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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G729 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/17/2012 |
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| NAME OF PROVIDER OR SUPPLIER AWS | STREET ADDRESS, CITY, STATE, ZIP CODE 4331 MELBOURNE RD INDIANAPOLIS, IN 46228 |
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| W0000 | <p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 08/13/2012, 08/14/2012, 08/15/2012, 08/16/2012, 08/17/2012</p> <p>Facility Number: 011220 Provider Number: 15G729 AIM Number: 200839230</p> <p>Surveyor: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed August 22, 2012 by Dotty Walton, Medical Surveyor III.</p> | W0000 | | |

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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| W0124 | <p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on record review and interview, the facility failed to ensure the guardian was notified of physical restraints used to complete routine dental care for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 08/14/2012 at 11:10 a.m. The "Patient Notes Master," dated 03/23/2012 indicated, "...Special needs high anxiety/combatative pt (patient) was presedated by home (facility) with Valium (sedative) 10 mg (milligrams) 1 tabs (tablet)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold where 2 people prevent client from moving) was sufficient to stabilize pt. and complete dental treatment...."</p> <p>The record did not indicate the guardian was notified of use of physical restraints to complete routine dental care.</p> | W0124 | Human Rights Committee and guardian approval will be requested for all restrictive intervention included in current client behavior and support plans. AWS Behavior Consultant will verify this with AWS QDDP at each client annual or sooner if a plan is amended.AWS staff training will be completed regarding updated support plans.Completion date: September 16, 2012. | 09/16/2012 | | | |

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| | <p>During an interview on 08/15/2012 at 12:15 p.m., Administrative staff #1 indicated there was no documentation to indicate guardian notification of the physical restraints.</p> <p>9-3-2(a)</p> | | | |

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| W0149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility neglected to implement their policy and procedures to prevent and thoroughly investigate an allegation of neglect for 1 of 3 incidents reviewed for allegations of abuse/neglect for 1 additional client (client #3).</p> <p>Findings include:</p> <p>During observations on 08/14/2012 at 6:45 a.m., client #3 was in the living room seated in a wheelchair with a seat belt unfastened. He rose from the wheelchair to a standing position and fell on the floor, landing on his left side. Direct Support Professional (DSP) #7 moved client #3 from a left side lying position to a seated position on the floor with his legs extended in front of him. DSP #7 left the area for 1 minute while client #3 remained on the floor. DSP #7 returned to the living room and stood at a counter separating the kitchen and living room. Staff were not supervising/monitoring client #3 when he moved from the seated position on the living room floor to a squatted position. Client #3 stood at 6:50 a.m. from the squatted position and fell forward and</p> | W0149 | <p>An incident report and investigation have been completed related to the incident that occurred on 8-14-12. AWS staff will receive updated training regarding general client wheelchair safety and client #4's risk plan, which will address mobility and OT/PT recommendations. AWS Compliance Officer will retrain QDDP, Manager, and Director regarding AWS Incident and Abuse/Neglect Reporting and Process. Completion date: September 16, 2012</p> | 09/16/2012 | | | |

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| | <p>rolled to his left side. DSP #4 came out of the laundry room and assisted DSP #7 with getting client #3 off the floor to a standing position. DSP #7 returned to the kitchen counter and resumed writing. DSP #4 removed the wheelchair from the living room and left client #3 standing unassisted in the middle of the living room.</p> <p>The facility's reportable incident reports and investigations were reviewed on 08/13/2012 at 1:30 p.m. On 08/15/2012 at 11:00 a.m., the facility indicated there were no additional incident reports for review.</p> <p>An 08/2008 policy, titled "Group Home Abuse and Neglect" was reviewed on 08/13/2012 at 3:00 p.m. The policy indicated, "...Neglect includes failure to provide appropriate care, food, medical care or supervision...If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protection Services, and client representatives...The Program Coordinator/QMRP (Qualified Mental</p> | | | | | | |

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| | <p>Retardation Professional) will need to fill out an incident form within 24 hours...If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place...."</p> <p>During an interview on 08/14/2012 at 7:00 a.m., DSP #7 stated the fall protocol was, "fill out a report and notify the nurse."</p> <p>During an interview on 08/14/2012 at 8:15 a.m., the RN #1 indicated the DSPs should have attended to the client and ensured safety before writing the fall report. RN #1 indicated client #3 should not have been left unattended and standing in the living room after falling.</p> <p>During an interview on 08/14/2012 at 8:15 a.m. the Qualified Developmental Disabilities Professional (QDDP) indicated the staff should have stayed with client #3 to prevent additional falls.</p> <p>During an interview on 08/15/2012 at 12:20 p.m., Administrative staff #1 indicated an incident report has not been completed and an investigation had not been initiated for an allegation of neglect of client #3. He indicated staff who allegedly neglected client #3 had not been</p> | | | |

