STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G640		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY ENTERPRISES INC	3102 AIRPORT RD PORTAGE, IN 46368

(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
W 0000 Bldg. 00	This visit was for an annual recertification and state licensure survey. Dates of Survey: June 9, 10, 11, 12 and 15, 2015. Facility number: 001220 Provider number: 15G640 AIM number: 100245730 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0153 Bldg. 00	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 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4, #5 and #6), to report an allegation of neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.	W 0153	As a result of the reporting staff not notifying agency personnel, according to the state and agency policy, staff received a corrective action. The late reporting resulted in late notifications to both the administrator and BDDS. The facility trains all staff, at minimum, annually,in the policies and procedures of reporting cases of abuse and neglect. A part of this	07/12/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated: -BDDS report dated 8/18/14...Date of Knowledge: 8/22/14...Submitted Date: 8/23/14 involving clients #1, #3, #4, #5 and #6 indicated: "I received a report late on the evening of 8/22/14 that earlier in the week, an [Group Home name] staff had stopped by the group home at 1:30 A.M. on the way to another job to drop a binder off at the home. When she arrived, she knocked (sic) laying down on the couch covered with a blanket. She rang the doorbell and saw staff simply roll over on the couch. Staff went back to her car to get the key to the home and let herself in. When she entered, the staff laying down got up and said, 'Oh, I forgot you were coming back by.' Reporting staff will receive a counseling as a result of her not following agency reporting policy (not reporting within an appropriate time frame)." Further review of the record failed to indicate staff		training includes notifying administration, immediately, upon discovery of an abuse or neglect case and notifying BDDS within 24 hours. Ongoing, the investigating staff will continue to ensure that once an allegation is filed, both BDDS and the administrator will be notified according to policy.	

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	immediately reported the incident to the administrator. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated the staff should have immediately reported the allegation of abuse/neglect. 9-3-2(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the facility failed to ensure all staff who worked with the clients were sufficiently trained to assure competence in regard to administering medications as ordered, documenting of administration of medications and competence in regard to providing supervision. Findings include:	W 0189	All staff were retrained on medication administration, according to agency policy (See Attached). Concerning client supervision; a high risk protocol was implemented, for client #3, on 4/27/15,and all staff were trained on that protocol on 4/27/15. Staff will be re-trained on client #3's high risk protocol on 7/13/15. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during med administration, nursing will monitor when completing random	07/15/2015

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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3102 AIRPORT RD PORTAGE, IN 46368	

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	1. A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated: -BDDS report dated 8/10/14 involving client #1 indicated: "[Staff #16] didn't pass [client #1]'s 8 P.M. Vimpat 200 mg (milligram) (seizure) controlled medication." -BDDS report dated 11/18/14 involving client #3 indicated: "On 11/19/14 at 6:45 A.M., [Staff #17] went to administer the morning medication and discovered the 7 A.M. medications Loratadine tab 10 mg (allergies) and Multi Vitamin Tab, for 11/18/14 were still present in the bubble pack." -BDDS report dated 12/10/14 involving client #1 indicated: "On 12/10/14, it was discovered that on 12/8/14 at 4 P.M., staff failed to administer participant's Tobramycin (antibiotic) eye drops." -BDDS report dated 12/11/14 involving client #1 indicated: "Staff failed to pick-up participant's medication Tobramycin eye drops from the nursing		home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will maintained of these observations and competency will need to be demonstrated by certified med passers. If it is determined at any time, that staff fail to follow the policy for med administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred.	

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	office. Due to failing to pick up the eye drops from the nursing office, the participant did not receive the medication on 12/11/14 at 4 P.M. and 8 P.M. then again on 12/12/14 at 7 A.M.." -BDDS report dated 12/15/14 involving client #1 indicated: "On 12/16/14 at approximately 8 P.M., staff discovered the participant's medication Folic Acid 1 mg (supplement) was not administered at 7 A.M. on 12/16/14." -BDDS report dated 4/9/15 involving client #2 indicated: On 4/9/15 it was discovered that staff failed to administer the client's P.M. dosage of Calcium Carb 600 mg tab (supplement) on 4/8/15." -BDDS report dated 5/6/15 involving client #1 indicated: "On 5/6/15 during morning medication administration, it was discovered that on 3/3/15, [Group Home Manager (GHM)] initialed the MAR (Medication Administration Record) to indicate the bedtime dosage of Vimpat 200 mg (seizures) was administered, however, failed to administer the medication." 2. A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental			

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	Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated: -GER dated 2/3/15 involving client #5 indicated: "I was passing medications for today and noticed Calcitonin (osteoporosis) was not signed for." -GER dated 2/7/15 involving client #6 indicated: "Came in to check meds on 2/4/15 and noticed that a spot wasn't signed for. It was for the following meds: X-Viate cream (tissue softener) and Ammonium cream (dry skin)." GER dated 2/7/15 involving client #4 indicated: "Came in on my shift and checked med book and noticed a spot for [client #4]'s Ciclopirox (fungal infection) was not signed for." -GER dated 2/10/15 involving client #1 indicated: "[Client #1]'s Lactulose (constipation) was not signed for, for the bedtime. I am unsure if it was passed." -GER dated 5/13/15 involving client #1 indicated: "I was passing A.M. meds and noticed that [client #1]'s Liquid Dry Mouth was not signed for. I don't know if the medication was passed or if it wasn't but it wasn't signed for."			

