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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G545 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/13/2012 |
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| W000C              | <p>This visit was for a recertification and state licensure survey.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00099909 completed on 11/29/11.</p> <p>Dates of Survey: 1/9/12, 1/10/12, 1/11/12, 1/12/12 and 1/13/12.</p> <p>Facility Number: 001059<br/>Provider Number: 15G545<br/>AIMS Number: 100245370</p> <p>Surveyor:<br/>Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/26/12 by Ruth Shackelford, 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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| W0136   | <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on record review and interview for 3 of 4 sampled clients (#2, #3 and #7), the facility failed to provide the clients with outings or community activities on a regular and/or ongoing basis.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 1/10/12 at 3:40 PM. Client #2's CIR for December 2011 indicated the following:</p> <p>-no community based outings/activities.</p> <p>Client #2's CIR for January 2012 from January 1, 2012 through January 11, 2011 indicated the following:</p> <p>-no community based outings/activities.</p> <p>2. Client #3's record was reviewed on 1/11/12 at 12:06 PM. Client #3's CIR for December 2011 was not available for review. Client #3's CIR for January 1 through 11, 2012 did not indicate any community based outings and/or activities.</p> <p>3. Client #7's record was reviewed on 1/10/12 at 1:50 PM. Client #7's CIR for</p> | W0136   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? The identified individuals as well as the remaining individuals in the home were assessed to have appropriate and current community integration goals and objectives identified in their program plan. The staff will be retrained on how those events will be scheduled, how they will know of the events and the responsibility to carry out and document the scheduled events. The home has a calendar of events, including appointments, household duties as well as individual community activities. The home Team Leader will review the schedule each week to ensure that individual community activities are incorporated. The Team Leader will ensure that the appropriate documentation was recorded for these events. How are other residents identified that could have the potential for also being affected by the same deficient practice? All the residents in the home have the potential to be affected by this deficient practice. All of the records and treatment plans for all individuals were reviewed and included in the corrective action</i></p> | 02/12/2012  |  |   |  |

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|   | <p>December 2011 did not indicate any community based outings and/or activities. Client #7's CIR for January 1, 2012 through January 11, 2012 did not indicate any community based outings and/or activities.</p> <p>Interview with TL #1 (Team Leader) on 1/11/12 at 12:45 PM indicated the clients' community based outings and activities should be documented on the CIR. TL #1 indicated the clients should be going out into the community for outings and activities at minimum of two times a week. TL #1 indicated the clients had not been going into the community for outings and/or activities two times a week.</p> <p>9-3-2(a)</p> |   | <p>noted above. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> The Team Leader will review the community integration success each week. The documentation will be reviewed as well and the summary of events will be recorded in the monthly QMRP case management reviews. Any refusals by individuals will be reviewed by the IDT monthly. Any lack of compliance by staff will be addressed in a progressive disciplinary plan. <i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i> The QMRP will monitor the average number of community activities on a monthly basis to ensure they increase and remain at an appropriate level of participation by individuals and staff. The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p> |                      |   |

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| W0159              | <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#7), the QMRP (Qualified Mental Retardation Professional) failed to monitor the client's medical recommendations.</p> <p>Findings include:</p> <p>Client #7's record was reviewed on 1/10/12 at 1:50 PM. Client #7's Vision Appointment form dated 11/8/10 indicated an annual eye exam and glaucoma check. The form indicated, "unable to perform fundamental exam...." Client #7's record did not contain a follow up to the 11/8/10 Vision Form through IDT (Interdisciplinary Team Meeting), communication with the guardian or recommendations for completion of a fundamental vision exam.</p> <p>Interview with AS #1 (Administrative Staff) and QMRP #1 (Qualified Mental Retardation Professional) on 1/11/12 at 1:30 PM indicated client #7's guardian had declined further action to complete the vision assessment for client #7. AS #1 and QMRP #1 indicated the directives from the guardian should be documented in the record. AS #1 and QMRP #1 indicated an IDT should have been</p> | W0159         | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>All records for the individuals in this home were audited to review any outstanding appointments that remained since change in Team Leader and plan of correction related to the complaint survey of 12/2011. The vision exam for this individual was not recovered during our audit and is presently being scheduled.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All the residents in the home have the potential to be affected by this deficient practice. All of the records for all individuals were reviewed and included in the corrective action noted above. The nurse consultant, QMRP and Team Leader have a schedule of all routine and specialty appointments.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The nurse consultant will review the medical chart monthly and submit an appointment form to the Team Leader of the home. The Team Leader will schedule the necessary</p> | 02/12/2012           |

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|   | completed to discuss alternate vision assessments and/or recommendations.<br><br>9-3-3(a)                              |   | appointments according to the home schedule and return the appointment form to the nurse with all necessary appointments documented as scheduled with date and time.<br><br><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i><br>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. |                      |   |