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| | suspended. 9-3-2(a) | | | | |

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| W0153 | <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview, the facility failed to immediately report an allegation of neglect to the administrator or other officials in accordance with State Law for 1 of 3 incidents reviewed for allegations of abuse/neglect for 1 additional client (client #3).</p> <p>Findings include:</p> <p>During observations on 08/14/2012 at 6:45 a.m., client #3 was in the living room seated in a wheelchair with a seat belt unfastened. He rose from the wheelchair to a standing position and fell on the floor, landing on his left side. Direct Support Professional (DSP) #7 moved client #3 from a left side lying position to a seated position on the floor with his legs extended in front of him. DSP #7 left the area for 1 minute while client #3 remained on the floor. DSP #7 returned to the living room and stood at a counter separating the kitchen and living room. Staff were not supervising/monitoring client #3 when he</p> | W0153 | <p>An incident report and investigation have been completed related to the incident that occurred on 8-14-12.AWS staff will receive updated training regarding general client wheelchair safety and client #4's risk plan, which will address mobility and OT/PT recommendations.AWS Compliance Officer will retrain QDDP, Manager, and Director regarding AWS Incident and Abuse/Neglect Reporting and Process.Completion date: September 16, 2012</p> | 09/16/2012 | |

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| | <p>moved from the seated position on the living room floor to a squatted position. Client #3 stood at 6:50 a.m. from the squatted position and fell forward and rolled to his left side. DSP #4 came out of the laundry room and assisted DSP #7 with getting client #3 off the floor to a standing position. DSP #7 returned to the kitchen counter and resumed writing. DSP #4 removed the wheelchair from the living room and left client #3 standing unassisted in the middle of the living room. Client #3 was placed in a recliner after DSP #4 was asked by the Indiana State Department of Health Surveyor how client #3's safety from falls was going to be ensured.</p> <p>The facility's reportable incident reports and investigations were reviewed on 08/13/2012 at 1:30 p.m. On 08/15/2012 at 11:00 a.m., the facility indicated there were no additional incident reports for review.</p> <p>An 08/2008 policy, titled "Group Home Abuse and Neglect" was reviewed on 08/13/2012 at 3:00 p.m. The policy indicated, "...Neglect includes failure to provide appropriate care, food, medical care or supervision...If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS</p> | | | | | | |

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| | <p>Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protection Services, and client representatives...The Program Coordinator/QMRP (Qualified Mental Retardation Professional) will need to fill out an incident form within 24 hours...If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place...."</p> <p>During an interview on 08/15/2012 at 12:20 p.m., Administrative staff #1 indicated an incident report has not been completed and an investigation had not been initiated for an allegation of neglect of client #3.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> | | | | |

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| W0210 | <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview, the facility failed to assess refusals to ambulate and necessity for wheelchair for 1 additional client (client #3).</p> <p>Findings include:</p> <p>During observations on 08/13/2012 between 4 p.m. and 6:30 p.m., client #3 was seated in a wheelchair without a fastened seat belt. At 6:00 p.m., Resident Manager (RM) #1 placed her arms under client #3's arms and reached around his chest and pulled him from the wheelchair to a standing position. RM #1 took client #3's hands and encouraged him to walk towards her. Client #3 refused to walk and was returned to the wheelchair for transport to the dining area. RM #1 transferred client #4 from the wheelchair to a dining chair for his meal. He returned to the wheelchair after the meal and was transported back to the living room.</p> <p>During observations on 08/14/2012 between 6:20 a.m. and 8:00 a.m., client</p> | W0210 | <p>A physician order for client #3 to use a wheelchair has been obtained. An order for a PT/OT assessment will be requested from client #3's physician. AWS Nurse will ensure that each client's ambulatory status is assessed at least annually. AWS staff will receive updated training regarding general client wheelchair safety and client #4's risk plan, which will address mobility and OT/PT recommendations. Completion date: September 16, 2012.</p> | 09/16/2012 | |