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	An interview with the nurse was conducted on 6/12/15 at 1:20 P.M.. The nurse indicated staff were to administer the clients' medications as ordered and indicated staff should sign the MAR as they administer the clients' medications. 3. A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated: -BDDS report dated 4/20/15 involving client #3 indicated: "It was alleged that staff at home did not provide appropriate supervision level for [client #3]. It was discovered that [client #3] had consumed antibacterial hand soap at home the previous evening....[Client #3] has a history of consuming non-edible items due to PICA. This is addressed in his ISP (Individual Support Plan) (dated 7/30/14) and BSP (Behavior Support Plan) (dated 10/22/14)." -GER dated 5/20/15 involving client #3 indicated: "We were bringing everything in from the van when we arrived back from out to eat at [Restaurant name].			

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	When everyone was inside, I was putting away supplies that we took with us to [Restaurant name] and I found a stick of deodorant. I then opened it up and found a little bit was bit (sic) off." -BDDS report dated 6/5/15 involving client #3] indicated: "Another client came to staff and asked if I had seen her bar of soap that is usually locked up in the cabinet. I told her no and started helping her look for it and then found a bar of soap in the bathroom garbage with bites taken out of it." -BDDS report dated 5/4/15 involving client #3 indicated: "It was reported [client #3] walked into the day service building without staff accompaniment. While staff was assisting another client in the vehicle, [client #3] walked from the vehicle into the building. Staff was unaware [client #3] left. Because of his PICA behaviors, [client #3] is at high risk for bolting and ingesting non-edible items and thus requires line of sight supervision. Upon the notification of the allegation of neglect an investigation was initiated and staff was immediately placed on suspension....It is recommended staff receive a corrective action as a direct result of the substantiated allegation."			

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	-BDDS report dated 8/18/14...Date of Knowledge: 8/22/14...Submitted Date: 8/23/14 involving clients #1, #3, #4, #5 and #6 indicated: "I received a report late on the evening of 8/22/14 that earlier in the week, an [Group Home name] staff had stopped by the group home at 1:30 A.M. on the way to another job to drop a binder off at the home. When she arrived, she knocked (sic) laying down on the couch covered with a blanket. She rang the doorbell and saw staff simply roll over on the couch. Staff went back to her car to get the key to the home and let herself in. When she entered, the staff laying down got up and said, 'Oh, I forgot you were coming back by.' Reporting staff will receive a counseling as a result of her not following agency reporting policy (not reporting within an appropriate time frame)." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated all staff are trained on client protocols and risk plans prior to working at the group home. The QIDP indicated staff are to provide supervision of clients at all times. The QIDP indicated staff are to supervise client #3 at all times due to his PICA behavior.			

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	9-3-3(a)			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed for 1 of 2 sampled clients and 2 additional clients (clients #3, #4 and #6), to promote their dignity by not ensuring they had hair cuts and client #6's eyebrows were trimmed. Findings include: A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:10 A.M.. During the entire observation period, clients #3 and #4 were observed to need hair cuts. Client #4 repeatedly asked Direct Support Professional (DSP) #4 "When can I go get my hair cut?" DSP #4 responded "I have to ask and I'll let you know." During the entire observation client #6 was observed squinting and his eyebrows were observed to reach his eyelids.	W 0268	The facility has ensured that no other clients were affected by this deficient practice. The group home manager,assistant manager, and QDDP will ensure all clients are properly groomed,promoting client dignity. To ensure further compliance in this area, the QDDP, Group Home Manger, and/or Assistant Manager will conduct daily quality assurance checks, for the duration of 7 days. After seven days, the QDDP will assess the quality assurance visits and determine if further, daily, checks are needed. If it is determined that daily checks are no longer needed; the QDDP will monitor client grooming and dignity during monthly quality assurance checks. If it is determined that daily checks are no longer needed; the QDDP will monitor client grooming and dignity during monthly quality assurance checks.	07/12/2015

