

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: October 14, 15, 16, 17 and 24, 2014</p> <p>Facility number: 001034 Provider number: 15G520 AIM number: 100245230</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/5/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000112	<p>483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed to keep 8 of 8 clients living at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8)'s information confidential by having each client's diet order in the open kitchen/dining/living room area.</p>	W000112	The diet order listing for each individual in the home was removed from the open kitchen/dining/living room area by 11/7/14. Now that it has been removed from the public area, visitors to the home no longer have access to the confidential information. All staff at the site will be re-trained by 11/23/14 on	11/23/2014

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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W000130	<p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 7:30 A.M., on the refrigerator located in the open kitchen/dining area in plain view where visitors to the home had access, was a list with clients #1, #2, #3, #4, #5, #6, #7 and #8's first and last initials and each client's diet order.</p> <p>An evening observation was conducted at the group home on 10/14/14 from 5:00 P.M. until 6:55 P.M.. On the refrigerator located in the open kitchen/dining area in plain view where visitors to the home had access, was a list with clients #1, #2, #3, #4, #5, #6, #7 and #8's first and last initials and each client's diet order.</p> <p>An interview with the PD/Qualified Intellectual Disabilities Professional (Program Director/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated the clients' information should not have been in the open area where visitors to the home could see.</p> <p>9-3-1(a)</p> <p>483.420(a)(7)</p>		the expectation that all client records, regardless of the form or storage method of the records, must be kept confidential. The Program Director/QIDP will monitor that the public areas of the home to ensure the areas are free from confidential information during weekly visits to the home. If any confidential information is discovered in a public area it will be removed immediately, and staff will be re-trained during the site visit.		

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	<p>PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) to ensure privacy during bathing/showering/hygiene tasks.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 5:50 A.M., Direct Support Professional (DSP) #1 began preparing medications in the main bathroom while client #1 sat in her bath water unclothed, with no shower curtain and with the bathroom door open. Beginning at 5:55 A.M., DSP #1 called client #7 into the bathroom and administered their medications while client #1 sat in the bathtub naked. At 6:00 A.M., DSP #1 prompted client #8 into the bathroom and administered their medications while client #1 sat in the bathtub naked. At 6:05 A.M., DSP #2 wheeled client #2 from client #4's bedroom bathroom across the hall to client #2's bedroom. Client #2 was naked. There was no training regarding privacy observed during the showering/hygiene task period.</p>	W000130	<p>Direct Support Staff #1 and #2 received disciplinary action for failing to protect client rights. In addition, both were re-trained on the expectation that staff are to ensure client privacy during treatment and care of personal needs. All staff at the home will be re-trained by 11/23/14 on the expectation to ensure the rights of all clients served, including the right to privacy during treatment and care of personal needs. A shower curtain was purchased and installed for the bathtub in an effort to ensure privacy. In addition, bathrobes were purchased for each individual in the home. Everyone at the home (clients and staff) will ensure that when entering or exiting the bathroom for personal care needs, that a bathrobe is worn when not wearing clothing. Training on this expectation will occur by 11/23/14. The Program Director/QIDP will monitor the implementation of client privacy through weekly site visits and a weekly documentation review of each individual's privacy goals (as appropriate).</p>	11/23/2014

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W000140	<p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated all clients should have privacy while showering/bathing and performing hygiene tasks.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 8 of 8 clients who reside at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), for whom the facility managed their personal funds accounts.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the group home on 10/17/14 at 1:30 P.M.. A review of client #1, #2, #3, #4, #5, #6, #7 and #8's personal</p>	W000140	<p>The Program Director/QIDP was re-trained on the expectation that a system which ensures a full and complete accounting of clients' personal funds is required at the home. Previously, all records of withdrawals, deposits, banking accounts and receipts of expenditures were maintained by the facility in a regional office. Going forward, copies of the monthly records for each of the clients' personal funds will be kept in the home as well as at the regional office. In order to monitor that the records of client finances are present in the home, the Lead DSP will</p>	11/23/2014			

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W000149	<p>financial records was conducted. Review of clients #1, #2, #3, #4, #5, #6, #7 and #8's financial records failed to indicate the facility maintained an accurate accounting system of the clients' personal finances for the months of 10/13, 11/13, 12/13, 1/14, 2/14, 4/14, 5/14, 6/14, 7/14, 8/14 and 9/14. There were no records of withdrawals and/or deposits of clients #1, #2, #3, #4, #5, #6, #7 and #8's banking accounts and no receipts of their expenditures available for review for the mentioned months.</p> <p>An interview with the Program Director (PD) was conducted on 10/17/14 at 3:20 P.M.. The PD indicated the facility managed clients #1, #2, #3, #4, #5, #6, #7 and #8's finances and further indicated the facility was to keep an accurate account of their finances at all times. The PD indicated the records submitted were all that were available for review.</p> <p>9-3-2(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.</p>		complete a monthly assessment which indicates if the documentation in the home is current and present. This monthly checklist will be reviewed by the PD/QIDP on a monthly basis for quality purposes. In addition, the Program Director/QIDP will conduct an audit of the clients' records on a quarterly basis. During the audit, the PD/QIDP will ensure that the previous twelve months worth of financials are present in the home.	

