

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G453	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 ALMQUIST KOKOMO, IN 46902
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: January 8, 9, 10, 13, 14, 15, 16 and 17, 2014.</p> <p>Facility Number: 000967 Provider Number: 15G453 AIMS Number: 100235220</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 24, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home for the worn finish on the dining</p>	W000104	The ongoing maintenance of the physical structure does have a monitoring system in place. The repair items cited by the surveyor were already identified and the gathering of estimates and scheduling of work had already begun. The physical structures are reviewed weekly and monthly in the following manner: 1. Residential house	02/16/2014

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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	<p>room table, the stained living room carpet, and tear in the living room carpet.</p> <p>Findings include:</p> <p>On 1/14/14 from 6:30am until 9:00am, and on 1/14/14 from 3:00pm until 5:20pm, observations were conducted at the group home. During both observation periods, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked to access the dining room and the living room areas of the facility. During both observation periods the dining room table had a worn finish which exposed the wood at each of the eight table placements where a chair was positioned. On 1/14/14 at 6:55am, GHS (Group Home Staff) #2 indicated the dining room table finish was worn and discolored. At 7:06am, the living room carpet had a two feet by two feet (2' x 2') stain in the center of the walkway of the carpet and had a tear GHS #1 indicated was "over" fifteen feet long and crossed near the center of the room. GHS #1 indicated client #5 used a walker because she was unsteady and the tear in the carpet affected the steadiness of client #5's walker.</p> <p>On 1/14/14 at 3:00pm, client #5 used a walker and indicated she was unsteady</p>		<p>manager completes a weekly safety report that is for the express purpose of reporting maintenance issues. The form was updated to include a section to report carpet stains and paint needs (Appendix A). This is sent to the Vice President of Residential Services, the Senior Vice President, and the Coordinator of Maintenance. 2. The Vice President of Residential Services completes a monthly environmental checklist. (Appendix B). 3. The maintenance department completes a preventative maintenance checklist (Appendix C). All of these checks are in place to identify needed maintenance issues. Hochstetler's Flooring has measured the identified area needing carpet replacement and is developing an estimate. The replacement will be made as soon as the estimate is complete and materials arrive. Maintenance staff will be completing the repair on the finish of the dining room table by February 16, 2014.</p>		

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W000331	<p>walking on different surfaces.</p> <p>On 1/15/14 at 3:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional), the Residential Manager (RM), and the DGHL (Director of Group Home Living) was conducted. The QIDP, the RM, and the DGHL indicated the group home maintenance requests had been submitted for the dining room table and the living room floor stains and tear. The DGHL provided the 2014 "Work Requested" form and both the QIDP and the form indicated the work requested did not include the dining room table, the living room carpet stain, and/or the living room carpet tear. The RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 lived in the group home and walked on the stained and torn living room carpet. The RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 sat at and ate meals on the dining room table with the worn wood finish.</p> <p>9-3-1(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client</p>	W000331	The nurse who failed to provide treatmentplans for client #2's MRSA is no longer employed by	02/16/2014			

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	<p>#2), the facility nursing services failed to develop nursing treatment plans to include client #2's bacterial blood infection of MRSA (Methicillin Resistant Staphylococcus Aureus), a record of skin areas, a description for client #2's open infected skin and/or scabbed infected skin areas, and client #2's potential for pain/discomfort.</p> <p>Findings include:</p> <p>On 1/14/14 at 7:18am, Group Home Staff (GHS) #2 selected, put on gloves, and administered from a medication tube "Clindamycin 1%" cream (for scabbed areas) to client #2's lower left leg; a coating of medication over client #2's scabs from his left ankle to below his left knee. GHS #2 stated client #2 "had scabbed areas" on client #2's lower left leg. Client #2 lifted his pant leg to expose his lower left leg which had scabbed areas with a reddened area encircling each scabbed area. GHS #2 stated client #2 had "over 20 to 30" scabbed areas. GHS #2 indicated client #2's lower leg looked red and he was unsure why client #2's leg was red in color. Client #2 and GHS #2 both indicated they did not know what caused the scabbed areas but that the cream was to help the areas heal. GHS #2 indicated client #2 did not have a skin tracking</p>		<p>Bona Vista programs. Nursing staff have created a MRSA protocol for client #2, (Appendix D) and a skin integrity documentation form (Appendix E). The QDDP also updated the risk assessment (Appendix F) and ISP (Appendix G) to indicate his history of MRSA. To monitor for continued compliance, all risk plans are submitted to the Vice President of Residential Services for review when completed (Appendix H). Risk plan review is also included as part of the Periodic Service Review that is completed quarterly by the Social Service Coordinator (Appendix I). Additionally, the residential nurses are now required to complete weekly documentation of risk plan monitoring (Appendix J) which will be added to the Periodic Service Review.</p>				

