STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G090	A. BUILDING 00 B. WING	11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICES INC	3839 CAMELOT LN COLUMBUS, IN47201

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W0000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: November 14, 15, 16, 17, 18, 21 and 22, 2011. Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/1/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0125	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. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to the refrigerator door having chimes attached to the handle.	W0125	The chimes have been removed from the refrigerator door. QIDP reviewed restriction of client's rights with staff and Client #6's current plan which does not include any such restriction. QIDP or designee will continue to document at least	12/22/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. During the observations, the refrigerator located in the kitchen area near the living room had wind chimes attached to the handle on the refrigerator side (side by side doors). When the door was opened, the wind chimes sounded an audible alert. This affected clients #1, #2, #3, #4, #5 and #6. A review of client #1's record was conducted on 11/16/11 at 11:19 AM. There was no documentation in his record indicating he required the use of wind chimes on the refrigerator handle to alert staff. A review of client #2's record was conducted on 11/16/11 at 11:23 AM. There was no documentation in his record indicating he required the use of wind chimes on the refrigerator handle to alert staff. A review of client #3's record was conducted on 11/16/11 at 12:47 PM. There was no documentation in his record indicating he required the use of wind chimes on the refrigerator handle to alert staff. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. There was no documentation in his record indicating he required the use of wind chimes on the refrigerator handle to alert staff. A review of client #5's record was conducted on 11/16/11 at 12:52 PM. There was no documentation in his record indicating he required		monthly observations in the home and will retrain staff in any area of client rights restrictions that are observed. Responsible for QA: QIDP	

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	the use of wind chimes on the refrigerator handle to alert staff. A review of client #6's record was conducted on 11/16/11 at 12:57 PM. There was no documentation in his record indicating he required the use of wind chimes on the refrigerator handle to alert staff. An interview with direct care staff (DCS) #8 was conducted on 11/15/11 at 7:45 AM. DCS #8 indicated the chimes were on the handle of the refrigerator door to alert the staff when the door was opened. An interview with DCS #3 was conducted on 11/14/11 at 5:11 PM. DCS #3 indicated the wind chimes were attached to the door handle due to client #6's food seeking. An interview with DCS #7 was conducted on 11/15/11 at 6:32 AM. DCS #7 indicated the chimes were attached to the door handle of the refrigerator due to client #6's behavior. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 1:08 PM. The QMRP indicated the use of wind chimes on the refrigerator door handle was not part of the client's plan and should not be used. The QMRP indicated it was unnecessary. 9-3-2(a)			
W0126	The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.			

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	Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients accessed their petty cash funds. Findings include: A review of the clients' finances was conducted on 11/16/11 at 10:10 AM. -Client #1: On 1/2/11, the balance in his petty cash was $29.44. On 1/7/11, the balance was $40.44. The balance remained unchanged until 9/22/11 when it was $10.34. On 10/4/11, the balance was $10.44. There was no description/documentation to account for the changes in the balances. -Client #2: From 11/10/10 until 8/4/11, the balance in his petty cash was $3.52. On 9/22/11, his balance was $2.52. There was no description/documentation to account for the change in the balance. -Client #3: On 11/8/10, his petty cash ledger indicated his balance was $4.56. The balance remained the same until August 2010 when the balance was $3.56. There was no description/documentation to account for the change in the balance. -Client #4: On 1/2/11, his petty cash balance was $5.47. It remained $5.47 until 8/4/11 when it changed to $3.47. On 9/22/11, the balance was $4.47. There was no description/documentation to	W0126	W126 QIDP will review each client's program plan to ensure goals are in place for money skills. Staff will be trained on importance of each client accessing their petty cash funds routinely, at least monthly. QIDP or designee will audit client petty cash reports at least monthly to ensure compliance in this area. Responsible for QA: QIDP	12/22/2011

