

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G703	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2012
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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5475 STONE AVE PORTAGE, IN 46368
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W0000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of survey: August 21, 22, 23 and 24, 2012</p> <p>Facility number: 003192 Provider number: 15G703 AIM number: 200360510</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/6/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation: Client Protections is not met, as the facility neglected to implement their policy to protect 2 of 4 clients who reside at the group home (clients #3 and #4) from eloping from their home. The facility failed to immediately report 1 of 1 allegation of neglect to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. The facility failed to thoroughly investigate 1 of 1 allegation of neglect. The facility failed to report investigative results to the administrator within 5 working days, and the facility failed to take sufficient corrective action to prevent elopement incidents.</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility neglected to implement its "Policy for Handling Cases of Neglect and Abuse" dated 2/15/12, by failing to prevent 2 of 4 clients residing at the group home (clients #3 and #4) from eloping from their home and failed to thoroughly investigate an allegation of abuse/neglect involving 1 of</p>	W0122	<p>DSPs will be trained on reporting reportable incidents within the 24 hour time frame. A copy of the reference guide for BDDS reportable incidents will be posted in the group home for staff reference. To ensure future compliance, all incidents reports are reviewed by Service Coordinator and/ or Community Services Nurse, and then sent to the Residential Supervisor for final review. Since client #4s family did not identify certain staff as being abusive, neglectful or harmful to client #4 in the complaint, no staffs were removed from the schedule. The agency was very diligent during the investigation, and all areas within the complaint were investigated, therefore it took longer than usual to complete. To ensure future compliance, investigations will be completed within the necessary time frames. An in-term meeting was conducted and elopement was added to client #3 behavioral plan. To ensure future compliance, staff will be re-trained on client # 3s Behavioral Plan. When client # 4 eloped from the group home the police were notified each time to have client #4 transported to the hospital for evaluation, but was told they only transport for</p>	09/23/2012	

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	<p>4 clients (client #4).</p> <p>2. Please refer to W153. The facility failed for 1 of 1 allegation involving 1 of 4 clients residing at the home (client #4), to report an allegation of neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>2. Please refer to W154. The facility failed to thoroughly investigate 1 of 1 allegation of neglect involving 1 of 4 clients residing at the group home (client #4).</p> <p>4. Please refer to W156. The facility failed to report the results of 1 of 1 pending investigation, involving 1 of 4 clients living in the group home (client #4), to the administrator within five business days.</p> <p>5. Please refer to W157. The facility failed for 1 of 4 clients residing at the group home (client #4) to take sufficient/effective corrective action for his documented elopement incidents.</p> <p>9-3-2(a)</p>		<p>suicidal ideation not homicidal ideation. During this time staffs were following his BSP and monitoring him closely. Finally later that day he was transported to the hospital, only to be sedated and sent back to the group home. Client # 4 was taken to his Psychiatrist and a medication change occurred. The Psychiatrist made arrangement with the local hospital to have him admitted for treatment if he had another manic episode. Client # 4 was admitted for treatment. Upon discharge from hospital, client # 4 was formally discharged from our facility at family's request. To ensure future compliance, all staff will be trained on BSP on all new incoming residents. During an behavioral crisis, staff will be trained to call the Service Coordinator immediately, if Coordinator is not available, they will contact the Behavioral Health Specialist. 10/4/12When incidents occur the staff will immediately inform the Service Coordinator and or the Behavioral Health Director to inform them of the incident. Staff will then shadow the client until the crisis is over. The IDT team will meet to discuss further interventions and make all recommened changes to the Behavioral Support Plan. Service Coordinator will then train staff on any changes made to the Behavioral Support Plan. To ensure future compliance, Service Coordinator will observe</p>		

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			clients at least weekly thereafter.	

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #1), to implement client #1's money management goal utilizing United States currency.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 8/24/12 at 10:45 A.M.. Review of the Individualized Support Plan (ISP) dated 5/10/12 indicated: "Will learn to identify pictures of coins, quarter and nickel."</p> <p>An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 8/24/12 at 12:00 P.M.. The SC indicated staff should use United States currency when implementing the client's money management goal.</p> <p>9-3-2(a)</p>	W0126	<p>The Service Coordinator will revise client# 1 money goal and train group home staff to use United States Currency when implementing Client #1 money management goal.</p> <p>To ensure future compliance, Service Coordinator will observe at least once a week for three months and monthly thereafter.</p>	09/23/2012			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 2 of 4 clients residing at the group home (clients #3 and #4), the facility neglected to implement its "Policy for Handling Cases of Neglect and Abuse" dated 2/15/12, by failing to prevent clients #3 and #4 from eloping from their home and failed to thoroughly investigate allegations of potential abuse/neglect for 4 of 15 reviewed Bureau of Developmental Disabilities Services (BDDS) reports involving 2 of 4 clients (clients #3 and #4).</p> <p>Findings include:</p> <p>A review of the facility's internal incident/accident reports was conducted at the facility's administrative office on 8/21/12 at 11:30 A.M.. Review of the facility's BDDS reports indicated:</p> <p>Client #3 incident:</p> <p>Incident dated 8/11/12...Date of Knowledge 8/14/12...Submitted Date: 8/16/12: Service Coordinator was notified that on 8/14/12 that [client #3] wandered away from the group home...Staff notified police who returned</p>	W0149	See W122Same as W12210/4/12 When incidents occur the staff will immediately inform the Service Coordinator and or the Behavioral Health Director to inform them of the incident. Staff will then shadow the client until the crisis is over. The IDT team will meet to discuss further interventions and make all recommended changes to the Behavioral Support Plan. Service Coordinator will then train staff on any changes made to the Behavioral Support Plan. To ensure future compliance, Service Coordinator will observe clients at least weekly thereafter.	09/23/2012			

