

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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W000000	<p>This visit was for a post certification revisit (PCR) to the annual recertification and state licensure survey and to the investigation of complaint #IN00120779 completed on 10/11/13.</p> <p>Complaint #IN00120779 - Not Corrected.</p> <p>Dates of Survey: December 2, 3 and 5, 2013</p> <p>Provider number: 15G458 Facility number: 000972 AIM number: 100244840</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/11/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility's</p>	W000104	A staff meeting was held on 12/12/13 at which time all staff were retrained on all dining plans, dietary recommendations, thickening liquids, fall risk plans	12/20/2013

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>governing body failed to exercise general policy and operating direction over the facility to ensure the staff were trained to provide the recommended thickened liquids for clients #3 and #4 who were at risk of choking and to ensure the flooring in the group home was maintained.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the staff provided clients #3 and #4 nectar thickened liquids as ordered by the physician and recommended by the speech therapist and the dietician. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services trained the staff to use the "Simply Thick" gel to modify client #3's and #4's liquids to a nectar thickness. Please see W331. 3. Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6 and #7 on 12/2/13 between 4 PM and 6:30 PM. ___The carpet in the hallway outside of client #3's and #5's bedrooms was a tight 		<p>and ambulation supports. Dietician observed each staff person demonstrate competence in accurate measuring of liquids and mixing of thickening product. Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will have thickener training and direct nursing observations in the next 60 days or sooner. Observation of appropriate liquid thickening and ambulation supports were completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily meal observations for an additional time period of 1/11/14 - 1/31/14. During those observations, Team Leader will observe that the thickener continues to be done correctly, that the goals are offered appropriately and that the meal is otherwise correct. Team Leader will also request random demonstrations of liquid consistency from staff. Upon completion of this increased monitoring time period, QIDP and Team Leader will review staff competency and return to weekly meal supervision. Group Home Director continues monthly home visits. Registered dietician will also continue quarterly home observations to ensure meal and liquid preparation remains adequate. Annual retraining will occur at staff training meetings.</p>	

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	<p>weave brown carpet with small unidentifiable particles on it and a large dark brownish/black circular stained area that extended the width of the hallway and approximately 3 to 4 feet long. At the far end of the hallway carpet and across from the exit door were several circular black charred areas.</p> <p>__The carpet in the living room near the kitchen had a metal strip to secure the edge of the carpet to the floor. Strands of the carpet had frayed and were unraveled.</p> <p>During interview with staff #1 and staff #2 on 12/2/13 at 5 PM, staff #1 stated client #2 likes to "play in the hallway on the floor with her baby dolls. She [client #2] gets down on the floor and spreads them all out." Staff #1 indicated the carpets in the home were to be vacuumed daily and as needed. Staff #1 stated "It doesn't look like it's been vacuumed for awhile." When asked had the carpets been cleaned professionally since 10/11/13, staff #1 stated, "I don't think so, but I could be wrong. I know they fixed the walls in the living room and I think they cleaned the living room carpet." Staff #2 stated, "I'm not sure. It doesn't look like it's been cleaned." Staff #1 stated "It would be nice if they just replaced it." When asked to describe the</p>		<p>The carpeting was trimmed and reglued to prevent further fraying or falls until carpeting could be replaced. Carpeting was also cleaned during the week of 10/11/13. Flooring company is expected to be at the home 12/17/13 to make an estimate for new carpet replacement. Carpet will be replaced as soon as possible with installation availability. All other flooring areas were observed. No other carpeting or flooring needs were noted. Staff will continue to complete daily house hold cleaning.</p>		

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	<p>carpet, staff #1 stated, "Like I said before, it's dirty and I wouldn't sit on it." Staff #1 indicated the living room carpet was frayed and unraveling from clients #1, #3, #7 and #8 running their walkers over the carpet. When asked if anything had been done to fix the frayed carpeting in the living room since 10/11/13, staff #1 stated, "I think all they did was cut the loose ends off."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 2 PM, the QIDP indicated the hallway carpet in front of client #3's and #5's bedrooms had been cleaned. The QIDP stated the staff "should vacuum every day or as needed." The QIDP indicated the home was to be maintained in good condition and repairs and improvements made as needed. The QIDP indicated the frayed carpet had been clipped but nothing had been done to stop the carpet from fraying again. The QIDP stated the frayed carpet "most definitely" could be a falls risk for the clients and "should be repaired."</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>This deficiency was cited on 10/11/13. The facility failed to implement a</p>				