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	<p>Based on record review and interview for 3 of 4 sampled clients and 1 additional client (clients #1, #3, #4 and #8), the facility failed to implement written policy and procedures in regard to prohibiting abuse/neglect and conducting a thorough investigation in regard to an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/14/14 at 11:10 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>Incidents involving client #3 indicated:</p> <p>-BDDS report dated 6/20/14 indicated: "[Client #3] had been asleep for the bulk of the night. She did get up once to use the restroom When [client #3] got up for the morning staff noticed that she had a small bump on the right side of her face immediately below her eye. [Client #3]'s face began to swell and the small bump became red and angry. [Client #3] went to the hospital for an examination. The doctor stated that it looked as if [client #3] had a fall and that the injury looked like carpet burn. [Client #3] had gotten</p>	W000149	<p>All staff are trained upon hire and on an annual basis on the policy and procedure concerning abuse, neglect, and exploitation. In addition, all staff are trained on the policy and procedure regarding reporting incidents. All staff at the home will be re-trained by 11/23/14 on the policies and procedures that prohibit mistreatment, neglect or abuse of the client. All staff will receive ongoing re-training and disciplinary action (as needed) if incidents occur or are not reported in a timely manner. The Program Director / QIDP will receive training on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and investigations of peer to peer aggression. The Program Director/QIDP will report findings of the investigations to management within 5 business days. On a monthly basis, all incident reports are to be tracked in a facility database, the Program Director / QIDP, Area Director and Safety Committee review timeliness of reporting, status of investigation(s), trending and future preventative measures not just for the individual directly involved but for all residents of the home. Results of this analysis will be discussed during monthly management meetings for quality assurance.</p>	11/23/2014

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	<p>up to tell staff that she needed to use the restroom so she obviously she (sic) fell as she was getting up." Further review of the record failed to indicate a thorough investigation had been conducted in regard to this injury of unknown origin.</p> <p>-BDDS report dated 7/1/14 indicated: "The group home was engaged in a table activity, when [client #3] was asked to come sit at the table to began (sic) activity with the group. [Client #3] became non-compliant with physical aggression and reached over to peer beside her and scratched the other consumer upper left arm area." Further review of the record indicated the other consumer involved was consumer #1.</p> <p>-BDDS report dated 8/29/14 indicated: "[Client #3] had a bone density test completed earlier in the day. She had been sedated for the test and it appeared that she was still lethargic from the PRN (as needed) medications that had been administered. [Client #3] was sitting on the couch in the living room late in the evening. Staff went to the kitchen and heard a noise from the living room. [Client #3] was seen on the floor with blood coming from her nose. She was transported by ambulance to the hospital. There she was evaluated and it was determined that she had a fracture to her</p>			

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	<p>nose." Further review of the record indicated staff left client #3 unsupervised during the fall with injury.</p> <p>Incident involving client #4 indicated:</p> <p>-BDDS report dated 5/1/14 indicated: "[Client #4] had been picked up from the workshop. She was wheeled to the van in her wheelchair and used the lift to enter the van. [Client #4]'s wheelchair was secured to the van floor. The staff pulled off and started driving home. The vehicle in front of the van slammed on brakes and [Staff name] had to slam on the brakes to stop the van. [Client #4] fell out of her van and hit her knee against the frame of the seat in front of her. [Client #4] had a gash in her right knee from this incident. She was transported to [Hospital name] for treatment and examination. [Client #4] had seven stitches to close the gash on her knee." Further review of the record indicated staff neglected to ensure client #4's seat belt was on during the incident with injury.</p> <p>Incident involving client #8 indicated:</p> <p>-Investigation record dated 7/12/14 indicated: "[Client #8] had been having behavioral issues all day. She wanted to complete a gardening project but did not</p>						

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	<p>have the dirt or pots. She requested that staff take her to secure the items and staff informed her that she would have to wait until lunch was over. [Client #8] began to display aggressive behaviors and spit upon staff. As [Staff name] walked by [client #8] spit upon her and attempted to hit her. [Staff name] initiated a restraint on [client #8] and released [client #8] back to her regular activity afterwards." Further review of the record indicated, "[Staff name] admits that she put [client #8] in an unapproved hold....The allegation of abuse is substantiated in this case."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 10/17/14 at 3:30 P.M.. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14, indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statues including intentionally touching another person in a</p>			

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	<p>rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...."</p> <p>An interview with the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) was conducted on 10/17/14 at 3:20 P.M.. The QIDP/PD indicated staff should follow the facility's abuse/neglect policy. The QIDP/PD indicated clients</p>			

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W000154	<p>should be free of abuse and neglect and staff are to ensure all clients are free of abuse and neglect.</p> <p>9-3-2(a)</p> <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 4 sampled clients (client #3), the facility failed to conduct an investigation of an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/14/14 at 11:10 A.M.. Review of the facility's Bureau of</p>	W000154	The Program Director / QIDP will receive training by 11/23/14 on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and investigations of peer to peer aggression. The Program Director/QIDP will report findings of the investigations to management within 5 business days. The Program Director / QIDP will maintain an annual file of all incident reports filed on	11/23/2014

