

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G721		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 6835 W CR 950 N SCIPIO, IN 47273			
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W000000	<p>This visit was for a post certification revisit (PCR) to the fundamental annual recertification and state licensure survey completed on 2/15/13.</p> <p>Survey dates: April 18 and 19, 2013.</p> <p>Facility number: 004492 Provider number: 15G721 AIM number: 200512660</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/24/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000					

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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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 4 of 4 clients (#1, #2, #3 and #4) observed to receive their medications, the facility failed to ensure all staff received competency-based training on medication administration.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. At 5:52 AM when staff #2 opened the front door, staff #2 stated she was "in trouble." Staff #2 indicated she was going to lose her job but did not indicate what she was talking about. Staff #2 stated she "didn't follow protocol." At 6:07 AM in the unlocked medication room, there was a poured container of Chlorhexidine sitting on the counter next to a toothbrush with toothpaste on it. Client #1's nasal spray (Fluticasone Prop) was sitting on the counter.</p> <p>At 7:17 AM when staff #2 went in to pass medications to client #2, staff #2 indicated she prepared client #2's medications during the overnight shift to</p>	W000189	Staff #2 was suspended, and then her employment with AWS was terminated. The AWS Nurse, QDDP, Manager, and Team Leader will each complete medication administration audits to insure that all shifts are correctly administering medication in compliance with their Core A and B training. Medication Administration Audits will be reviewed and discussed at Management staff meetings to determine if additional training or monitoring is needed.	05/19/2013			

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	<p>save time. Staff #2 indicated she prepared clients #1, #3 and #4's medications as well. Staff #2 stated, "I'm going to be fired." At 7:20 AM, the Team Leader knocked on the closed medication room door and asked for client #3's toothbrush. Client #3's toothbrush was sitting on the counter with toothpaste already on it. Staff #2 handed the Team Leader client #3's toothbrush and a cup with Chlorhexidine that was also sitting on the counter, unlocked. At 7:20 AM, staff #2 stated, "I know it's not right." Staff #2 indicated it was safer to prepare the medications prior to the medication pass. Staff #2 stated, "It's a no-no and I'm sure I'll be wrote up and not be able to give meds." At 7:22 AM, the Medication Administration Record (MAR) was noted to be initialed by staff #2 prior to the medication administration. Client #1's nasal spray (Fluticasone Prop) was sitting on the counter unlocked.</p> <p>At 7:26 AM, client #4 received his medications from staff #2. Client #4's medications were prepared and stored in a locked cabinet prior client #4 entering the medication room. Client #4's MAR was signed prior to staff #2 administering his medications.</p> <p>At 7:31 AM, client #3 received her medications from staff #2. Client #3's</p>				

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	<p>medications were in a cup prepared prior to client #3 entering the medication room. Client #3's MAR was signed prior to client #3 receiving her medications.</p> <p>At 7:38 AM, client #1 received his medications from staff #2. Client #1's medications were already prepared prior to client #1 entering the medication room. Client #1's MAR was signed prior to the medication administration.</p> <p>An interview with the Team Leader (TL) was conducted on 4/18/13 at 8:53 AM. The TL indicated the clients' medications should be locked until they are used. The TL indicated the MAR was to be initialed after medications were administered. The TL indicated the medications should be prepared for administration when the client entered the medication room.</p> <p>An interview with the Home Manager (HM) was conducted on 4/18/13 at 10:01 AM. The HM indicated medications should be locked unless being prepared for administration. The HM indicated the MAR should be initialed after the medication pass and the client was observed to swallow the medication. The HM indicated the clients' medications should be prepared individually at the time of administration with the client present. The HM indicated on 4/18/13 at</p>						

