

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G732		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2013	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1730 OSAGE DR KOKOMO, IN 46902			
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W000000	<p>This visit was for the annual recertification and state licensure survey.</p> <p>Dates of Survey: August 21, 22, 23, 26, 27, 29, and 30, 2013</p> <p>Facility Number: 011266 Provider Number: 15G732 AIM Number: 200840950</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/25/13 by Ruth Shackelford, QIDP.</p>			W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure client #2 had access to his identification to carry on his person during his independent community bowling outing per his assessments.</p> <p>Findings include:</p> <p>On 8/21/13 at 3:20pm, client #2 arrived home with the facility staff from the workshop. At 3:20pm, client #2 showed his wallet from his pocket which held multiple dollar bills and no personal identification was in client #2's wallet. Client #2 indicated he did not know his address and client #2 interchanged two of the number digits for the correct group home phone number. Client #2 indicated the staff at the group home had his personal identification card and he did not have access to his identification card. At 3:40pm, client #2 left the group home with Direct Care Staff (DCS) #1 to go to the bowling alley. At 3:40pm, DCS #1 indicated she dropped off client #2 at the bowling alley and client #2 will use his</p>	W000125	<p>Direct Support Professionals, Residential House Manager and QDDP were retrained on human rights. Client #2 has been given his personal ID to carry in his wallet. All residents of the home have access to personal ID cards at all times. If a resident chooses not to carry his/her personal ID card, staff have also printed personal ID information on business sized cards and distributed to those residents. For continued monitoring, a line has been added to the annual risk assessment tool of all consumers to ensure the IDT is reviewing the benefit/appropriateness of each consumer in carrying his/her personal ID information. Client #2's Risk Assessment (Appendix A) and Health and Safety Risk Plan (Appendix B) were updated to reflect this change.</p>	10/07/2013	

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	<p>personal cell phone to call the group home when he was ready to be picked up. At 4:35pm, DCS #1 returned to the group home without client #2. At 5:15pm, DCS #1 returned with client #2 from his bowling outing.</p> <p>On 8/22/13 at 6:35am, client #2 indicated his correct phone number and address. Client #2 stated "I was nervous yesterday" when asked for his address and/or phone number.</p> <p>On 8/23/13 at 10:45am, a record review for client #2 was conducted. Client #2's 2/28/13 Risk Assessment and Individual Support Plan (ISP) both indicated client #2 needed verbal prompts to understand his finances and/or medical care. Client #2's record indicated he had a community job at a local restaurant. Client #2's 12/8/08 Diagnostic Evaluation (D & E) indicated client #2 would benefit from carrying his own personal identification. Client #2's record indicated he had verbal skills and client #2 did not articulate responses when he was frustrated or upset.</p> <p>On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #2 was alone in the community at his job, at the bowling</p>				

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	<p>alley, and on other occasions. The DRS indicated client #2 does have limited verbal skills around strangers or when client #2 was upset. The DRS indicated it would be beneficial for client #2's safety for him to carry his personal identification.</p> <p>9-3-2(a)</p>			

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>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 on record review and interview, for 2 of 4 sample clients (clients #1 and #3), the facility failed to obtain an accurate accounting of client #1 and #3's personal funds and failed to follow their policy and procedure for client finances.</p> <p>Findings include:</p> <p>On 8/22/13 at 8:50am, client #1 and #3's personal funds were audited at the group home with the Residential Manager (RM). Client #1's personal funds indicated he had no cash in his personal funds account at the group home. Client #1's ledger indicated a zero balance. Client #1 had an undated expense of \$1.00 on his personal funds ledger and no receipt to indicate if the money was given to client #1 or something else. Client #3's personal funds had a zero balance and zero cash in his personal funds account at the group home. Client #3 had an undated expense withdrawal for \$2.00 which indicated the withdrawal was for a snack and there was no receipt to indicate if the money was given to client #3 or something else. At 8:50am, the RM stated clients #1 and #3 "must have"</p>	W000140	<p>Direct Support Professionals, Residential House Manager and QDDP were re-trained on 10/7/13 on the Money & Receipt Policy which includes the proper procedure for supporting clients in managing their money: withdrawal slips, petty cash protocol, receipts for funds disbursed. Written receipts for each transaction are mandatory and staff were re-trained on that point. Because of the lack of receipt for the withdrawn funds, the agency reimbursed client #1 \$1.00 and client #3 \$2.00. For continued monitoring, a monthly review of consumer petty cash funds will be completed by the Social Services Coordinator and documented in each consumer's file.</p>	10/07/2013
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	<p>withdrawn the funds for their personal use and no receipt or withdrawal slip was available for review. The RM indicated the facility staff should have filled out a withdrawal slip when each client makes a withdrawal from their personal funds.</p> <p>On 8/21/13 at 8:50am, the facility's policy and procedure 5/2008 "Control of Disbursements" indicated the facility staff should fill out a withdrawal slip for each time each client made a withdrawal from their facility maintained personal funds to ensure a complete accounting of their finances.</p> <p>An interview on 8/22/13 at 8:55am, was conducted with the DRS (Director of Residential Services). The DRS indicated client personal funds accounts were kept separate for each client. The DRS indicated she was unaware what clients #1 and #3 spent their money on after they withdrew the money from their accounts at the group home. The DRS indicated the facility's personal funds policy and procedure was not followed by the facility staff when no receipt of the withdrawal was documented.</p> <p>9-3-2(a)</p>				