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	<p>Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 6/20/14 indicated: "[Client #3] had been asleep for the bulk of the night. She did get up once to use the restroom When [client #3] got up for the morning staff noticed that she had a small bump on the right side of her face immediately below her eye. [Client #3]'s face began to swell and the small bump became red and angry. [Client #3] went to the hospital for an examination. The doctor stated that it looked as if [client #3] had a fall and that the injury looked like carpet burn. [Client #3] had gotten up to tell staff that she needed to use the restroom so she obviously she (sic) fell as she was getting up." Further review of the record failed to indicate a thorough investigation had been conducted in regard to this injury of unknown origin.</p> <p>An interview with the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) was conducted on 10/17/14 at 3:20 P.M.. The QIDP indicated there was no written documentation to indicate an investigation had been conducted in regard to the mentioned injury of unknown origin.</p>		<p>behalf of each client in the home. The Program Director / QIDP will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. All incident reports are tracked by the facility. The Program Director / QIDP and the Area Director receive notification every time an incident report is filed, requires follow-up, and is closed. An additional item will be incorporated on the database indicating the status of the investigation. This tracking system will be monitored by the Program Director, Area Director, and Safety Committee on a monthly basis for quality review. 11/20/2014 Update The Program Director/QIDP will be instructed to inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted.</p>				

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W000189	<p>9-3-2(a)</p> <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. Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients and 2 additional clients (clients #1, #2, #3, #5 and #8), to ensure staff were sufficiently trained to assure competence in administering medications without error.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/14/14 at 11:10 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 3/27/14 involving client #5 indicated: "Med exchange with [Pharmacy name] took place on Thursday 3/27/14. The medication Abilify had been changed by the psychiatrist from 10 mg (milligram) to 15 mg in the P.M.. However, the staff had not discontinued 10 mg in the A.M. once the 15 mg for the</p>	W000189	<p>Each employee is provided with initial and continuous training opportunities to enable the employee to perform his or her duties effectively, efficiently, and competently. Upon hire, all staff are required to pass Med Core A and Med Core B in order to fulfill the orientation period. In addition, all staff are required to complete an on-site medical orientation in order to work within the assigned facility. All staff are subsequently required to complete an individual specific medical administration refresher training on an annual basis as a condition of employment. All staff at the home will be re-trained on the policy and procedure for medical administration by 11/23/14. Topics will include; how to enter and discontinue medications on the medication administration record, how to ensure an adequate supply of medication is in the home (how to order medications from the pharmacy), how to ensure the prescription</p>	11/23/2014			

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	<p>P.M. had been delivered. This was approximately 4/13/14. Disciplinary action was taken with staff." Further review of the record indicated client #5 received both doses of Abilify.</p> <p>-BDDS report dated 6/4/14 involving client #2 indicated: "On 6/4/14 [client #2] took her 6 P.M. dosage of Nitrofurantoin at 4 P.M.. During the 6 P.M. medication pass the medication was readministered. [Client #2] receive (sic) 200 mg (milligram) instead of 100 mg of this medication. A total staff retraining on medication administration has been scheduled within the next two weeks."</p> <p>-BDDS report dated 6/9/14 involving client #2 indicated: "[Client #2] was taking Macrochantin 100 mg for urinary tract infection. The supply had run out and the doctor had not authorized a refill. However he had not discontinued the medication. [Client #2] missed her morning dose of medication."</p> <p>-BDDS report dated 6/15/14 involving client #3 indicated: "[Client #3] is prescribed Loperamide 2 mg every other day at 6 A.M.. Staff administered the medication but it was the wrong day. Staff received disciplinary action for failure to administer medications properly."</p>		<p>label matches the order and matches the MAR, how to ensure the right medication is given to the right person at the right time in the right dosage through the right route. Each staff member of the home will be observed by the facility nurse while completing a medication pass within the next 90 days. Documentation of these observations will be collected and submitted to be held in the employee personnel record. If any errors are observed, they will be corrected immediately and the staff will be re-trained by the nurse at the time of the occurrence. Going forward, once all staff have been observed by the facility nurse, staff competency will be evaluated on an ongoing basis through unannounced medical administration observations to be conducted by the Program Director/QIDP, facility nurse, Lead DSP or Medical Support DSP. The Program Director/QIDP, facility nurse, Lead DSP, and Medical Support DSP meet on a weekly basis to review the recent and upcoming medical appointments and consultations for each client in the home. In addition, during these meeting the MARs of each individual in the home are reviewed for accuracy by comparing them to the orders. The minutes from this weekly medical meeting are forwarded by the facility nurse to the Program</p>	