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	<p>sheet and/or a documented record to indicate if the treatment was effective. When asked when and/or if the staff would contact the agency nurse in regards to client #2's reddened scabbed areas. GHS #2 indicated he did not know. GHS #2 indicated there was no available information to identify when staff should be concerned regarding client #2's reddened scabbed skin areas. At 8:15am, GHS #2 selected, put on gloves, and administered from an unlabeled medication tube of "Bacitracin" first aid 1% cream to client #2's left thumb nail which client #2 stated he had "pulled off." GHS #2 indicated the unlabeled tube of "Bacitracin" was stored in client #2's medication storage box and the tube did not have client #2's name, a pharmacy label for the directions of its use, and/or did not document the date the tube was opened. At 8:18am, client #2's 1/2014 MAR (Medication Administration Record) was reviewed and indicated "Bacitracin 500u (units) Oint (Ointment), apply to affected areas as needed (and) Clindamycin 1% Lot, apply to affected area twice a day." Client #2's medication administration record did not include client #2's skin care protocol, did not include a skin tracking record, did not include nursing guidance for skin care, and/or</p>						

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	<p>documentation for client #2's open skin area on his thumb, and/or scabbed areas on his left lower leg.</p> <p>On 1/10/14 at 11:00am, a record review was conducted of the facility's BDDS (Bureau of Developmental Disabilities Services) Reports from 1/1/13 through 1/10/14.</p> <p>-A BDDS report on 7/7/13 for an incident on 7/6/13 at 12:00pm, indicated client #2 "went to the Dermatologist on 7/6/13 due to an open sore on his left ankle from picking a scab. The doctor (indicated) it was dermatitis at this time. A culture was also taken and the result of that will be in 10 days."</p> <p>-A BDDS follow up report on 7/13/13 indicated "Culture (results) came back MRSA."</p> <p>Client #2's record was reviewed on 1/15/14 at 1:05pm. Client #2's 8/30/13 ISP (Individual Support Plan), 5/1/13 Risk Plan, and 6/2013 Behavior Support Plan (BSP) did not include client #2's history of MRSA infection, client #2's skin issues, and/or client #2's potential for pain/discomfort. Client #2's 3/4/13 "Health and Safety Related Incident Management System" did not identify client #2 had MRSA and/or a history of MRSA. Client #2's Health and Safety system had not been updated since</p>						

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	<p>3/4/2013 to include MRSA infection. Client #2's record did not indicate a "MRSA Protocol," did not include and/or identify a description of client #2's skin areas. Client #2's record did not identify when client #2's skin areas were considered an open wound, a scabbed wound, and/or healed wound. Client #2's record did not identify and/or describe what staff should complete when client #2 had a skin area opened and/or scabbed areas on his skin.</p> <p>On 1/15/14 at 10:00am, the CDC (Centers for Disease Control) "General Information About MRSA in the Community" at http://www.cdc.gov/mrsa/community/index.html was reviewed. The CDC information indicated "...Can I prevent MRSA? How? (sic) There are the personal hygiene steps you can take to reduce your risk of MRSA infection: Maintain good hand and body hygiene. Wash hands often, and clean body regularly especially after exercise. Keep cuts, scrapes, and wounds clean and covered until healed. Avoid sharing personal items such as towels and razors...What are MRSA Symptoms?...Red, swollen, painful, warm to the touch, full of pus or other drainage, accompanied by a fever...Cover your wounds. Keep</p>						

