</p> <p>-Operative Report dated 7/30/13 indicated: "The patient was referred from the emergency room with a wound over his left long finger that he reportedly sustained while caregivers at his living facility who were trying to cut his nails with regular nail clippers....Evaluation in the office revealed a wound over the volar (same side as the palm of the hand) aspect of the long finger proximal interphalangeal joint with exposed tendon." Review of</p>						

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	<p>the record did not indicate the facility's nursing services developed plans to give staff guidance on how to care for his wound.</p> <p>3. A review of client #1's record was conducted on 12/6/13 at 5:00 P.M. Client #1's record indicated a most current vision evaluation dated 10/26/11 which indicated "Return in 2 years." Further review of the record did not indicate the nurse had ensured client #1 returned for a vision evaluation as recommended by the optometrist.</p> <p>4. An observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. At 7:15 A.M., the Qualified Intellectual Disabilities Professional (QIDP) stated to client #2 "[Client #2], what is wrong with your eye? It is red and running." Client #2's eye looked swollen, red and was watering.</p> <p>A facility owned day program observation was conducted on 11/19/13 from 9:40 A.M. until 11:30 A.M. During the entire observation, client #2's eye was red, swollen and watering. At 10:30 A.M., GHT #6 called the nurse and notified her of client #2's eye. The Nurse did not assess client #2's eye. GHT #6 kept wiping client #2's eye with</p>			

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W000369	<p>a wet paper towel.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated the nurse should have assessed each client after the noted injuries of unknown origin. The RD indicated there was no documentation to indicate the nurse had assessed the clients injuries of unknown origin. The RD indicated GHTs at the group home were responsible for trimming clients finger nails. The RD indicated client #1 did not go for his follow up appointment as recommended by the optometrist.</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>			
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	<p>Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during the morning medication administration (client #2) to ensure staff administered 2 of 15 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:30 P.M. At 7:10 P.M., Group Home Trainer (GHT) #1 began administering client #2's prescribed oral medications. GHT #1 retrieved all of client #2's medications and crushed them. GHT #1 administered client #2's "Levetiracetam 500 mg (milligram) tablet (seizures)...Quetiapine 50 mg tablet (bipolar)." Review of the bubble pack and Medication Administration Record (MAR) dated 11/1/13 to 11/30/13 indicated: "Levetiracetam 500 mg (milligram) tablet...3 tablets orally twice a day...Not to be chewed or crushed...Quetiapine 50 mg tablet...1 tablet orally 3 times a day...5 P.M."</p> <p>GHT #1 was interviewed on 11/19/13 at 7:15 P.M. GHT #1 indicated she always crushes client #2's medications and indicated client #2's Quetiapine should have been administered at 5:00 P.M.</p>	W000369	<p>All staff received re-training on the AWS Medication Administration Policy including discrepancies with pharmacy labels and physician orders. All staff will be monitored by the QDDP, residential manager, or nurse to ensure the training has been effective and that medication labels coincide with physicians orders including delivery method and time frame of medication. Monthly spot checks will be completed at various times to ensure proper labels by pharmacy and that medications are administered as ordered by the physician. These observations will be documented on the Medication Administration tracking form and turned into the director for review to ensure compliance. 1/20/14 update: For 30 days, unannounced medication observations will be completed three times on first shift, three times on second shift and three times on third shift. Once competency is ensured through those checks, AWS management staff will conduct weekly checks of medication administration. These will be documented on the medication administration tracking form which will be turned into the director monthly so compliance can be monitored.</p>	01/18/2014			

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W000383	<p>GHT #1 further indicated client #2's medications should have been administered as directed on the label and MAR.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated client #2's medications should have been administered as directed on the label and MAR.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), to ensure only authorized persons had access to the keys to the medication lock box and cabinet.</p> <p>Findings include:</p> <p>A morning observation was conducted at clients #1, #2, #3 and #4's home on 11/19/13 from 6:40 A.M. until 8:40 A.M. During the entire observation,</p>	W000383	Staff have received additional training on the proper storage of medications. This training included securing the medication keys by keeping them on an authorized person. Weekly observations of staff by the QDDP, Residential Manager or nurse will be completed to ensure that the medication storage policy is being followed. Observations will be documented on a Medication Administration Tracking form and turned into the director so compliance can be monitored.	01/18/2014			