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	An evening observation was conducted at the group home on 6/9/15 from 5:30 P.M. until 6:45 P.M.. During the entire observation period, clients #3 and #4 were observed to need hair cuts. During the entire observation client #6 was observed squinting and his eyebrows were observed to reach his eyelids. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated clients should be groomed at all times. The QIDP further indicated staff should take the clients for haircuts when needed. 9-3-5(a)			
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #3) to provide an annual physical. Findings include: A review of client #1's record was	W 0322	The facility has ensured that no other clients were affected by this deficient practice. The QDDP will ensure that all clients obtain an annual physical examination. A physical examination, for client #1 and #3 has been scheduled. To ensure future compliance, the group home director will conduct monthly record reviews to ensure	07/15/2015

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	conducted on 6/10/15 at 12:30 P.M.. Client #1's record indicated a most current annual physical dated 5/19/14. Client #1's record did not contain evidence he had an annual physical. A review of client #3's record was conducted on 6/10/15 at 1:10 P.M.. Client #3's record indicated a most current annual physical dated 1/29/14. Client #3's record did not contain evidence he had an annual physical. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated clients should have a physical annually. The QIDP indicated she would have to look to find documentation to indicate if clients #1 and #3 had an annual physical. No written documentation was submitted for review to indicate there was evidence of an annual physical. 9-3-6(a)		an annual physical is completed for each client.	
W 0323	483.460(a)(3)(i) PHYSICIAN SERVICES			

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Bldg. 00	The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3), to have hearing and vision evaluation/assessments as recommended by the audiologist and optometrist. Findings include: A review of client #1's record was conducted on 6/10/15 at 12:30 P.M.. Client #1's record indicated a most current vision assessment/evaluation dated 4/8/13 which indicated "Return 2 years." Further review of the record did not indicate client #1 returned in 2 years for an eye exam as recommended by the optometrist. A review of client #2's record was conducted on 6/10/15 at 2:00 P.M.. Client #2's record indicated an admission date of 3/20/15. Client #2's record failed to indicate a hearing assessment/evaluation had been completed. A review of client #3's record was conducted on 6/10/15 at 1:10 P.M.. Client #3's record indicated a most	W 0323	The facility has ensured that no other clients were affected by this deficient practice. The QDDP will ensure that all clients obtain an annual physical examination, which includes a hearing and vison examination. A hearing and vison examination, for client #1, #2, and #3 has been scheduled. To ensure future compliance, the group home director will conduct monthly record reviews to ensure an annual physical is completed for each client.	07/15/2015

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	current hearing assessment/evaluation dated 7/22/08 with the recommendation to return in 2 years. Further review of the record failed to indicate client #3 had a current hearing assessment/evaluation completed. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated she would look for documentation to indicate the clients followed up as recommended. No documentation was submitted for review to indicate clients #1, #2 and #3 had their vision and hearing evaluated/assessed as recommended. 9-3-6(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for	W 0331	During the facilitation of a meeting on 3/19/15, it	07/15/2015

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	3 of 3 sampled clients and 1 additional client (clients #1, #2, #3 and #5), the facility's nursing services failed to ensure client #1's prescribed medication was available at the group home. The facility's nursing staff failed to reconcile medication labels with the Medication Administration Record (MAR). The facility's nursing staff failed to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT). The facility's nursing services failed to assess and seek medical attention after being notified of client #1's injury of unknown origin, in a timely manner. The facility's nursing services failed to ensure clients were provided proper nursing services in regard to medical assessments/evaluations. Findings include: 1. A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated: -GER dated 1/1/15 involving client #1 indicated: "Errors:		was discussed that nursing will ensure all client's medications are available for administration. As medications are ordered/delivered from the pharmacy,member(s) of nursing will conduct a check-in of the medication to ensure properdelivery as well as the accuracy of the medications. They will then ensure the medication gets tothe home for ongoing administration. All staff were retrained on medication administration, according to company policy, to ensure they are competent in the administration of medications for all clients(including the 6 rites of medication administration). Staff will continue to receive annualretraining in medication administration (Med Review) at minimum or morefrequently as needed. To ensure furthercompliance in this area, the QDDP will conduct random monthly home visits andwill observe staff during med administration, nursing will monitor whencompleting random home visits, and the manager will monitor med passes by thecertified med passer while on shift. Documentation will maintained of these observations and competency willneed to be demonstrated by certified med passers. If it is determined at any time, that stafffail to follow the policy for med administration, they will be required to retakeMed	