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W000149	<p>systemic plan of correction to prevent recurrence.</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 observation, record review and interview for 2 of 3 sampled clients at risk for choking (#3 and #4), the facility failed to implement its policy and procedures to ensure the staff were trained to modify the clients' liquids as prescribed by the physician.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. At 5:40 PM clients #3 and #4 were prompted to go to the dining room table for their evening meal. __ Client #3 sat down at the table and poured water into a red plastic glass. Client #3 then added two partial pumps of "Simply Thick" (a liquid thickener) gel into the water and placed his toddler spoon into the glass, moved the spoon side to side once and removed the spoon. Client #3 drank all of the water</p>	W000149	<p>A staff meeting was held on 12/12/13 at which time all staff were retrained on all dining plans, dietary recommendations, thickening liquids, fall risk plans and ambulation supports. Dietician observed each staff person demonstrate competence in accurate measuring of liquids and mixing of thickening product. Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will have thickener training and direct nursing observations in the next 60 days or sooner. Observation of appropriate liquid thickening and ambulation supports were completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily meal observations for an additional time period of 1/11/14 - 1/31/14. During those observations, Team Leader will observe that the thickener continues to be done correctly,</p>	12/20/2013

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	<p>and asked for milk. Client #3 then filled his glass with milk and repeated the process of placing two partial pumps of "Simply Thick" gel into the glass, putting his spoon in the glass and moving the spoon side to side. The staff did not assist client #3 with putting the thickener into his glass to ensure the proper thickness or to ensure client #3 stirred the thickener properly. At 6 PM staff #2 was asked how many ounces client #3's cup held. Staff #2 stated, "I think it's four ounces." After client #3 had finished his meal, staff #2 was asked to measure the amount of liquid the red glass would hold. Staff #2 stated the red glass held "12 ounces."</p> <p>__ Client #4 sat down at the table and was provided an 18 ounce plastic bottle of water with a pull top spout to drink from during her evening meal. Before client #4 began her meal, staff #1 removed the pull top lid and added one pump of "Simply Thick" gel, replaced the cap and shook the bottle back and forth twice and placed it back on the table in front of client #4. Client #4 drank all of her water. Her plastic bottle was then filled with Soy milk and staff #1 placed one pump of "Simply Thick" gel into client #4's plastic bottle, shook it once and put it back on the table in front of client #4. At 6 PM staff #1 stated, "Her bottle holds 18 ounces, I</p>		<p>that the goals are offered appropriately and that the meal is otherwise correct. Team Leader will also request random demonstrations of liquid consistency from staff. Upon completion of this increased monitoring time period, QIDP and Team Leader will review staff competency and return to weekly meal supervision. Group Home Director continues monthly home visits. Registered dietician will also continue quarterly home observations to ensure meal and liquid preparation remains adequate. Annual retraining will occur at staff training meetings.</p>		

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	<p>thought it was only 8 ounces." Staff #1 read the back of the "Simply Thick" container and stated, "This says we're supposed to use one pump per four ounces of liquid for nectar thick liquids. We haven't been doing that."</p> <p>During interview with staff #1 and staff #2 on 12/2/13 at 5:50 PM, staff #2 stated client #3 "usually gets 2 pumps in his cup." When asked how much thickener client #4 was given for her 18 ounce drinking bottle with the pull top lid, staff #1 stated, "I only put in one pump."</p> <p>Review of the back of the "Simply Thick" pump bottle on 12/2/13 at 5:55 PM indicated to use one pump of gel per 4 fluid ounces of liquid to get a nectar thick consistency.</p> <p>Review of the "Simply Thick" Internet web site of "http://www.simplythick.com" on 12/3/13 at 8:30 AM indicated an instructional video of how to use the product. The video on the web site indicated a spoon was not to be used to stir the product in liquids but instead a fork or a whisk was to be used with a brisk whisking action, "like that of beating an egg." The video indicated a "15 to 20 second brisk shaking action" could also be used in mixing the</p>			

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	<p>product.</p> <p>Client #3's record was reviewed on 12/3/13 at 12 PM. Client #3's 12/1/13 physician's orders indicated client #3 had a diagnosis of, but not limited to, Dysphasia (difficulty swallowing) and was on a mechanical soft diet with nectar thick liquids. Client #3's ISP (Individualized Support Plan) of 8/30/13 indicated the staff were to assist client #3 with putting the thickener into his cup and then to prompt the client to stir his drink. The ISP did not specify how the thickener was to be stirred. Client #3's dining plan of 7/11/13 indicated client #3 was to take single sips of nectar thick liquids and to alternate between sips of liquids and bites of food while eating.</p> <p>Client #4's record was reviewed on 12/3/13 at 12:30 PM. Client #4's record indicated client #4 was at risk for aspiration. Client #4's 11/1/13 physician's orders indicated client #4 was to have a mechanical soft diet with thin liquids. Client #4's swallow study of 11/21/13 indicated a recommendation for client #4 to have a mechanical soft diet with nectar thick liquids.</p> <p>During interview with the facility LPN (Licensed Practical Nurse) and the QIDP</p>				