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	<p>9:45 AM staff #2 needed to be retrained in Core A and B.</p> <p>An interview with the nurse was conducted on 4/18/13 at 9:51 AM. The nurse indicated medications should be locked until being prepared for administration. The nurse indicated the MAR should be initialed after medications were administered. The nurse indicated the clients' medications should be prepared right before the staff administered the medications.</p> <p>9-3-3(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 1 of 2 clients in the sample (#3) and one additional client (#1), the facility failed to ensure their mealtime training objectives were implemented during breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. During the observation for breakfast preparation from 6:30 AM to 6:56 AM, clients #1 and #3 sat at the dining room table. At 6:39 AM, staff #2 put napkins on the table while client #3 sat at the table. At 6:54 AM, staff #2 used a cart to take the bowls of cream of wheat to the table. Client #3 was not prompted to assist with putting napkins on the table. Client #3 was not prompted to place neck napkins on the table. Client #3 was not prompted to put prepared food into serving bowls. Client #1 was not prompted to push the cart with the food to the dining room table with staff</p>	W000249	The AWS QDDP and Manager will complete staff retraining regarding meal preparation goals and client meal preparation participation. The AWS QDDP, Manager, and Team Leader will complete weekly Dining Checklist audits to ensure the appropriate implementation of meal preparation goals and participation is occurring.	05/19/2013			

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	<p>assistance.</p> <p>A review of client #1's record was conducted on 4/18/13 at 9:31 AM. On 2/28/13, client #1's Individual Support Plan (ISP) had an addendum to be implemented on 3/1/13. The addendum indicated, in part, "[Client #1] will push the cart with the food to the dinning (sic) table with staff assistance."</p> <p>A review of client #3's record was conducted on 4/18/13 at 9:38 AM. On 2/28/13, client #3's ISP had an addendum to be implemented on 3/1/13. The addendum indicated, in part, "To add meal activity goal...". The meal activity goal indicated, "[Client #3] will place neck napkins and napkins at each person's table spot with hand over hand assistance." A second meal activity goal indicated, "[Client #3] will assist with putting the prepared food into bowls with hand over hand assistance."</p> <p>An interview with the Team Leader (TL) was conducted on 4/18/13 at 9:42 AM. The TL indicated there were mealtime goals for clients #1 and #3 and they should have been implemented.</p> <p>An interview with the Home Manager (HM) was conducted on 4/18/13 at 9:42 AM. The HM indicated client #1 and #3's</p>						

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	<p>mealtime goals should be implemented anytime they eat.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/18/13 at 9:42 AM. The QIDP indicated clients #1 and #3 had goals for staff to implement for meals. The QIDP indicated the goals should have been implemented.</p> <p>This deficiency was cited on 2/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (#3 and #4) and one additional client (#2), the facility failed to ensure the specially constituted committee (Human Rights Committee - HRC) reviewed, approved and monitored restrictive program plans to manage inappropriate mealtime behavior by client #3 and the use of an audible monitor for clients #2 and #4.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. During the observation, an audible monitor was in use for client #2 and #4's bedroom. The monitor was located on the kitchen island. The monitor was turned on and the activity in client #2 and #4's bedroom could be heard through the monitor.</p> <p>A review of client #2's record was conducted on 4/18/13 at 8:36 AM. His Individual Support Plan (ISP), dated 8/22/12, indicated the use of a monitor</p>	W000262	Human Rights Committee approval and written informed consent from the guardian will be obtained for client's #2 and #4 bedroom monitor use. Human Rights Committee approval and written informed consent from the guardian will be obtained for client #3 to remove plate as needed during mealtime. Client #2 and #4 ISPs will be updated to include information regarding the purpose of the use of a bedroom monitor. The need for Human Rights Committee approval and written informed consent from the guardian for items being implemented in client plans will be reviewed by the AWS QDDP with the IDT during each client's quarterly and annual meeting.	05/19/2013	

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	<p>was added to his plan on 2/18/13. The ISP did not indicate the purpose of the use of the monitor. There was no documentation the HRC reviewed, approved and monitored the use of an audible monitor.</p> <p>A review of client #4's record was conducted on 4/18/13 at 8:34 AM. His ISP, dated 8/9/12, indicated the use of a monitor was added to his plan on 2/18/13. The ISP did not indicate the purpose of the use of the monitor. There was no documentation the HRC reviewed, approved and monitored the use of an audible monitor.</p> <p>A review of client #3's record was conducted on 4/18/13 at 8:31 AM. Client #3's Physical and Nutritional Management Plan, dated 1/11/13, indicated, in part, "If client continues to eat her food too quickly, remove the plate and wait a short time then return the plate and continue with the meal." There was no documentation the HRC reviewed, approved and monitored the use of staff removing her plate.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/18/13 at 8:33 AM. The QIDP indicated the HRC did not review, approve and monitor the use</p>				