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	15G640		06/15/2015

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	Medications...Vimpat 200 mg (milligram) (seizure) oral twice daily at 7:00 A.M.. Medication was not delivered by pharmacy so it was not available to be given. Nursing was contacted and the problem was resolved. The script was not filled until afternoon on 1/1/15." Further review of the report indicated client #1 did not receive his 7:00 A.M. prescribed dosage of Vimpat because it was not available at the group home for administration. -GER dated 1/1/15 involving client #5 indicated: "Errors: Medications: Clonazepam 5 mg (seizures) oral twice daily 7:00 A.M. and 8:00 P.M.. Medications not received on 1/1/15 in the A.M. or P.M. and on 1/2/15 in the A.M.. Pharmacy error. Medication is not in the house. Nursing is aware." Further review of the report indicated client #5 did not receive her prescribed dosages of Clonazepam on 1/1/15 or 1/2/15. -BDDS report dated 4/13/15 involving client #3 indicated: "The client did not receive his evening dosage of Antacid Maximum Strength Sus 30 ml (milliliter) (gas relief) on 4/10/15, morning, afternoon and evening dosages on 4/11/15 , and morning, afternoon and evening dosages on 4/12/15, due to the medication not being in the group		Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passesduring this time. The certified Nursetrainer will ensure the appropriate measures have occurred. Nursing willcontinue to send the quarterly pharmacy reviews to the physician's for followup. All recommendations will be sent tothe appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacyrecommendations on her monthly summaries so the recommendations can bediscussed by the interdisciplinary team. The QA coordinator will conduct random checks with the nursing office toensure these pharmacy checks are being sent to the physicians. On April 2,2015, Policy number #5080 (Nurses Monthly Report/Nursing Notes) and #5075(Health Care Documentation) were revised to reflect the procedure fordocumentation of medical information. Toensure ongoing compliance, the following steps will be taken: TheDirector of Nursing, or designee, will conduct a check, once per month, of theTherap system, to ensure nursing is completing thorough and accuratedocumentation on each individual's health status, along with any conversationwith physicians/families regarding the	

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	home...." An interview with the nurse was conducted on 6/12/15 at 1:10 P.M.. The group home nurse indicated clients #1, #3 and #5 did not receive their prescribed medications as ordered. The nurse further indicated the facility should have ensured clients #1, #3 and #5's prescribed medications were available as ordered for administration. 2. A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:30 A.M.. At 5:45 A.M., client #6 was observed eating his breakfast. At 6:55 A.M., Direct Support Professional (DSP) #3 crushed each of client #6's medications and administered them to him. Review of the Medication Administration Record (MAR) dated 6/1/15 to 6/30/15 on 6/9/15 at 7:00 A.M. indicated: "Oyster shell Calcium 500/D200 tablet (supplement)...1 tablet by mouth twice daily with meals...Simethicone 80 mg (milligram) (gas) chew tablet...Chew and swallow 1 tablet twice daily after meals." Review of the medication labels did not indicate take by mouth with meals, did not indicate to crush medications and did not indicate chew and swallow. Client #6 did not take his Oyster shell Calcium with his meal and was not prompted to		clients' medical condition	

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	chew and swallow his Simethicone medication. An interview with the group home nurse was conducted on 6/12/15 at 1:10 P.M.. The nurse indicated staff are trained prior to working at the group home on medication administration and annually. The nurse indicated staff are trained to check the medication labels 3 times, before administering, during administration and after administration, with the MAR to ensure proper medication administration. The nurse indicated staff check to ensure the correct medication, dosage, client, route and directions are reflective on the medication label and MAR to prevent medication errors. The nurse further indicated the information on the label and the MAR should be the same information. 3. A review of the facility's pharmacy reviews was conducted on 6/10/15 at 1:30 P.M.. The consulting pharmacist indicated: Consultation Report for Recommendation Created 7/30/14: "Please clarify the directives for [client #5]'s Pulmomate nebulizer to prevent any confusion/mistakes for staff and			

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	caregivers." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT (Interdisciplinary Team) and physician. Consultation Report for Recommendation Created 11/12/14: "This patient (client #5) is prescribed both oxcarbazepine and carbazepine. Recommendation: Re-evaluate the need/necessity of these medications and adjust if appropriate." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician. "[Client #5] has been taking clonazepam for the past 6 months without a dosage reduction. Please evaluate and consider reducing dose if applicable." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician. An interview with the group home nurse was conducted on 6/12/15 at 1:40 P.M.. The nurse indicated the facility assigned a person who was responsible for reviewing the pharmacist's recommendations and reporting the			

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	recommendations to the IDT. The nurse indicated she did not know if the pharmacist's recommendations were reported to the prescribing physician or the IDT by the assigned person. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated the pharmacist's recommendations were not reported to the IDT. 4. A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:30 A.M.. At 6:00 A.M., client #1's left arm had a bandage. When asked what happened to client #1's arm, DSP #2 indicated client #1 was injured. When asked how he was injured, DSP #2 indicated she was not sure but the facility believed he got burned from his warming packs used to bring his temperature up when his temperature drops. A review of the facility's records was conducted at the facility's administrative office on 6/9/15 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GER), Internal Reports (IR) and investigation records indicated:			