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	<p>(Qualified Intellectual Disabilities Professional) on 12/3/13 at 10:45 AM, the LPN indicated the staff were to use "Simply Thick" to thicken client #3's and #4's liquids. The LPN stated client #4 had "just recently been switched to nectar thick liquids" due to frequent coughing throughout meals. When asked if the staff had been trained on the use of the "Simply Thick" gel to thicken liquids, the LPN indicated she had not conducted a formal training in regard to how the staff were to use the "Simply Thick" gel. The QIDP stated the house manager had conducted "some informal training" in regard to the use of the thickening gel, but did not have documentation of the training. When asked if the staff were to follow the instructions of the product in regard to use, the LPN stated, "Yes." The QIDP indicated a formal training would be arranged for the dietician to instruct the facility staff on the use of "Simply Thick" to alter the consistency of the clients' liquids.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>This deficiency was cited on 10/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

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W000240	<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 for 2 of 4 sampled clients (#1 and #3), the clients' ISPs (Individualized Support Plans) failed to address how the staff were to supervise, assist and monitor the clients while ambulating.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. __ Client #1 ambulated with a slow shuffle while using a walker and wearing a gait belt. During this observation the staff were observed to walk with client #1 with hands on assistance using the gait belt and to walk with client #1 with stand by assistance not using the gait belt. Client #1 was also observed walking a short distance without staff assistance or supervision. __ From 4 PM until 5 PM, client #3 wore a helmet and a gait belt and ambulated with the assistance of a walker with</p>	W000240	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. A staff meeting was held on 12/12/13 at which time all staff were retrained on fall risk plans and ambulation supports. Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will review Fall Risk Plans to include ambulation support needs. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All fall risk plans were reviewed for all individuals in the home. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Observation of appropriate liquid thickening and ambulation supports were</p>	12/20/2013	

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	<p>hands on assistance from the staff. After client #3 took his bath at 5 PM, client #3 did not wear the gait belt and ambulated independently without staff assistance. At 6 PM after eating his meal, client #3 got up from the table and was walking through the music room when staff #2 stated, "Sit down in this chair and I'll go get your gait belt."</p> <p>Client #1's record was reviewed on 12/3/13 at 11 AM. __ Client #1's ISP of 7/29/13 indicated client #1 used a rolling walker and a gait belt while ambulating. The ISP indicated "Staff will have [client #1] use gait belt/walker. Staff to do 15 minute checks when in bed." __ Client #1's Fall Prevention Plan of 11/11/13 indicated client #1 was to use the walker at all times with gait belt during all ambulation. __ Client #1's record did not indicate how the staff were to supervise, assist and monitor client #1 while the client was ambulating.</p> <p>Client #3's record was reviewed on 12/3/13 at 12 PM. __ Client #3's ISP of 8/30/13 indicated client #3 was to use a walker and wear a hard shell helmet and specialty shoes whenever ambulating. The ISP indicated client #3 used a gait belt whenever he</p>		<p>completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily observations for an additional time period of 1/11/14 - 1/31/14. Upon completion of this increased monitoring time period, QIDP and Team Leader will review staff competency and resume weekly observations. Group Home Director continues monthly home visits.</p>				