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	<p>him to the group home." No documentation was available for review to indicate the facility had conducted a thorough investigation of the incident. No documentation of staff retraining was available for review after the incident occurred to prevent further elopement.</p> <p>Client #4 incidents:</p> <p>Incident dated 8/10/12...Date of Knowledge: 8/14/12...Submitted Date: 8/16/12: "When [client #4] came in from Day Services, he went into the home where he punched and kicked on (sic) of his house mates in the stomach." Further review of the report indicated the incident involved client #3. No documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p> <p>Incident dated 8/12/12...Date of Knowledge: 8/12/12...Submitted Date: 8/17/12: "A complaint was received from a family member (sibling) in regards to consumer [Client #4] in regards to staffing and training issues, safety issues in regards to the consumer elopement from the home as well as diet concerns and recreational activities not being met." No documentation was available for review to indicate the facility had</p>						

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	<p>conducted a thorough investigation of the incident.</p> <p>Incident dated 8/17/12...Date of Knowledge: 8/17/12...Submitted Date: 8/17/12: "At approximately 11:15 a.m. Service Coordinator received a call from the group home staff stating [client #4] left the group home. Staff called the [Police Department name] and his (client #4's) father. [Client #4] was returned back to the group home by his father. At 4:00 P.M. Service Coordinator received call from Group Home staff that [client #4] had left the group home again, this time he went to the grade school a block from the group home where he opened a car door of a citizen, and kick (sic) the passenger several times. The staff explained that [client #4] had a disability and then loaded [client #4] into the group home van. [Client #4]'s father also showed up at the school and spoke with the driver. At approximately 6:30 P.M. Service Coordinator received another call, [client #4] had left the group home again, this time he was kicking at cars...After the morning incident, staff were instructed to monitor [client #4] and to get him involved in busy activities that he likes per his Behavior Support Plan...Plan to Resolve: After the morning incident, staff were instructed to monitor [client #4] and get him involved in busy activities that</p>			

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	<p>he likes (games, video games) per his Behavioral Support Plan...After the second elopement Service Coordinator talked with a [name of city] Police Officer and asked for a hospital transport because of [client #4] being a danger to himself and others. However, the coordinator was informed that this only happens if the person is suicidal. Staff took [client #4] back to the group home where staff monitored him closely and set the perimeter alarm so they would know if he left the home. They also followed his Behavioral Support Plan and engaged him in activities, [client #4] is young and has an athletic build which allowed him to move faster than staff and elope a third time. (staff followed him in van) (sic) This occurred after Dinner (sic). The police were notified again and asked that safe transportation be arranged so that he could be evaluated for psychiatric needs at the hospital. This time the police brought [client #4] to hospital for evaluation. Group home staff went with [client #4] and his parents met him there. [Client #4] was evaluated, given medication to calm him down and sent back to the group home. He was calm at the hospital so they refused to keep him for further evaluation. On Tuesday 8/14/12 [client #4] was taken to his Psychiatrist [Doctor name]. At the time of the evaluation [client #4] was calm,</p>			

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	<p>however, [doctor name] indicated that he should be hospitalized and evaluated for these episodes and that he was not able to at the time of his appointment as he was calm. [Doctor name] indicated that he would speak to the head of inpatient unit at hospital so that [client #4] would be admitted if further incidents occur. The Doctor discontinued his Abilify as it may be increasing agitation and interfering with [client #4]'s sleep. [Client #4] was given Ambien as he had not slept more than a few hours during the week prior to these episodes. He has a diagnosis of Bi-Polar disorder and his parents have indicated that this is how [client #4] expresses manic episodes. [Client #4]'s behavior plan was modified to address these issues. His family also removed [client #4]'s video game 'Grand Theft Auto' from the home as he admitted to [doctor name] that he was acting out portions of this game. [Client #4] will go back to his psychiatrist on 8/22/12 for further evaluation." No documentation was available for review to indicate the facility had conducted a thorough investigation of the incident. No staff retraining documentation was available for review after the incident occurred to prevent further elopement.</p> <p>A review of client #3's record was conducted at the facility's administrative</p>			