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	-GER dated 5/21/15 involving client #1 indicated: "While changing [client #1] I saw what appeared to be to (sic) red abrasion, on his left inside bicep. They appear to look pinched and skin was scraped back away from the red area. 1st aid was applied and report written. Manager was called and message left." -GER dated 5/24/15 involving client #1 indicated: "[Client #1] was laying in bed this morning sleeping when I came in for my shift and [DSP #1] went to show me the mark she found on [client #1]'s upper left arm that she found during the night. The mark is about 3 x (by) 3 cm (centimeter) of small scattered marks that are black/white. Staff (DSP #1) called nurse and she directed us to apply Bacitracin and apply a gauze over the skin breakdown. Spoke with nurse later this evening and she said that he will have to go to the emergency room tomorrow to get it checked out....QDDP (Qualified Developmental Disabilities Professional) notified of the injury 12 hours after Nurse was notified. Q asked staff to send a picture of the injury. Q forwarded the picture to nurse and asked if she thought it would be okay to wait to have the injury seen. Nurse stated that the client would need to be taken to Urgent Care the next morning and that staff who contacted her this morning			

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	regarding this injury stated it was some sort of bite and did not relay the extensive redness and discoloration of this infection. Once nurse was notified of the actual extent of this infection immediate action was taken. An Urgent Care visit was completed on 5/25/15." -GER dated 5/29/15 involving client #1 indicated: "As staff was changing [client #1]'s bandage on the sore on his left arm, staff noticed a bruise on the front of his arm. It measured to be 1 3/4 inch by 2 inches. Staff contacted nurse, [QDDP] and attempted to contact group home manager....Staff instructed not to apply any tape directly to his skin. The bandage needs to go around his arm and the ends taped together." -Investigation record dated 5/28/15 involving client #1 indicated: "[DSP #4] 1st noticed the 'pinch' on arm, GER submitted. T-Log (electronic documentation), health note not completed. No infection noted just redness....Nursing comment on GER that she would examine the area on Friday the next day (5/22/15). There is no documentation from nursing regarding this exam of the injury....5/26/15 [Nurse name] looked at the wound, looked the same as the picture showed....5/27/15 [Nurse name] looked at it and the			

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	bandage was dried on, stuck to the wound. [Nurse name] changed bandage....5/28/15 [Nurse name] met [DSP #3] at [Physician name]'s for f/u (follow up). [Physician name] determined 2nd degree burns, ordered silvadene (antibiotic) daily, no need for wound care finish clindamycin (bacterial cream) for Urgent Care, f/u 2 weeks." -GER dated 2/2/15 involving client #1 indicated: "[Staff #14] and I was (sic) getting [client #1] out of his wheel chair to position him on the toilet. We started to take his shirt of (sic) and notice (sic) a 1 1/2 by 1 inch skin abrasion underneath his left shoulder blade. It is bright red and have (sic) skin hanging. Contacted nurse and was told to apply antibiotic ointment as well as a bandage on it. I spoke with [QDDP] and she wants me to do a GER." Further review of the report failed to indicate the nurse assessed this injury of unknown origin. -GER dated 2/19/15 involving client #1 indicated: "While giving [client #1] a bath, after his foot was accidentally wheeled over by another client's wheelchair. Staff noticed a 2 inch by 1 3/4 inch bruise forming on the top of [client #1]'s left foot by his toes. It is red in color and beginning to turn purple. Staff notified group home manager and			

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	she notified [QDDP]. Staff was advised to complete a GER." Further review of the report failed to indicate the nurse assessed client #1's foot after the incident. A review of client #1's record was conducted on 6/10/15 at 12:30 P.M.. Review of client #1's record failed to indicate the facility's nursing services assessed client #1's documented injury of unknown origin on 5/21/15, 5/22/15, 5/23/15 and 5/24/15. The record failed to indicate the facility's nursing services sought medical attention for client #1's injury of unknown origin in a timely manner. Review of the record failed to indicate the nurse assessed client #1's 2/2/15 injury of unknown origin. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated there was no documentation to indicate the facility's nursing services assessed client #1's documented injury of unknown origin until 5/26/15. The QIDP indicated the nurse gave directives to staff to take client #1 to the Urgent Care on 5/25/15. There was no documentation available for review to indicate the group home nurse assessed client #1's injury of unknown origin on 5/21/15. There was			

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	no documentation available for review to indicate client #1 was assessed by the facility's nursing services and given medical attention in a timely manner in regard to his documented injury of unknown origin. Please refer to W322: The facility nursing services failed for 2 of 3 sampled clients (clients #1 and #3) to provide an annual physical. Please refer to W323: The facility nursing services failed for 3 of 3 sampled clients (clients #1, #2 and #3), to have hearing and vision evaluation/assessments as recommended by the audiologist and optometrist. Please refer to W352: The facility nursing services failed to assure 3 of 3 sampled clients (clients #1, #2 and #3) had an annual dental evaluation. 9-3-6(a)			