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	<p>of an audible monitor for clients #2 and #4. The QIDP indicated the HRC did not review, approve and monitor staff removing client #3's plate when she ate too quickly.</p> <p>This deficiency was cited on 2/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (#3 and #4) and one additional client (#2), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the restrictive program plans to manage inappropriate mealtime behavior by client #3 and the use of an audible monitor for clients #2 and #4 were conducted with written informed consent of the clients' guardians.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. During the observation, an audible monitor was in use for client #2 and #4's bedroom. The monitor was located on the kitchen island. The monitor was turned on and the activity in client #2 and #4's bedroom could be heard through the monitor.</p> <p>A review of client #2's record was conducted on 4/18/13 at 8:36 AM. His Individual Support Plan (ISP), dated 8/22/12, indicated the use of a monitor</p>	W000263	Human Rights Committee approval and written informed consent from the guardian will be obtained for client's #2 and #4 bedroom monitor use. Human Rights Committee approval and written informed consent from the guardian will be obtained for client #3 to remove plate as needed during mealtime. Client #2 and #4 ISPs will be updated to include information regarding the purpose of the use of a bedroom monitor. The need for Human Rights Committee approval and written informed consent from the guardian for items being implemented in client plans will be reviewed by the AWS QDDP with the IDT during each client's quarterly and annual meeting.	05/19/2013			

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	<p>was added to his plan on 2/18/13. The ISP did not indicate the purpose of the use of the monitor. There was no documentation the guardian gave written informed consent for the use of an audible monitor.</p> <p>A review of client #4's record was conducted on 4/18/13 at 8:34 AM. His ISP, dated 8/9/12, indicated the use of a monitor was added to his plan on 2/18/13. The ISP did not indicate the purpose of the use of the monitor. There was no documentation the guardian gave written informed consent for the use of an audible monitor.</p> <p>A review of client #3's record was conducted on 4/18/13 at 8:31 AM. Client #3's Physical and Nutritional Management Plan, dated 1/11/13, indicated, in part, "If client continues to eat her food too quickly, remove the plate and wait a short time then return the plate and continue with the meal." There was no documentation the guardian gave written informed consent for the staff to remove client #3's plate.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/18/13 at 8:33 AM. The QIDP indicated there was no written informed consent from the clients'</p>				

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	guardians for the use of an audible monitor for clients #2 and #4 and staff removing client #3's plate if she ate too quickly. 9-3-4(a)				

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W000365	<p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 4 of 4 clients observed to receive their medications (#1, #2, #3 and #4), the facility failed to ensure staff documented medications that were administered on the Medication Administration Record (MAR) after the medications were administered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. At 5:52 AM when staff #2 opened the front door, staff #2 stated she was "in trouble." Staff #2 indicated she was going to lose her job but did not indicate what she was talking about. Staff #2 stated she "didn't follow protocol."</p> <p>At 7:17 AM when staff #2 went in to pass medications to client #2, staff #2 indicated she prepared client #2's medications during the overnight shift to save time. Staff #2 indicated she prepared clients #1, #3 and #4's medications as well. Staff #2 stated, "I'm going to be fired." At 7:22 AM, the Medication Administration Record (MAR) was noted to be initialed by staff #2 prior to the medication administration.</p>	W000365	Staff #2 was suspended, and then her employment with AWS was terminated. The AWS Nurse, QDDP, Manager, and Team Leader will each complete medication administration audits to insure that all shifts are correctly administering medication in compliance with their Core A and B training. Medication Administration Audits will be reviewed and discussed at Management staff meetings to determine if additional training or monitoring is needed.	05/19/2013			

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	<p>At 7:26 AM, client #4 received his medications from staff #2. Client #4's medications were prepared and stored in a locked cabinet prior client #4 entering the medication room. Client #4's MAR was signed prior to staff #2 administering his medications.</p> <p>At 7:31 AM, client #3 received her medications from staff #2. Client #3's medications were in a cup prepared prior to client #3 entering the medication room. Client #3's MAR was signed prior to client #3 receiving her medications.</p> <p>At 7:38 AM, client #1 received his medications from staff #2. Client #1's medications were already prepared prior to client #1 entering the medication room. Client #1's MAR was signed prior to the medication administration.</p> <p>An interview with the Team Leader (TL) was conducted on 4/18/13 at 8:53 AM. The TL indicated the MAR was to be initialed after medications were administered.</p> <p>An interview with the Home Manager (HM) was conducted on 4/18/13 at 10:01 AM. The HM indicated the MAR should be initialed after the medication pass and the client was observed to swallow the</p>						