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	<p>office on 8/24/12 at 11:35 A.M.. Review of client #3's Behavior Support Plan (BSP) dated 6/2012 indicated: "Targeted Behaviors: Wandering-not reporting or staying in areas that he is scheduled to be in. This may include leaving the group home or wandering into other parts of the day program." There was no further documentation available for review to indicate client #3's BSP was reviewed after the elopement incident.</p> <p>A review of client #4's record was conducted on 8/23/12 at 1:50 P.M.. Review of client #4's BSP dated 6/2012 indicated: "Targeted Behaviors: Running Away-Rapidly leaving or attempting to leave an area in which he is being supervised." There was no further documentation available for review to indicate client #4's BSP was reviewed after the elopement incident.</p> <p>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 2/15/12 was conducted on 8/23/12 at 10:30 A.M.. Review of the facility's policy indicated: "In order to protect the general welfare of the clients, The Arc Northwest Indiana has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff. II. Staff will immediately report any allegations of abuse, neglect or</p>			

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	<p>exploitation of our clients per agency reporting procedure. [Facility name] will meet current regulatory requirements for reporting all incidents...Neglect- is defined as knowingly placing a client in a situation that poses a threat to his/her health and well-being. Examples include but are not limited to depriving a client of food, clothing, shelter or medical care; not providing adequate personal care, leaving clients unsupervised, etc....The designated staff conducting the investigation will submit an immediate verbal report, a written summary (preferably within 24 hours...if investigation continues past 1 day give a status update...will complete a follow up report within 5 days."</p> <p>An interview with the Service Coordinator (SC) was conducted on 8/23/12 at 1:30 P.M.. When asked what measures were put in place to prevent clients #3 and #4 to prevent any further elopement, the SC stated "I verbally directed the staff to monitor them closely and to implement their BSPs as written." When asked if each client's BSP had been revisited since the documented incidents, the SC stated, "We just had a meeting today (8/23/12) for [client #4] and we kept [client #3's] as it is."</p> <p>An interview with the Behavior Health</p>			

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	<p>Director (BHD) was conducted at the facility's administrative office on 8/24/12 at 12:45 P.M.. The BHD indicated the investigation was not completed in regards to the incidents. No further documentation was available for review to indicate a thorough investigation was conducted.</p> <p>9-3-2(a)</p>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 1 of 1 allegation involving 1 of 4 clients residing at the home (client #4), to report an allegation of neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's internal incident/accident reports was conducted at the facility's administrative office on 8/21/12 at 11:30 A.M.. Review of the facility's BDDS reports indicated:</p> <p>Incident dated 8/12/12...Date of Knowledge: 8/12/12...Submitted Date: 8/17/12: "A complaint was received from a family member (sibling) in regards to consumer [Client #4] in regards to staffing and training issues, safety issues in regards to the consumer elopement from the home as well as diet concerns and recreational activities not being met."</p>	W0153	See W122	09/23/2012			

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	<p>An interview was conducted with the Service Coordinator (SC) at the facility's administrative office on 8/23/12 at 1:30 P.M.. The SC indicated the incident was reported late. The SC stated "Incidents are to be reported immediately to the administrator and within 24 hours to BDDS."</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5475 STONE AVE PORTAGE, IN 46368
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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 allegation of neglect, involving 1 of 4 clients (client #4), the facility failed to provide written evidence a thorough investigation was conducted.</p> <p>Findings include:</p> <p>A review of the facility's internal incident/accident reports was conducted at the facility's administrative office on 8/21/12 at 11:30 A.M.. Review of the facility's BDDS reports indicated:</p> <p>Client #4 incidents:</p> <p>Incident dated 8/12/12...Date of Knowledge: 8/12/12...Submitted Date: 8/17/12: "A complaint was received from a family member (sibling) in regards to consumer [Client #4] in regards to staffing and training issues, safety issues in regards to the consumer elopement from the home as well as diet concerns and recreational activities not being met." No documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p>	W0154	See W154	09/23/2012

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	<p>Incident dated 8/17/12...Date of Knowledge: 8/17/12...Submitted Date: 8/17/12: "At approximately 11:15 a.m. Service Coordinator received a call from the group home staff stating [client #4] left the group home. Staff called the [Police Department name] and his (client #4's) father. [Client #4] was returned back to the group home by his father. At 4:00 P.M. Service Coordinator received call from Group Home staff that [client #4] had left the group home again, this time he went to the grade school a block from the group home where he opened a car door of a citizen, and kick (sic) the passenger several times. The staff explained that [client #4] had a disability and then loaded [client #4] into the group home van. [Client #4]'s father also showed up at the school and spoke with the driver. At approximately 6:30 P.M. Service Coordinator received another call, [client #4] had left the group home again, this time he was kicking at cars...After the morning incident, staff were instructed to monitor [client #4] and to get him involved in busy activities that he likes per his Behavior Support Plan" No documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p> <p>An interview with the Behavior Health</p>			
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	<p>Director (BHD) was conducted at the facility's administrative office on 8/24/12 at 12:45 P.M.. The BHD indicated the investigation was not completed in regards to the incidents. No further documentation was available for review to indicate a thorough investigation was conducted.</p> <p>9-3-2(a)</p>			