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W000149	<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 8 of 23 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility neglected to supervise clients according to their identified needs for clients #3 and #6 to be within arm's reach of staff while in the community, to supervise client #3 during dining to prevent the potential of choking, and to supervise client #1 according to his identified behavioral needs, and the facility neglected to implement the facility's policy and procedure to prohibit staff neglect for 3 of 8 clients (clients #1, #3, and #6).</p> <p>Findings include:</p> <p>1. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for clients #3 and #6:</p> <p>-A 7/31/13 BDDS report for an incident on 7/30/13 at 9:00pm, indicated a facility staff person "took [clients #3 and #6] to [Name] High School baseball field for Special O (Olympics) practice." The report indicated client #3 played on the</p>	W000149	<p>1. Direct Support Professionals, Residential HouseManager and QDDP were re-trained on 10/7/13 on the agency policy prohibiting the mistreatment, neglect or abuse of a consumer. The staff member involved in the incident for client #3 and client #6 was terminated when the incident occurred. For continued monitoring, this policy is trained on annually. Further, the agency has implemented an Incident Report Review Committee to review BDDS incident reports on a monthly basis to monitor trends/patterns in the types of incidents reported. The committee will make recommendations to the residential department and act as another layer of oversight for all consumers in the residential program. Direct Support Professionals, Residential House Manager and QDDP were re-trained on 10/7/13 on the identified level of supervision for client #3. This includes the addition of personal identification information to be carried on his person. The annual Risk Assessment (Appendix C) for client #3 was updated and all staff were trained on 10/7/13. For further monitoring, incidents of abuse and neglect are reviewed</p>	10/07/2013	

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	<p>team and client #6 "went to watch" client #3 play. The report indicated the staff person who was supervising clients #3 and #6 indicated the weather started to "drizzle," the supervising staff person went to sit in the van, and "stated [clients #3 and #6] were within line of sight the entire time." The report indicated at 7:15pm, a staff from a different group home arrived. This staff "knew" clients #3 and #6, observed clients #3 and #6 "walking without staff," and when she asked the clients where their staff was, both clients indicated they did not know. The staff from a different group home "saw the van with [client #3 and #6's] staff inside sitting in the parking lot," and the second staff monitored clients #3 and #6 "until practice was over." The report indicated client #6 had experienced a toileting accident while alone at the practice. The report indicated "Plan to Resolve:" Clients #3 and #6 "require staff be within arm's reach while in the community because of vulnerability, behaviors, and the lack of communication skills." The report indicated Client #3 was non verbal.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS stated "It was neglectful" when clients #3 and #6 were left alone at the baseball field while</p>		<p>monthly by the Incident Report Review Committee which will make recommendations to the residential department and act as another layer of oversight to all consumers in the residential program. Direct Support Professionals, Residential House Manager and QDDP were re-trained on 10/7/13 on the identified level of supervision for client #6. This includes the addition of personal identification information to be carried on her person. The annual Risk Assessment (Appendix D) was updated for client #6 and all staff were trained on 10/7/13. For further monitoring, incidents of abuse and neglect are reviewed monthly by the Incident Report Review Committee which will make recommendations to the residential department and act as another layer of oversight to all consumers in the residential program. 2. Direct Support Professionals, Residential House Manager, QDDP, and day program staff were retrained on client #3's choking management risk plan which includes line of sight supervision while eating, and cutting food into dime sized pieces (Appendix E). For continued monitoring, the choking risk plan of client #3 will be reviewed at each Residential/Day Program IDT meeting which occurs monthly to ensure that all staff are implementing the plan as written. Meetings are</p>		

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	<p>the staff sat in the van across two baseball diamonds and the far side of the parking lot away from clients #3 and #6. The DRS indicated client #3 was non verbal and clients #3 and #6 both needed staff assistance to be within arm's reach while in the community.</p> <p>2. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for client #3:</p> <p>-A 5/29/13 BDDS report for an incident on 5/28/13 at 9:45am, indicated client #3 "was sitting outside on the picnic table eating his snack" at the facility owned workshop. An office clerk "approached [client #3] as [client #3] approached the trash can and was placing his index finger in his mouth and his head in the trash can. [The office clerk] inquired Are you choking [client #3]? [Client #3] signed yes (client #3 is non verbal and uses sign language to communicate), [client #3] (had) visible tears in his eyes. [Client #3] continued to have air movement as he was placing his finger in his mouth in a sweeping motion." The report indicated the agency nurse "prompted [client #3] to continue to cough as he was using his finger in the sweeping motion. A section of celery 1 1/2" (one and one half inches)</p>		<p>scheduled for the third Tuesday of each month. It will be the responsibility of the leadQDDP in day program, and client #3's residential QDDP to ensure that the planis included on each month's agenda for review. 3. The annual survey report indicated that client #1 has a BSP (4/2013) thatindicates the client's supervision level is "to be in line of sight". However,client # 1's BSP indicates staff supervision and not direct line of sight(Appendix F). Additionally, thestatement indicating staff supervision while in the community is directlyrelated to church attendance due to historical behaviors. Direct SupportProfessionals, Residential House Manager, QDDP and all day program staff werere-trained on client #1's BSP on 10/7/13 (Appendix F). For further monitoring,day program staff were trained on a client BPR (behavior problem record) (Appendix G) and will be required to document daily behaviors. For further monitoring, client #1's BPR willbe reviewed at each monthly Residential/Day Program IDT meeting. Client #1continues to be supervised at all times by either residential staff or dayprogram staff. Client #1 attends a groupcounseling session each Friday to discuss appropriate social behaviors.</p>		