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	<p>wounds covered with clean, dry bandages until healed."</p> <p>On 1/15/14 at 10:00am, an interview with the agency RN (Registered Nurse) and the DGHL (Director of Group Home Living) was conducted. The RN indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The RN stated client #2 had "MRSA" within the past couple of months and client #2's skin was healing. The RN indicated client #2 had a skin care protocol but that the protocol was not at the group home for direct care staff to use, no documentation was available for client #2's skin care, and no documentation was available to determine if the skin treatments were effective. The RN indicated client #2's record did not include and/or identify a description of client #2's skin areas. The RN indicated client #2's record and 3/4/13 "Skin Integrity Plan (protocol)" did not identify client #2's history of MRSA infection, when client #2's skin areas were considered an open wound, a scabbed wound, and/or healed wound. The RN indicated client #2's protocol did not identify and/or describe what staff should complete when client #2 had a skin area opened and/or scabbed areas on his skin. The RN indicated</p>			

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W000369	<p>client #2 was verbal and the facility had not completed an assessment to determine client #2's pain/discomfort. The DGHL stated she was "unaware" client #2's 2/5/13 ISP (Individual Support Plan), 3/4/13 Risk Plan, and 2/20/13 Behavior Support Plan (BSP) did not include client #2's history of MRSA infections, client #2's skin issues, and/or client #2's potential for pain/discomfort. The RN indicated client #2's nursing services did not meet client #2's identified needs. The RN stated "No" the facility staff had not contacted her in regards to client #2's reddened left lower leg and/or the scabbed areas on 1/14/14 and/or on 1/15/14 at the time of interview.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 1 of 34 doses of medications administered at the morning</p>	W000369	All staff were retrained on BonaVista Medication Administration policy (Appendix K). Any staff who fails to follow	03/08/2014

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	<p>medication administration (client #2), the facility failed to administer medications without error for client #2.</p> <p>Findings include:</p> <p>On 1/14/14 at 7:18am, Group Home Staff (GHS) #2 selected, client #2's Pot Chloride (Potassium Chloride for low potassium levels) 20meq, poured one tablespoon of full strength liquid medication into a medication cup, handed the medication cup to client #2, and instructed client #2 to drink the medication. Client #2 consumed the full strength medication. At 7:40am, client #2's 1/2014 MAR (Medication Administration Record) indicated "Pot. (Potassium) Chloride 20meq/15 milliliters 10% liq. (liquid), dilute 1 tablespoonful in liquid and drink daily" for low potassium levels.</p> <p>On 1/15/14 at 1:05pm, client #2's 11/20/13 "Physician's Order" indicated "Pot. Chloride 20meq/15 (milliliters) 10% liq., dilute 1 tablespoonful in liquid and drink daily."</p> <p>On 1/15/14 at 10:00am, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated the agency staff followed the "Living in the Community: Core A/Core B"</p>		<p>the medication administration policy are subject to discipline as outlined in the policy. For further monitoring, Nurses perform unannounced observation of med passes on an increased schedule as follows: Week 1: 5 unannounced observations Week 2: 4 unannounced observations Week 3: 3 unannounced observations Week 4: 2 unannounced observations Following week 4, observations will return to the standard unannounced schedule of 1 per week. The nurse will only decrease monitoring level from week to week if no errors are observed. If errors are observed, nurse will continue monitoring at the increased level. Monitoring will be tracked on Appendix ZZ.</p>				

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W000383	<p>medication training. The RN stated "All medication" and physician's orders should be followed. The RN indicated client #2's potassium chloride medication should have been diluted as the medication label and client #2's physician had instructed. The RN indicated the facility staff erred when the label and the physician's order were not followed.</p> <p>On 1/15/14 at 10:00am, a review of the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders.</p> <p>On 1/15/14 at 10:00am, a record review was completed of the facility's policy and procedures, 2013 "Medication Administration" which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review,</p>	W000383	All staff were retrained on	02/16/2014			

