

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G327		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING INC				STREET ADDRESS, CITY, STATE, ZIP CODE 417 N ASH ST BUTLER, IN 46721			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 13, 14, 15, 16, 2012.</p> <p>Facility number: 000845 Provider number: 15G327 AIM number: 10043810</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/24/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon observation, record review and interview, the facility's governing body failed to exercise operating direction over the facility by charging 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7, #8) for tips associated with facility provided personal care haircuts.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/13/12 from 3:00 PM until 6:35 PM. During dinner, the house manager instructed clients who were going to get hair cut the following weekend to save their dollars for tipping.</p> <p>Client #3 was interviewed on 8/13/12 at 6:05 PM. Client #3 indicated the agency paid for clients' haircuts, but he and the other clients pay for the tip.</p> <p>Client #3's financial record was reviewed on 8/13/12 at 5:20 PM. Client #3's record indicated personal spending money was available for client #3 to use as discretionary funds.</p>	W0104	<p>W 104 Governing Body</p> <p>The governing body exercises general policy, budget, and operating direction over the facility.</p> <p>The management team reviewed this citation and moved to immediately halt the practice of clients providing a voluntary tip for haircuts. The Agency will have hair stylists add a suitable tip onto the bill given to the agency. Even though there were questions raised as to whether the rate setters, Myers and Stauffer, would approve tips for haircuts as an allowable expense on the Medicaid cost report, the insignificance of the item seemed to make it a non-issue to pursue</p>	08/21/2012			

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	<p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 8/14/12 at 2:00 PM and indicated it was facility practice and all clients living in the group home (#1, #2, #3, #4, #5, #6, #7, and #8) used their discretionary personal funds to provide tips for haircuts.</p> <p>The QMRP was interviewed again on 8/16/12 at 12:31 PM. She indicated while it was optional for clients to tip for haircuts, if they chose not to tip, the stylist would not receive a tip. When asked why the clients paid for tips, she stated, "It's basic training," and indicated it was usual and customary practice to tip for haircut services. She stated, "We also train them to tip at restaurants."</p> <p>9-3-1(a)</p>		<p>further. The agency has provided haircuts as part of the daily rate since the interpretation of the rule in recent years, and the paying of tips for haircuts seems to make equal sense.</p> <p>1. QMRP's are trained to instruct staff to not allow consumers to pay a tip for their haircuts. Completed: 08/21/2012 Responsible: CEO, QMRP</p> <p>2. Stylists are contacted and asked to include the tip for haircuts onto the bill given to the agency. In addition, stylists are asked to not accept tips from consumers, if offered. Completed: 08/21/2012 QMRP</p>				

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W0149	<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.</p> <p>Based on observation, record review and interview, the facility neglected to develop written policy and procedures to protect 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7, and #8) by failing to include in their procedures the need to report the reasonable suspicion of a crime to law enforcement authorities, failed to conspicuously post the requirement, and failed to train staff on the requirement to report reasonable suspicion of a crime to law enforcement authorities.</p> <p>Findings include:</p> <p>During observation periods at the group home on 8/13/12 from 3:00 PM to 6:35 PM and on 8/14/12 from 6:43 AM to 7:48 AM, there was no evidence posted of the need to report a reasonable suspicion of a crime to law enforcement. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were present in the group home. There was no evidence of the requirement to report the suspicion of a crime to law enforcement posted at the facility offices during the dates of the survey from 8/13/12 to 8/16/12.</p>	W0149	<p>W149 The governing body exercises general policy, budget, and operating direction over the facility.</p> <p>System To Prevent Recurrence: Please note that policies and procedures developed to correct this finding were subsequently reviewed by the same surveyor when one of our other facilities was surveyed. The surveyor found our policies and procedures to be in compliance. Copies of these are not appended to this document, but are available for upload and review if needed.</p> <p>A. Description: Facility Determination of Applicability. The facility has determined that the facility received at least \$10,000 in Federal funds under the Act during the preceding fiscal year. A facility that received at least \$10,000 must comply with provisions of the Act. Completion Date: 08/20/2012 Responsible: CEO 1. Action Item: The CEO of the Agency makes this determination annually and sends notification to the Board of Directors.. Completion Date: 08/20/2012</p>	08/24/2012			