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of 1 of 1 pending investigation, involving 1 of 4 clients living in the group home (client #4), to the administrator within five business days.</p> <p>Findings include:</p> <p>A review of the facility's internal incident/accident reports was conducted at the facility's administrative office on 8/21/12 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Service reports indicated:</p> <p>Incident dated 8/17/12...Date of Knowledge: 8/17/12...Submitted Date: 8/17/12: Staff called the [Police Department name] and his (client #4's) father. [Client #4] was returned back to the group home by his father. At 4:00 P.M. Service Coordinator received call from Group Home staff that [client #4] had left the group home again, this time he went to the grade school a block from the group home where he opened a car</p>	W0156	See W122	09/23/2012			

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	<p>door of a citizen, and kick (sic) the passenger several times. The staff explained that [client #4] had a disability and then loaded [client #4] into the group home van. [Client #4]'s father also showed up at the school and spoke with the driver. At approximately 6:30 P.M. Service Coordinator received another call, [client #4] had left the group home again, this time he was kicking at cars."</p> <p>An interview with the Behavior Health Director (BHD) was conducted at the facility's administrative office on 8/24/12 at 12:45 P.M.. The BHD indicated the investigation was not completed in regards to the elopement incidents and results of the investigation were not forwarded to the administrator.</p> <p>9-3-2(a)</p>				

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 4 clients residing at the group home (client #4) to take sufficient/effective corrective action for his documented elopement.</p> <p>Findings include:</p> <p>A review of the facility's internal incident/accident reports was conducted at the facility's administrative office on 8/21/12 at 11:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>Client #4 incidents:</p> <p>Incident dated 8/12/12...Date of Knowledge: 8/12/12...Submitted Date: 8/17/12: "A complaint was received from a family member (sibling) in regards to consumer [Client #4] in regards to staffing and training issues, safety issues in regards to the consumer elopement from the home as well as diet concerns and recreational activities not being met." Further review of the report failed to indicate the facility took effective/sufficient corrective action to</p>	W0157	See W122Same as W12210/4/12 When incidents occur the staff will immediately inform the Service Coordinator and or the Behavioral Health Director to inform them of the incident. Staff will then shadow the client until the crisis is over. The IDT team will meet to discuss further interventions and make all recommended changes to the Behavioral Support Plan. Service Coordinator will then train staff on any changes made to the Behavioral Support Plan. To ensure future compliance, Service Coordinator will observe clients at least weekly thereafter.	09/23/2012			

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	<p>prevent recurrence.</p> <p>Incident dated 8/17/12...Date of Knowledge: 8/17/12...Submitted Date: 8/17/12: Staff called the [Police Department name] and his father. [Client #4] was returned back to the group home by his father. At 4:00 P.M. Service Coordinator received call from Group Home staff that [client #4] had left the group home again, this time he went to the grade school a block from the group home where he opened a car door of a citizen, and kick (sic) the passenger several times. The staff explained that [client #4] had a disability and then loaded [client #4] into the group home van. [Client #4]'s father also showed up at the school and spoke with the driver. At approximately 6:30 P.M. Service Coordinator received another call, [client #4] had left the group home again, this time he was kicking at cars." Further review of the report failed to indicate the facility took effective/sufficient corrective action to prevent recurrence.</p> <p>A review of client #4's record was conducted on 8/23/12 at 1:50 P.M.. Review of client #4's BSP dated 6/2012 indicated: "Targeted Behaviors: Physical aggression: hitting, kicking, scratching, punching or otherwise intentionally causing physical injury to another</p>			
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	<p>person...Running Away-Rapidly leaving or attempting to leave an area in which he is being supervised."</p> <p>An interview with the Service Coordinator (SC) was conducted on 8/23/12 at 1:30 P.M.. When asked what measures were put in place to prevent client #4 from further elopement, the SC stated "I instructed the group home staff to follow the client's behavior plan." When asked if client #4's BSP had been revisited after the incidents, the SC stated "No." When asked if the family members concerns had been addressed, the SC stated we are still investigating the allegations." The SC indicated there was no documentation available for review to indicate the facility took effective/sufficient corrective action to address each of the incidents involving client #4 and to prevent recurrence.</p> <p>9-3-2(a)</p>						