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	<p>Group Home Trainers (GHT) #3, #4, #5 walked in and out of the unlocked medication room. At 7:12 A.M., GHT #3 retrieved the group home medication cabinet keys out of a drawer in the unlocked room located off the open dining/kitchen/living area and began administering client #2's prescribed medications. At 7:15 A.M., GHT #3 placed the medication keys on top of the cabinet and left the room. At 8:05 A.M., GHT #3 re-entered the room, picked the medication keys up from the top of the cabinet, and began administering another of client #1's prescribed medications.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2), who had adaptive equipment, to ensure client #1's wheelchair headrest fit properly and client #2's wheelchair footrest strap was available for use.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:30 P.M. During the entire observation, client #1's wheelchair headrest top was observed to be parallel with his shoulders. Group Home Trainer (GHT) #1 kept adjusting client #2's feet onto his wheelchair's footrest.</p> <p>A morning observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. During the entire observation, client #1's wheelchair headrest top was observed to be parallel with his shoulders. Group Home Trainer (GHT) #1 kept adjusting client #2's feet onto his wheelchair's footrest.</p>	W000436	<p>Client #1's head rest was adjusted on 12/20/13. Client #2's foot rest strap was removed per the teams recommendation. A wheelchair evaluation for client #2 has been requested to evaluate alternate foot rest options to promote foot propelling of wheelchair. Staff have been trained on function and monitoring of adaptive equipment. A wheelchair checklist has been developed to assist staff in assessing proper function and positioning of wheelchair parts. The wheelchair checklist will be completed weekly and reviewed by the QDDP. The QDDP will notify the vendor of necessary repairs.</p>	01/18/2014			

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	<p>GHT #5 stated to the Qualified Intellectual Disabilities Professional (QIDP), "He needs his foot strap that goes behind his legs to keep them on the footrests and keeps his feet from getting tangled around the footrests. It's been missing since his parents took him home about a month ago." When GHT #5 was asked about client #1's headrest, she stated "It's always low like that."</p> <p>A review of client #1's record was conducted on 12/6/13 at 1:55 P.M. Review of client #1's Individual Support Plan (ISP) dated 8/30/13 indicated he used a wheelchair for mobility at all times.</p> <p>A review of client #2's record was conducted on 12/6/13 at 4:18 P.M. Review of client #2's ISP dated 2/28/13 indicated he used a wheelchair for mobility at all times.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated client #2's footrest strap should be available to keep his feet from slipping off the foot rests. The RD further indicated client #1's wheelchair headrest shifts depending how he holds his head.</p>						

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W000446	<p>9-3-7(a)</p> <p>483.470(i)(2)(ii) EVACUATION DRILLS The facility must make special provisions for the evacuation of clients with physical disabilities. Based on observation, record review and interview, the facility failed to assure that 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4), could safely be evacuated from the facility during the overnight hours when only one direct care staff was on duty; for clients #1, #2, and #3 who were not ambulatory and who typically required the use of a mechanical lift/two person lifting during transfers, and for client #4, who required supervision for challenging behaviors including non-compliance and refusals to leave his bedroom.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/18/13 from 5:00 P.M. until 7:30 P.M. Client #4 stayed in his room until dinner time, ate his dinner and immediately returned to his room.</p>	W000446	<p>This home is a one story facility which is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and common living areas. The sprinkler and fire system are fully functioning and inspected as required. All consumers in this home have a personal evacuation plan which is reviewed every 60 days to ensure appropriate supports. Fire drills are completed regularly as required. All clients can be evacuated as needed with the support of one staff and although client #4 is non-compliant with many tasks, he does not have a history of refusals during fire drills. The personal evacuation plans will be reviewed within the POC timeframe to ensure they are adequate in describing the needs of the clients and emergency procedures to be implemented by staff in case of evacuation. These will be reviewed by the director</p>	01/18/2014	

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	<p>During the observation, Group Home Trainer (GHT) #1 prompted client #4 once to come out of his room. Client #4 would not come out of his room. Clients #1, #2 and #3 were observed sitting in their wheelchairs and required complete physical assistance from staff with their mobility.</p> <p>A morning observation was conducted at the group home on 11/19/13 from 6:40 A.M. until 8:40 A.M. Client #4 stayed in his room the entire observation period. Client #4 did not come out of his room. Clients #1, #2 and #3 were observed sitting in their wheelchairs and required complete physical assistance from staff with their mobility.</p> <p>A facility owned day program observation was conducted on 11/19/13 from 9:40 A.M. until 11:30 A.M. Client #4 did not attend the day program. When the Day Program Manager was asked if client #4 was at the day program, she stated "No. His staff reported he refused to attend." The Day Program Manager further indicated client #4 gets "In his moods" and refuses to attend the day program/stays in his room. Clients #1, #2 and #3 were observed sitting in their wheelchairs and required complete physical assistance from staff with their mobility.</p>		and staff training will be completed as necessary.		