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	<p>and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sample clients (#1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 1/14/14 from 6:30am until 9:00am, and on 1/14/14 from 3:00pm until 5:20pm, observations were conducted and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. During both observation periods, the medication administration office door was open and/or not locked with the medication cabinet keys hanging on the wall at waist level in the entrance to the medication room. On 1/14/14 at 3:35pm, the Residential Manager (RM) stated the medication cabinet keys "should be on the staff" person who was working at the group home and "not" hung on the wall at the entrance/exit of the medication room. The RM stated "the medication cabinet keys were not secure" when staff left the keys hanging on the wall.</p> <p>An interview was conducted on 1/15/14 at 10:00am, with the agency RN (Registered Nurse) and the QIDP (Qualified Intellectual Disabilities</p>		<p>BonaVista Money & Receipt Procedure (Appendix L) which clearly states that during each shift one staff member will be designated as the key holder to the locked money/medication. This ensures that the keys to the medication cabinets are secure. When consumers are out of the home, the keys to the medication cabinet will be kept in a storage container that is located in the Residential House Managers desk. This ensures that the keys are out of line of sight even if someone opened the desk drawer. Residential house manager will monitor compliance through observation daily. Any staff that is not compliant with this policy will receive agency discipline. Additionally, the Periodic Service Review form (Appendix I) has been updated to include a line that addresses the proper storage of medication cabinet keys. This will be monitored during the PSR review on a monthly basis..</p>		

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W000391	<p>Professional). The RN and the QIDP both indicated the medication keys should be kept secured when medications were not administered and the keys were not secured. The RN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication keys to the medication cabinet. The RN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 1/15/14 at 10:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cabinet keys should be kept secure.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 3 of 34 medications observed administered at the morning medication administration (clients #1 and #2), the facility failed to ensure each medication was labeled.</p>	W000391	<p>1. Client#1 initials have been marked on his tube of chapstick. The chapstick is stored in the original container with the pharmacy label. In addition, the original container is stored in a ziplock bag with a pharmacy label</p>	02/16/2014

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3261 ALMQUIST KOKOMO, IN 46902			
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	<p>Findings include:</p> <p>1. On 1/14/14 at 7:40am, GHS (Group Home Staff) #2 selected and administered from an unlabeled medication tube of "Chapstick (for dry lips)," GHS #2 removed the unlabeled medication lid, and handed the unlabeled tube of Chapstick to client #1. GHS #2 encouraged and instructed client #1 to apply it to his dry, cracked, and scabbed lips. At 7:40am, GHS #2 removed an unlabeled medication container of "Advair Diskus 50mg" (milligrams) for asthma/breathing disorder, GHS #2 handed the container to client #1 and encouraged client #1 to inhale one puff from the unlabeled medication container. At 7:55am, GHS #2 indicated the medication tube and Advair Diskus medications did not have client #1's name, a pharmacy label for the directions of its use, and/or did not document the date when the Chapstick tube was opened. At 7:55am, client #1's 1/2014 MAR (Medication Administration record) was reviewed and indicated "Advair Disc 100/50, one puff twice a day (for) Asthma" and "Carmex Lip Balm, apply three times a day as needed."</p> <p>On 1/15/14 at 2:45pm, client #1's</p>		<p>on the ziplock bag. 2. Client #1's initials have been marked on his inhaler. The inhaler is stored in the original box with the pharmacy label. In addition, the original container is stored in a ziplock bag with a pharmacy label on the ziplock bag. 3. Client #2's initials have been marked on his tube of bacitracin. The tube is stored in the original container with the pharmacy label. In addition, the original container is stored in a ziplock bag with a pharmacy label on the ziplock bag. All staff will be retrained on medication administration policy (Appendix K) which indicates that all medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route, the dates and times for administration and the date of expiration. To monitor for continued compliance, the Residential nurse or the Residential House Manager is required to review all medications for appropriate labeling and expiration dates. This will be documented on Appendix M and will be monitored as part of the monthly Periodic Service Review.</p>				

