

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2014
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NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 665 E BURRELL DR CROWN POINT, IN 46307
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: June 17, 18, 20, 25 and 27, 2014.</p> <p>Facility number: 011988 Provider number: 15G758 AIM number: 200952910</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 7, 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 and interview, the governing body failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) living at the group home, to exercise general operating direction in a manner to ensure toilet paper holders were in the bathrooms.</p>	W000104	<p>On 7/18/2014, the toilet paper holder was repaired in the Burrell Group Home. The group home manager is responsible for monitoring and ensuring that the group home has all items that are needed and to ensure that all items are working properly to run efficiently. In addition, the QDDP</p>	07/18/2014

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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W000149	<p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/17/14 from 5:10 A.M. until 6:45 A.M. There were no toilet paper holders in the bathrooms.</p> <p>An evening observation was conducted at the group home on 6/17/14 from 5:00 P.M. until 6:20 P.M. There were no toilet paper holders in the bathrooms.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 1:40 P.M. The QIDP indicated there should be toilet paper holders in the bathrooms at all times.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 4 sampled clients (#2), and 1 additional client (#8), the facility neglected to implement its "Policy on Abuse and Neglect, Exploitation, Mistreatment, Violation of an</p>	W000149	<p>will observe during unannounced visits that the group home has all items that are needed and to ensure that all items are working properly to run efficiently. The QDDP will observe during weekly unannounced visits that the group home has all items that are needed and to ensure that all items are working properly to run efficiently. In addition to the House Managers visits and the QDDP's unannounced weekly visits, the Residential Coordination will conduct monthly unannounced visits to the group homes.</p> <p>TradeWinds has a policy on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injury of an unknown origin. The Policy Statement states: "Violating an Individuals Rights, Abuse and or neglect or any mistreatment of</p>	07/18/2014

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	<p>Individual's Rights, and Injuries of an unknown Origin" in regards to an improper restraint and an allegation of abuse.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/17/14 at 1:20 P.M. and indicated:</p> <p>-BDDS report dated 10/16/13 of improper restraining involving client #8 indicated: "On 10/16/13 at approximately 5:36 A.M., the group home staff informed the QDDP (Qualified Developmental Disabilities Professional) that [client #8] had a behavior. Staff stated [client #8] became verbally aggressive because he didn't want to eat the breakfast that was prepared. Staff stated while trying to redirect [client #8], he started calling the staff out their names and us (sic) foul language. Then [client #8] picked up a chair and threw it against the wall. [Client #8] went and picked up the chair he had thrown and attempted to hit staff with it. Staff blocked the chair with her arms to keep from being hit. The other two female staff had all the residents move out the way of the incident and</p>		<p>any consumer who participates in a TradeWinds Services, Inc., program is strictly prohibited and will result in severe disciplinary action up to and include discharge from employment and may further result in criminal prosecution. All allegations of violating an Individuals rights or abuse and neglect of consumers served and certain other incidents defined in this policy are to be reported and investigated in prompt and procedurally correct manner." (Please see attached Policies and Procedures on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injuries of an Unknown Origin). On 7/17/2014, staff was re-trained on the Abuse, Neglect, Exploitation, Mistreatment and Protection of an Individual's Rights and Injury of an unknown origin policy for the incident involving client #8. In addition, staff was re-trained CPI restraints. (Please see attached training documents) On 7/17/2014, staff was re- trained on the Abuse, Neglect, Exploitation, Mistreatment and Protection of an Individual's Rights and Injury of an unknown origin policy for the incident involving client #2 (Please see attached training documents) For all allegations of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin, the investigation will start within 24 hours of the alleged incident.</p>	