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	<p>-BDDS report dated 6/19/14 involving client #5 indicated: "[Client #5] is prescribed 500 mg of Calcium each day at 6:30 A.M. This morning she did not receive her medication because medication exchange had not taken place."</p> <p>-BDDS report dated 6/19/14 involving client #8 indicated: "[Client #8] is prescribed Spironolactone 25 mg at 6:30 A.M.. The medication exchange had not taken place with [Pharmacy name]. The medication was unavailable for administration today."</p> <p>-BDDS report dated 6/19/14 involving client #3 indicated: "On 6/19 staff discovered [client #3] was given an incorrect dosage of her scheduled medication. She received 1800 mg of Oxcarbazepine instead of her normal 1200 mg dosage. Staff will be reminded to pay better attention when dispensing medication."</p> <p>-BDDS report dated 6/25/14 involving client #2 indicated: "[Client #2] was discharged from the hospital with orders to continue her medications as ordered. [Client #2] was taking 20 mg of Famotidine twice each day. [Client #2] came home and continued this</p>		<p>Director/QIDP, the nurse manager, and the Area Director for quality review. 11/20/2014 Update The Program Director/QIDP or Facility Nurse will conduct six medication administration observations per week to ensure staff compliance and competence in administering medication. Immediate feedback will be offered to the staff from the Program Director/QIDP if an area of improvement is observed. Each observation will be documented on the agency medication administration observation form and submitted to the Area Director for quality review. To ensure continued compliance, the six observations per week will taper to one observation per week once it is assessed that the staff members have achieved competency in administering medication.</p>	

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	<p>medication. An order was faxed over on Monday, June 23, 2014 changing the Famotidine from 20 mg to 10 mg. However, [client #2] continued to receive the 20 mg dosage for the evening dosage on Monday, both dosages on Tuesday and the morning dose on Wednesday."</p> <p>A review of the facility's "Policy and Procedure on Medication Administration" dated 4/2011 was conducted on 10/15/14 at 3:15 P.M.. Review of the policy indicated: "The purpose of this policy is to establish guidelines for the direct care employees, which will assure safe administration of medications...Procedure: B. All medications administered will be checked by the staff dispensing them to see that the:</p> <ol style="list-style-type: none"> 1. Right medication; 2. Right person; 3. Right time; 4. Right dose/strength; 5. Right route. <p>E. When preparing medications for administration, the labels will be checked against the Medication Administration Record (Therap or ARS-13) to ensure that the prescription label corresponds to the order. The labels must be checked on 3 separate occasions which are:</p>			

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	<p>1. Before dispensing medication. 2. After dispensing medication. 3. Before administering medication.</p> <p>F. Prompt documentation will be made in the individual's permanent Medication Administration Record (Therap or ARS-13) following administration of any given medication."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional Designee (PD/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated staff should have checked the label three times prior to dispensing the medications to prevent medication errors. The PD/QIDP further indicated staff should have followed the facility's medication administration policy.</p> <p>2. A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 6:25 A.M., Direct Support Professional (DSP) #1 was observed administering client #1's prescribed medications. DSP #1 administered client #1's "Naproxen 500 mg (milligram) tablet (pain)...1 tablet orally once a day with food." Review of the medication packet label and the Medication Administration Record</p>			

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W000249	<p>(MAR) dated 10/2014 was done at 6:30 A.M. and indicated "Naproxen 500 mg (milligram) tablet...1 tablet orally once a day with food." Client #1 was observed to eat breakfast at 7:20 A.M.. Client #1 did not take her medications with food.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 10/17/14 at 3:20 P.M.. The QIDP indicated staff are trained on medication administration upon employment The PD/QIDP indicated the client should have been given her medication with her breakfast. The QIDP further indicated staff should have followed the directions on the label.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active</p>			

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	<p>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 (clients #1, #2, #3 and #4), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 5:50 A.M., Direct Support Professional (DSP) #1, began administering medications. DSP #1 popped each of client #1's medications into a medication cup and handed the cup to client #1. Client #1 did not learn the names and purposes of her medications. From 6:10 A.M. until 7:30 A.M., clients #1, #2, #3 and #4 sat in the living room area with no meaningful activity. Direct Support Professionals (DSP) #1, #2 and #3 would walk into the rooms and occasionally check on clients #1, #2, #3 and #4, but did not offer any meaningful activity.</p> <p>An evening observation was conducted at the group home on 10/14/14 from 5:00 P.M. until 6:55 P.M.. During the entire</p>	W000249	<p>All staff will be re-trained on the expectation that 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 in the individual program plan. Each staff member will be trained on the goals for each individual in the home by 11/23/14. The Program Director / QIDP will develop a schedule of meaningful activities and train each staff member on his/her assigned goal implementation duties per shift. Each staff member will be re-trained by 11/23/14 on the expectation that goals are to be completed each shift and that meaningful activities are to be offered throughout the day. The Program Director / QIDP will complete three active treatment observations per week for the next six weeks. During the observations, the Program Director / QIDP will offer immediate feedback to the staff members in an effort to coach the staff who are not providing active treatment and goal implementation and to ensure the staff understand what needs to be done to complete the expectations to provide a</p>	11/23/2014			