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	<p>11/30/13 "Physician's Order" indicated "Advair Disc 100/50, one puff twice a day (for) Asthma" and "Carmex Lip Balm, apply three times a day as needed."</p> <p>2. On 1/14/14 at 8:15am, GHS #2 selected, put on gloves, and administered from an unlabeled medication tube of "Bacitracin" first aid 1% cream to client #2's left thumb nail which client #2 stated he had "pulled off." GHS #2 indicated the unlabeled tube of "Bacitracin" was stored in client #2's medication storage box and the tube did not have client #2's name, a pharmacy label for the directions of its use, and/or did not document the date the tube was opened. At 8:18am, client #2's 1/2014 MAR was reviewed and indicated "Bacitracin 500u (units) Oint (Ointment), apply to affected areas as needed."</p> <p>On 1/15/14 at 1:05pm, client #2's 11/20/13 "Physician's Order" indicated "Bacitracin 500 Oint (Ointment), apply to affected areas as needed."</p> <p>On 1/15/14 at 10:00am, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated the agency staff followed the "Living in the Community: Core A/Core B"</p>			

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	<p>medication training. The RN stated "All medications should be labeled with a pharmacy label." The RN indicated the facility staff should have dated each medication when the medication was opened to document first use. The RN indicated client #1 and #2's medications were not labeled correctly. The RN indicated each medication should have client's identification on each medication to signify it belonged to that client, a direction for the medication use, and open date if not replaced every thirty days.</p> <p>On 1/15/14 at 10:00am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when the medication was opened.</p> <p>On 1/15/14 at 10:00am, a review of the facility's undated "Medication Administration Plan" indicated "Medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route of</p>			

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W000436	<p>administration, the dates and times for administration and the date of expiration...Staff shall refer to the Medication Administration Record (MAR) and compare to the packaged medication to verify the medication, the time of administration, and the correct dosage."</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 informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #1) with adaptive equipment, the facility failed to teach and encourage client #1 to wear his prescribed eye glasses. Findings include: Observations were conducted at the group home on 1/14/14 from 6:30am until 9:00am, and on 1/14/14 from</p>	W000436	The QDDP wrote a vision goal for client #1 (Appendix N). The following documents were alsodeveloped/updated for client #1: RiskAssessment (Appendix O); Vision Plan (Appendix P); and ISP (Appendix Q). All staff will be trained on updated plans. To monitor for continued compliance, QDDP's will complete the Residential ServicesAnnual Checklist (Appendix H) when they develop new program goals. The checklist, along with the	02/16/2014			

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	<p>3:00pm until 5:20pm, client #1 did not wear his prescribed eye glasses, was not prompted and/or encouraged to wear, and client #1's eye glasses were hung on the outside of his shirt collar. From 6:30am until 9:00am, client #1 fed himself breakfast, watched television, completed medication administration with facility staff, and completed his morning care without his prescribed eye glasses. From 3:00pm until 5:20pm, client #1 wrote his name on paper, bent at the waist in a seated position over the paper with his head down and without redirection from the facility staff to wear his prescribed eye glasses. Client #1 cooked in the kitchen with staff, watched television, completed medication administration, and did not wear his prescribed eyeglasses.</p> <p>On 1/15/14 at 2:45pm, client #1's record review was conducted. Client #1's 4/18/13 ISP (Individual Support Plan) indicated he wore prescribed eye glasses. Client #1's 7/2/12 vision evaluation indicated he wore prescribed eye glasses.</p> <p>On 1/17/14 at 2:35pm, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the DGHL (Director of Group Home Living) was conducted. The QIDP and the DGHL both indicated</p>		<p>respectivedocumentation will be reviewed by the Vice President of ResidentialServices. QDDP was trained on the ResidentialServices Annual Checklist.</p>	

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	<p>client #1 wore prescribed eye glasses. The DGHL indicated client #1 should have been taught and encouraged to wear his prescribed eye glasses.</p> <p>9-3-7(a)</p>			