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| W0227   | <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the client's Individual Support Plan (ISP) failed to address the client's drooling.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/9/12 from 4:30 PM through 6:15 PM. Client #3 was observed in the group home throughout the observation period. Client #3 was observed to have drool stretching from his chin to his shirt throughout the observation period. Client #3's shirt was saturated from the saliva/drool.</p> <p>Observations were conducted at the group home on 1/10/12 from 6:15 AM through 8:30 AM. Client #3 was observed in the group home throughout the observation period. Client #3 was observed to have strings of drool stretching from his chin to his shirt throughout the observation period. Client #3's shirt was saturated from the saliva/drool.</p> <p>Client #3's record was reviewed on 1/11/12 at 12:06 PM. Client #3's ISP (Individual Support Plan) dated 6/27/11</p> | W0227   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The individual was assessed and a Saliva Management Program was implemented to better address his drooling. He is participating in a training program to wipe his mouth with a paper towel, to remove his fingers from his mouth and to participate in meal preparation with only his dishes and utensils.</p> <p>In addition, he routinely sees a physician to monitor the medication for saliva management. At his next appointment, physician will review dosage to see if he would benefit from an increased medication control of saliva.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All other residents were assessed and 2 other individuals were identified to be at risk of this deficient practice. Each of those residents will have a program plan to address the saliva management issues specific to their assessed needs.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient</i></p> | 02/12/2012  |  |   |  |

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|   | <p>did not indicate a formal or informal training objective to address drooling.</p> <p>Interview with AS #1 (Administrative Staff) and TL #1 (Team Leader) on 1/11/12 at 1:30 PM indicated client #3 drools throughout the day. AS #1 and TL #1 indicated client #3 did not have a training objective to address the drooling. AS #1 and TL #1 indicated client #3 should be trained/coached to wipe his mouth through formal and/or informal training.</p> <p>9-3-4(a)</p> |   | <p><i>practice does not recur?</i></p> <p>The program implementation will be reviewed weekly by the Team Leader and/or QMRP for effectiveness in addition to the monthly overall case management review.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p> |                      |   |

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| W0249   | <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 for 3 of 4 sampled clients (#2, #3 and #7), the facility failed to ensure clients' objectives and/or behavior plans were implemented when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/9/12 from 4:30 PM through 6:15 PM.</p> <p>At 5:45 PM client #7 participated in family style dining with his peers. Client #7 placed food into his mouth prior to chewing and/or swallowing the previous portion of food. Staff #1, #2, #3 and/or TL #1 (Team Leader) were not observed prompting client #7 to alternate bites of food with fluids or to rest his utensil on the table between bites of food.</p> <p>Observations were conducted at the group home on 1/10/12 from 6:15 AM through 8:30 AM. At 7:10 AM client #3 was prompted by staff #4 to come to the</p> | W0249   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The staff will be retrained on all of the program requirements for the individuals. Staff will be supplied with a job aide to identify which programs are scheduled for each shift to highlight the requirements.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All individuals have the potential to be affected by this deficient practice. All individuals records and treatment plans were reviewed and incorporated into the above corrective action.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The Team Leader and/or QMRP are conducting weekly on site survey observations of the meal and medication routines to note and implement improvements.</p> <p>The Team Leader and/or QMRP are also reviewing the daily notes, the program data books and the</p> | 02/12/2012  |  |   |  |

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|   | <p>medication administration area. Client #3 reported to the medication administration area. Staff #4 proceeded to administer client #3's morning medications. Staff #4 did not prompt or encourage client #3 to participate in the medication administration or offer training regarding client #3's medication regime. At 7:40 AM client #2 reported to the medication administration area. Staff #4 proceeded to administer client #2's morning medications. Staff #4 did not prompt or encourage client #2 to participate in the medication administration or offer training regarding client #2's medication regime. At 7:50 AM client #7, was observed participating in the group homes family style breakfast. Client #7 used his fingers to eat his bowl of cereal with milk. Client #7 placed food into his mouth prior to chewing and/or swallowing the previous portion of food. Staff #4, #5, #6 and/or TL #1 (Team Leader) were not observed prompting client #7 to alternate bites of food with fluids or to rest his utensil on the table between bites of food.</p> <p>Client #2's record was reviewed on 1/10/12 at 3:40 PM. Client #2's ISP (Individual Support Plan) dated 4/8/11 indicated formal training objectives to state the reason for Lipitor (High Cholesterol), bring a cup to the medication administration area for water</p> |   | <p>medication administration record routinely, at minimum weekly to ensure staff are adequately documenting and implementing the goals as well as the effectiveness of said goals.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p> |   |  |   |  |