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	<p>in length was forced out during [client #3's] coughing." The report indicated client #3 had a 5/4/12 "Dysphasia Plan" which indicated client #3 was to have reminders in place to eat slowly and take small bites. Client #3's plan was changed to include his lunch items to be cut when prepared at the group home and before it was packed daily for workshop.</p> <p>On 8/23/13 at 11:15am, client #3's record was reviewed. Client #3's 8/15/13 "Physician's Order" indicated client #3 was on a regular diet. Client #3's 1/9/13 ISP and 1/9/13 Risk Plan both indicated client #3 had "Chewing Difficulties: yes, [client #3] tends to stuff his mouth too full and not chew thoroughly enough. His choking plan is located in the medical binder. Swallowing Difficulties: yes, [client #3] needs to be prompted to take drinks of liquid between bites...." Client #3's 6/10/13 "Choking Management Plan" indicated he needed reminders to slow his rate and take small bites while eating. Client #3's plan indicated client #3 was to be within eye sight when eating, his food was to be cut up into dime size pieces when his lunch was prepared and packed for workshop, and client #3 was to remain upright 30 minutes after dining to minimize his choking risk.</p> <p>On 8/30/13 at 11:05am, an interview with</p>						

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	<p>the DRS was conducted. The DRS indicated client #3 had eaten his snack at the picnic table on 5/28/13 when he choked. The DRS indicated the office clerk walked by client #3 and client #3 was within the line of sight of other staff, however the other staff did not identify that client #3 was choking. The DRS indicated client #3's food was to have been cut up into bite size pieces before the incident. The DRS stated staff's opinion of "bite size" was different from one staff to another staff assisting client #3 to fix his lunch. The DRS stated "we changed his plan to specify" dime size after the incident. The DRS indicated workshop staff knew client #3 was a choking risk, needed supervision during dining, and client #3 was to have reminders to slow his rate of eating before the 5/28/13 incident. The DRS indicated the facility staff neglected to implement client #3's plans to limit the potential of client #3 choking.</p> <p>3. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for client #1:</p> <p>-A 7/29/13 BDDS report for an incident on 7/29/13 at 2:20pm, indicated client #1 was at workshop, refused to return an</p>						

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	<p>IPod to another client, and threw and broke the IPod. Workshop client #11 punched client #1. The two clients tore each other's clothing, "went to the floor," and client #1 had a red left eye injury.</p> <p>-A 6/12/13 BDDS report for an incident on 6/11/13 at 1:30pm, indicated while client #1 was in the men's restroom at the workshop, client #1 was looking over the stalls to watch "men urinate."</p> <p>-A 5/30/13 BDDS report for an incident on 5/29/13 at 11:50am, indicated client #1 was verbally aggressive with workshop client #14. Workshop client #11 stepped in between client #1 and workshop client #14, and both clients were verbally aggressive. The report indicated client #1 shoved workshop client #11, workshop client #11 hit client #1, and both clients went to the ground physically aggressive and hit one another "several times." A "Code Yellow-clients out of Control was called" and both clients were separated. Client #1 had a red mark on his forehead and on the bridge of his nose. The report indicated client #1 also complained of rib pain and groin pain.</p> <p>-A 4/25/13 BDDS report for an incident on 4/25/13 at 9:15am, indicated client #1 was verbally aggressive toward workshop client #13. The report indicated client #1</p>			

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	<p>spat in workshop client #13's face.</p> <p>-A 1/11/13 BDDS report for an incident on 1/10/13 at 1:45pm, indicated workshop client #11 was in the men's restroom. Client #1 and workshop client #11 were verbally aggressive to one another and workshop client #11 hit client #1 in the face. No injury was noted.</p> <p>-A 10/17/12 BDDS report for an incident on 10/16/12 at 11:15am, indicated client #1 and workshop client #12 were at the picnic table when client #1 used "both hands and rubbed [workshop client #12's] sides, ribs, and top of (her) pants."</p> <p>Client #1's record was reviewed on 8/23/13 at 10am. Client #1's 4/11/13 ISP (Individual Support Plan) and 4/11/13 Risk plan both indicated client #1 had behaviors and required direct supervision by facility staff when in the community because of his behaviors. Client #1's 4/2013 BSP (Behavior Support Plan) indicated client #1 had the targeted behaviors of property destruction, Suicide threats, stealing, physical aggression, verbal aggression, inappropriate sexual behavior, resistant to staff supervision, and elopement. Client #1's BSP indicated staff were to know client #1's location and to be in the line of sight. Client #1's behaviors were to be redirected by the</p>						

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	<p>facility staff before client #1 escalated to physical aggression.</p> <p>On 8/21/13 at 1:30 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated staff was suspended for leaving clients #3 and #6 alone at the community baseball field. The DRS indicated the facility staff neglected to supervise client #3 according to identified dining needs, and neglected to supervise client #1 according to his identified behavioral needs to be in the line of sight of client #1. The DRS indicated clients #1, #3,</p>			