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed 2 of 3 clients observed at the group home (clients #1 and #2) to provide sufficient numbers of direct care staff to supervise and to implement Individual Support Plans (ISP) during formal/informal training opportunities.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 7:45 A.M.. At 5:50 A.M., Direct Support Professional (DSP) #1 went into client #1's room and began getting him dressed while client #2 lay awake in his room. At 6:00 A.M., DSP #1 assisted client #1 into the living room and entered client #2's room and began getting him dressed. At 6:40 A.M., DSP #1 was observed transferring client #2 from his bed into his wheelchair and assisted him into the living room. During the entire observation period, clients #1</p>	W0186	<p>Area Manager will have two staff scheduled to work each shift. Service Coordinator will re-train staff on providing active treatment for all clients, including medication administration and independently feeding himself for client #2.</p> <p>To ensure future compliance, Service Coordinator will observe active treatment programming at least once per week for 3 months and monthly thereafter.</p>	09/23/2012	

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	<p>and #2 sat in the living room. Direct Support Professional (DSP) #1 would occasionally walk through and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives. During medication administration client #1 did not learn information about his medications. During mealtime, client #2 did not feed himself independently. During the entire observation period there was only one staff working.</p> <p>An evening observation was conducted at the group home on 8/22/12 from 4:40 P.M. until 6:15 P.M.. During the entire observation period as DSP #1 was cooking dinner, clients #1 and #2 sat in the living room. DSP #1 would occasionally walk through and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives. During mealtime, client #2 did not feed himself independently. During the entire observation period there was only one staff working.</p> <p>A review of client #1's records was conducted on 8/24/12 at 10:45 A.M.. A review of the client's 5/10/12 Individual Support Plan (ISP) indicated the following objectives which could have been implemented during the 8/21/12</p>			

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	<p>morning and 8/22/12 evening observation periods: "Will participate in group activity...Use will learn to use a communication book to identify pictures...Will participate in structured activities...Will exercise...Will learn information about his medications."</p> <p>A review of client #2's records was conducted on 8/24/12 at 9:40 A.M.. A review of the client's 6/4/12 ISP indicated the following objectives which could have been implemented during the 8/21/12 morning and 8/22/12 evening observation periods: "Will learn to dust the furniture in the living room...Will read to staff then explain what he read...Will interact verbally with peers...Will exercise...Will learn to independently feed himself."</p> <p>The Service Coordinator (SC) was interviewed on 8/24/12 at 12:00 P.M.. The SC indicated active treatment should be ongoing and training should be both formally and informally. She further indicated there should be enough staff present to carry out the training objectives.</p> <p>9-3-3(a)</p>				

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W0192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 clients observed during medication administration (clients #1, #2 and #3) by staff not demonstrating skills and competency to administer medications as prescribed.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 8:00 A.M.. At 6:55 A.M., client #1 received his morning prescribed medications. Direct Support Professional (DSP) #1 administered his "Levothyroxine 100 mcg (microgram) tablet (thyroid)...1 tablet orally once a day...Take with plenty of water...Thera M tablet (supplement)...1 tablet daily...Take with plenty of water." Client #1 took a sip of water. Client #1 did not take his medication with plenty of water.</p> <p>At 7:00 A.M., client #2 received his morning medications. DSP #1 administered his "Aspirin 81 mg (milligram) (heart health) tablet...Give 1 tablet orally daily...Take with plenty of</p>	W0192	<p>Service Coordinator and or Community Services Nurse will re-train group home staff on following proper medication directions when administering medication for clients # 1, 2, and 3.</p> <p>To ensure future compliance, Service Coordinator and or Community Services Nurse will observe one medication at least once per week for three months and monthly thereafter.</p>	09/23/2012	

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	<p>water...Docusate Sodium (stool softener) 100 mg capsule...1 capsule twice daily...Take with plenty of water." Client #2 was not given any water during this medication administration.</p> <p>At 7:25 A.M., client #3 received his morning medications. DSP #1 administered client #3's "Levothyroxine 75 mcg tablet (thyroid)...Give on an empty stomach...Take with plenty of water...Sacralfate 1 gm (gram) tablet...Take on an empty stomach 1 hour before or 2 to 3 hours after meals." Client #3 was given his medications with a container of applesauce. Client #3 did not take his medication on an empty stomach and was not given any water during this medication administration.</p> <p>An interview with the nurse was conducted on 8/24/12 at 11:40 A.M.. The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets.</p> <p>9-3-3(a)</p>			

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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, interview and record review, the facility failed to have a sensorimotor assessment which addressed the need of a mechanical lift for 1 of 2 sampled clients (client #2).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 8:00 A.M.. At 6:40 A.M., Direct Support Professional (DSP) #1 was transferring client #2 from his bed in his bedroom to his wheelchair in the living room using a mechanical lift. While being moved from the bed to his wheelchair, client #2 was suspended from the lift in the lift sling.</p> <p>A review of client #2's record was conducted on 8/24/12 at 9:40 A.M.. The review failed to indicate a physical therapy evaluation (PT) or occupational therapy evaluation (OT) to determine how and when the mechanical lift should be used for client #2.</p> <p>An interview with the Service Coordinator (SC) was conducted on 8/24/12 at 10:30 A.M.. The SC indicated there were no PT or OT assessments for</p>	W0218	<p>Community Services Nurse will develop a high risk plan for client # 2 use of the Hoyer lift and staff at the group home will be trained.</p> <p>To ensure future compliance, Community Services Nurse will review annually during IDT. Or as needed.</p>	09/23/2012