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	<p>was in the community.</p> <p>__ Client #3's Fall Prevention Plan of 10/31/13 indicated client #3 was to use a walker and wear his helmet wherever ambulating. The plan indicated client #3 wore the gait belt when out in the community. The plan indicated the staff were to prompt client #3 to use his walker correctly.</p> <p>__ Client #3's record did not specify how the staff were to supervise, assist and monitor client #3 while the client was ambulating.</p> <p>Interview with staff #2 on 12/2/13 at 4:45 PM indicated clients #1 and #3 were to wear a gait belt and use a walker whenever ambulating. Staff #2 indicated the staff were to assist clients #1 and #3 by holding on to the back of their gait belts while they were walking.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 2 PM, the QIDP stated, "I understand what you're saying, and no, it (the ISP) doesn't specify how" the staff were to supervise, assist and monitor clients #1 and #3 while the clients were ambulating.</p> <p>9-3-4(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the staff implemented the clients' ISPs (Individualized Support Plans) and their dining plans.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. During this time clients #1, #2, #3 and #4 were served spaghetti with meat sauce, salad, bread and sliced pears for their evening meal. Staff #1, #2 and #3 sat at the table with clients #1, #2, #3 and #4 while eating.</p> <p>__ Client #1 ate her meal using a toddler spoon and taking occasional large bites. Client #1 did not alternate bites of food with a drink of liquid while eating. The staff did not prompt or sign to client #1 to take a drink between each bite of food or prompt or sign to client #1 to take smaller bites of food when taking too</p>	W000249	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. A staff meeting was held on 12/12/13 at which time all staff were retrained on dining plans, dietary recommendations, thickening liquids, fall risk plans and ambulation supports. Staff also reviewed all goals and training opportunities. Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will have thickener training and direct nursing observations in the next 60 days or sooner. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? Goals for all individuals in the home were reviewed and staff implementation strategies were discussed. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective</p>	12/20/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
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	<p>large of bites.</p> <p>__ Client #2 ate at a fast pace taking large bites of food. After client #2 finished her meal, she held her dinner plate up to her mouth and scooped the last of the food into her mouth. The staff did not prompt client #2 to slow down while eating her meal or to chew her food thoroughly with each bite. When client #2 had finished eating, staff #1 stated, "I can't believe you stayed at the table for the whole meal."</p> <p>__ Client #3 poured water into a red plastic glass and then added two partial pumps of Simply Thick It (a liquid thickener) gel into the water. Client #3 then put a toddler spoon into the glass, moved the spoon side to side once and removed the spoon. Client #3 proceeded to eat his meal, taking large bites and eating at a fast pace. Client #3 did not alternate food and liquids while eating. Client #3 drank all of the water and asked for milk. Client #3 then filled his glass with milk and repeated the process of placing two partial pumps of Simply Thick It gel into the glass, putting his spoon in the glass and moving the spoon side to side once. The staff did not assist client #3 with putting the thickener into his glass or ensure client #3 stirred the thickener properly. The staff did not prompt client #3 to slow his pace of eating, to take smaller bites or to take a</p>		<p>action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Observation of appropriate liquid thickening and ambulation supports were completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily meal observations for an additional time period of 1/11/14 - 1/31/14. During those observations, Team Leader will observe that the thickener continues to be done correctly, that the goals are offered appropriately and that the meal is otherwise correct. Team Leader will also request random demonstrations of liquid consistency from staff. Upon completion of this increased monitoring time period, QIDP and Team Leader will review staff competency and return to weekly meal supervision. Group Home Director continues monthly home visits.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	<p>sip of liquid between bites of food each time client #3 took a bite.</p> <p>__ Client #4 was provided an 18 ounce plastic bottle of water with a pull top spout to drink from during her evening meal. The staff did not prompt client #4 to get her plate from the cabinet prior to the evening meal. Client #4 ate her meal at a fast pace and took large bites of food. Client #4 used a toddler spoon and overfilled the spoon with each bite. Some of client #4's food had spilled off onto the table. After finishing all of the food on her plate, client #4 scooped up the food on the table and ate it. The staff did not prompt client #4 not to eat from the table, to alternate sips of liquids with each bite of food, to slow her rate of eating throughout the meal or check client #4's mouth for pocketing food after the meal.</p> <p>Client #1's record was reviewed on 12/3/13 at 11 AM. Client #1's ISP of 7/29/13 indicated "[Client #1] has a Dx. (diagnosis) of Dysphasia (difficulty swallowing)." Client #1's ISP indicated client #1 had an objective to alternate sips of liquids and bites of food with 3 verbal prompts or less from the staff during the meal. The ISP indicated the staff were to sign to client #1 when it was time to eat, to sit down with client #1 at the dining table and to sign to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	<p>client #1 to take a bite, to chew her food and then to swallow. The ISP indicated the staff were to sign to client #1 to take a drink after swallowing her food. Client #1's dining plan of 11/7/13 indicated client #1 was to be encouraged to eat slowly, take small bites and was to alternate drinking and eating with each bite of food.</p> <p>Client #2's record was reviewed on 12/3/13 at 11:30 AM. Client #2's ISP of 8/15/13 indicated client #2 had an objective to chew her food thoroughly with 3 or less verbal prompts from the staff. The ISP indicated client #2 "tends to eat very quickly and she will swallow food before chewing it." The ISP indicated the staff were to prompt client #2 to slow her pace of eating and to chew her food. The ISP indicated "If [client #2] gets frustrated/agitated, give her a moment but continue to cue her to chew as needed. Praise her when she chews thoroughly..." Client #2's dining plan dated 9/16/13 indicated client #2 was to be encouraged to not over stuff her mouth and chew before taking another bite.</p> <p>Client #3's record was reviewed on 12/3/13 at 12 PM. Client #3's ISP of 8/30/13 indicated client #3 "has a dx. of Dysphasia and is on a mechanical soft</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
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	<p>diet with nectar thick liquids." Client #3's ISP indicated client #3 had an objective to stir the thickener into his liquids with staff assistance. The ISP indicated the staff were to assist client #3 with putting the thickener into his cup and then to prompt the client to stir his drink. The ISP did not specify how the thickener was to be stirred. Client #3's dining plan of 7/11/13 indicated client #3 was to take single sips of nectar thick liquids and to alternate between sips of liquids and bites of food while eating. The dining plan indicated client #3 was to be encouraged not to overstuff his mouth and to chew before taking another bite.</p> <p>Client #4's record was reviewed on 12/3/13 at 12:30 PM. Client #4's record indicated client #4 was at risk for aspiration. Client #4's ISP of 7/29/13 indicated client #4 had an objective to get her own plate out of the cabinet with hand over hand assistance from the staff. The ISP indicated the staff were to prompt client #4 it was time to eat. The staff were to inform client #4 they were going to help her get her plate out for her meal. The staff were to open the cabinet door and point to client #4's plate, prompting her to get her plate. Client #4's dining plan dated 11/21/13 indicated client #4 was to limit foods to</p>						