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	and #6 required twenty-four hour staff supervision. The DRS indicated the staff neglected to follow the abuse/neglect policy and procedure to supervise the clients. 9-3-2(a)			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, for 2 of 4 sample clients (clients #1 and #3) and 1 additional client (client #6), the facility staff failed to implement behavior management plans and to supervise clients according to their identified need for clients #3 and #6 to be within arm's reach of staff while in the community, to supervise client #3 during dining to prevent the potential of choking, and to supervise client #1 within the line of staff eyesight according to his identified behavioral needs.</p> <p>Findings include:</p> <p>1. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for clients #3 and #6:</p> <p>-A 7/31/13 BDDS report for an incident on 7/30/13 at 9:00pm, indicated a facility staff person "took [clients #3 and #6] to [Name] High School baseball field for</p>	W000249	<p>1. Direct Support Professionals, Residential HouseManager and QDDP were re-trained on 10/7/13 on the agency policy prohibiting the mistreatment, neglect or abuse of a consumer. The staff member involved in the incident for client #3 and client #6 was terminated when the incident occurred. For continued monitoring, this policy is trained on annually. Further, the agency has implemented an Incident Report Review Committee to review BDDS incident reports on a monthly basis to monitor trends/patterns in the types of incidents reported. The committee will make recommendations to the residential department and act as another layer of oversight for all consumers in the residential program. Direct Support Professionals, Residential House Manager and QDDP were re-trained on 10/7/13 on the identified level of supervision for client #3. This includes the addition of personal identification information to be carried on his person. The annual Risk</p>	10/07/2013	

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	<p>Special O (Olympics) practice." The report indicated client #3 played on the team and client #6 "went to watch" client #3 play. The report indicated the staff person who was supervising clients #3 and #6 indicated the weather started to "drizzle," the supervising staff person went to sit in the van, and "stated [clients #3 and #6] were within line of sight the entire time." The report indicated at 7:15pm, a staff from a different group home arrived. This staff "knew" clients #3 and #6, observed clients #3 and #6 "walking without staff," and when she asked the clients where their staff was, both clients indicated they did not know. The staff from a different group home "saw the van with [client #3 and #6's] staff inside sitting in the parking lot," and the second staff monitored clients #3 and #6 "until practice was over." The report indicated client #6 had experienced a toileting accident while alone at the practice. The report indicated "Plan to Resolve:" Clients #3 and #6 "require staff be within arm's reach while in the community because of vulnerability, behaviors, and the lack of communication skills." The report indicated Client #3 was non verbal.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS stated</p>		<p>Assessment(Appendix C) for client #3 was updated and all staff were trained on 10/7/13.For further monitoring, incidents of abuse and neglect are reviewed monthly bythe Incident Report Review Committee which will make recommendations to theresidential department and act as another layer of oversight to all consumersin the residential program. Direct Support Professionals,Residential House Manager and QDDP were re-trained on 10/7/13 on the identifiedlevel of supervision for client #6. Thisincludes the addition of personal identification information to be carried onher person. The annual Risk Assessment(Appendix D) was updated for client #6 and all staff were trained on 10/7/13.For further monitoring, incidents of abuse and neglect are reviewed monthly bythe Incident Report Review Committee whichwill make recommendations to the residential department and act as anotherlayer of oversight to all consumers in the residential program. 2. Direct Support Professionals, Residential HouseManager, QDDP, and day program staff were retrained on client #3's chokingmanagement risk plan which includes line of sight supervision while eating, andcutting food into dime sized pieces (Appendix E). For continued monitoring, the choking riskplan of client # 3 will be</p>		

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	<p>"It was neglectful" when clients #3 and #6 were left alone at the baseball field while the staff sat in the van across two baseball diamonds and the far side of the parking lot away from clients #3 and #6. The DRS indicated client #3 was non verbal and clients #3 and #6 both needed to be within arm's reach while in the community.</p> <p>2. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for client #3:</p> <p>-A 5/29/13 BDDS report for an incident on 5/28/13 at 9:45am, indicated client #3 "was sitting outside on the picnic table eating his snack" at the facility owned workshop. An office clerk "approached [client #3] as [client #3] approached the trash can and was placing his index finger in his mouth and his head in the trash can. [The office clerk] inquired Are you choking [client #3]? [Client #3] signed yes (client #3 is non verbal and uses sign language to communicate), [client #3] (had) visible tears in his eyes. [Client #3] continued to have air movement as he was placing his finger in his mouth in a sweeping motion." The report indicated the agency nurse "prompted [client #3] to continue to cough as he was using his</p>		<p>reviewed at each Residential/Day Program IDT meeting which occurs monthly to ensure that all staff are implementing the plan as written. Meetings are scheduled for the third Tuesday of each month. It will be the responsibility of the lead QDDP in day program, and client #3's residential QDDP to ensure that the plan is included on each month's agenda for review. 3. The annual survey report indicated that client #1 has a BSP (4/2013) that indicates the client's supervision level is "to be in line of sight". However, client #1's BSP indicates staff supervision and not direct line of sight (Appendix F). Additionally, the statement indicating staff supervision while in the community is directly related to church attendance due to historical behaviors. Direct Support Professionals, Residential House Manager, QDDP and all day program staff were retrained on client #1's BSP on 10/7/13 (Appendix F). For further monitoring, day program staff were trained on a client BPR (behavior problem record) (Appendix G) and will be required to document daily behaviors. For further monitoring, client #1's BPR will be reviewed at each monthly Residential/Day Program IDT meeting. Client #1 continues to be supervised at all times by either residential staff or day program staff. Client #1</p>		