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|   | <p>at medication pass and state the reason for Tizanidine (Spasticity) and Detrol (Bladder Control).</p> <p>Client #3's record was reviewed on 1/11/12 at 12:06 PM. Client #3's ISP dated 6/27/11 indicated formal training objectives to state the name of his pill(s) at medication administration pass with cues from staff.</p> <p>Client #7's record was reviewed on 1/10/12 at 1:50 PM. Client #7's ISP dated 10/25/11 indicated the formal training objective to, "rest hands between bites of food at meal times." Client #7's Dietary Review form dated 4/25/11 indicated, "continue to prompt to use utensil, slow down, not over stuff mouth, assist with cutting (sic) spreading and serving food...."</p> <p>Interview with TL #1 (Team Leader) on 1/11/12 at 12:45 PM indicated training should occur at every available opportunity. TL #1 indicated medication and dining training objectives should be implemented at each opportunity.</p> <p>9-3-4(a)</p> |   |   |                      |   |

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| W0259   | <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the clients had functional assessments reviewed annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/11/12 at 11:10 AM. Client #1's CFA (Comprehensive Functional Assessment) dated 12/1/10 was reviewed. The record did not indicate the CFA had been reviewed or updated annually.</p> <p>Client #2's record was reviewed on 1/10/12 at 3:40 PM. Client #2's CFA dated 12/1/10 was reviewed. The record did not indicate the CFA had been reviewed or updated annually.</p> <p>Client #3's record was reviewed on 1/11/12 at 12:06 PM. Client #3's CFA dated 12/1/10 was reviewed. The record did not indicate the CFA had been reviewed or updated annually.</p> <p>Client #7's record was reviewed on 1/10/12 at 1:50 PM. Client #7's CFA dated 12/1/10 was reviewed. The record did not indicate the CFA had been reviewed or updated annually.</p> | W0259   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? The Comprehensive Functional Assessments for the affected individuals were reviewed and updated. How are other residents identified that could have the potential for also being affected by the same deficient practice? All individual CFAs were reviewed. The assessments for all individuals were updated and reviewed by IDT. No significant assessment changes were noted, therefore no change to treatment plans resulted from the updated assessments. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The ISP will include the Comprehensive Functional Assessment date to indicate the appropriate timing for the update at the 6 month or annual review. How will the corrective action be monitored to ensure the deficient practice will not recur? The QMRP will review the monthly case management reviews to ensure that assessments remain current and accurate as well as monitor progression/regression on goals. The Team Leader and/or QMRP will be onsite at the home at least</i></p> | 02/12/2012  |  |   |  |

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|   | <p>Interview with TL #1 (Team Leader) on 1/11/12 at 12:45 PM indicated there were no CFAs to review with a date later than 12/1/10. TL #1 indicated the functional skills assessment should be completed annually.</p> <p>9-3-4(a)</p> |   | <p>daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. Director will conduct random monthly chart audit of facility program and nursing charts</p> |                      |   |

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| W0369   | <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 record review, observation and interview for 1 of 4 sampled clients (#2), the facility failed to ensure the client was administered the client's prescribed medications.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/10/12 from 6:15 AM through 8:30 AM. At 7:40 AM client #2 reported to the medication administration area. Staff #4 proceeded to administer client #2's morning medications. Staff #4 administered the following medications:</p> <ul style="list-style-type: none"> <li>-1 Dantrolene Capsule 100 mg (Spasticity)</li> <li>-1 Docusate Sodium 100 mg (Stool Softener)</li> <li>-1 V-C Forte Capsule (Dietary Supplement)</li> <li>- 2 Tizanidine 2 mg tablets total dose of 4 mg (Muscle Pain)</li> </ul> <p>Client #2's record was reviewed on 1/10/12 at 3:40 PM. Client #2's Physicians Order form date 11/26/11</p> | W0369   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>All staff will be retrained on reordering procedures for medications. The previous process was that the home would have a designated person to account that a 7 day supply of medications is in the home on a weekly basis. The Team Leader will now assume this responsibility. In addition, the Team Leader will now notify the nurse consultant of medication reorders. The nurse consultant will track and account for the delivery of those medications in a timely manner so as not to disrupt administration.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All residents have the potential to be affected by this deficient practice. All resident medications and records are included in this corrective action plan. No other residents are presently identified to be without sufficient supply of medication.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The Team Leader will review the 7 day supply of medications weekly</p> | 02/12/2012  |  |   |  |