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	<p>the use of the mechanical lift for review.</p> <p>9-3-4(a)</p>			

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W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility failed to have updated Individual Support Plans (ISP) for 3 of 4 clients residing at the group home (clients #1, #2 and #3), available for all staff who worked at the group home.</p> <p>Findings include:</p> <p>Client #1, #2 and #3's records were reviewed at the group home on 8/22/12 at 5:10 P.M. Review of client #1's record indicated a most current ISP dated 5/16/11. Review of client #2's record indicated a most current ISP dated 6/20/11. Review of client #3's record indicated a most current ISP dated 5/23/11. No further documentation was available for review to indicate client #1, #2 and #3's current ISPs were available for staff who worked with the clients at the group home.</p> <p>Interview with Direct Service Professional (DSP) #1 was conducted on 8/22/12 at 5:20 P.M.. DSP #1 indicated client #1, #2 and #3's most current ISPs were not available for the group home staff.</p>	W0248	<p>Individual Support Plans for clients 3 1, 2, will be completed and available at the group home.</p> <p>To ensure future compliance, Service Coordinator will audit client files bi-annually.</p>	09/23/2012			

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	<p>A review of client #1's record was conducted at the facility's administrative office on 8/24/12 at 10:45 A.M.. The record indicated a most current ISP dated 5/10/12.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 8/24/12 at 9:40 A.M.. The record indicated a most current ISP dated 6/4/12.</p> <p>A review of client #3's record was conducted at the facility's administrative office on 8/24/12 at 11:35 A.M.. The record indicated a most current ISP dated 5/11/12.</p> <p>An interview with the Service Coordinator (SC) was conducted on 8/24/12 at 12:00 P.M.. The SC indicated the group home staff should have updated ISPs for clients #1, #2 and #3.</p> <p>9-3-4(a)</p>			

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W0249	<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, the facility failed to implement written objectives during times of opportunity for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 7:45 A.M.. During the entire observation period clients #1 and #2 sat in the living room. Direct Support Professionals (DSP) #1 would occasionally walk through and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives. During medication administration client #1 did not learn information about his medications. During mealtime, client #2 did not feed himself independently.</p> <p>A facility owned day program observation was conducted on 8/22/12 from 12:00 P.M. until 1:30 P.M.. During the entire</p>	W0249	See tag 186	09/23/2012			

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	<p>observation period client #1 did not communicate with others. Client #1 did not use a communication book and did not identify pictures.</p> <p>An evening observation was conducted at the group home on 8/22/12 from 4:40 P.M. until 6:15 P.M.. During the entire observation period clients #1 and #2 sat in the living room. DSP #1 would occasionally walk through and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives. During mealtime, client #2 did not feed himself independently.</p> <p>A review of client #1's records was conducted on 8/24/12 at 10:45 A.M.. A review of the client's 5/10/12 Individual Support Plan (ISP) indicated the following objectives which could have been implemented during the 8/21/12 morning and 8/22/12 evening observation periods: "Will participate in group activity...Use will learn to use a communication book to identify pictures...Will participate in structured activities...Will exercise...Will learn information about his medications."</p> <p>A review of client #2's records was conducted on 8/24/12 at 9:40 A.M.. A review of the client's 6/4/12 ISP indicated</p>						

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	<p>the following objectives which could have been implemented during the 8/21/12 morning and 8/22/12 evening observation periods: "Will learn to dust the furniture in the living room...Will read to staff then explain what he read...Will interact verbally with peers...Will exercise...Will learn to independently feed himself."</p> <p>The Service Coordinator (SC) was interviewed on 8/22/12 at 12:00 P.M.. The SC stated client objectives should be implemented "during times of opportunity." The SC further indicated clients #1 and #2 should have been provided with meaningful active treatment activities during the morning and evening observation periods.</p> <p>9-3-4(a)</p>			

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W0268	<p>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 (client #1), to promote the client's dignity by not ensuring the client was neatly groomed.</p> <p>Findings include:</p> <p>An morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 8:00 A.M.. During the entire observation, client #1's hair was unkempt and his mustache hair was over his top lip and hairs were going into his nostrils.</p> <p>A facility owned day program observation was conducted on 8/22/12 from 12:00 P.M. until 1:30 P.M.. During the entire observation, client #1's hair was unkempt and his mustache hair was over his top lip and hairs were going into his nostrils.</p> <p>An evening observation was conducted at the group home on 8/22/12 from 5:00 P.M. until 7:15 P.M.. During the entire observation, client #1's hair was unkempt and his mustache hair was over his top lip and hairs were going into his nostrils.</p> <p>An interview with the Service</p>	W0268	<p>Service Coordinator will re-train group home staff on properly grooming client # 1s hair and mustache.</p> <p>To ensure future compliance, Service Coordinator will visit client 1 one weekly to monitor his personal grooming, and thereafter.</p>	09/23/2012			