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	<p>observation period, clients #1, #2, #3 and #4 sat in the living room area with no meaningful activity. DSP #4, #5 and #6 would walk into the rooms and occasionally check on clients #1, #2, #3 and #4, but did not offer any meaningful activity.</p> <p>A review of client #1's record was conducted on 10/17/14 at 9:00 A.M.. A review of client #1's Individual Support Plan (ISP) dated 3/4/14 indicated the following objectives that could have been implemented during both observations: "Will improve her housekeeping skills by sorting and washing her laundry...Will improve her health/safety skills by learning the names of her medications...Will improve her personal safety skills by learning her address...Will improve her money management skills by learning how to recognize coins...Will improve her social skills by responding to simple instructions."</p> <p>A review of client #2's record was conducted on 10/17/14 at 9:30 A.M.. The ISP dated 11/11/13 indicated the following objectives that could have been implemented during both observations: "Will increase her money management skills and social skills by learning the value of money. She will learn to equate a quarter to .25 and a dime to .10 and so</p>		<p>meaningful day. The completed active treatment observation forms will be submitted to the Area Director for quality review purposes. Going forward, the Program Director / QIDP will monitor the staff implementation of the meaningful activity calendar in weekly reviews of the documentation of individual daily goals and narratives for each individual in the home. In addition, active treatment observations will be conducted during weekly visits to the home.</p> <p>11/20/2014 Update The three active treatment observations per week for four weeks has been extended to six weeks. The observations will taper as staff continue to demonstrate a full understanding of active treatment and their responsibility to help foster meaningful days for the individuals in the home. Going forward, to ensure continued compliance the Program Director/QIDP will conduct an active treatment observation during weekly visits to the home. Immediate feedback will be provided to the staff on duty and coaching will be provided to the staff if more direction is required based on the observation.</p>		

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	<p>on...Will increase her meal preparation skills by preparing her lunch."</p> <p>A review of client #3's record was conducted on 10/17/14 at 10:00 A.M.. The ISP dated 6/22/14 indicated the following objectives that could have been implemented during both observations: "Will improve her meal preparation skills by selecting an item from the cabinet and giving it to staff for preparation. After staff opens the item, she will put it in the pot/pan."</p> <p>A review of client #4's record was conducted on 10/17/14 at 10:30 A.M.. The ISP dated 10/19/13 indicated the following objectives that could have been implemented during both observations: "Will increase her money management skills by budgeting for the purpose of her personal items on a monthly basis... Will increase her handwriting skills by writing cards to family members, addressing the envelopes and mailing them off... Will increase her health and well being by exercising... Will increase her meal preparation skills by planning, preparing and storing her own lunch and a side dish... Will learn to crochet and complete other arts and crafts."</p> <p>An interview with the Program Director/Qualified Intellectual</p>						

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W000368	<p>Disabilities Professional (PD/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on observation, record review, and interview, the facility failed to assure drugs administered to 3 of 4 sampled clients and 2 additional clients (clients #1, #2, #3, #5 and #8) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/14/14 at 11:10 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 3/27/14 involving client #5 indicated: "Med exchange with [Pharmacy name] took place on Thursday</p>	W000368	Each staff member at the home will be retrained by 11/23/14 on the expectation that all drugs are administered in compliance with the physician's orders and will be retrained on the policy and procedure for medical administration. Topics will include but not limited to: how to ensure the prescription label matches the order and matches the MAR, how to ensure the right medication is given to the right person at the right time in the right dosage through the right route. Each staff member of the home will be observed by the facility nurse while completing a medication pass within the next 90 days. Documentation of these observations will be collected and submitted to the Area Director to be held in the employee	11/23/2014

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	<p>3/27/14. The medication Abilify had been changed by the psychiatrist from 10 mg (milligram) to 15 mg in the P.M.. However, the staff had not discontinued 10 mg in the A.M. once the 15 mg for the P.M. had been delivered. This was approximately 4/13/14. Disciplinary action was taken with staff."</p> <p>-BDDS report dated 6/4/14 involving client #2 indicated: "On 6/4/14 [client #2] took her 6 P.M. dosage of Nitrofurantoin at 4 P.M.. During the 6 P.M. medication pass the medication was readministered. [Client #2] receive (sic) 200 mg (milligram) instead of 100 mg of this medication. A total staff retraining on medication administration has been scheduled within the next two weeks."</p> <p>-BDDS report dated 6/9/14 involving client #2 indicated: "[Client #2] was taking Macrochantin 100 mg for urinary tract infection. The supply had run out and the doctor had not authorized a refill. However he had not discontinued the medication. [Client #2] missed her morning dose of medication."</p> <p>-BDDS report dated 6/15/14 involving client #3 indicated: "[Client #3] is prescribed Loperamide 2 mg every other day at 6 A.M.. Staff administered the medication but it was the wrong day.</p>		<p>personnel record. If any errors are observed, they will be corrected immediately and the staff will be re-trained by the nurse at the time of the occurrence. The Program Director/QIPD, facility nurse, Lead DSP, and Medical Support DSP are responsible for monitoring the accuracy of the MAR sheets. Each MAR for each client is to be reviewed on a weekly basis during the weekly medical house meeting and if any errors are noted, the responsible staff member will receive disciplinary action. Progressive discipline and ongoing training opportunities will be completed for staff who continue to make medication errors up to and including termination. Going forward, once all staff have been observed by the facility nurse, staff competency will be evaluated on an ongoing basis through unannounced medical administration observations to be conducted by the Program Director/QIDP, facility nurse, Lead DSP or Medical Support DSP. The Program Director/QIDP, facility nurse, Lead DSP, and Medical Support DSP meet on a weekly basis to review the recent and upcoming medical appointments and consultations for each client in the home. In addition, during these meeting the MARs of each individual in the home are reviewed for accuracy by</p>		