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	<p>contacted the police. [Client #8] hit staff in the face with his hand and grabbed a hand full of hair. Staff stated she panicked when [client #8] grabbed her hair and started punching her in the face. Before the other two staff could intervene, [Staff name] stated she grabbed the paper towel holder off the counter and hit [client #8] in the chest with it. [Client #8] let go of staff's hair and stopped hitting her when he was hit. The other staff intervened and was able to redirect [client #8] to his room. [Client #8] walked to his room saying 'I beat that m-----r a--. The police arrived and spoke to [client #8] in regards to his behavior....[Client #8] had a small abrasion.'</p> <p>-BDDS report dated 1/18/14 involving client #2 indicated: "On 1/19/14, the QDDP received a call from the House manager stating she received a voice message from [client #2's Mother]. [Mom's name] stated on voice mail that she spoke with [client #2] and he told her that staff member [Staff #20 name], told [client #2] to 'suck his private parts.' Group home manager stated to the QDDP that she made several attempts to contact [Mother name] but was unsuccessful contacting her....The out come of the investigation was that there was no evidence to substantiate that staff told</p>		<p>When there is an allegation of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin the staff person(s) involved will be removed immediately from the schedule pending outcome of the investigation. The staff person(s) involved is responsible for completing an internal incident report and notifying all necessary person(s), such as: House Manager, QDDP and Residential Nurse (if medical attention is needed). The QDDP must be notified as soon as the incident is under control and there is no further danger to either client(s) involved. The QDDP is responsible for making all necessary incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of incident). TradeWinds Quality Assurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitors trends for each incident. The QDDP is responsible for conducting a thorough investigation, involving all staff members and consumers involved in incident through written documentation. The group home manager is responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the</p>	

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	<p>[client #2] to 'suck his private part'." Further review of the record failed to indicate a thorough investigation was conducted in regards to this incident.</p> <p>A review of the facility's "Policy on Abuse, Neglect, Exploitation, Mistreatment, Violation of an Individual's Rights and Injuries of an unknown Origin" dated 3/10/09 was conducted at the facility's administrative office on 6/25/14 at 10:00 A.M. Review of the policy indicated: "To establish prompt, accurate and effective procedures and investigating of all allegations of abuse and neglect and any incident or crime as defined...All allegations of abuse and neglect of consumers served and certain other incidents defined in this policy are to be reported and investigated in prompt and procedurally correct manner...Accidents and other injuries not defined as abuse or neglect must still be documented on the incident report form and reviewed according to policy and applicable standards...It is mandatory that all personnel follow this policy. This includes: reporting incidents immediately upon becoming aware of them, completing all forms as required by this policy...Physical abuse: willful infliction of injury...Verbal abuse: Oral, written and or gestured language that includes disparaging and derogatory</p>		<p>QDDP will observe during un announced visits that the staffs are following the rights of the consumers. It is the policy of TradeWinds Services to ensure that all clients have a safe environment free of aggression, exploitation, abuse, neglect and mistreatment. It is also the policy of TradeWinds to ensure the health, welfare and rights of the individuals we serve. The QDDP will observe during weekly unannounced visits that the group home has all items that are needed and to ensure that all items are working properly to run efficiently. In addition to the House Managers visits and the QDDP's unannounced weekly visits, the Residential Coordination will conduct monthly unannounced visits to the group homes.</p>	

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W000154	<p>remarks toward consumers...Exploitation. Financial, any deliberate misplacement, exploitation, or wrongful temporary or permanent use of an individual's belongings or money."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 1:40 P.M. The QIDP indicated there was no documentation available for review to indicate a through investigation was conducted in regards to the allegation of verbal abuse. The QIDP indicated the staff was retrained on how to properly restrain client #8.</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. Based on record review and interview for 1 of 25 Bureau of Developmental Disabilities Services reports (BDDS) reviewed involving 1 of 4 sampled</p>	W000154	TradeWinds has a policy on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injury of an unknown origin. The Policy	07/18/2014