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| | <p>#3 was seated in a wheelchair with the seat belt unfastened. At 6:45 a.m., he rose from the wheelchair to a standing position and fell on the floor, landing on his left side. Direct Support Professional (DSP) #7 moved client #3 from a left side lying position to a seated position on the floor with his legs extended in front of him. Client #3 fell a second time when he attempted to stand from a squatted position on the floor.</p> <p>During an interview on 08/13/2012 at 6:00 p.m., RM#1 indicated client #3 likes to sit and roll around on the floor. She stated, "Lately he has been refusing to get up when it is time to go so we have to put him in the wheelchair." RM #1 indicated client #3 was capable of walking.</p> <p>During an interview on 08/14/2012 at 8:15 a.m., RN #1 indicated client #3 did not have a history of falls. She indicated a fall protocol was in place for client #3.</p> <p>During an interview on 08/14/2012 at 8:15 a.m., the Qualified Developmental Disabilities Professional (QDDP) indicated client #3 had not been assessed for alternative mobility needs such as a wheelchair. She indicated she was not aware client #3 had been refusing to walk.</p> <p>Client #3's record was reviewed on</p> | | | | | | |

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| | 08/15/2012 at 11:00 a.m. The record indicated no assessment to determine ambulatory status and necessity of mobility aids/wheelchair. 9-3-4(a) | | | | |

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| W0249 | <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to implement Individual Support Plan (ISP) objectives when training opportunities existed for 2 of 2 sampled clients (client #1 and #2).</p> <p>Findings include:</p> <p>1. During observations on 08/13/2012 between 4 p.m. and 6:30 p.m. and on 08/14/2012 between 6:20 p.m. and 8:15 a.m., client #2 did not have a communication devise to request positioning in his tilt in space wheelchair.</p> <p>During observations on 08/13/2012 at 4:35 p.m., dinner was prepared by staff without participation of clients. Client #2 did not place his dirty dishes in the dishwasher after the meal.</p> <p>During observations on 08/15/2012 between 1:40 p.m. and 2:30 p.m., client #2 did not have a communication devise to request changes in seating position in his tilt in space wheelchair.</p> | W0249 | Staff will be re-trained regarding the implementation of all current client ISP goals.AWS QDDP and/or AWS Manager will conduct weekly ISP goal observation and monitoring for three consecutive months and document staff compliance related to ISP implementation. Completion date: September 16, 2012 | 09/16/2012 | | | |

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| | <p>Client #2's record was reviewed on 08/14/2012 at 12:15 p.m. The ISP, dated 10/01/2012, indicated client #2 had training objectives for pushing the button on the food processor to puree his food daily and for placing dirty dishes in the dishwasher daily.</p> <p>During an interview on 08/14/2012 at 8:15 a.m., the Qualified Developmental Disabilities Professional (QDDP) indicated client #2 should have been provided the communication devise to request position changes while seated in his wheelchair. The QDDP indicated client #2 should have participated in preparing his food to the correct texture and should have been encouraged to place his dirty dishes in the dishwasher.</p> <p>2. During observations of medication administration on 08/13/2012 at 5:40 p.m., client #1 did not remove medications from a punch card for self medication administration.</p> <p>Client #1's record was reviewed on 08/14/2012 at 11:10 a.m. The ISP, dated 05/08/2012, indicated client #1 had a training objective for removing a medication from the punch card daily in the evening for self medication administration.</p> | | | |

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| | <p>During an interview on 08/14/2012 at 8:15 a.m., the QDDP indicated client #1 should have removed a medication from the punch card for self medication administration.</p> <p>9-3-4(a)</p> | | | |

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| W0262 | <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility failed to ensure the Human Rights Committee (HRC)/Specially Constituted Committee approved the use of physical restraints during routine dental care for 1 of 2 sampled clients (client #1). Findings include: Client #1's record was reviewed on 08/14/2012 at 11:10 a.m. The "Patient Notes Master," dated 03/23/2012 indicated, "...Special needs high anxiety/combatative pt (patient) was presedated by home (facility) with Valium (sedative) 10 mg (milligrams) 1 tabs (tablet)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold where 2 people prevent client from moving) was sufficient to stabilize pt. and complete dental treatment...."</p> <p>The facility's Human Rights Committee (HRC)/Specially Constituted Committee</p> | W0262 | Human Rights Committee and guardian approval will be requested for all restrictive intervention included in current client behavior and support plans. AWS Behavior Consultant will verify this with AWS QDDP at each client annual or sooner if a plan is amended.AWS staff training will be completed regarding updated support plans.Completion date: September 16, 2012. | 09/16/2012 | |