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	<p>Staff received disciplinary action for failure to administer medications properly."</p> <p>-BDDS report dated 6/19/14 involving client #5 indicated: "[Client #5] is prescribed 500 mg of Calcium each day at 6:30 A.M. This morning she did not receive her medication because medication exchange had not taken place."</p> <p>-BDDS report dated 6/19/14 involving client #8 indicated: "[Client #8] is prescribed Spironolactone 25 mg at 6:30 A.M.. The medication exchange had not taken place with [Pharmacy name]. The medication was unavailable for administration today."</p> <p>-BDDS report dated 6/19/14 involving client #3 indicated: "On 6/19 staff discovered [client #3] was given an incorrect dosage of her scheduled medication. She received 1800 mg of Oxcarbazepine instead of her normal 1200 mg dosage. Staff will be reminded to pay better attention when dispensing medication."</p> <p>-BDDS report dated 6/25/14 involving client #2 indicated: "[Client #2] was discharged from the hospital with orders to continue her medications as ordered.</p>		<p>comparing them to the orders. The minutes from this weekly medical meeting are forwarded by the facility nurse to the Program Director/QIDP, the nurse manager, and the Area Director for quality review. 11/20/2014 Update The Program Director/QIDP or Facility Nurse will conduct six medication administration observations per week to ensure staff compliance and competence in administering medication. Immediate feedback will be offered to the staff from the Program Director/QIDP if an area of improvement is observed. Each observation will be documented on the agency medication administration observation form and submitted to the Area Director for quality review. To ensure continued compliance, the six observations per week will taper to one observation per week once it is assessed that the staff members have achieved competency in administering medication.</p>				

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	<p>[Client #2] was taking 20 mg of Famotidine twice each day. [Client #2] came home and continued this medication. An order was faxed over on Monday, June 23, 2014 changing the Famotidine from 20 mg to 10 mg. However, [client #2] continued to receive the 20 mg dosage for the evening dosage on Monday, both dosages on Tuesday and the morning dose on Wednesday."</p> <p>A review of the facility's "Policy and Procedure on Medication Administration" dated 4/2011 was conducted on 10/15/14 at 3:15 P.M.. Review of the policy indicated: "The purpose of this policy is to establish guidelines for the direct care employees, which will assure safe administration of medications...Procedure: B. All medications administered will be checked by the staff dispensing them to see that the:</p> <ol style="list-style-type: none"> 1. Right medication; 2. Right person; 3. Right time; 4. Right dose/strength; 5. Right route. <p>E. When preparing medications for administration, the labels will be checked against the Medication Administration Record (Therap or ARS-13) to ensure</p>			

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	<p>that the prescription label corresponds to the order. The labels must be checked on 3 separate occasions which are:</p> <ol style="list-style-type: none"> 1. Before dispensing medication. 2. After dispensing medication. 3. Before administering medication. <p>F. Prompt documentation will be made in the individual's permanent Medication Administration Record (Therap or ARS-13) following administration of any given medication."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional Designee (PD/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated staff should have checked the label three times prior to dispensing the medications to prevent medication errors. The PD/QIDP further indicated staff should have followed the facility's medication administration policy.</p> <p>2. A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 6:25 A.M., Direct Support Professional (DSP) #1 was observed administering client #1's prescribed medications. DSP #1 administered client #1's "Naproxen 500 mg (milligram) tablet (pain)...1 tablet</p>			
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	<p>orally once a day with food." Review of the medication packet label and the Medication Administration Record (MAR) dated 10/2014 was done at 6:30 A.M. and indicated "Naproxen 500 mg (milligram) tablet...1 tablet orally once a day with food." Client #1 was observed to eat breakfast at 7:20 A.M.. Client #1 did not take her medications with food.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated the client should have been given her medication with her breakfast. The QIDP further indicated staff should have followed the directions on the label.</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, record review and interview, the facility failed for 1 of 6 clients observed during the morning medication administration (client #1) to ensure staff administered 1 of 6 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 6:25 A.M., Direct Support Professional (DSP) #1 was observed administering client #1's prescribed medications. DSP #1 administered client #1's "Naproxen 500 mg (milligram) tablet (pain)...1 tablet orally once a day with food." Review of the medication packet label and the Medication Administration Record (MAR) dated 10/2014 was done at 6:30 A.M. and indicated "Naproxen 500 mg (milligram) tablet...1 tablet orally once a day with food." Client #1 was observed to eat breakfast at 7:20 A.M.. Client #1 did not take her medications with food.</p>	W000369	<p>Each staff member at the home will be retrained by 11/23/14 on the expectation that all drugs, including those that are self-administered, are to be administered without error. The staff will be retrained on the policy and procedure for medical administration. Each staff member of the home will be observed by the facility nurse while completing a medication pass within the next 90 days. Documentation of these observations will be collected and submitted to the Area Director to be held in the employee personnel record. If any errors are observed, they will be corrected immediately and the staff will be re-trained by the nurse at the time of the occurrence. Going forward, once all staff have been observed by the facility nurse, staff competency will be evaluated on an ongoing basis through unannounced medical administration observations to be conducted by the Program Director/QIDP, facility nurse, Lead DSP or Medical Support DSP. The Program Director/QIPD, facility nurse, Lead DSP, and Medical Support DSP are responsible for</p>	11/23/2014