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	<p>clients, (client #2), the facility failed to provide written evidence of a thorough investigation.</p> <p>Findings include:</p> <p>-BDDS report dated 1/18/14 involving client #2 indicated: "On 1/19/14, the QDDP received a call from the House manager stating she received a voice message from [client #2's Mother]. [Mom's name] stated on voice mail that she spoke with [client #2] and he told her that staff member [Staff #20 name], told [client #2] to 'suck his private parts.' "</p> <p>Group home manager stated to the QDDP that she made several attempts to contact [Mother name] but was unsuccessful contacting her....The out come of the investigation was that there was no evidence to substantiate that staff told [client #2] to 'suck his private part'."</p> <p>Further review of the record failed to indicate a thorough investigation was conducted in regards to this incident.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 6/25/14 at 1:40 P.M. The QIDP indicated there was no written documentation to indicate a thorough investigation was conducted.</p>		<p>Statement states: "Violating an Individuals Rights, Abuse and or neglect or any mistreatment of any consumer who participates in a TradeWinds Services, Inc., program is strictly prohibited and will result in severe disciplinary action up to and include discharge from employment and may further result in criminal prosecution. All allegations of violating an Individuals rights or abuse and neglect of consumers served and certain other incidents defined in this policy are to be reported and investigated in prompt and procedurally correct manner." (Please see attached Policies and Procedures on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injuries of an Unknown Origin). For all allegations of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin, the investigation will start within 24 hours of the alleged incident. When there is an allegation of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin the staff person(s) involved will be removed immediately from the schedule pending outcome of the investigation. The staff person(s) involved is responsible for completing an internal incident report and notifying all necessary person(s), such as: House Manager, QDDP and Residential Nurse (if medical attention is</p>	

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	9-3-2(a)		needed). The QDDP must be notified as soon as the incident is under control and there is no further danger to either client(s) involved. The QDDP is responsible for making all necessary incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of incident). TradeWinds Quality Assurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitors trends for each incident. The QDDP is responsible for conducting a thorough investigation, involving all staff members and consumers involved in incident through written documentation. On 7/17/2014, staff was re- trained on the Abuse, Neglect, Exploitation, Mistreatment and Protection of an Individual's Rights and Injury of an unknown origin policy for the incident involving client #2 (Please see attached training documents) To ensure and monitor the investigations that are conducted by the QIDP's, the Residential Coordinator will request a copy for review. When the investigation is completed, it will be reviewed by the Residential Coordinator and General Manager for review to ensure the investigations are thorough. A copy of all completed investigations will be kept by the		

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W000249	<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 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 4 sampled clients (client #1), the facility failed to implement the client's 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 6/17/14 from 5:10 A.M. until 6:45 A.M. During the entire observation period, client #1 sat in the living room with no activity. Direct Support Professionals (DSP) #1, #2 and #3 would walk into the room and occasionally check on client #1, but did not offer any meaningful activity.</p> <p>An observation was conducted at the facility owned day program on 6/17/14 from 8:25 A.M. until 9:45 A.M. During</p>	W000249	<p>residential coordinator and a copy will be submitted to Human Resources for filing.</p> <p>A meaningful day activity/active treatment schedule has been developed and implemented into the Burrell Group Home for all consumers. (Please see attached documents). The meaningful day schedule outlines active treatment opportunities, training objectives and various activities for the consumers to be involved in. In addition, each consumer has goals that are developed & implemented. The goals developed are individualized based upon each consumer's needs, wants and desires. The group home manager is responsible for monitoring the meaningful day activities and individualized goals on a weekly basis. In addition, the QDDP monitors the activities and goals for each consumer monthly. The QDDP also completes monthly Q notes based upon the attempts and or success of each of the consumer's activities and individualized goals. If a</p>	07/18/2014

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	<p>the entire observation period, client #1 sat in a chair with no activity. Direct Support Professionals (DSP) #7, #8 and #9 would walk around the room and occasionally check on client #1, but did not offer any meaningful activity.</p> <p>A review of client #1's record was conducted on 6/18/14 at 11:00 A.M. A review of client #1's Individual Support Plan (ISP) dated 11/26/13 indicated the following objectives that could have been implemented during both observations: "Will state my wants to my staff...Will assist making a salad...Will participate in some form of exercise...Will learn to identify and learn the value of money...Will learn to cross the street safely...Will learn to grocery shop for items that are appropriate... Will participate in activities with my peers..."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 1:40 P.M. The QIDP indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(a)</p>		<p>consumer has successfully reached his or her individualized goal then another goal will be developed and implemented by the QDDP with the input of the consumer's team. The new goal will then be monitored by the house manager on a weekly basis; in addition to the monthly review of the QDDP. The group home manager is responsible for monitoring the staff to ensure that the proper procedure is being followed and that all consumers are actively involved in their own care and ensuring that staff is implementing the consumer's training objectives when formal and or informal opportunities exists in the home. In addition, the QDDP observes staff during unannounced visits to the group home to ensure that staff is following proper procedure of all consumer's is being actively involved in their own care and ensuring that staff is implementing the consumer's training objectives when formal and or informal opportunities exists in the home. On 7/17/2014, staffs were re-trained on the meaningful day schedule/active treatment with all consumers. (Please see attached training documents) The Behaviorist has reviewed all Behavior Support Plans for the Burrell Group Home consumers and is in the process of making revisions to include the least restrictive to most effective measures using the CPI methods</p>	