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	<p>The facility's Abuse Reporting Policy/Purpose Statement was reviewed on 8/13/12 at 3:30 PM and failed to include the requirement to report the suspicion of a crime to law enforcement authorities.</p> <p>The director of group homes was interviewed on 8/16/12 at 4:00 PM. She indicated the agency's team leaders had been trained on the requirement to report suspicion of a crime to law enforcement authorities, but no other staff had been trained. She indicated there were no posted notices in the agency of the requirement.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 8/16/12 at 12:45 PM and indicated the requirement was not included in the agency's written policy and procedures to protect clients from abuse, neglect and exploitation. She indicated agency staff reported any suspicion of a crime to APS (Adult Protective Services).</p> <p>A Memorandum dated June 17, 2011 from Centers for Medicaid Services was reviewed on 8/14/12 at 10:00 AM indicated in part, "Section 1150 B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care</p>		<p>Responsible: CEO B. Description: Coordinate Law Enforcement. The facility coordinates with the facility's local law enforcement entities to determine reporting process and what actions are considered crimes in their political subdivision. . Completion Date: 08/17/2012 Responsible: CEO Action Items: 1. Determine contact information and process for reporting suspicions of crimes. A. Description: Facility Determination of Applicability. The facility has determined that the facility received at least \$10,000 in Federal funds under the Act during the preceding fiscal year. A facility that received at least \$10,000 must comply with provisions of the Act. Completion Date: 08/20/2012 Responsible: CEO 1. Action Item: The CEO of the Agency makes this determination annually and sends notification to the Board of Directors.. Completion Date: 08/20/2012 Responsible: CEO B. Description: Coordinate Law Enforcement. The facility coordinates with the facility's local law enforcement entities to determine reporting process and what actions are considered crimes in their political subdivision. . Completion Date: 08/17/2012 Responsible: CEO Action Items: The facility contacted the local law enforcement entities to discuss</p>		

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	<p>Act of 2010 (Affordable Care Act), requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility...LTC (Long Term Care) facilities should have policies and procedures to comply with this law...LTC Facility Responsibilities</p> <p>1. Required Functions: A Medicare-or Medicaid-participating LTC facility must:</p> <p>a) <i>Determine Applicability:</i>" Determine annually whether the facility received at least \$10, 000 in Federal funds under the Act during the preceding fiscal year;</p> <p>b) <i>Notify Covered Individuals:</i> Annually notify each covered individual of that individual's reporting obligations described in section 1150B(b) of the Act, if the facility determines that it received at least \$10,000 in Federal Funds under the Act during the preceding fiscal year.</p> <p>c) <i>Post Conspicuous Notice:</i> Conspicuously post, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute. The notice must include a statement that an employee may file a complaint with the SA (State Agency) against a LTC facility that retaliates against an employee as specified</p>		<p>the reporting process. The County Sheriff and local police entity (City Police Department) are the two primary local law enforcement entities in order to:</p> <p>1. Determine contact information and process for reporting suspicions of crimes. Completion Date: 08/17/2012 Responsible: CEO</p> <p>2. Discuss actions that are crimes. Completion Date: 08/17/2012 Responsible: CEO</p> <p>3. Discuss training opportunities to increase crime awareness among facility covered individuals. Completion Date: 08/17/2012 Responsible: CEO</p> <p>C. Description: Post Conspicuous Notice. The facility conspicuously posts, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute. The notice includes a statement that an employee may file a complaint with the ISOH against a long term care facility that retaliates against an employee as well as include information with respect to the manner of filing such a complaint. Completion Date: 08/20/2012 Responsible: QMRP</p> <p>1. Action Items: The facility uses the ISDH template for the notice that meets Federal requirements. The facility posts the notice in a "conspicuous" and "appropriate location". Completion Date: 08/20/2012 Responsible: QMRP</p> <p>D. Description: Notify Covered</p>				