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	<p>finger in the sweeping motion. A section of celery 1 1/2" (one and one half inches) in length was forced out during [client #3's] coughing." The report indicated client #3 had a 5/4/12 "Dysphasia Plan" which indicated client #3 was to have reminders in place to eat slowly and take small bites. Client #3's plan was changed to include his lunch items to be cut when prepared at the group home and before it was packed daily for workshop.</p> <p>On 8/23/13 at 11:15am, client #3's record was reviewed. Client #3's 8/15/13 "Physician's Order" indicated client #3 was on a regular diet. Client #3's 1/9/13 ISP and 1/9/13 Risk Plan both indicated client #3 had "Chewing Difficulties: yes, [client #3] tends to stuff his mouth too full and not chew thoroughly enough. His choking plan is located in the medical binder. Swallowing Difficulties: yes, [client #3] needs to be prompted to take drinks of liquid between bites...." Client #3's 6/10/13 "Choking Management Plan" indicated he needed reminders to slow his rate and take small bites while eating. Client #3's plan indicated client #3 was to be within eye sight when eating, his food was to be cut up into dime size pieces when his lunch was prepared and packed for workshop, and client #3 was to remain upright 30 minutes after dining to minimize his choking risk.</p>		attends a groupcounseling session each Friday to discuss appropriate social behaviors.		

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	<p>On 8/30/13 at 11:05am, an interview with the DRS was conducted. The DRS indicated client #3 had eaten his snack at the picnic table on 5/28/13 when he choked. The DRS indicated the office clerk walked by client #3 and client #3 was within the line of sight of other staff, however the other staff did not identify that client #3 was choking. The DRS indicated client #3's food was to have been cut up into bite size pieces before the incident. The DRS stated staff's opinion of "bite size" was different from one staff to another staff assisting client #3 to fix his lunch. The DRS stated "we changed his plan to specify" dime size after the incident. The DRS indicated workshop staff knew client #3 was a choking risk, needed supervision during dining, and client #3 was to have reminders to slow his rate of eating before the 5/28/13 incident. The DRS indicated the facility staff neglected to implement client #3's plans to limit the potential of client #3 choking.</p> <p>3. On 8/21/13 at 1:55pm, the facility's BDDS Reports and investigations were reviewed from 08/21/12 through 08/21/13. The review indicated the following for client #1:</p> <p>-A 7/29/13 BDDS report for an incident</p>						

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	<p>on 7/29/13 at 2:20pm, indicated client #1 was at workshop, refused to return an IPod to another client, and threw and broke the IPod. Workshop client #11 punched client #1. The two clients tore each other's clothing, "went to the floor," and client #1 had a red left eye injury.</p> <p>-A 6/12/13 BDDS report for an incident on 6/11/13 at 1:30pm, indicated while client #1 was in the men's restroom at the workshop, client #1 was looking over the stalls to watch "men urinate."</p> <p>-A 5/30/13 BDDS report for an incident on 5/29/13 at 11:50am, indicated client #1 was verbally aggressive with workshop client #14. Workshop client #11 stepped in between client #1 and workshop client #14, and both clients were verbally aggressive. The report indicated client #1 shoved workshop client #11, workshop client #11 hit client #1, and both clients went to the ground physically aggressive and hit one another "several times." A "Code Yellow-clients out of Control was called" and both clients were separated. Client #1 had a red mark on his forehead and on the bridge of his nose. The report indicated client #1 also complained of rib pain and groin pain.</p> <p>-A 4/25/13 BDDS report for an incident on 4/25/13 at 9:15am, indicated client #1</p>				

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	<p>was verbally aggressive toward workshop client #13. The report indicated client #1 spat in workshop client #13's face.</p> <p>-A 1/11/13 BDDS report for an incident on 1/10/13 at 1:45pm, indicated workshop client #11 was in the men's restroom. Client #1 and workshop client #11 were verbally aggressive to one another and workshop client #11 hit client #1 in the face. No injury was noted.</p> <p>-A 10/17/12 BDDS report for an incident on 10/16/12 at 11:15am, indicated client #1 and workshop client #12 were at the picnic table when client #1 used "both hands and rubbed [workshop client #12's] sides, ribs, and top of (her) pants."</p> <p>Client #1's record was reviewed on 8/23/13 at 10am. Client #1's 4/11/13 ISP (Individual Support Plan) and 4/11/13 Risk plan both indicated client #1 had behaviors and required direct supervision by facility staff when in the community because of his behaviors. Client #1's 4/2013 BSP (Behavior Support Plan) indicated client #1 had the targeted behaviors of property destruction, Suicide threats, stealing, physical aggression, verbal aggression, inappropriate sexual behavior, resistant to staff supervision, and elopement. Client #1's BSP indicated staff were to know client #1's location and</p>						

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	<p>to be in the line of sight. Client #1's behaviors were to be redirected by the facility staff before client #1 escalated to physical aggression.</p> <p>On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated the facility staff failed to supervise client #3 according to his identified dining needs, and failed to supervise client #1 according to his identified behavioral needs in which client #1 was to have been within the line of sight of staff at all times. The DRS indicated clients #1, #3, and #6 required twenty-four hour staff supervision.</p> <p>9-3-4(a)</p>			