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	<p>A group home observation was conducted at the group home on 11/19/13 from 12:00 P.M. until 2:30 P.M. During the entire observation period, client #4 stayed in his room. Client #4 would not come out of his room. Clients #1, #2 and #3 were observed sitting in their wheelchairs and required complete physical assistance from staff with their mobility.</p> <p>A review of the facility's evacuation drills were conducted on 12/6/13 at 1:47 P.M. The reports of all overnight drills documented one staff conducted each drill. The evacuation documents did not contain information regarding clients #1, #2, and #3 who were non-ambulatory and required the use of a mechanical lift/two person lifting during transfers to their wheelchairs from bed were to be evacuated by one staff who also would be evacuating client #4 who had refusal/non-compliance behaviors.</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated clients #1, #2 and #3 required complete staff assistance for mobility. The RD indicated there is only 1 staff scheduled to work during the overnight asleep hours. The RD indicated GHTs</p>			
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	are trained on getting clients out of the house in case of an emergency 9-3-7(a)				
W000460	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 2 sampled clients (#1), and 1 additional (#3), the facility failed to assure the staff provided food in accordance with clients' diet orders. Findings include: A morning observation was conducted at the group on 11/19/13 from 6:40 A.M. until 8:40 A.M. At 7:35 A.M., the Qualified Intellectual Disabilities Professional (QIDP) fed clients #1 and	W000460	All staff have been retrained on the preparation of modified diets. This training included the preparation and proper consistency of pureed foods. Compliance with meal preparation guidelines and dietary requirements will be monitored using the dining checklist. The QDDP, Residential Manager, and Nurse will complete three meal observations on each shift then monthly spot checks will be completed to ensure proper consistencies of diets. These observations will be documented	01/18/2014	

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	<p>#3 their blended cereal which was of a thick oatmeal consistency. The QIDP stated "This needs some more milk." The QIDP added milk. She then fed client #1 the cereal which was still a thick oatmeal consistency. The cereal was not of a pureed consistency for easy swallowing.</p> <p>A review of client #1's record was conducted on 12/6/13 at 2:35 P.M. Review of client #1's Nutritional Assessment dated 4/24/13 indicated: "Pureed diet...thin liquids."</p> <p>A review of client #3's record was conducted on 12/6/13 at 4:40 P.M.. Review of client #3's Nutritional Assessment dated 12/30/12 indicated: "Pureed...pudding thick liquids."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated staff should have followed each client's prescribed diet.</p> <p>9-3-8(a)</p>		<p>on a dining checklist form and turned into the director so compliance can be monitored. Update 1/20/14: For 30 days, unannounced spot checks will be completed three times on first shift, three times on second shift and three times on third shift. Once competency is ensured through those checks, AWS management staff will conduct weekly checks of meals. These will be documented on the dining checklist which will be turned into the director monthly so compliance can be monitored. Spot checks include routine visits to the home. These are completed to monitor various tasks such as meals, medication administration and active treatment. Monthly quality assurance checks are also completed to document overall monitoring of the home, programming and treatments.</p>		

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W000488	<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.</p> <p>Based on observation and interview, the facility failed to assure 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), were involved in meal preparation and served themselves at meal times as independently as possible.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group on 11/18/13 from 5:00 P.M. until 7:30 P.M. During the observation period, clients #1, #2 and #3 sat in the living room with no activity. Client #4 stayed in his bedroom lying in his bed. At 5:10 P.M., Group Home Trainer (GHT) #1 took several containers filled with prepared blended food out of the refrigerator and placed them into the microwave oven. The containers were labeled and indicated the meal consisted of Lasagna, garlic bread, baked apples and beets. At 5:30 P.M., GHT #1 served clients #1, #2, #3 and #4's meal while the clients sat at the dining table with no activity. At 5:35 P.M., clients #1, #2, #3 and #4 ate their already prepared dinner. Clients #1, #2, #3 and #4 did not assist in meal preparation. At 5:40 P.M.,</p>	W000488	<p>All staff have been re-trained on family style dining and giving individuals the opportunity to be as independent as possible. The clients should have had the opportunity to assist with meal preparation, setting the table, and serving the food as they are able. The clients can/will have additional opportunities for meal preparation as identified by their functional assessment. The QDDP and Residential Manager will observe every mealtime at least one time monthly to ensure that staff are implementing proper procedures and will document this oversight on the dining checklist. 1/20/14 update: For 30 days, unannounced meal observations will be completed for three breakfast times, three lunch times and three dinner times. Once competency is ensured through those checks, AWS management staff will conduct weekly checks of meals. These will be documented on the dining checklist which will be turned into the director monthly so compliance can be monitored.</p>	01/18/2014
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	<p>labeled clear plastic containers of already prepared blended food was observed in the refrigerator. The labels indicated: "Chicken... potato salad."</p> <p>And interview with GHT #2 was conducted on 11/18/13 at 5:45 P.M. When asked who prepared the labeled containers of food, she stated: "I do when working overnights. Overnight staff cook the clients' meals."</p> <p>An interview with the Residential Director (RD) was conducted on 12/19/13 at 10:30 A.M. The RD indicated clients were capable of assisting in meal preparation and of serving themselves with assistance and further indicated they should be assisting in preparation and serving themselves with assistance at meal time.</p> <p>9-3-8(a)</p>				