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	above, as well as include information with respect to the manner of filing such a complaint...." 9-3-2(a)		Individuals. The facility annually notifies each covered individual of that individual's reporting obligations described in Section 1150(8). Completion Date: 08/17/2012 Responsible: CEO Action Items: The facility does the following: 1. Provide annual notice to each covered individual of that individual's reporting obligations which is mailed out annually at time of CEO compliance review.. Completion Date: 08/20/2012 Responsible: CEO 2. Develop policies and procedures for annual notice of covered individuals to include reporting requirements and process, what constitutes a crime, and prohibitions against retaliation for reporting. Completion Date: 08/20/2012 Responsible: CEO 3. Develop procedures for training of additional covered individuals who begin providing care or services at the facility during the year. Element is added to orientation and annual on-going training. Completion Date: 08/20/2012 Responsible: CEO, Residential Director E. Description: Covered Individuals Reporting. Covered individuals must timely report any reasonable suspicion of a crime against a resident of, or who is receiving care from, a long term care facility. Completion Date: 08/24/2012 Responsible: CEO, QMRP Action Items: Once covered		

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			<p>individuals have been provided notice and training on reporting requirements, covered individuals must begin reporting reasonable suspicions of a crime against a resident to a local law enforcement entity and the ISOH. Completion Date: 08/24/2012 Responsible: QMRP F.</p> <p>Description: Review Protocols and Procedures. The facility reviews existing facility protocols and procedures to ensure adherence to existing CMS and State policies and procedures for reporting at the time of the annual review for compliance or more often as needed. Completion Date: 08/20/2012 Responsible: CEO Completion Date: 08/17/2012 Responsible: CEO</p> <p>2. Discuss actions that are crimes. Completion Date: 08/17/2012 Responsible: CEO</p> <p>3. Discuss training opportunities to increase crime awareness among facility covered individuals. Completion Date: 08/17/2012 Responsible: CEO</p> <p>C. Description: Post Conspicuous Notice. The facility conspicuously posts, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute. The notice includes a statement that an employee may file a complaint with the ISOH against a long term care facility that retaliates against an employee as well as include</p>		

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			<p>information with respect to the manner of filing such a complaint. Completion Date: 08/20/2012 Responsible: QMRP 1. Action Items: The facility uses the ISDH template for the notice that meets Federal requirements. The facility posts the notice in a "conspicuous" and "appropriate location". Completion Date: 08/20/2012 Responsible: QMRP</p> <p>D. Description: Notify Covered Individuals. The facility annually notifies each covered individual of that individual's reporting obligations described in Section 1150(8). Completion Date: 08/17/2012 Responsible: CEO Action Items: The facility does the following: 1. Provide annual notice to each covered individual of that individual's reporting obligations which is mailed out annually at time of CEO compliance review.. Completion Date: 08/20/2012 Responsible: CEO 2. Develop policies and procedures for annual notice of covered individuals to include reporting requirements and process, what constitutes a crime, and prohibitions against retaliation for reporting. Completion Date: 08/20/2012 Responsible: CEO 3. Develop procedures for training of additional covered individuals who begin providing care or services at the facility during the year. Element is added to orientation and annual on-going</p>		

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			<p>training. Completion Date: 08/20/2012 Responsible: CEO, Residential Director E.</p> <p>Description: Covered Individuals Reporting. Covered individuals must timely report any reasonable suspicion of a crime against a resident of, or who is receiving care from, a long term care facility. Completion Date: 08/24/2012 Responsible: CEO, QMRP Action Items: Once covered individuals have been provided notice and training on reporting requirements, covered individuals must begin reporting reasonable suspicions of a crime against a resident to a local law enforcement entity and the ISOH. Completion Date: 08/24/2012 Responsible: QMRP F.</p> <p>Description: Review Protocols and Procedures. The facility reviews existing facility protocols and procedures to ensure adherence to existing CMS and State policies and procedures for reporting at the time of the annual review for compliance or more often as needed. Completion Date: 08/20/2012 Responsible: CEO</p>		

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to establish a protocol to address high blood pressure for 1 of 4 sampled clients (client #1), and failed to follow a protocol to address diabetes for 1 additional client (client #7).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/14/12 at 10:40 AM. Client #1's record indicated his blood pressure (BP) was in excess of 120/80 when taken on a weekly basis in April, May, June of 2012, ranging from a low of 138/78 to a high of 181/96. There was no BP protocol available for review to indicate when the staff should contact the nurse. Client #1's physician's orders dated 8/1/12 indicated he took medication to address high blood pressure.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 8/14/12 at 2:36 PM and indicated there was no protocol to address client #1's BP. She indicated the nurse monitored client #1's blood pressure on a monthly basis.</p> <p>2. The facility's reports to BDDS (Bureau</p>	W0331	<p>W 331 NURSING SERVICES</p> <p>The Agency provides clients with nursing services in accordance with their needs.</p> <p>System to prevent recurrence: The QA Team investigated these findings and determined that these issues highlight issues that extend beyond this facility. The agency recently (June,2012) hired a new nurse who has been involved with the review and upgrading of agency procedures and protocols. These findings for Client#1 and Client#7 fall within the scope of issues we have moved to correct prior to this survey. We have secured a protocol to follow for all Agency consumers, including Client#1, who are diagnosed with high blood</p>	09/06/2012			