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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 4 clients (clients #3 and #4) who required sedation during medical/dental procedures, the facility failed to incorporate the use of client #3 and #4's medications to reduce anxiety into a specific active treatment program.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 08/23/13 at 11:15am. Client #3's record indicated an 8/15/13 "Physician's Order" for "Vistaril 50mg (milligrams) PRN (as needed), 1-2 hrs (hours) before dental appts. (appointments)" which was prescribed by client #3's physician on 2/05/13. Client #3's 1/2013 Behavior Support Plan (BSP) indicated client #3 had anxiety and received Vistaril medication before dental appointments. The BSP did not indicate the use of Vistaril and did not have a specific active treatment program available for review. Client #3's 1/9/13 ISP (Individual Support Plan) did not include a specific active treatment program to address the client's</p>	W000312	An individual program plan directed towards addressing client #3's anxiety towards dental appointments has been developed. The program plan includes individual dayprogram habilitation goal to familiarize client #3 with dental visit elements that may not be familiar to him (Appendix H). Staff will implement the use of cue cards or other images of dentists, dental chairs, teeth, etc. These images will be incorporated with a positive activity in order to build a positive association. Habilitation staff were retrained on 10/7/13. A residential program goal has also been developed (Appendix I) to help desensitize client #3 to dental visits. The program consists of weekly drives to the dental office building to increase familiarity and will incorporate client #3 getting out of the vehicle and walking in the parking lot. As his tolerance builds, additional steps will be incorporated. Direct Support Professionals, QDDP, and Residential House Manager were trained on residential goal on 10/7/13. Further, client #3's BSP was updated (Appendix J) to include the history of his anxiety,	10/07/2013
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	<p>anxiety. Client #3's HRC (Human Rights Committee) record indicated Vistaril medication for anxiety was administered on 1/26/13 and was changed from "Halcion .50mg PRN (as needed) for dental anxiety" and on 7/30/13 before his dental appointment. Client #3 was sedated for dental cleanings on 3/13/13 and on 2/26/13. Client #3's record did not include a specific active treatment program to address the use of Vistaril for anxiety related to dental procedures.</p> <p>Client #4's record was reviewed on 8/23/13 at 11:50am. Client #4's record indicated an 8/15/13 "Physician's Order" for "Ativan 2mg, take 1 tablet by mouth as needed prior to appointment" for dental procedures. Client #4's 11/7/12 ISP (Individual Support Plan) did not include a specific active treatment program to address client #4's anxiety during dental procedures. Client #4's 12/2012 BSP did not include a specific active treatment program for his use of Ativan. Client #4's BSP indicated he used Ativan for anxiety prior to dental/medical appointments. Client #4's HRC record indicated consent for the use of "Ativan 2mg prior to medical/dental appt." on 7/30/13, 2/26/12, and 8/9/12. Client #4 was sedated for dental appointments on 7/2013, 3/11/13, and 9/4/12. Client #4's 12/2012 BSP indicated he used Ativan to reduce</p>		<p>as well as to list the desensitization activities that staff are currently implementing. The PRN medication that is prescribed for dental visits is HRC approved and is currently listed in the BSP. Client # 3's ISP was also updated/revised to reflect the above changes (Appendix K) Residential staff were trained on updated BSP and ISP on 10/7/13. For continued monitoring, an annual Residential Services Annual Checklist (Appendix L) has been developed and will be required to be submitted to the Director of Residential Services when annual meetings have taken place. A desensitization plan and/or medication reduction plan has been included on this checklist to ensure that plans are in place each year. The QDDP was trained on this worksheet on 10/7/13. An individual program plan directed towards addressing client #4's anxiety towards dental appointments has been developed. The program plan includes a goal to familiarize client #4 with dental visit elements that may not be familiar to him (Appendix M). Staff will implement the use of cue cards or other images of dentists, dental chairs, teeth, etc. These images will be incorporated with a positive activity in order to build a positive association. Additionally, client #4's ISP was updated to include the additional program goal</p>				

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	<p>anxiety for dental/labs and did not include a specific active treatment program to address client #4's anxiety during dental procedures.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated client #3 and #4's ISPs and BSPs did not include a specific active treatment program to address anxiety during dental procedures.</p> <p>9-3-5(a)</p>		<p>(Appendix N). Staff will continue to implement steps included in the current BSP which include giving client #4 adequate notice of appointments, speaking with him about what to expect, and practicing opening his mouth wide, and be given step by step information about what his happening during appointments (Appendix O). Residential staff were trained on residential program plan, updated ISP, and current BSP on 10/7/13. For continued monitoring, an annual Residential Services Annual Checklist (Appendix L) has been developed and will be required to be submitted to the Director of Residential Services when annual meetings have taken place. A desensitization plan and/or medication reduction plan has been included on this checklist to ensure that plans are in place each year. The QDDP was trained on this worksheet on 10/7/13.</p>		