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
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	<p>less than 1 teaspoon per bite, to dry swallow 1 to 2 times between bites and to alternate sips of liquids and bites of food. The plan indicated the staff were to encourage client #4 to eat slowly and to check her mouth after eating for pocketed food.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 2 PM the QIDP stated the staff were to follow the clients' ISPs "as written and to provide training at every available opportunity." When asked if the staff were to follow the clients' dining plans, the QIDP stated, "Yes, they are." The QIDP stated the staff were to help client #3 to thicken his drink "to ensure the right consistency." The QIDP stated the staff "should have" prompted client #4 not to eat off of the table.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>This deficiency was cited on 10/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
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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, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), nursing services failed to ensure:</p> <p>___The staff were trained to use the thickener to modify client #3's and #4's liquids.</p> <p>___The staff followed client #1's, #2's, #3's and #4's dining plans.</p> <p>___Client #1 was reassessed by a speech therapist for a swallow study and consulted with the dietician prior to changing client #1's diet in regard to pocketing food.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. During this time clients #1, #2, #3 and #4 were served spaghetti with meat sauce, salad, bread and sliced pears for their evening meal. Staff #1, #2 and #3 sat at the table with clients #1, #2, #3 and #4 while eating.</p> <p>___Client #1 was served a pureed diet and ate her meal using a toddler spoon. Client #1 ate at a slow pace and taking occasional large bites. Client #1 did not alternate bites of food with a drink of</p>	W000331	<p>A staff meeting was held on 12/12/13 at which time all staff were retrained on all dining plans, dietary recommendations, thickening liquids, fall risk plans and ambulation supports. Dietician observed each staff person demonstrate competence in accurate measuring of liquids and mixing of thickening product. Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will have thickener training and direct nursing observations in the next 60 days or sooner. Observation of appropriate liquid thickening and ambulation supports were completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily meal observations for an additional time period of 1/11/14 - 1/31/14. During those observations, Team Leader will observe that the thickener continues to be done correctly, that the goals are offered appropriately and that the meal is otherwise correct. Team Leader will also request random demonstrations of liquid consistency from staff. Upon completion of this increased monitoring time period, QIDP and</p>	12/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
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	<p>liquid while eating. The staff did not prompt or sign to client #1 to take a drink between each bite of food or prompt or sign to client #1 to take smaller bites of food when taking too large of bites.</p> <p>__ Client #2 ate at a fast pace taking large bites of food. Once client #2 had eaten the majority of her food, she held her dinner plate up to her mouth and scooped the last of the food into her mouth. Client #2 then got up and left the table. The staff did not prompt client #2 to slow down while eating her meal or to chew her food thoroughly with each bite. When client #2 had finished eating, staff #1 stated, "I can't believe you stayed at the table for the whole meal."</p> <p>__ Client #3 poured water into a red plastic glass and then added two partial pumps of "Simply Thick" (a liquid thickener) gel into the water. Client #3 then put a toddler spoon into the glass, moved the spoon side to side once and removed the spoon. Client #3 proceeded to eat his meal, taking large bites and eating at a fast pace. Client #3 did not alternate food and liquids while eating. Client #3 drank all of the water and asked for milk. Client #3 then filled his glass with milk and repeated the process of placing two partial pumps of "Simply Thick" gel into the glass, putting his spoon in the glass and moving the spoon</p>		<p>Team Leader will review staff competency and return to weekly meal supervision. Group Home Director continues monthly home visits. Registered dietician will also continue quarterly home observations to ensure meal and liquid preparation remains adequate. Annual retraining will occur at staff training meetings. All other goals and informal training opportunities were reviewed with staff. QIDP will complete weekly observations in home that goals are being implemented and documented appropriately.</p>		