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	<p>of Developmental Disabilities Services) were reviewed on 8/13/12 at 3:15 PM. Reports dated 7/15/12 indicated client #7 was taken to the emergency room because of blood sugar levels over 500. Client #7 was taken to the hospital on 11/29/11 because of blood sugar of 397 and on 11/6/11 was taken to the hospital on 11/6/11 for a blood sugar reading in excess of 400. The report indicated client #7 had a history of high blood sugar readings with no apparent cause.</p> <p>Client #7's record was reviewed on 8/14/12 at 10:50 AM. An objective to check client #7's blood sugar 5 times daily indicated his target range was 60-250 and client #7's blood sugar "has not been controlled." A Blood Sugar (BS) Protocol for client #7 dated 1/25/12 indicated if client #7's BS was over 350, test for Ketones. If BS is between 250-499, have him drink a lot of water, exercise and retake in one hour. Client #7's Medication Administration Record (MAR) dated July, 2012 indicated client #7's diabetes protocol to recheck his blood sugar after a reading in excess of 250 was not followed on July 10, July 5, July 14, July 17, July 21, and July 22, 2012, and was not followed on June 1, June 3, June 4, June 7, June 9, 10, June 21, June 24, June 25, and June 28, 2012.</p>		<p>pressure and are being treated by a physician. This protocol will serve as a basis for all clients, but would be tailored to individual needs by the agency nurse, if necessary.</p> <p>The Blood Sugar levels protocol for Client#7 is deemed adequate, but the strategy to follow it, failed in the extent that staff were not recording subsequent level readings after a level higher than 250 was recorded. Staff interviewed reported that they followed the protocol, but did not always record it since the form did not allow space for the recording. A new form is developed and staff are trained in its use thus ensuring that the finding will not recur. This form would be used by any agency clients who are monitoring BS levels, but would be tailored to their particular needs. The agency only serves one consumer with type 2 diabetes at this time.</p>				

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	The QMRP was interviewed on 8/14/12 at 2:45 PM. She indicated it appeared client #7's protocol to address his diabetes was not followed. 9-3-6(a)		<p>1. The BP protocol for clients with high blood pressure readings is developed by the agency physician. This protocol was written in response to Client#1's needs, but can serve any agency consumer as appropriate.</p> <p>Date completed: August 20, 2012</p> <p>Responsible QMRP, RN</p> <p>2. Staff are trained with the protocol for Client#1 to be used when dangerously elevated BP readings above 180/105 occur.</p> <p>3. A new form for recording the measurement of Blood Glucose levels for Client#7 is developed and implemented.</p> <p>Date completed: 09/06/2012</p>		

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			<p>Responsible: CEO, RN</p> <p>4. Staff are trained to use the new recording form for blood sugar readings for Client#7.</p> <p>Completed: 09/06/2012</p> <p>Responsible: QMRP</p>		

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W0362	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>Based on record review and interview, the facility failed for 4 of 4 sampled clients, (clients #1, #2, #3 and #4) to provide evidence the pharmacist reviewed their medications on a quarterly basis.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/14/12 at 10:40 AM. A print out of client #1's medications included psychotropic medications, medication to treat COPD (chronic pulmonary obstructive disorder), and high blood pressure included a typed statement at the top, "A drug regimen review for this patient has been performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date to indicate a pharmacist's review of client #1's medications.</p> <p>Client #2's record was reviewed on 8/14/12 at 12:10 PM. A print out of client #2's medications included psychotropic medication and included a typed statement at the top, "A drug regimen review for this patient has been</p>	W0362	<p>W 362 A pharmacist with input from the IDT reviews the drug regimen of each client at least quarterly. System to prevent recurrence: The QA Team reviewed this issue and it was brought to the team's attention that the current procedure had been used since 2010; however, it is agreed that the current system does not provide a clear trail for review. The pharmaceutical company contracted by the Agency has agreed to use the new form provided by the Agency for future drug regimen reviews. Working with the pharmacist, the IDT developed a form which reflects the scope of the review performed by the pharmacy provider. The use of this form will provide a clearer paper trail of reviews. 1. A "Drug Regimen Review" form is created to track reviews in a clear and consistent manner. Completed: 08/30/2012 Responsible: CEO, IDT, Pharmacist 2. The pharmacy provider is contacted and agrees to use the new form on a quarterly basis starting with the quarter which begins 09/01/2012. Completed: 08/31/2012 Responsible: CEO</p>	08/31/2012			