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	account for the changes in the balances. -Client #5: On 11/8/10, his petty cash balance was $29.27. It remained unchanged until 7/29/11 when it was $12.27. On 9/22/11, his balance was $1.33. There was no description/documentation to account for the changes in the balances. -Client #6: On 11/23/10, his petty cash balance was $14.45. It remained unchanged until 6/30/11 when it was $14.25. On 7/29/11, the balance was $14.45. On 7/29/11, the balance was $1.45. On 8/24/11, the balance was $1.57. There was no description/documentation to account for the changes in the balances. An interview with the Director of Supported Group Living was conducted on 11/16/11 at 10:10 AM. The Director indicated the clients should be accessing their petty cash routinely for personal transactions. The Director stated one time per month would be "reasonable." 9-3-2(a)			
W0140	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 6 of 6 clients living in the group home	W0140	W140 Each client was reimbursed for the petty cash that was unaccounted	12/22/2011

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	(#1, #2, #3, #4, #5 and #6), the facility failed to ensure an accurate accounting of the clients' petty cash. Findings include: A review of the clients' finances was conducted on 11/16/11 at 10:10 AM. -Client #1: On 1/2/11, the balance in his petty cash was $29.44. On 1/7/11, the balance was $40.44. The balance remained unchanged until 9/22/11 when it was $10.34. On 10/4/11, the balance was $10.44. There was no description/documentation to account for the changes in the balances. -Client #2: From 11/10/10 until 8/4/11, the balance in his petty cash was $3.52. On 9/22/11, his balance was $2.52. There was no description/documentation to account for the change in the balance. -Client #3: On 11/8/10, his petty cash ledger indicated his balance was $4.56. The balance remained the same until August 2010 when the balance was $3.56. There was no description/documentation to account for the change in the balance. -Client #4: On 1/2/11, his petty cash balance was $5.47. It remained $5.47 until 8/4/11 when it changed to $3.47. On 9/22/11, the balance was $4.47. There was no description/documentation to account for the changes in the balances. -Client #5: On 11/8/10, his petty cash		for. The finance procedures were reviewed and revised to include nightly auditing by staff. Staff will be trained on these procedures which include notification to the QIDP by the end of the shift when any discrepancies are found in any finance book. Monthly auditing by the Administrative Finance Specialist and notification to the QIDP and SGL division manager of any discrepancies will continue. Responsible for QA: QIDP, SGL Manager	

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	balance was $29.27. It remained unchanged until 7/29/11 when it was $12.27. On 9/22/11, his balance was $1.33. There was no description/documentation to account for the changes in the balances. -Client #6: On 11/23/10, his petty cash balance was $14.45. It remained unchanged until 6/30/11 when it was $14.25. On 7/29/11, the balance was $14.45. On 7/29/11, the balance was $1.45. On 8/24/11, the balance was $1.57. There was no description/documentation to account for the changes in the balances. An interview was conducted with finance department employee #1 on 11/16/11 at 10:52 AM. Employee #1 indicated she was aware of the issue with the clients' finances in their petty cash. She indicated she reported her concerns to the Director of Supported Group Living on 9/23/11. Employee #1 indicated the issues she noted had not been addressed and the clients will need to be reimbursed for the unaccounted spending. An interview with the Director of Supported Group Living was conducted on 11/16/11 at 10:10 AM. The Director indicated the facility should ensure deposits and withdrawals from the clients' petty cash was documented. The Director			

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	indicated the facility should keep an accurate accounting of the clients' funds. On 11/16/11 at 11:02 AM, the Director stated she, "dropped the ball" in regard to being notified of the issues with the clients' petty cash accounts. 9-3-2(a)			
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 19 incident/investigative reports reviewed affecting client #5, the facility failed to prevent neglect of a client by not ensuring a medication error was reported immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law and a thorough investigation was conducted. Findings include: A review of the facility's incident/investigative reports was conducted on 11/14/11 at 1:30 PM. The BDDS report, dated 10/15/11, indicated the following, "At [client #5's] last psychiatric visit his psychotropic medication, Abilify, was increased from 7.5 mg (milligrams) to 10 mg. This	W0149	W149 Agency policy and procedures were reviewed and determined to be appropriate in prohibiting the mistreatment, neglect or abuse of a client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the med error in a more timely manner. QIDP's will be responsible for reporting to the SGL Manager monthly information regarding med errors occurring each month. Responsible for QA: QIDP, SGL Manager	12/22/2011