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	<p>side to side once. The staff did not assist client #3 with putting the thickener into his glass or ensure client #3 stirred the thickener properly. The staff did not prompt client #3 to slow his pace of eating, to take smaller bites or to take a sip of liquid between bites of food each time client #3 took a bite. At 6 PM staff #2 was asked how many ounces client #3's cup held. Staff #2 stated, "I think its four ounces." After client #3 had finished his meal, staff #2 was asked to measure the amount of liquid the red glass would hold. Staff #2 stated the red glass held "12 ounces."</p> <p>__ Client #4 was provided an 18 ounce plastic bottle of water with a pull top spout to drink from during her evening meal. Before client #4 began her meal, staff #1 removed the pull top lid and added one pump of "Simply Thick" gel, replaced the cap and shook the bottle back and forth twice and placed it back on the table in front of client #4. Client #4 ate her meal at a fast pace using a toddler spoon and taking large bites of food. Client #4 drank all of her water. Her plastic bottle was filled with Soy milk and staff #1 placed one pump of "Simply Thick" gel into client #4's plastic bottle, shook it once and put it back on the table in front of client #4. At 6 PM staff #1 stated, "Her bottle holds 18 ounces, I thought it was only 8</p>			

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	<p>ounces." Staff #1 read the back of the "Simply Thick" container and stated, "This says we're supposed to use one pump per four ounces of liquid. We haven't been doing that." The staff did not prompt client #4 to slow her rate of eating throughout the meal or check client #4's mouth for pocketing food after the meal.</p> <p>During interview with staff #1 and #2 on 12/2/13 at 5:50 PM, staff #2 stated client #3 "usually gets 2 pumps in his cup." When asked how much thickener client #4 was given for her 18 ounce drinking bottle with the pull top lid, staff #1 stated, "I only put in one pump."</p> <p>Review of the back of the "Simply Thick" pump bottle on 12/2/13 at 5:55 PM indicated to use one pump of gel per 4 fluid ounces of liquid.</p> <p>Review of the "Simply Thick" Internet web site of "http://www.simplythick.com" on 12/3/13 at 8:30 AM indicated an instructional video of how to use the product. The video on the web site indicated a spoon was not to be used to stir the product in liquids but instead a fork or a whisk was to be used with a brisk whisking action, "like that of beating an egg." The video indicated a</p>			

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
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	<p>"15 to 20 second brisk shaking action" could also be used in mixing the product.</p> <p>Client #1's record was reviewed on 12/3/13 at 11 AM. Client #1's ISP (Individualized Support Plan) of 7/29/13 indicated "[Client #1] has a Dx. (diagnosis) of Dysphasia." The ISP indicated the staff were to sign to client #1 to take a bite, to chew her food and then to swallow. The ISP indicated the staff were to sign to client #1 to take a drink after swallowing her food. Client #1's dining plan of 11/7/13 indicated client #1 was to be encouraged to eat slowly, take small bites and to alternate drinking and eating with each bite of food. Client #1's swallow evaluation from the speech therapist on 6/20/13 indicated "Oral dysphasia (difficulty swallowing) but swallow appeared overall functional with no aspiration seen." The evaluation indicated a recommendation for a mechanical soft diet with thin liquids with the use of a sippy cup. Client #1's Quarterly Nutrition Review from the dietician on 9/16/13 indicated client #1 was to have a mechanical soft diet with thin liquids. The review indicated the dietician did not observe client #1 having any chewing and/or swallowing difficulties. Client #1's November 2013 quarterly</p>				

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	<p>physician's orders indicated client #1 was to have a mechanical soft diet with thin liquids. Client #1's IDT (Interdisciplinary Team) note of 11/6/13 indicated client #1 was to continue with a mechanical soft diet and thin liquids. Client #1's 11/7/13 physician's orders indicated a note from the facility nurse requesting the facility doctor to change client #1's diet consistency to pureed because client #1 "is having more difficulty eating and pocketing her food in her checks (sic). Staff is having to cue her to chew her food." Client #1's record indicated no reassessment by the speech therapist, dietician and/or the client's physician in regard to the need for a change to a pureed diet.</p> <p>Client #2's record was reviewed on 12/3/13 at 11:30 AM. Client #2's ISP of 8/15/13 indicated client #2 "tends to eat very quickly and she will swallow food before chewing it." The ISP indicated the staff were to prompt client #2 to slow her pace of eating and to chew her food. Client #2's dining plan dated 9/16/13 indicated client #2 was to be encouraged to not over stuff her mouth and chew before taking another bite.</p> <p>Client #3's record was reviewed on 12/3/13 at 12 PM. Client #3's ISP of 8/30/13 indicated client #3 "has a dx. of</p>			