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	<p>performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date to indicate a pharmacist's review of client #2's medications.</p> <p>Client #3's record was reviewed on on 8/14/12 at 1:25 PM. A print out of client #3's medications included psychotropic medication and topical prescription medications and included a typed statement at the top, "A drug regimen review for this patient has been performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date to indicate a pharmacist's review of client #3's medications.</p> <p>Client #4's record was reviewed on on 8/14/12 at 1:02 PM. A print out of client #4's medications included psychotropic medication and included a typed statement at the top, "A drug regimen review for this patient has been performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date to indicate a pharmacist's review of client #4's medications.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed</p>						

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	<p>on 8/16/12 at 12:30 PM. She indicated the pharmacy they contracted with had indicated the statement at the top was sufficient as evidence of a pharmacist's review of client medications. She indicated there was no other evidence of a review by the pharmacist of client #1, #2, #3, or #4's medications.</p> <p>A contract with the pharmacy for the period of March 2010 to March 18, 2011 used by the facility was reviewed on 8/16/12 at 12:45 PM and indicated drug regimen reviews would be performed monthly, and "A statement attesting to the review with any potential problems will posted (sic) on the Physician's order form which accompanies med orders."</p> <p>9-3-6(a)</p>				

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon observation, record review and interview, the facility failed to ensure a posted menu item (cottage cheese) was provided, or an appropriate substitution was available at mealtime to follow a diabetic diet for 1 additional client (client #7), and failed to ensure preferred choice of food (eggs) was available for breakfast for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>1. During the evening meal served on 8/13/12 at 6:05 PM, client #7 ate 1 piece of chicken, 2 pieces of bread with margarine, 2 red potatoes, broccoli, milk, and pineapple.</p> <p>The posted menu for Monday was reviewed on 8/13/12 at 6:06 PM. The menu for client #7 indicated 1 cup of chicken Alfredo, 1/2 cup green beans, 1/2 cup lite mandarin oranges, 1/2 cup sugar free low fat chocolate pudding, 2 oz (ounces) of baked chicken and 1/2 cup 1% milk.</p> <p>Client #7's record was reviewed on 8/14/12 at 10:50 AM. Client #7's Risk</p>	W0460	<p>W 460 FOOD AND NUTRITION SERVICES</p> <p>Each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>System to prevent recurrence: The QA Team investigated the findings under this tag and feel that both issues can be resolved by staff training. Although the findings appear to be conflicting in that one is cited for not providing a 50 calorie ¼ cup of cottage cheese which was on the menu for Client#7, and the second citation for not having eggs as a preferred choice for Client#1 when he did not want to eat any of the posted menu selections for breakfast, both issues</p>	09/06/2012			

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	<p>Plan dated 7/6/11 indicated he was at high risk for diabetes and staff were to encourage client #7 to follow his diet. Client #7's MAR (medication administration record) for June and July 2012 indicated more than 5 instances each month where his blood sugar was in excess of 250.</p> <p>The Qualified Mental Retardation Professional was interviewed on 8/15/12 at 2:35 PM. She indicated the menu for Thursday was being followed on 8/13/12 and provided a copy of the menu. The provided menu indicated client #7 should have received 1 cup of chicken with red potato, 1/4 cup of cottage cheese, 1/2 cup of broccoli, 1 slice of french bread, 2 T (tablespoons) of margarine, 1/2 cup pineapple, 1/2 cup milk. The QMRP indicated staff usually ensure client #7 follows his diet, cottage cheese was available in the home, and she was unsure as to why it was not on the table. She indicated client #7's menu should be followed.</p> <p>2. During the observation period on 8/14/12 from 6:43 AM until 7:48 AM, client #1 ate 4 sausages for breakfast. Client #1 was not offered other choices of breakfast foods or beverages. Clients #3, #5 ate cold cereal, milk and grape juice during the observation.</p>		<p>are training issues. For Client#1 it appears that the morning staff need to communicate with the facility team leader when food items are not available or are running low. Even though the food log for Client#1 shows that he did have eggs available for twelve of the fourteen days prior to August 13, 2012, it also shows that it should be expected that eggs would be available every day because Client#1 will be expecting them. Staff are trained to leave a note for the team leader whenever any menu or preferred items are not available. In addition, the facility will keep egg beaters on hand for any times that there are shortages of eggs for any unavoidable reason.</p> <p>For Client#7's missing menu item, the training issue is not so easy to resolve. The Team leader who forgot to make the cottage cheese available is</p>				