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	<p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated the client should have been given her medication with her breakfast. The QIDP further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p>		<p>monitoring the accuracy of the MAR sheets. Each MAR for each client is to be reviewed on a weekly basis during the weekly medical house meeting, if any errors are noted, the responsible staff member will receive disciplinary action. Progressive discipline and ongoing training opportunities will be completed for staff who continue to make medication errors up to and including termination. The minutes from this weekly medical meeting are forwarded by the facility nurse to the Program Director/QIDP, the nurse manager, and the Area Director for quality review. 11/20/2014 Update The Program Director/QIDP or Facility Nurse will conduct six medication administration observations per week to ensure staff compliance and competence in administering medication. Immediate feedback will be offered to the staff from the Program Director/QIDP if an area of improvement is observed. Each observation will be documented on the agency medication administration observation form and submitted to the Area Director for quality review. To ensure continued compliance, the six observations per week will taper to one observation per week once it is assessed that the staff members have achieved competency in administering medication.</p>	

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W000382	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 from 5:50 A.M. until 8:00 A.M. for clients #1, #2, #3, #4, #5, #6, #7 and #8. At 5:50 AM Direct Support Professional (DSP) #1 was preparing medications on the counter in the main bathroom while client #1 was sitting in her bath water. At 6:15 A.M., DSP #1 left the medications unattended on the counter, walked out of the bathroom, down the hallway and entered client #4's bedroom at the end of the hall where the medication counter was out of her sight for 2 minutes. DSP #1 prepared client #3's medications and left the medication area again with the medications on the counter and not locked and went to the living room to give client #3 her medications. DSP #1 was away from the medications for 90 seconds.</p>	W000382	<p>Direct Support Professional #1 received disciplinary action for failing to ensure the medications were locked except while being prepared for administration. Each staff member at the home will be retrained by 11/23/14 on the expectation that all drugs and biologicals are to be locked except when being prepared for administration. The staff will be retrained on the policy and procedure for medical administration. Each staff member of the home will be observed by the facility nurse while completing a medication pass within the next 90 days. Documentation of these observations will be collected and submitted to the Area Director to be held in the employee personnel record. If any errors are observed, they will be corrected immediately and the staff will be re-trained by the nurse at the time of the occurrence. Going forward, once all staff have been observed by the facility nurse, staff competency will be evaluated on an ongoing basis through unannounced medical administration observations to be conducted by the Program Director/QIDP, facility nurse, Lead DSP or Medical Support</p>	11/23/2014			

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W000436	<p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD indicated the medications should be locked at all times except when being administered and if staff needed to leave the area they needed to lock the medications in the closet.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make</p>		<p>DSP. If any errors are noted, the responsible staff member will receive disciplinary action. Progressive discipline and ongoing training opportunities will be completed for staff who continue to make medication errors up to and including termination. All medication errors are tracked by the Program Director / QIDP, Area Director, and Safety Committee and reviewed on a monthly basis for quality review purposes. The Program Director/QIDP or Facility Nurse will conduct six medication administration observations per week to ensure staff compliance and competence in administering medication. Immediate feedback will be offered to the staff from the Program Director/QIDP if an area of improvement is observed. Each observation will be documented on the agency medication administration observation form and submitted to the Area Director for quality review. To ensure continued compliance, the six observations per week will taper to one observation per week once it is assessed that the staff members have achieved competency in administering medication.</p>		

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	<p>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, for 1 of 4 sampled clients who used adaptive aids and devices (client #1), the facility failed to encourage and teach the use of her seizure helmet.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/14/14 between 5:50 A.M. and 8:00 A.M.. From 6:30 until 7:15 A.M., client #1 got up and walked down the hallway past Direct Support Professionals (DSP) #1 and #2 without her seizure helmet on. DSP #1 and #2 did not prompt client #1 to wear her seizure helmet.</p> <p>An evening observation was conducted at the group home on 10/14/14 between 5:00 P.M. and 6:55 P.M.. At 5:10 P.M., client #1 got up, walked past DSP #4, down the hallway and then back to the living room. At 5:30 P.M., client #1 got up and walked into the kitchen where DSP #5 was without her seizure helmet on. DSP #4, #5 and #6 did not prompt client #1 to wear her seizure helmet.</p>	W000436	<p>All staff at the home will be retrained by 11/23/14 on Client #1's IPP which indicates that she is to wear a seizure helmet at all times while ambulating. In addition, all staff at the home will be retrained by 11/23/14 on the expectation that they are to prompt all individuals at the home to wear adaptive equipment as prescribed and during the timeframe when the equipment should be used. The staff will be trained all the IPPs for all individuals using adaptive equipment at the home. The Program Director/QIDP will conduct two observations a week for the next four weeks to ensure each individual in the home is using / being prompted to use all adaptive equipment as prescribed. Ongoing monitoring will occur during unannounced weekly site visits by the Program Director/QIDP and/or facility nurse. If staff are observed to fail to implement the necessary prompting to the individual(s) to wear adaptive equipment, he/she will be immediately coached on the expectation and progressive disciplinary action will be implemented. The Area Director will visit the site and observe if adaptive equipment is being used as prescribed on at least a</p>	11/23/2014