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	<p>medication.</p> <p>An interview with the nurse was conducted on 4/18/13 at 9:51 AM. The nurse indicated the MAR should be initialed after medications were administered.</p> <p>9-3-6(a)</p>				

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation and interview for 1 of 4 clients (#1) observed to receive their medications, the facility failed to ensure staff administered the client's medications without error.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM.</p> <p>At 6:01 AM, staff #2 was interviewed. Staff #2 indicated client #2's Small Volume Nebulizer (SVN) machine broke last night during the 12:00 AM treatment. Staff #2 indicated client #2's Albuterol was going to be sent to the facility-operated day program to be administered. Staff #2 indicated he would be receiving his medication late.</p> <p>At 7:38 AM, client #1 received his medications from staff #1. After client #1 stood up to leave the medication administration room, a brown pill was observed to roll across the med room floor and ended up next to the med room door. Staff #2 had exited the room and</p>	W000369	The nebulizer machine for client #2 has been replaced with a new one. A back up nebulizer will be kept in place for client #2. The AWS Nurse will monitor equipment in the home to insure it is in working order, and make replacements as necessary.	05/19/2013			

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	<p>did not observe the pill on the floor. The surveyor informed staff #2 of the brown pill on the floor. Staff #2 stated she "thought" client #1 took all of his medications. The brown pill was a Senna Laxative for constipation. At 7:45 AM, staff #2 contacted the nurse regarding the found brown pill. The nurse instructed staff #2 to administer another Senna Laxative pill.</p> <p>During the observations at the group home on 4/18/13, client #2 did not receive his Albuterol 0.083% inhalant solution for bronchitis.</p> <p>A review of client #2's April 2013 Medication Administration Record (MAR) was conducted on 4/18/13 at 8:19 AM. The MAR had staff #2's initials with a circle around the initials. On the back of the MAR, staff #2 documented, "SVN machine broke" for the 12:00 AM and 6:00 AM doses.</p> <p>An interview with the nurse was conducted on 4/19/13 at 11:24 AM. The nurse indicated client #2's SVN machine, she was told, stopped working during the 12:00 AM treatment. The nurse indicated she was notified of the issue when she arrived to the home for her interview with the surveyor (4/18/13 at 9:51 AM). The nurse indicated the machine was not</p>						

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	<p>fixable so an order was obtained to get a new machine. The machine from the day program was being sent back and forth until a new machine could be obtained. The nurse indicated client #2 received his treatment on 4/18/13 when he arrived to the day program. The nurse indicated it was a medication error due to faulty equipment. The nurse indicated for client #1 the staff should have ensured client #1 swallowed all of his pills prior to leaving the medication room. The nurse indicated someone may have found the pill. The nurse indicated she was contacted and client #1 did receive his medication. The nurse indicated the staff should have ensured client #1 took his medication.</p> <p>9-3-6(a)</p>				

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation, record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure staff kept all medications locked except when being prepared for administration.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. At 5:52 AM when staff #2 opened the front door, staff #2 stated she was "in trouble." Staff #2 indicated she was going to lose her job but did not indicate what she was talking about. Staff #2 stated she "didn't follow protocol." At 6:07 AM in the unlocked medication room, there was a poured container of Chlorhexidine sitting on the counter next to a toothbrush with toothpaste on it. Client #1's nasal spray (Fluticasone Prop) was sitting on the counter. This affected clients #1, #2, #3 and #4.</p> <p>At 7:20 AM, the Team Leader knocked on the closed medication room door and asked for client #3's toothbrush. Client #3's toothbrush was sitting on the counter with toothpaste already on it. Staff #2</p>	W000382	<p>Staff #2 was suspended, and then her employment with AWS was terminated. The AWS Nurse, QDDP, Manager, and Team Leader will each complete medication administration audits to insure that all shifts are correctly administering medication in compliance with their Core A and B training. Medication Administration Audits will be reviewed and discussed at Management staff meetings to determine if additional training or monitoring is needed.</p>	05/19/2013			