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			utilized by TradeWinds. The QIDP will continue to communicate on a weekly basis with the behavior specialist to ensure compliance with consumer specific restraints are very descriptive (for least restrictive to most effective measures) that will give staff specific instructions on proper restraint to use per consumer's BSP. In addition, the Residential Coordinator will follow up with the communication between the QIDP and behaviorist to monitor and to ensure compliance. The house manager is responsible for observing the group homes and making sure all items that are needed are in the home at least 5 days a week. The QIDP will observe during weekly unannounced visits that the group home has all items that are needed and to ensure that all items are working properly and efficiently. A residential QIDP weekly site visit checklist has been developed as an onsite monitoring system, effective August 5, 2014 and will be utilized by the QIDP's on the weekly visits. (Please see attached weekly checklist) The weekly checklist will be turned into the residential coordinator on a weekly basis for additional auditing for the group home. In addition to the house managers and QIDPs visits to the group homes, the residential coordinator will conduct monthly unannounced visits to the group homes.	

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview, for 1 additional client (clients #8), the facility failed to ensure systematic interventions (physical holds) in the Behavior Support Plans (BSP) were specifically written/described.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/17/14 at 1:20 P.M. and indicated:</p> <p>-BDDS report dated 10/16/13 of improper restraining involving client #8 indicated: "On 10/16/13 at approximately 5:36 A.M., the group home staff informed the QDDP (Qualified Developmental Disabilities Professional) that [client #8] had a behavior. Staff stated [client #8] became verbally aggressive because he didn't want to eat the breakfast that was prepared. Staff stated while trying to</p>	W000289	<p>On 7/15/2014, the QDDP emailed the behaviorist for the Burrell Group Home to request an update/revision made to the BSPs for the Burrell Group Home that will give a thorough indication of what is least restrictive to most restrictive measures during a behavior that involves ahold/restraint. A thorough description of the holds to be utilized by staff must be thoroughly listed in the BSP for each consumer to guide staff to ensure proper implementation. The QDDP is responsible for ensuring that the BSPs have thorough descriptions of various holds to utilize (for least restrictive to most effective measures) during a behavior in the BSP for staff guidance to ensure proper implementation for each consumer in his/her BSP (client specific).</p> <p>All new hires, will receive CPI training and every 2 years all staff will receive a re-training on CPI or as needed to ensure staff can demonstrate competency. In addition, all staff will receive behavioral training annually or as needed to ensure competency.</p>	07/18/2014

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	<p>redirect [client #8], he started calling the staff out their names and us (sic) foul language. Then [client #8] picked up a chair and threw it against the wall. [Client #8] went and picked up the chair he had thrown and attempted to hit staff with it. Staff blocked the chair with her arms to keep from being hit. The other two female staff had all the residents move out the way of the incident and contacted the police. [Client #8] hit staff in the face with his hand and grabbed a hand full of hair. Staff stated she panicked when [client #8] grabbed her hair and started punching her in the face. Before the other two staff could intervene, [Staff name] stated she grabbed the paper towel holder off the counter and hit [client #8] in the chest with it. [Client #8] let go of staff's hair and stopped hitting her when he was hit. The other staff intervened and was able to redirect [client #8] to his room. [Client #8] walked to his room saying 'I beat that m-----r a--.' The police arrived and spoke to [client #8] in regards to his behavior...[Client #8] had a small abrasion." Further review of the report failed to indicate what type of restraints/holds staff are to use when client #8 is physically aggressive.</p> <p>A review of client #8's record was conducted on 6/18/14 at 3:15 P.M..</p>		<p>All staff will be tested after the trainings and all staff must receive at least 80% or better on all test to ensure that staff can demonstrate competency. However, if staff receives a score below 80%, he/she must re-test until he/she has met the requirements of receiving an 80% or higher on all competency tests.</p>	