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	<p>Coordinator (SC) was conducted on 8/24/12 at 12:00 P.M.. The SC indicated the group home DSP staff are responsible for ensuring the clients get their hair cut and are shaven/trimmed.</p> <p>9-3-5(a)</p>			

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, the facility failed to assure the repair of adaptive equipment for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 8:00 A.M.. Client #1 was sitting in a slouched position, leaning to the right, with his shoulders squeezed inward, in a standard wheelchair.</p> <p>A day program observation was conducted at the facility owned day program on 8/21/12 from 12:00 P.M. until 1:30 P.M.. During the entire observation, client #1 was sitting in a slouched position, leaning to the right, with his shoulders squeezed inward, sitting in a standard wheelchair. Client #1's personalized wheelchair was in the corner located in the day program classroom and was observed with the right wheel broken.</p> <p>An interview with day program Direct</p>	W0436	<p>Client # 1 and # 2s wheelchairs have been assessed for repairs and parts are on order.</p> <p>To ensure future compliance, wheel chairs will be checked for any needed repairs bi-monthly.</p>	09/23/2012			

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	<p>Support Professional (DSP) #3 was conducted on 8/22/12 at 12:30 P.M.. Day program DSP #3 indicated client #1's personalized wheelchair has been broken for a couple of weeks and he has been sitting in a standard size wheelchair since then.</p> <p>A review of a facility owned day program incident report dated 8/14/12 was conducted on 8/22/12 at 12:55 P.M.. The incident report indicated: "Screw was loose on [client #1]'s wheelchair causing outer rim to touch the ground. (Several) screws were loose for over a month before this incident. Plus one of the spokes on the right wheel is broken."</p> <p>An evening observation was conducted at the group home on 8/22/12 from 5:00 P.M. until 7:15 P.M.. During the entire observation period, client #1 was sitting in a slouched position, leaning to the right, with his shoulders squeezed inward, in a standard wheelchair. At 6:15 P.M., client #2 pointed to his left side of his wheelchair and stated "Broken." This surveyor looked and saw client #2 was pointing to an automatic button, which would allow him to maneuver his wheelchair independently if working. DSP #1 was asked how long client #2's wheelchair had been broken and she responded "About a month." Client #2</p>						

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	<p>then yelled "Broke, June." When client #2 was asked if his wheelchair had been broken since June, he nodded his head indicating "Yes."</p> <p>An interview with the Service Coordinator (SC) was conducted on 8/22/12 at 6:30 P.M.. The SC indicated clients #1 and #2's wheelchairs were broken and needed repairs. The SC further indicated she did not know when clients #1 and #2's wheelchairs would be repaired. No further documentation was available for review to indicate when clients #1 and #2's personalized wheelchairs would be repaired.</p> <p>A review of client #1's record was conducted on 8/24/12 at 10:45 A.M.. The record indicated: Medical notation dated 8/15/12: "...Wheelchair is too small and only has one brake. He needs one that tilts back and has brakes and also is for his size. It makes it very difficult to clean his teeth due to his strength, Thank you."</p> <p>9-3-7(a)</p>			

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W0448	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview, the facility failed to investigate problems with evacuation drills for 3 of 4 clients (clients #1, #2 and #3) who reside at the group home.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 8/21/12 at 12:20 P.M.. The reports of evacuation drills conducted from July 2011 to June 2012 indicated the following:</p> <p>Emergency drill record dated 8/7/11 at 4:30 A.M.: "[Client #1]...Time Required: 19 minutes 20 seconds...[client #2]...Time Required: 15 minutes 10 seconds...[client #3]...Time Required: 8 minutes 55 seconds."</p> <p>Emergency drill record dated 11/15/11 at 5:47 P.M.: "[Client #1]...Time Required: 5 minutes 40 seconds...[client #2]...Time Required: 5 minutes 38 seconds...[client #3]...Time Required: 6 minutes 2 seconds."</p> <p>Emergency drill record dated 11/30/11 at 6:15 A.M.: "[Client #1]...Time Required: 7 minutes 45 seconds...[client #2]...Time</p>	W0448	Area Manager will train staff at the group to document and report all difficulties during evacuation drills. The staff will be trained on the most expeditious route for all evacuation points. House has sprinkler system installed. To ensure future compliance, Area Manager and or maintenance will observe at least weekly, at least one fire drill for 60 days and at least quarterly thereafter.	09/23/2012			