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	<p>Staff #4 was interviewed on 8/14/12 at 7:10 AM. When asked if client #1 ate anything else for breakfast, he indicated client #1 did not like anything but eggs and sausage for breakfast. He indicated the group home was out of eggs.</p> <p>The posted menu for 8/14/12 was reviewed on 8/14/12 at 7:10 AM and indicated for client #1, 1/2 cup juice, 1/2 cup of oatmeal, 1 piece of toast, margarine and 8 ounces of milk.</p> <p>Client #1 was interviewed on 8/14/12 at 7:30 AM. He indicated he liked eggs and sausage in the morning and indicated he didn't like cereal, grape juice, oatmeal or toast. He indicated he liked orange, but didn't like grape juice, and stated, "I don't like that kind."</p> <p>Client #1's record was reviewed on 8/14/12 at 10:40 AM. His dietary assessment dated 3/5/12 indicated he was on a regular high fiber diet and "on Ensure for added calories and protein." An objective dated 7/28/11 indicated client #1 "will eat 3 meals a day." The objective indicated client #1 "should be eating breakfast every morning. Encourage him to find something he likes and to have breakfast."</p>		<p>the main reason that Client#7 has been able to be served by the agency. The team leader has helped Client#7 follow the strict diet plan prepared for him, and has trained his staff to be diligent in following the menus. The Team Leader actually had cottage cheese in the facility for that evening meal. Even though the T.L. has worked for the agency for over twenty-five years and has been through numerous surveys as a T.L., he has always suffered high anxiety about and during the survey process. He described himself as being overly nervous with the surveyor watching during the meal, and he simply forgot the cottage cheese. This staff receives informal counseling from management staff every year before, during, and after annual surveys, and this enables him to overcome most of the anxiety beforehand and some of the remorse</p>		

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	<p>The QMRP was interviewed on 8/15/12 at 2:45 PM. She indicated staff were conducting a food diary to ensure client #1 received proper nutrition as he had become thin. She provided a copy of client #1's food diary for 8/13/12 and 8/14/12 which indicated client #1 ate only sausage for breakfast on those days. She indicated client #1 apparently preferred eggs as the food diary indicated he ate only eggs and sausage for breakfast and the group home was evidently out of eggs on 8/13/12 and 8/14/12.</p> <p>9-3-8(a)</p>		<p>afterwards when there are any findings. This staff has a proven record of being a capable and detail oriented leader and that record assures that this finding is not systematic or any indication of a trend. The up and down record of blood sugar levels for Client#7 might seem to point to a menu related issue, but the agency has maintained a strict adherence to the prescribed menu plan, and it has enabled the prescribing endocrinologist to make medication adjustments on a bi-weekly basis which have allowed Client#7 to avoid the extreme historical highs and lows he experienced since childhood.</p> <p>1. The Team Leader and staff are re-trained on the importance of maintaining a strict menu plan for Client#7.</p> <p>Completed: 09/06/2012</p>		

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			<p>Responsible: QMRP</p> <p>2. Staff are trained to notify the team leader in writing whenever there is a shortage of food items for Client#1 and any of the clients. It is not acceptable to wait until the major weekly shopping trip to re-stock. Items should be re-stocked as shortages occur.</p> <p>Completed: 09/06/2012</p> <p>Responsible: QMRP</p> <p>3. Egg Beaters are available for Client#1 whenever unavoidable shortages occur.</p> <p>Completed: 08/18/2012</p> <p>Responsible: Team Leader</p>		