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, for 3 of 3 sampled clients (clients #1, #3, and #4) who received psychotropic medications, the facility failed to evaluate client #1, #3, and #4's status for an annual decrease or contraindication of their psychotropic medication.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/23/13 at 10am. Client #1's 4/11/13 ISP (Individual Support Plan) and client #1's 4/2013 BSP (Behavior Support Plan) indicated the targeted behaviors of property destruction, elopement, Sexually inappropriate behavior, Verbal Aggression, Physical Aggression, Suicidal Threats, and stealing. Client #1's plans indicated the use of Zyprexa 10mg (milligrams) 1/2 tablet twice daily for behavior and Hydroxyzine Pam (Vistaril) 50mg 1 tablet in the morning and 2 tablets at bedtime for anxiety. Client #1's 8/23/13, 4/17/13, 10/4/12, and 6/4/12 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #1's psychiatric medications or a contraindication. Client #1's record did not indicate the last psychotropic</p>	W000316	<p>1. The annual survey report states that client #1's "Psychiatric medication reviews did not indicate a change in client #1's psychiatric medications or a contraindication". Client #1 psychiatric medication check on 8/23/13 with Dr. Michelle Carter indicates "continue all current medications due to positive response" (Appendix P). Physician clearly indicates a review of psychotropic medications and states the reason for no changes is due to the effectiveness of current medications (a contraindication). The current physician form used for psychiatric appointments has been updated to include the specific wording that changes are either contraindicated or that changes are needed (Appendix Q). All staff were trained on this new form on 10/7/13. Continued compliance is ensured by revising the departmental form for psychiatrist appointments.</p> <p>2. The current physician form used for psychiatric appointments has been updated to include the specific wording that changes are either contraindicated or that changes are needed (Appendix Q). All staff were trained on this new form on 10/7/13. Continued</p>	10/07/2013	

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	<p>medication change or contraindication. No data of targeted behaviors was provided for review.</p> <p>2. Client #3's record was reviewed on 8/23/13 at 11:15am. Client #3's 1/9/13 ISP and client #3's 1/2013 BSP both indicated the targeted behaviors of extreme irritability, physical aggression, throws objects, and resistant to supervision. Client #3's plans indicated the use of Clonidine 0.1mg 1 tablet twice daily. Client #3's 6/10/13, 3/5/13, 12/4/12, and 9/4/12 "Psych Medication Reviews" did not indicate a change in client #3's psychiatric medication or a contraindication. Client #3's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided for review.</p> <p>3. Client #4's record was reviewed on 8/23/13 at 11:50am. Client #4's 11/7/12 ISP and client #4's 12/2012 BSP both indicated the targeted behaviors of Self Injurious Behavior, physical aggression, Deep Pressure Technique (when client #4 requests; staff offer his pressure helmet which was tight fitting and applies pressure to relieve client #4's head pressure, and client #4's behaviors decrease), destroys property, extreme irritability, and and resistant to</p>		<p>compliance is ensured by revisingthe departmental form for psychiatrist appointments.3. The annual survey report indicates client #4's"psych medication reviews did not indicate a change in client #4's psychiatricmediation or a contraindication". Client#4 was seen by psychiatrist, Dr. Dzera on 6/24/13 and on 9/16/13 and on bothvisits, Dr. Dzera documented "essentially stable, continue Zyprexa 10 mg ½ tabQID" and "overall is improved and better frustration tolerance and impulsecontrol, continue zyprexa 10 mg ½ tab QID" (Appendix R). Physician clearly indicates a review ofpsychotropic medications and states the reason for no changes is due to theeffectiveness of current medications(a contraindication). The current physicianform used for psychiatric appointments has been updated to include the specificwording that changes are either contraindicated or that changes are needed(Appendix Q). All staff were trained onthis new form on 10/7/13. Continuedcompliance is ensured by revising the departmental form for psychiatristappointments.</p>		

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	<p>supervision. Client #4's plans indicated the use of Zyprexa 10mg tablet take 1/2 tablet by mouth four times a day. Client #4's 6/24/13, 12/3/12, and 9/10/12 "Psych Medication Reviews" did not indicate a change in client #4's psychiatric medication or a contraindication. Client #4's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided for review.</p> <p>Interview with the Director of Residential Services (DRS) was conducted on 8/30/13 at 11:05am. The DRS indicated client #1, #3, and #4's psychiatric medication had not been changed in over a year and no contraindication for client #1, #3, and #4's psychiatric medication had been documented. The DRS indicated she would look for additional written evidence for clients #1, #3, and #4. No additional information was available for review.</p> <p>9-3-5(a)</p>				

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W000371	<p>483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to develop medication goals/objectives to provide medication training for medications.</p> <p>Findings include:</p> <p>1. On 8/21/13 at 3:30pm, client #4 washed his hands independently in the kitchen, filled a glass with water, and walked to the medication administration room. At 3:20pm, Direct Care Staff (DCS) #3 administered client #4's medications. Client #4 peeled back the sealed cover to his medications, took the medications, and drank his water. No teaching was completed about client #4's specific medications.</p> <p>On 8/23/13 at 11:50am, a record review for client #4 was conducted. Client #4's 11/7/12 Risk Assessment and Individual Support Plan (ISP) both indicated client #4 did not understand his medications. Client #4's ISP indicated a goal/objective</p>	W000371	<p>1. An individual program plan directed at providing client #4 with medication training has been developed. The program plan includes a goal to teach client #4 the reason for taking Zyprexa (Appendix S). Client #4 is primarily non-verbal. He takes Zyprexa to assist him with appropriate behavior. Staff will prompt client #4 to point to the picture of an individual displaying appropriate behavior when he takes his Zyprexa to help him understand the reason that he takes the medication. The goal is to teach him the correlation between the Zyprexa and appropriate behavior. As client #4 masters this medication, additional medication uses will be taught in the same manner. ISP was updated to reflect program (Appendix N). All staff were trained on the medication teaching program on 10/7/13.</p> <p>2. An individual program plan directed at providing client #3 with medication training has been developed. The program plan includes a goal to teach client #3 the reason for taking Norvasc (Appendix T). Client #3 is primarily non-verbal.</p>	10/07/2013