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W 0352 Bldg. 00	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed to assure 3 of 3 sampled clients (clients #1, #2 and #3) had an annual dental evaluation. Findings include: A review of client #1's record was conducted on 6/10/15 at 12:30 P.M.. Client #1's record indicated a most current dental assessment/evaluation dated 5/20/14 which indicated "Return 6 months." There was no indication when client #1 had a dental evaluation in his file. A review of client #2's record was conducted on 6/10/15 at 2:00 P.M.. Review of client #2's record indicated an admission date of 3/20/15. Review of the record failed to indicate client #2 had a dental evaluation/assessment. There was no indication when client #2 had a dental evaluation in her file.	W 0352	The facility has ensured that no other clients were affected by this deficient practice. The QDDP will ensure that all clients obtain a comprehensive dental examination. A dental examination, for client #1, #2, and#3 has been scheduled. To ensure future compliance, the group home director will conduct monthly record reviews to ensure an annual dental examination is completed for each client.	07/15/2015

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	A review of client #3's record was conducted on 6/10/15 at 1:10 P.M.. Client #3's record indicated a most current dental assessment/evaluation dated 12/11/14 with the recommendation to return in 6 months. There was no documentation available for review to indicate client #3 returned to the dentist in 6 months as recommended by the dentist. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 6/12/15 at 1:40 P.M.. The QIDP indicated there was no documentation to indicate clients #1, #2 and #3 had dental exams completed. 9-3-6(a)			
W 0362 Bldg. 00	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. Based on record review and interview, the facility failed for 5 of 6 clients living	W 0362	Nursing will continue to send the quarterly pharmacy reviews to the physician's for followup. All	07/12/2015

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	at the group home, (clients #1, #3, #4, #5 and #6) to ensure the pharmacist reviewed clients' medications on a quarterly basis. Findings include: The pharmacist's medication review record was reviewed on 6/10/15 at 1:30 P.M.. Review of the pharmacist's medication review record indicated no medication reviews for the second quarter of 2014 for clients #1, #3, #4, #5 and #6. A review of client #1's record was conducted on 6/10/15 at 12:30 P.M.. The record indicated client #1 was prescribed medications which consisted of: Bisacodyl (bowels), Calcium with Vitamin D (supplement), Divalproex (Seizures), Vimpat (Seizures), Docusate (constipation), Folic Acid (supplement), Lactulose (constipation), Levothyroxin (thyroid), Topiramate (seizures) and Biotene (dry mouth). A review of client #3's record was conducted on 6/10/15 at 1:10 P.M.. The record indicated client #3 was prescribed medications which consisted of: Thera Tab (supplement), Triamcinolone (asthma), Crestor (cholesterol), Lamotrigine (mood stabilizer),		recommendations will be sent to the appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacy recommendations on her monthly summary so the recommendations can be discussed by the interdisciplinary team. The QA coordinator will conduct random checks with the nursing office to ensure these pharmacy checks are being sent to the physicians.	

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	Loratadine (allergies), Olanzapine (mood stabilizer), Omeprazole (acid reflux) and Risperidone (mood disorder). A review of client #4's record was conducted on 6/10/15 at 1:40 P.M.. The record indicated client #4 was prescribed medications which consisted of: Docusate (stool softener), Loratadine (allergies), Oxcarbazepine (aggression) and Venlafaxine (depression). A review of client #5's record was conducted on 6/10/15 at 2:10 P.M.. The record indicated client #5 was prescribed medications which consisted of: Gabapentin (seizures) Haloperidol (seizures), Loratadine (allergies) Oxcarbazepin (seizures), Oxybutynin (urinary incontinence), Pantoprazole (acid reflux), Synthroid (thyroid) and Triamt (hypertension). A review of client #6's record was conducted on 6/10/15 at 2:30 P.M.. The record indicated client #6 was prescribed medications which consisted of: Divalproex (seizures), Docusate (constipation), Oyster Shell Calcium (osteoporosis), Reguloid (constipation) and Thera tab (supplement). An interview with the Qualified Intellectual Disabilities Professional			

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	(QIDP) was conducted on 6/12/15 at 1:40 P.M.. When asked how often medications are to be reviewed by the pharmacist, the QIDP indicated they should be reviewed quarterly. The QIDP further indicated there was no written documentation available for review to indicate medications were reviewed by the pharmacist on a quarterly basis. 9-3-6(a)			
W 0369 Bldg. 00	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. Based on observation, record review and interview, the facility failed for 1 of 2 clients observed during the morning medication administration (client #6) to ensure staff administered 2 of 7 of the client's medications, as ordered without error.	W 0369	All staff, that commit an error during medication administration, will be retrained on medication administration, according to agency policy (See Attached). To ensure aptitude, and before a staff is re-certified, the staff must demonstrate competency, during a mock pass, before a nurse, according to company policy. Further compliance in this area	07/15/2015