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	<p>Dysphasia and is on a mechanical soft diet with nectar thick liquids." Client #3's ISP indicated the staff were to assist client #3 with putting the thickener into his cup and then to prompt the client to stir his drink. The ISP did not specify how the thickener was to be stirred. Client #3's dining plan of 7/11/13 indicated client #3 was to take single sips of nectar thick liquids and to alternate between sips of liquids and bites of food while eating. The dining plan indicated client #3 was to be encouraged not to overstuff his mouth and to chew before taking another bite.</p> <p>Client #4's record was reviewed on 12/3/13 at 12:30 PM. Client #4's record indicated client #4 was at risk for aspiration. Client #4's swallow study of 11/21/13 indicated a recommendation for client #4 to have a mechanical soft diet with nectar thick liquids. Client #4's dining plan dated 11/21/13 indicated client #4 was to limit foods to less than 1 teaspoon per bite, to dry swallow 1 to 2 times between bites and to alternate sips of liquids and bites of food. The plan indicated the staff were to encourage client #4 to eat slowly and to check her mouth after eating for pocketed food.</p> <p>During interview with the facility LPN</p>						

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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	(Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 10:45 AM, the LPN indicated the staff were to use "Simply Thick" to thicken client #3's and #4's liquids. The LPN stated client #4 had "just recently been switched to nectar thick liquids" due to frequent coughing throughout meals. The LPN stated the staff "are to follow" the clients' ISPs, dining plans, and the physician's orders in regard to the clients' dining instructions. When asked if the staff had been trained on the use of the "Simply Thick" gel in thickening liquids, the LPN indicated she had not conducted a formal training in regard to how the staff were to use the "Simply Thick" gel. The QIDP stated the house manager had conducted "some informal training" in regard to the use of the thickening gel, but did not have documentation of the training. When asked if the staff were to follow the instructions of the product in regard to use, the LPN stated, "Yes." The QIDP indicated a formal training would be arranged for the dietician to instruct the facility staff on the use of "Simply Thick" to alter the consistency of the clients' liquids. The LPN indicated due to client #1 pocketing food, the LPN had asked client #1's physician to change client #1's diet order to a pureed diet.			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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W000460	<p>The LPN indicated she had talked with the dietician but had no documentation of the discussion. The LPN indicated the dietician had not reassessed client #1 since the assessment of 9/16/13. When asked if the client was reassessed by a speech pathologist for the need for a change in the consistency of her food, the LPN stated, "No, I'll change the order back and get her reassessed."</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>This deficiency was cited on 10/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 2 sampled clients that received altered liquids (clients #3 and #4), the facility failed to ensure the staff provide the right consistency of liquids to the clients.</p> <p>Findings include:</p>	W000460	<p>A staff meeting was held on 12/12/13 at which time all staff were retrained on all dining plans, dietary recommendations, thickening liquids, fall risk plans and ambulation supports. Dietician observed each staff person demonstrate competence in accurate measuring of liquids and mixing of thickening product.</p>	12/20/2013

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	<p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. At 5:40 PM clients #3 and #4 were prompted to go to the dining room table for their evening meal.</p> <p>__ Client #3 sat down at the table and poured water into a red plastic glass. Client #3 then added two partial pumps of "Simply Thick" (a liquid thickener) gel into the water and placed his toddler spoon into the glass, moved the spoon side to side once and removed the spoon. Client #3 drank all of the water and asked for milk. Client #3 then filled his glass with milk and repeated the process of placing two partial pumps of "Simply Thick" gel into the glass, putting his spoon in the glass and moving the spoon side to side once. The staff did not assist client #3 with putting the thickener into his glass to ensure the proper thickness or to ensure client #3 stirred the thickener properly. At 6 PM staff #2 was asked how many ounces client #3's cup held. Staff #2 stated, "I think its four ounces." After client #3 had finished his meal, staff #2 was asked to measure the amount of liquid the red glass would hold. Staff #2 stated the red glass held "12 ounces."</p> <p>__ Client #4 sat down at the table and was provided an 18 ounce plastic bottle of water with a pull top spout to drink</p>		<p>Group Home Director will review the nursing services findings with all group home nurses. Each remaining group home facility will have thickener training and direct nursing observations in the next 60 days or sooner. Observation of appropriate liquid thickening and ambulation supports were completed daily Monday, December 16, 2013 through Thursday, December 19, 2013. Team Leader will continue to conduct daily meal observations for an additional time period of 1/11/14 - 1/31/14. During those observations, Team Leader will observe that the thickener continues to be done correctly, that the goals are offered appropriately and that the meal is otherwise correct. Team Leader will also request random demonstrations of liquid consistency from staff. Upon completion of this increased monitoring time period, QIDP and Team Leader will review staff competency and return to weekly meal supervision. Group Home Director continues monthly home visits. Registered dietician will also continue quarterly home observations to ensure meal and liquid preparation remains adequate. Annual retraining will occur at staff training meetings.</p>				