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	<p>Required: 7 minutes 17 seconds...[client #3]...Time Required: 5 minutes 55 seconds."</p> <p>Emergency drill record dated 3/30/12 at 6:10 A.M.: "[Client #1]...Time Required: 19 minutes 15 seconds...[client #2]...Time Required: 18 minutes 45 seconds...[client #3]...Time Required: 13 minutes 30 seconds."</p> <p>Emergency drill record dated 3/24/12 at 5:55 A.M.: "[Client #1]...Time Required: 24 minutes 15 seconds...[client #2]...Time Required: 15 minutes 45 seconds...[client #3]...Time Required: 19 minutes 45 seconds."</p> <p>None of the reports documented any problems encountered during evacuation drills.</p> <p>The Area Manager (AM) was interviewed on 8/24/12 at 12:46 P.M.. The AM indicated she was aware that some clients who lived at the residence needed complete assistance with evacuating the home. The AM further stated there is "always" only one staff working the overnight/sleep hours. When asked if the facility investigated the times documented by staff, the AM indicated there had been no formalized investigation of the times taken to</p>						

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	<p>evacuate. When asked if the facility analyzed data that documented times encountered during evacuation drills, and conducted investigations of those times, the AM indicated the facility did not currently analyze data associated with evacuation drills nor did they conduct investigations of the problems encountered during evacuation drills.</p> <p>9-3-7(a)</p>			

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W0449	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview, the facility failed to take corrective action to address the drill times for 3 of 4 clients, (client #1, #2 and #3) living at the group home.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 8/21/12 at 12:20 P.M.. The reports of evacuation drills conducted from July 2011 to June 2012 indicated the following:</p> <p>Emergency drill record dated 8/7/11 at 4:30 A.M.: "[Client #1]...Time Required: 19 minutes 20 seconds...[client #2]...Time Required: 15 minutes 10 seconds...[client #3]...Time Required: 8 minutes 55 seconds."</p> <p>Emergency drill record dated 11/15/11 at 5:47 P.M.: "[Client #1]...Time Required: 5 minutes 40 seconds...[client #2]...Time Required: 5 minutes 38 seconds...[client #3]...Time Required: 6 minutes 2 seconds."</p> <p>Emergency drill record dated 11/30/11 at 6:15 A.M.: "[Client #1]...Time Required:</p>	W0449	See W448	09/23/2012			

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	<p>7 minutes 45 seconds...[client #2]...Time Required: 7 minutes 17 seconds...[client #3]...Time Required: 5 minutes 55 seconds."</p> <p>Emergency drill record dated 3/30/12 at 6:10 A.M.: "[Client #1]...Time Required: 19 minutes 15 seconds...[client #2]...Time Required: 18 minutes 45 seconds...[client #3]...Time Required: 13 minutes 30 seconds."</p> <p>Emergency drill record dated 3/24/12 at 5:55 A.M.: "[Client #1]...Time Required: 24 minutes 15 seconds...[client #2]...Time Required: 15 minutes 45 seconds...[client #3]...Time Required: 19 minutes 45 seconds."</p> <p>The Area Manager (AM) was interviewed on 8/24/12 at 12:46 P.M.. The AM indicated she was aware that some clients who lived at the residence needed complete assistance with evacuating the home. The AM further stated there is "always" only one staff working the overnight/sleep hours. When asked if the facility had identified what corrective action could be taken to address the time concerns, the AM indicated no corrective actions were identified or implemented.</p> <p>9-3-7(a)</p>						

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 5475 STONE AVE 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			
W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed to assure 3 of 3 clients observed during meal times (clients #1, #2 and #3), participated in family style dining.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/12 from 5:40 A.M. until 8:00 A.M.. During the observation Direct Support Professional (DSP) #1 toasted bread and spread jelly on the slices of toast. While DSP #1 toasted the bread, clients #1, #2 and #3 sat at the dining table with no activity. Clients #1, #2 and #3 did not assist in toasting the bread and did not serve themselves.</p> <p>An evening observation was conducted at the group home on 8/22/12 from 5:00 P.M. until 7:15 P.M.. At 6:15 P.M., DSP #1 began preparing dinner which consisted of hamburgers, fries and california blend vegetables, while clients #1, #2 and #4 sat in the living room with no activity. Clients #1, #2 and #3 did not assist in preparing dinner.</p>	W0488	<p>Service Coordinator will train group home staff on having each client participate to the extent of their abilities in meal preparation and serving themselves.</p> <p>To ensure future compliance, Service Coordinator will observe once a week for one month and monthly thereafter</p>	09/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G703	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2012
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	<p>An interview with the Service Coordinator (SC) was conducted on 8/24/12 at 12:00 P.M.. The SC indicated clients #1, #2 and #3 were developmentally capable of participating in the family dining process and meal preparation.</p> <p>9-3-8(a)</p>			