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	<p>to wash his hands before medications administration was completed.</p> <p>2. On 8/21/13 at 3:53pm, client #3 walked to the kitchen, washed his hands in the sink, obtained a glass of water, and returned to the medication room with DCS #3 beside him. DCS #3 administered client #3's oral medication. Client #3 took the medication with water, and left the medication room. No teaching was completed about client #3's specific medications.</p> <p>On 8/21/13 at 11:15am, client #3's record review was conducted. Client #3's 1/9/13 ISP indicated a goal/objective to independently wash his hands before medication administration.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated client #3 and #4's medication goal/objective was to wash their hands. The DRS indicated no goals/objectives for clients #3 and #4 were available for review for teaching each client about their specific medications.</p> <p>9-3-6(a)</p>		<p>He takes Norvasc to treat high bloodpressure. A cue card will be used toteach him the connection between taking his Norvasc and high blood pressure. Staff will present him with a picture of ablood pressure cuff and/or any other image that is blood pressure related toassist him with learning the reason for taking his medication. ISP was updatedto reflect program (Appendix K). Allstaff were trained on the medication teaching program on 10/7/13. Tomonitor the appropriateness of goal writing, QDDP's will complete theResidential Services Annual Checklist (Appendix L)when they develop new programgoals. The checklist, along with therespective documentation will be reviewed by the Director of ResidentialServices. QDDP was trained on theResidential Services Annual Checklist on 10/7/13.</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3) with adaptive equipment, the facility failed to teach and encourage client #3 to wear his eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/21/13 from 3:20pm until 5:55pm. Client #3 wore his prescribed eye glasses during the observation.</p> <p>Observations were conducted at the group home on 8/22/13 from 6:05am until 8:35am. Client #3 did not wear his prescribed eye glasses. Client #3 walked independently throughout the group home, watched television, assisted with preparing the meal, measured his food with a measuring cup, fed himself, rinsed his dishes, shaved, wrote with a pen on paper, and completed medication administration. DCS (Direct Care Staff) #2 did not prompt client #3 to wear his eye glasses. At 7:55am, client #3 left for workshop with the facility staff and wore</p>	W000436	An individual program plan directed at encouraging client #3 to wear his glasses has been developed. The program plan includes a program goal to encourage him to put his glasses on first thing in the morning (Appendix U). Staff were trained on program goal on 10/7/13. In addition, the following documents have been updated/revised: client #3 risk assessment (Appendix C), client #3 vision plan (Appendix V), and client #3 ISP (Appendix K). To monitor the appropriateness of goal writing, QDDP's will complete the Residential Services Annual Checklist (Appendix L) when they develop new program goals. The checklist, along with the respective documentation will be reviewed by the Director of Residential Services. QDDP was trained on the Residential Services Annual Checklist on 10/7/13.	10/07/2013			

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	<p>his prescribed eye glasses. At 7:55am, DCS #2 indicated client #3's glasses were kept safe.</p> <p>On 8/23/13 at 11:15am, client #3's record review was conducted. Client #3's 1/9/13 ISP (Individual Support Plan) indicated he wore prescribed eye glasses. Client #3's 4/8/13 and 10/2012 vision evaluation indicated he wore prescribed eye glasses.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was completed. The DRS indicated client #3 wore prescribed eye glasses. The DRS indicated client #3 should have been taught and encouraged to wear his prescribed eye glasses at the group home.</p> <p>9-3-7(a)</p>				

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W000484	<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.</p> <p>Based on observation 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 staff failed to teach and encourage the clients on the use of dining utensils.</p> <p>Findings include:</p> <p>On 8/21/13 at 5:25pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the dining room table for supper which consisted of bread, butter, corn on the cob, baked potato, cheese, mixed fruit, and sliced chicken. No knives and napkins were set on the table. Clients #1, #2, #3, #4, #5, #6, #7, and #8 split their baked potatoes with a spoon/fork or opened them with their fingers and buttered their bread with a spoon or fork. At 5:45pm, Direct Care Staff (DCS) #1 offered a single knife for clients #1, #2, #3, #4, #5, #6, #7, and #8 to share during their meal. No napkins were encouraged by the facility staff.</p> <p>On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated staff should have redirected</p>	W000484	On 10/7/13, Direct Support Professionals, Residential HouseManager and QDDP were all retrained on agency family style dining policy which includes the use of dining utensils and napkins. To ensure continued monitoring for compliance, a dining checklist (Appendix W) has been developed that will be added to the monthly menu and will serve as a reminder when preparing for meals. Further, the Residential HouseManager will document at least twice per month, observation of meal time to ensure the policy is being followed (Appendix X). Direct Support Professionals, Residential House Manager and QDDP were all trained on the dining checklist and documentation of meal time observation on 10/7/13.	10/07/2013	

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	clients to use knives and napkins during dining opportunities. 9-3-8(a)			