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	Findings include: A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:30 A.M.. At 5:45 A.M., client #6 was observed eating his breakfast. At 6:55 A.M., Direct Support Professional (DSP) #3 crushed each of client #6's medications and administered them to him. Review of the Medication Administration Record (MAR) dated 6/1/15 to 6/30/15 conducted on 6/9/15 at 7:00 A.M. indicated: "Oyster shell Calcium 500/D200 tablet (supplement)...1 tablet by mouth twice daily with meals...Simethicone 80 mg (milligram) (gas) chew tablet...Chew and swallow 1 tablet twice daily after meals." Client #6 did not take his Oyster shell Calcium with his meal and was not prompted to chew and swallow his Simethicone medication. An interview with the facility's Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated DSP #3 should have administered client #6's medications as ordered. 9-3-6(a)		will be monitored through the Nurse conducted random monthly home visits and observing staff during med administration. The manager will also monitor med passes by the certified med passer while on shift. Documentation will maintained of these observations and competency will need to be demonstrated by certified med passers. If it is determined at any time, that staff fail to follow the policy for med administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred. Regarding this specific incident cited in the survey, under W369: Staff #3 was retrained, by the group home nurse, to pass the medication, “Oyster Shell Calcium” during a meal. This training was consistent with company policy, which states that this retraining does not need to include supervised medication passes, at this point. If further errors were to be committed, by Staff #3, in accordance with policy, Staff #3 would be suspended from medication passing, required to retake a medication administration review class, and undergo 6 supervised medication passes. Client #6 has no teeth and therefore	

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			requires all his medications to be crushed and administered. Staff were trained to crush and administer client #6's medications; however, at the time of the survey, the medication label did not correlate with these instructions. The Medication Administration Record has been amended, by the Nurse, with approval from the client's primary care physician, to state that all of Client 6's medications are to be crushed and administered. To ensure this deficient practice does not reoccur, the Medication Administration Records will now only contain two weeks of administration records, instead of a month, as this will ensure that medication administration records are constantly updated on a bi-weekly basis.	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview, for 2 of 2 clients who used a wheelchair for all mobility needs, (clients #1 and #4), the facility failed to teach and encourage the use of their foot rests.	W 0436	Client #1 was evaluated for a new wheelchair, including footrests, on 6.26.15 and will have a custom seat molding on 7.30.15. During this timeframe, before client #1 receives the new wheelchair, a formal goal has been implemented to teach Client#1 the importance of utilizing his	07/15/2015

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	Findings include: An evening observation was conducted at the group on 6/9/15 from 5:30 P.M. until 6:45 P.M.. During the entire observation period client #4's feet dangled a foot from the floor. Client #4's wheel chair did not have foot rests attached. Client #4's feet looked dark in color. During the entire observation period Direct Support Professional #6 pushed client #1 around in his wheelchair as his feet were dragging on the floor. Client #1's wheel chair did not have foot rests attached. A review of client #1's record was conducted on 6/10/15 at 12:30 P.M.. The record indicated client #1 used a wheelchair for his mobility needs. A review of client #4's record was conducted on 6/10/15 at 1:40 P.M.. The record indicated client #4 used a wheelchair for his mobility needs. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated staff should have put client #1 and #4's foot rests on their wheelchairs to support their feet. 9-3-7(a)		footrests. This formal goal will teach and encourage the use of footrests, as well as respect the independent choice of client #1. No other clients were affected by the same deficient practice. To ensure further compliance, the QDDP will train all staff on this formal goal, as well as conduct monthly quality assurance visits, to ensure the formal goal is being implemented.	

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W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the day shift (7:00 A.M. to 3:00 P.M.), the evening shift (3:00 P.M. to 11:00 P.M.) and the overnight/asleep shift (11:00 P.M. to 7:00 A.M.) during the second quarter (April 1st through June 30th) of 2014, the third quarter (July 1st through September 30th) of 2014, the last quarter (October 1st through December 31st) of 2014 and for the overnight/asleep shift for the first quarter (January 1st through March 31st) 2015 which affected 6 of 6 clients living in the facility (clients #1, #2, #3, #4, #5 and #6.) Findings include: A review of the facility's evacuation drills was conducted on 6/10/15 at 12:15 P.M.. The review failed to indicate the facility held any evacuation drills for clients #1, #2, #3, #4, #5 and #6 for the second, third and fourth quarters of 2014 and no evacuation drill for the overnight/asleep	W 0440	Evacuation drills will be conducted a minimum of once per quarter for each shift. The GHM will schedule these drills and see that they are completed. Once a drill is conducted, the drill form will be signed by the staff on shift and will include information on the client's in the home as far as their level of participation in the survey. Once these forms are completed, they will be turned into the Executive Assistant to Programs. She/he will add this drill tracking to a checklist of monthly action items and will assure that all drills are conducted within the regulatory timeframes.	07/15/2015