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	<p>handed the Team Leader client #3's toothbrush and a cup with Chlorhexidine that was also sitting on the counter, unlocked. At 7:20 AM, staff #2 stated, "I know it's not right." Staff #2 indicated it was safer to prepare the medications prior to the medication pass. Staff #2 stated, "It's a no-no and I'm sure I'll be wrote up and not be able to give meds." At 7:22 AM, client #1's nasal spray (Fluticasone Prop) was sitting on the counter unlocked.</p> <p>An interview with the Team Leader (TL) was conducted on 4/18/13 at 8:53 AM. The TL indicated the clients' medications should be locked until they are used.</p> <p>An interview with the Home Manager (HM) was conducted on 4/18/13 at 10:01 AM. The HM indicated medications should be locked unless being prepared for administration.</p> <p>An interview with the nurse was conducted on 4/18/13 at 9:51 AM. The nurse indicated medications should be locked until being prepared for administration.</p> <p>9-3-6(a)</p>				

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the clients were involved with breakfast and lunch preparation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/18/13 from 5:52 AM to 8:02 AM. Upon arrival to the group home, there was a pan on the stove with cooked eggs. At the time of arrival, clients #1, #2, #3 and #4 were in their bedrooms. There were three bowls sitting on the counter with packets of cream of wheat. At 6:14 AM, staff #1 put the eggs in a divided plate with cut up toast and placed the plate into the refrigerator. During the observation for breakfast preparation from 6:30 AM to 6:58 AM, clients #1, #2, and #3 sat at the dining room table. At 6:30 AM, staff #1 turned on the stove to heat up a pot of water. At 6:36 AM, staff #1 poured the packets of cream of wheat into the bowls on the counter. Staff #2 placed a neck napkin on client #1. Staff #1 got client #1's food out of the refrigerator. At 6:39 AM, staff #2 put napkins on the table while clients #1,</p>	W000488	The AWS QDDP and Manager will complete staff retraining regarding meal preparation goals and client meal preparation participation. The AWS QDDP, Manager, and Team Leader will complete weekly Dining Checklist audits to ensure the appropriate implementation of meal preparation goals and participation is occurring.	05/19/2013			

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	<p>#2 and #3 sat at the table. Staff #1 asked client #2 if he wanted chocolate milk. Client #2 stated, "White." Staff #1 poured client #2's milk. Staff #2 gave clients #2 and #3 their pureed breakfast. Staff #1 turned off the stove. At 6:42 AM, staff #1 put bread in the toaster. At 6:43 AM, staff #1 got plates out of the cabinet. At 6:45 AM, staff #1 put hot water into the bowls. At 6:46 AM, staff #2 stirred client #2's drink. Staff #1 peeled a banana and put it onto a plate. At 6:48 AM, staff #1 cut up the banana. At 6:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) gave client #4 his drink and asked him to stir it. At 6:54 AM, staff #2 used a cart to take the bowls of cream of wheat to the table. At 6:56 AM, staff #2 used client #4's knife to cut his toast. At 6:58 AM, staff #2 put thickener into client #2's milk. Client #1 was given a plate with toast and eggs. During the observation, clients #1, #2, #3 and #4 were not involved with preparing their lunches. The clients did not put their lunches into a lunch box and did not carry their lunches to the van. At 8:02 AM, the large lunchbox was observed to be in the van.</p> <p>An interview with staff #2 was conducted on 4/18/13 at 8:00 AM. Staff #2 indicated she prepared the clients' lunches during the overnight shift (12:00 AM to</p>						

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	<p>6:00 AM). Staff #2 indicated the clients were asleep when she made the lunches.</p> <p>An interview with the Team Leader (TL) was conducted on 4/18/13 at 9:42 AM. The TL indicated the clients should be more involved with meal preparation.</p> <p>An interview with the QIDP was conducted on 4/18/13 at 9:42 AM. The QIDP indicated the clients could be more involved with meal preparation.</p> <p>This deficiency was cited on 2/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>				