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| | <p>minutes were reviewed on 08/14/12 at 10:30 a.m. The record did not indicate HRC approved the use of physical restraints to complete routine dental care.</p> <p>During an interview on 08/15/2012 at 12:15 p.m., Administrative staff #1 indicated there was no documentation to indicate the Rainbow restraint and four handed dentistry restraint had been approved by the HRC.</p> <p>9-3-4(a)</p> | | | |

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| W0369 | <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 to ensure all medications were administered without error for 1 of 25 medications observed for administration (additional client #4).</p> <p>Findings include:</p> <p>During observations on 08/13/2012 at 5:10 p.m. Direct Support Professional (DSP) #4 administered Niaspan ER (cholesterol reducing medication) 500 mg (milligrams) at the same time Aspirin 81 mg was administered.</p> <p>Client #4's record was reviewed on 08/15/2012 at 12:00 p.m. The Physician's Orders, dated 08/01/2012-08/31/2012, indicated. "...ASPIRIN 81 MG TABLET CHEW GIVE 1 TABLET DAILY AS DIRECTED (TAKE 20 MINUTES BEFORE TAKING NIASPAN PILL)...."</p> <p>During an interview on 08/14/2012 at 8:15 a.m., RN #1 indicated DSP #4 should have waited 20 minutes after administering aspirin before administering Niaspan.</p> | W0369 | DSP #4 will receive re-training regarding the appropriate med pass procedure from the AWS Nurse.AWS Nurse will complete and document two med pass observations with DSP#4 following the retraining.Completion date: September 16, 2012 | 09/16/2012 | | | |

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| W0466 | <p>483.480(a)(6) FOOD AND NUTRITION SERVICES Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.</p> <p>Based on observation, record review and interview, the facility failed to ensure recommended dietary portion sizes for 1 of 2 sampled clients (client #2) and 1 additional client (client #4).</p> <p>Findings include</p> <p>1. During observations on 08/13/2012 at 6:00 p.m. Direct Support Professional (DSP) #3 served client #2 bite size servings of each food item from family style serving bowls. One bite of an individual food item was placed in client #2's divided plate. Client #2 fed himself the plated bite of food. and additional bites were added to the plate until client #2 removed his clothing protector and turned away from the table. There was no system for determining portion sizes served.</p> <p>Client #2's record was reviewed on 08/14/2012 at 12:15 p.m. The Physician's Orders, dated 08/01/2012-08/31/2012, indicated client #2 was on a high calorie</p> | W0466 | Staff will be re-trained regarding client dining plans and meal preparation, including proper portion measurements and food temperature. AWS QDDP and/or AWS Manager will conduct weekly client Dining Observation and monitoring for three consecutive months and document staff compliance related to Dining Plan compliance. Completion date: September 16, 2012 | 09/16/2012 | | | |

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| | <p>pureed diet with 2 cans of Ensure (dietary supplement) daily.</p> <p>A Nutritional Assessment, dated 08/06/2012 indicated, "...Continue with diet and supplement as ordered...."</p> <p>A menu, dated, Spring/summer week 2, indicated portion sizes for each food item and beverage. The menu indicated, "...1 LF (low fat) Hot Dog, 3/4 c. (cup) Baked Beans, 1 c. Fzn (frozen)/fresh ck (cooked) carrots, 1 Bun or 1 c. Cr (cream) of Wheat, Mustard/Catsup, 1/2 c. Mandarin Oranges, 1 tsp (teaspoon) Margarine, 1 c. Water, !c, SK (skim) or 1/2 (half) % milk, 8 to 12 oz (ounces) SF (sugar free) punch...."</p> <p>During an interview on 08/13/2012 at 6:30 p.m. DSP #3 stated, "[Client #2] can eat as much as he wants," when asked how quantity of food consumed was determined.</p> <p>2. During observations on 08/13/2012 at 6:00 p.m. DSP #2 served client #4 bite size servings of each food item from family style serving bowls. One bite of an individual food item was placed in client #4's divided plate. Client #4 fed himself the plated bite of food. and additional bites were added to the plate until client #4 pushed his chair away from the dining</p> | | | | | | |