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W000331	<p>Review of client #8's BSP dated 3/1/13 indicated: "If [client #8] is not able to calm himself down and blocking has been proven to be unsuccessful, and staff feel that [client #8] is a risk to himself or others, staff should utilize the least restrictive but most effective form of physical restraint." Further review of the BSP did not indicate nor describe what the least restrictive but most effective hold/restraint that should be implemented when client #3 was a risk to herself or to others.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 6/25/14 at 1:40 P.M. The QIDP indicated client #8's BSPs did not indicate how the holds/techniques would be implemented when needed. The QIDP further indicated they did not have the description of the holds to be used in the BSP for staff guidance to ensure proper implementation.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p>				

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	<p>Based on observation, record review and interview for 1 of 4 clients observed during the evening medication administration, (client #3), the facility's nursing services failed to reconcile the medication label with the Medication Administration Records (MAR).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/17/14 from 5:10 A.M. until 6:45 A.M. At 6:10 A.M., Direct Support Professional (DSP) #3 administered client #3's prescribed medications with a 2 ounce solo cup of water.</p> <p>Review of the medication label indicated: "Sulfamethoxazole 60 mg (milligram) tablet (antibiotic)...1 tablet twice daily orally twice daily...Take with plenty of water." A review of the Medication Administration Record (MAR) dated June 1, 2014 to June 30, 2014 at 6:15 A.M. did not indicate "Take with plenty of water."</p> <p>An interview with the Registered Nurse (RN) was conducted on 6/25/14 at 1:40 P.M. The RN indicated client #3 should have taken his medication with at least 8 ounces of water. The RN indicated the she was responsible for reconciling the MAR and medication labels. The RN further indicated the she had not reconciled the medication label and MAR for client #3's medication.</p> <p>9-3-6(a)</p>	W000331	<p>The sulfamethoxazole prescription for client #3 was discontinued by the ordering physician on 7/1/14. The documentation of the order to discontinue the sulfamethoxazole for client #3 is attached. If client #3 or any other clients are prescribed sulfamethoxazole in the future, the Residential Nurse will reconcile the medication label with the medication administration record by recording on the medication administration record (MAR) that the client should drink 8oz. of water following administration of the sulfamethoxazole. The Residential Nurse is responsible to reconcile the medication label with the medication administration record (MAR). The Residential Nurse will be responsible to reconcile medication labels with medication adjustment records for all clients in the future.</p>	07/18/2014

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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, the facility failed to assure 4 of 4 sampled clients (#1, #2, #3, #4,) and 4 additional clients (#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 6/17/14 from 5:10 A.M. until 6:45 A.M. At 5:10 A.M., Direct Support Professional (DSP) #2 put English muffins into the toaster as clients #1, #2, #3, #4, #5, #6, #7 and #8 sat with no activity. DSP #2 then placed the English muffins on a plate and set the plate on the dining table. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not toast their English muffins.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 1:40 P.M. The QIDP indicated clients were capable of toasting their English muffins and further indicated they should be doing so at all times.</p> <p>9-3-8(a)</p>	W000488	<p>The staff has been re-trained on involving consumers in meal preparation. (Please see attached document)The group home manager is responsible for monitoring staff to ensure that the consumers are involved in the meal preparations. In addition, the QDDP will also observe staff during unannounced visits to the group home to ensure that the consumers are involved in the meal preparation and serving the meals according to their level of functioning. The QDDP will observe during weekly unannounced visits that the group home has all items that are needed and to ensure that all items are working properly to run efficiently. In addition to the House Managers visits and the QDDP's unannounced weekly visits, the Residential Coordination will conduct monthly unannounced visits to the group homes. The house manager is responsible for observing the group homes and making sure all items that are needed are in the home at least 5 days a week. The QIDP will observe during weekly unannounced visits that the group home has all items that are needed and to ensure that all items are working properly and efficiently. A residential QIDP weekly site visit checklist has been</p>	07/18/2014

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			<p>developed as an onsite monitoring system, effective August 5, 2014 and will be utilized by the QIDP's on the weekly visits. (Please see attached weekly checklist) The weekly checklist will be turned into the residential coordinator on a weekly basis for additional auditing for the group home. In addition to the house managers and QIDPs visits to the group homes, the residential coordinator will conduct monthly unannounced visits to the group homes.</p>		