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W000484	<p>A review of client #1's record was conducted at the group home on 10/15/14 at 9:30 A.M.. A review of client #1's Individual Support Plan (ISP) dated 3/4/2014 indicated client #1 wore a seizure helmet at all times while ambulating.</p> <p>The Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed at the facility's administrative office on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated staff should be teaching clients to wear their adaptive equipment at all times. The PD/QIDP further indicated staff should have prompted client #1 to wear her helmet.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 8 of 8 clients (clients #1, #2, #4, #5, #6, #7 and #8) residing in the group home to provide table knives at</p>	W000484	<p>quarterly basis for quality review purposes.</p> <p>All staff will be re-trained by 11/23/14 on the expectation that each client should be equipped with tables, chairs, eating utensils, and dishes designed to</p>	11/23/2014

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	<p>the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 10/14/14 from 5:50 A.M. until 8:00 A.M.. At 7:30 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 began eating their breakfast which consisted of cold oat cereal and toasted English muffins. There was no sugar/sugar substitute or butter on the table for the clients' use. Direct Support Professional (DSP) #3 went into a drawer and got a knife, walked around the table and began spreading jelly on clients #1, #2 and #3's English muffins on their plates. No table knives were observed on the table for clients #1, #2, #3, #4, #5, #6, #7 and #8's use.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated condiments and table knives should be put on the table for the clients to use.</p> <p>9-3-8(a)</p>		<p>meet his/her developmental needs This training will also include the expectation that a full array of condiments and appropriate dining place settings are available for each individual during each meal time. A condiment basket will be stocked and placed on the table prior to each meal. The tray will include a selection of salt/salt substitute, pepper, sugar/sugar substitute, and condiments such as ketchup, mustard, and salad dressing. The individuals at the home will have opportunities for learning at each mealtime by setting place settings including utensils at the table, and preparing and eating meals in a manner consistent with their developmental level. The Program Director/QIDP will conduct three observations a week for the next four weeks during mealtime to monitor that each individual is being offered the opportunity to eat in a manner consistent with her developmental level. The Program Director/QIDP will also observe if the condiment basket and table place settings include all of the necessary items including utensils. Going forward the Program Director/QIDP will monitor the dining service area through monthly unannounced site visits and record the observation on the active treatment observation form. The form will be submitted to the Area Director on a monthly basis for quality review.</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. Based on observation, record review and interview, the facility failed to assure 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) were involved in meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 10/14/14 from 5:50 A.M. until 8:00 A.M.. From 6:30 A.M. until 7:30 A.M., clients #1, #3, #5, #6, #7 and #8 sat in the living room with no activity and clients #2 and #4 sat in their bedrooms with no activity. At 6:55 A.M., Direct Support Professional (DSP) #3 walked into the kitchen, retrieved a bag of english muffins, toasted the english muffins and placed them on a serving plate. At 7:30 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their breakfast independently. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist in meal preparation.</p> <p>A review of client #2's record was conducted on 10/17/14 at 10:00 A.M.. A review of client #2's Individual Support Plan (ISP) dated 11/11/13 indicated: "Will increase her meal preparation skills</p>	W000488	<p>All staff will be re-trained by 11/23/14 on the expectation that each client is able to eat in a manner that is consistent with his or her developmental level. This training will also include the expectation that a full array of condiments and appropriate dining place settings are available for each individual during each meal time. All staff members will be re-trained on the expectation that individual formal meal preparation goals and informal meal preparation participation should be encouraged at each meal time. A condiment basket will be stocked and placed on the table prior to each meal. The tray will include a selection of salt/salt substitute, pepper, sugar/sugar substitute, and condiments such as ketchup, mustard, and salad dressing. The individuals at the home will have opportunities for learning at each mealtime by setting place settings including utensils at the table, and preparing and eating meals in a manner consistent with their developmental level. The Program Director/QIDP will conduct six observations a week for the next six weeks during mealtime to monitor that each individual is being offered the opportunity to participate in meal</p>	11/23/2014

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	<p>by preparing her lunch."</p> <p>A review of client #3's record was conducted on 10/17/14 at 10:30 A.M.. A review of client #3's ISP dated 6/22/14 indicated: "Will improve her meal preparation skills by selecting an item from the cabinet and giving it to staff for preparation."</p> <p>A review of client #4's record was conducted on 10/17/14 at 11:00 A.M.. A review of client #4's ISP dated 10/19/13 indicated: "Will improve her meal preparation skills by planning, preparing and storing her own lunch."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 10/17/14 at 3:20 P.M.. The PD/QIDP indicated clients were capable of assisting in meal preparation and further indicated they should be assisting in meal preparation at all times.</p> <p>9-3-8(a)</p>		<p>preparation and eat in a manner consistent with her developmental level. The Program Director/QIDP will also observe if the condiment basket and table place settings include all of the necessary items. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the Program Director/QIDP will monitor the dining service area through monthly unannounced site visits and record the observation on the active treatment observation form. The form will be submitted to the Area Director on a monthly basis for quality review.</p> <p>11/20/2014 Update The initial corrective action of four observations per week has been increased to six observations per week to ensure staff competency and facility compliance.</p>		