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| | <p>table. There was no system for determining portion sizes served.</p> <p>During observations on 08/14/2012 at 7:15 a.m., DSP #7 served client #4 bite size servings of each food item from family style serving bowls. One bite of an individual food item was placed in client #4's divided plate and client #4 used a regular spoon to feed himself the bite. DSP #7 poured a small amount of orange juice from the pitcher into a nosey cup. Client #4 drank the liquid in one gulp and additional orange juice was added to the cup. The processes of serving the food and drink were repeated until client #4 indicated he was finished eating and drinking by pushing his chair away from the table. There was no system for measuring the amount of food or liquid that was consumed.</p> <p>Client # 4's record was reviewed on 08/15/2012 at 12:00 p.m. The Physician' Orders, dated 08/01/2012-08/31/2012, indicated client #4 was on a mechanical soft, low oxidate, high fiber diet. The record indicated client #4 received Boost dietary supplements twice daily.</p> <p>A Nutritional Review, dated 08/06/2012, indicated, "..Continue with diet and supplement orders. Instruct staff to make sure I&O's (food and liquid intake and</p> | | | |

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| | <p>output) are completed accurately...."</p> <p>A menu, dated, Spring/summer week 2, indicated portion sizes for each food item and beverage served during the evening meal on 08/13/2012. The menu indicated, "...1 LF (low fat) Hot Dog, 3/4 c. (cup) Baked Beans, 1 c. Fzn (frozen)/fresh ck (cooked) carrots, 1 Bun or 1 c. Cr (cream) of Wheat, Mustard/Catsup, 1/2 c. Mandarin Oranges, 1 tsp (teaspoon) Margarine, 1 c. Water, 1 c. SK (skim) or 1/2 (half) % (percentage) milk, 8 to 12 oz (ounces) SF (sugar free) punch...."</p> <p>The menu, dated Spring/summer week 2, indicated portion sizes for each food item and beverage served during the breakfast meal on 08/14/2012. The menu indicated, "... 3/4 c. Grape Juice, 1 scrambled egg, 2 Slice Whole Wheat Toast, 1 tsp Margarine, 2 tsp Low/sugar Jelly, 1/2 c Whole Grain ck (cooked) Cereal, 1 c. Water, Coffee/Tea if desired, 1 c. SK or 1/2 % Milk...."</p> <p>During an interview on 08/142012 at 8:15 a.m., RN #1 indicated the DSPs should have premeasured the food/drinks served from the family style serving bowl and pitcher to ensure clients #2 and #4 received the recommended dietary servings.</p> | | | | | | |

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| W0473 | <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to ensure food was served at an appropriate temperature, within 15 minutes of removing the food from the stovetop or oven for 1 of 2 sampled clients (client#2) and 2 additional clients (clients #3 and #4).</p> <p>Findings include:</p> <p>During observations on 08/14/2012 at 6:30 a.m., client #2 carried menu items of pureed toast, oatmeal, and scrambled eggs in serving bowls covered with plastic wrap from the kitchen and placed them on the dining table. Client #4 ate his breakfast at 7:15 a.m. The food was not reheated prior to being eaten. Client #2 ate his breakfast at 7:30 a.m. The food was not reheated prior to being eaten. Client #3 ate his breakfast at 7:40 a.m. The food was not reheated prior to being eaten.</p> <p>During an interview on 08/15/2012 at 8:15 a.m., RN #1 indicated client #2, #3, and #4's food should have been reheated prior to being eaten.</p> <p>9-3-8(a)</p> | W0473 | <p>Staff will be re-trained regarding client dining plans and meal preparation, including proper portion measurements and food temperature. AWS QDDP and/or AWS Manager will conduct weekly client Dining Observation and monitoring for three consecutive months and document staff compliance related to Dining Plan compliance. Completion date: September 16, 2012</p> | 09/16/2012 | | | |

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| W0488 | <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed to encourage clients to participate in dining procedures to the extent they were capable for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>During observations on 08/13/2012 at 4:35 p.m., dinner was prepared by staff without participation of clients.</p> <p>1. Client #1's record was reviewed on 08/14/2012 at 11:10 a.m. The ISP, dated 05/08/2012, indicated client #1 had a training objective for assisting with meal preparation twice weekly.</p> <p>2. Client #2's record was reviewed on 08/14/2012 at 12:15 p.m. The ISP, dated 10/01/2012, indicated client #2 had training objectives for pushing the button on the food processor to puree his food daily.</p> <p>During an interview on 08/14/2012 at 8:15 a.m., the Qualified Developmental Disabilities Professional (QDDP) indicated clients should have been encouraged to participate in meal</p> | W0488 | <p>Staff will be re-trained regarding the implementation of all current client ISP goals.AWS QDDP and/or AWS Manager will conduct weekly ISP goal observation and monitoring for three consecutive months and document staff compliance related to ISP implementation. Completion date: September 16, 2012</p> | 09/16/2012 |

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