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|   | <p>indicated an order for Tizanidine 2 mg tablets for a total dose of 6 mg.</p> <p>Interview with staff #4 on 1/10/12 at 8:00 AM indicated client #2 should receive 3 tablets of 2 mg Tizanidine for a total dose of 6 mg. Staff #4 indicated the pharmacy had not delivered enough of the Tizanidine for the 6 mg dose.</p> <p>Interview with TL #1 on 1/11/12 at 2:10 PM indicated client #2 should have received a 6 mg dose of Tizanidine during the medication administration morning pass on 1/10/12. TL #1 indicated the pharmacy did not deliver the correct dose and was notified. TL #1 indicated the pharmacy was not able to deliver the additional dose of Tizanidine in time for client #2 to receive the medication.</p> <p>9-3-6(a)</p> |   | <p>and reorder as needed. The nurse consultant will maintain her record of ordered medications and confirm supply was delivered.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p> |                      |   |

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| W045  | <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #7) plus 2 additional clients (#5 and #8), the facility failed to ensure proper handwashing procedures were followed while a client set the table.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/9/12 from 4:30 PM through 6:15 PM. At 5:15 PM client #3 was prompted by staff #2 to assist with setting the dining room table for the evening meal. Client #3's left thumb was in his mouth and drool was hanging from his mouth to his shirt. Client #3 removed his thumb from his mouth and placed client #1's plate on the table. Client #3 re-inserted his thumb into his mouth while walking around the dining room table to place his plate in its spot and client #7's plate in its place. Client #3 then assisted staff #2 to place client #5 and #8's utensils and cups in their places. Staff #2 was not observed prompting client #3 to remove his thumb from his mouth, to wash his hands prior to handling the plates, utensils, and/or cups.</p> <p>Interview with AS #1 (Administrative</p> | W0455   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The individual was assessed and a Saliva Management Program was implemented to better address his drooling. He is participating in a training program to wipe his mouth with a paper towel, to remove his fingers from his mouth and to participate in meal preparation with only his dishes and utensils. In addition, he routinely sees a physician to monitor the medication for saliva management. At his next appointment, physician will review dosage to see if he would benefit from an increased medication control of saliva.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All other residents were assessed and 2 other individuals were identified to be at risk of this deficient practice. Each of those residents will have a program plan to address the saliva management issues specific to their assessed needs.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> | 02/12/2012  |  |   |  |

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|   | <p>Staff) and TL #1 (Team Leader) on 1/11/12 at 1:30 PM indicated client #3 should have been encouraged to remove his thumb from his mouth and wipe the drool from his mouth prior to assisting with setting the table. AS #1 and TL #1 indicated the clients' plates should not be handled with unclean hands.</p> <p>9-3-7(a)</p> |   | <p>The program implementation will be reviewed weekly by the Team Leader and/or QMRP for effectiveness in addition to the monthly overall case management review.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this and all other deficient standards.</p> |                      |   |

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| W0484   | <p>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 1 additional client (#6), the facility failed to ensure the group home dining room table was accessible for client #6 and her wheelchair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/9/12 from 4:30 PM through 6:15 PM.</p> <p>At 5:45 PM client #6 was prompted to participate in the group home's family style dining. Client #6, who used a wheelchair to ambulate, drove her motorized wheelchair into the dining area and positioned herself 6 feet away from the dining room table along the East wall of dining room. Client #6 did not join her peers at the dining room table and remained next to the wall throughout the meal period.</p> <p>Observations were conducted at the group home on 1/10/12 from 6:15 AM through 8:30 AM. At 7:50 AM client #6 was prompted to participate in the group home's family style dining. Client #6, who used a wheelchair to ambulate, drove her motorized wheelchair into the dining area and positioned herself 6 feet away from</p> | W0484   | <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>There are 3 tables in this home's dining room to accommodate the individuals in the home at their meal. One of the tables does accommodate this individual's wheelchair. She elects not to sit with her peers. The IDT identified a program goal to encourage her to participate and assess the impact of this on her emotionally.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All other residents were assessed to have ample accommodation and can easily eat and participate in the routine meals of the home.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The program plan will further assess her willingness to participate in the meal with her peers or remain to the side. The IDT will review the progress or regression of this goal and determine further treatment plan recommendations.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> | 02/12/2012  |  |   |  |

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|   | <p>the dining room table along the East wall of dining room. Client #6 did not join her peers at the dining room table and remained next to the wall throughout the meal period.</p> <p>Interview with AS #1 (Administrative Staff) and TL #1 (Team Leader) on 1/11/12 at 1:30 PM indicated client #6's wheelchair did not fit under the group home table. AS #1 indicated client #6 should be able to join her peers at the group home dining room table if she chose.</p> <p>9-3-8(a)</p> |   | <p>The Team Leader and/or QMRP is reviewing the data and program notes for all individuals on a weekly basis to note concerns, compliance and needed revisions.</p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily.</p> <p>The Director will be onsite at the home routinely, no less than weekly.</p> <p>The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this and all other deficient standards.</p> |                      |   |