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	<p>from during her evening meal. Before client #4 began her meal, staff #1 removed the pull top lid and added one pump of "Simply Thick" gel, replaced the cap and shook the bottle back and forth twice and placed it back on the table in front of client #4. Client #4 drank all of her water. Her plastic bottle was filled with Soy milk and staff #1 placed one pump of "Simply Thick" gel into client #4's plastic bottle, shook it once and put it back on the table in front of client #4. At 6 PM staff #1 stated, "Her bottle holds 18 ounces, I thought it was only 8 ounces." Staff #1 read the back of the "Simply Thick" container and stated, "This says we're supposed to use one pump per four ounces of liquid. We haven't been doing that."</p> <p>During interview with staff #1 and #2 on 12/2/13 at 5:50 PM, staff #2 stated client #3 "usually gets 2 pumps in his cup." When asked how much thickener client #4 was given for her 18 ounce drinking bottle with the pull top lid, staff #1 stated, "I only put in one pump." Staff #1 indicated clients #3 and #4 were to have nectar thick liquids due to a high risk of choking.</p> <p>Review of the back of the "Simply Thick" pump bottle on 12/2/13 at 5:55 PM indicated for nectar thick liquids,</p>			

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	<p>one pump of gel was to be added per 4 fluid ounces of liquid.</p> <p>Review of the "Simply Thick" Internet web site of "http://www.simplythick.com" on 12/3/13 at 8:30 AM indicated an instructional video of how to use the product. The video on the web site indicated a spoon was not to be used to stir the product into liquids but instead a fork or a whisk was to be used with a brisk whisking action, "like that of beating an egg." The video indicated a "15 to 20 second brisk shaking action" could also be used in mixing the product.</p> <p>Client #3's record was reviewed on 12/3/13 at 12 PM. Client #3's 12/1/13 physician's orders indicated client #3 had a diagnosis of, but not limited to, Dysphasia (difficulty swallowing) and was on a mechanical soft diet with nectar thick liquids. Client #3's ISP (Individualized Support Plan) of 8/30/13 indicated the staff were to assist client #3 with putting the thickener into his cup and then to prompt the client to stir his drink. Client #3's dining plan of 7/11/13 indicated client #3 was to take single sips of nectar thick liquids and to alternate between sips of liquids and bites of food while eating.</p>						

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	<p>Client #4's record was reviewed on 12/3/13 at 12:30 PM. Client #4's record indicated client #4 was at risk for aspiration. Client #4's 11/1/13 physician's orders indicated client #4 was to have a mechanical soft diet with thin liquids. Client #4's swallow study of 11/21/13 indicated a recommendation for client #4 to have a mechanical soft diet with nectar thick liquids.</p> <p>During interview with the facility LPN (Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 10:45 AM, the LPN indicated the staff were to use "Simply Thick" to thicken client #3's and #4's liquids to a nectar consistency. The LPN stated client #4 had "just recently been switched to nectar thick liquids" due to frequent coughing throughout meals.</p> <p>This deficiency was cited on 10/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>				

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W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview for 2 of 4 sample clients (#2 and #3), the facility failed to ensure the clients' feet and legs were supported while sitting at the dining room table.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/13 between 4 PM and 6:30 PM. Clients #2 and #3 were small in size/height. The clients were prompted to go to the dining room for their evening meal. While sitting at the dining room table in the straight chairs, client #2's and #3's feet did not rest on the floor while eating their meal, their feet dangled without support. Once done, client #3 slid down in his chair and placed his toes on the floor to push himself backward, tipping his chair backward on the back legs. When this surveyor stated, "Be careful, you are going to tip over," staff #2 prompted client #3 to sit back up in the chair and she would help him. Client #3 scooted back up in the chair, his feet not touching the floor.</p>	W000484	<p>The group home team leader has purchased foot stools for the two individuals whose feet did not touch the floor during meal. They have implemented the foot stools and the individuals both seem to like them. All other individuals have appropriate seating arrangement. All Group Home leadership staff will review the other homes for similar needs. Team Leader will observe that footstools are utilized as indicated for the individuals. Those observations will occur during daily meal observations from 1/13/14 - 1/31/14. Weekly meal observations will resume after 1/31/14 and noted compliance with meal requirements.</p>	12/20/2013			

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	<p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/13 at 3 PM, the QIDP stated the clients "should sit up straight with their feet on the floor" to eat their meals. The QIDP stated "I wasn't aware their (client #2's and #3's) feet didn't touch the floor when they sat at the table to eat."</p> <p>9-3-8(a)</p>			
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