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	shift for the first quarter of 2015. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 6/12/15 at 1:45 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift. 9-3-7(a)			
W 0460 Bldg. 00	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 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the facility failed to ensure the staff provided food in accordance with the menu. Findings include: A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:30 A.M.. Beginning at 5:45 A.M., clients #1, #2, #3, #4, #5 and #6 began eating their breakfast which consisted of oatmeal and orange juice. Direct Support Professionals #1 and #2 did not provide whole wheat toast or milk with the clients' meal.	W 0460	To ensure staff will provide food, in accordance with the posted menu, the agency dietician conducted a training, wherein the menus for the home were revised to better suit the needs of the clients. To ensure the menus are implemented and followed, quality assurance checks will be conducted once a day, by the Group Home Manager and/or QDDP and/or Group Home Director and/or dietician . After seven quality checks, the QDDP and/or dietician will assess and determine if further quality checks are needed. If it is determined that daily checks are no longer needed; the QDDP will ensure menus are being followed during monthly quality assurance checks. The dietician will also	07/15/2015

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	A evening observation was conducted at the group home on 6/9/15 from 5:30 P.M. until 6:45 P.M.. At 5:30 P.M., clients #1, #2, #3, #4, #5 and #6 were observed eating their dinner which consisted of macaroni and beef, broccoli, peas and carrots, milk and water. DSPs #4, #5 and #6 did not provide strawberries or fruit or salad with the clients' meal. A review of the group home menu dated "Week 2 1600-2200 calorie diet" was conducted on 6/9/15 at 6:00 P.M. and indicated: "Tuesday...Breakfast: Apple/Orange, 1 1/2 cup oatmeal, 1 slice whole wheat toast, 1 cup 2% milk....Dinner: Lasagna, broccoli, squash, strawberries, 1 cup 2% milk and salad." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated staff should follow the menus at all times. 9-3-8(a)		monitor menu implementation, during quarterly visits.	
W 0484 Bldg. 00	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables,			

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	chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 6 of 6 (clients #1, #2, #3, #4, #5 and #6), to provide condiments at the dining table. Findings include: A morning observation was conducted at the group home on 6/9/15 from 5:40 A.M. until 7:30 A.M.. Beginning at 5:45 A.M., clients #1, #2, #3, #4, #5 and #6 began eating their breakfast which consisted of oatmeal and orange juice. There were no milk, sugar/sugar substitute, cinnamon, and butter/margarine available for the clients' use. Direct Support Professionals (DSPs) #1 and #2 failed to provide condiments for clients #1, #2, #3, #4, #5 and #6 to use with their meal. An evening observation was conducted at the group home on 6/9/15 from 5:30 P.M. until 6:45 P.M.. At 5:30 P.M., clients #1, #2, #3, #4, #5 and #6 were observed eating their dinner which consisted of macaroni and beef, broccoli, peas and carrots, milk and water. The table did not have salt, pepper, butter or margarine for the clients use. DSPs #4, #5 and #6 did not provide condiments on the table for	W 0484	The QDDP will retrain staff on active treatment which includes involving the clients in meal prep and serving themselves, according to their abilities. Staff will ensure that clients have access to condiments, according to the meal at hand. To ensure further compliance, quality assurance checks will be conducted once a day, by the Group Home Manager and/or QDDP and/or Group Home Director and/or Dietician. After seven quality checks, the QDDP and/or Dietician will assess and determine if further quality checks are needed. If it is determined that daily checks are no longer needed; the QDDP will monitor active treatment,specifically meal preparation, through monthly quality assurance checks.	07/15/2015

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	the clients to use. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated condiments should be placed on the table at all meal times for clients to use with their meals. 9-3-8(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), were involved in meal preparation. Findings include: An observation was conducted at the group home on 6/9/15 from 5:30 P.M. until 6:45 P.M.. At 6:30 P.M., Direct Support Professional (DSP) #4 prepared and packed clients #1, #2, #3, #4, #5 and #6's lunches while they sat in the living room and were available to assist staff. Clients #1, #2, #3, #4, #5 and #6 were not	W 0488	The QDDP will retrain staff on active treatment which includes involving the clients in meal prep and serving themselves, according to their abilities, which includes packing and or help in packing their lunches. To ensure further compliance, quality assurance checks will be conducted once a day, by the Group Home Manager and/or Assistant Manager and/or QDDP and/or Group Home Director and/or Dietitian. After seven quality checks, the QDDP will assess and determine if further quality checks are needed.	07/15/2015

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	prompted to participate in preparing and packing their lunches. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/12/15 at 1:40 P.M.. The QIDP indicated clients #1, #2, #3, #4, #5 and #6 were capable of assisting in preparing and packing their lunches and further indicated they should be assisting in preparing and packing their lunches at all times. 9-3-8(a)			