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	medication was ordered and was added to the MAR (medication administration record). When the medication came in staff began giving it. However, for some reason, the previous order was not discontinued. Consequently [client #5] was receiving 17.5 mg of Abilify. This dosage was given from 10/5/11 until it was discovered by staff person, [staff #7], on 10/12/11... It is currently unknown why the original order of Abilify was not discontinued and the QA (Qualified Mental Retardation Professional assistant) who was handling the change of the medications has been on vacation this week." The facility did not provide documentation of an investigation into the medication error." The BDDS report indicated the date of knowledge of the incident was on 10/14/11. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 12:42 PM. The QMRP indicated the staff failed to immediately report this issue to her therefore the BDDS report was submitted late. She indicated her date of knowledge was 10/14/11 and she reported it to BDDS within 24 hours of being notified. An interview with the Director of Supported Group Living was conducted on 11/16/11 at 12:42 PM. The Director			

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	indicated an investigation was not conducted. 9-3-2(a)			
W0153	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 record review and interview for 1 of 19 incident/investigative reports reviewed affecting client #5, the facility failed to ensure a medication error was reported immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 11/14/11 at 1:30 PM. The BDDS report, dated 10/15/11, indicated the following, "At [client #5's] last psychiatric visit his psychotropic medication, Abilify, was increased from 7.5 mg (milligrams) to 10 mg. This medication was ordered and was added to the MAR (medication administration record). When the medication came in staff began giving it. However, for some	W0153	W153 Agency policy and procedures were reviewed and determined to be appropriate in prohibiting the mistreatment, neglect or abuse of a client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the med error in a more timely manner. QIDP's will be responsible for reporting to the SGL Manager monthly information regarding med errors occurring each month. Responsible for QA: QIDP, SGL Manager	12/22/2011

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	reason, the previous order was not discontinued. Consequently [client #5] was receiving 17.5 mg of Abilify. This dosage was given from 10/5/11 until it was discovered by staff person, [staff #7], on 10/12/11." The BDDS report indicated the date of knowledge of the incident was on 10/14/11. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 12:42 PM. The QMRP indicated the staff failed to immediately report this issue to her therefore the BDDS report was submitted late. She indicated her date of knowledge was 10/14/11 and she reported it to BDDS within 24 hours of being notified. 9-3-2(a)			
W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 19 incident/investigative reports reviewed affecting client #5, the facility failed to thoroughly investigate a medication error involving a psychotropic medication. Findings include: A review of the facility's incident/investigative reports was	W0154	W154 Agency policy and procedures were reviewed and determined to be appropriate in prohibiting the mistreatment, neglect or abuse of a client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the med error in a more timely manner.	12/22/2011

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	conducted on 11/14/11 at 1:30 PM. The BDDS report, dated 10/15/11, indicated the following, "At [client #5's] last psychiatric visit his psychotropic medication, Abilify, was increased from 7.5 mg (milligrams) to 10 mg. This medication was ordered and was added to the MAR (medication administration record). When the medication came in staff began giving it. However, for some reason, the previous order was not discontinued. Consequently [client #5] was receiving 17.5 mg of Abilify. This dosage was given from 10/5/11 until it was discovered by staff person, [staff #7], on 10/12/11... It is currently unknown why the original order of Abilify was not discontinued and the QA (Qualified Mental Retardation Professional assistant) who was handling the change of the medications has been on vacation this week." The facility did not provide documentation of an investigation into the medication error. An interview with the Director of Supported Group Living was conducted on 11/16/11 at 12:42 PM. The Director indicated an investigation was not conducted. 9-3-2(a)		QIDP's will be responsible for reporting to the SGL Manager monthly information regarding med errors occurring each month. Responsible for QA: QIDP, SGL Manager	

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W0227	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. Based on observation, record review and interview for 3 of 6 clients (#1, #2 and #6), the facility failed to ensure: 1) client #2's program plan addressed the use of a handheld radio and 2) clients #1 and #6 had training objectives for meal preparation. Findings include: 1) An observation was conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM. At 4:10 PM, staff #1 asked client #2 if he wanted his radio. Staff #1 gave client #2 his handheld radio while he was seated in the living room with clients #1, #3, #4 and #5. Client #2 turned his radio on to a loud, disruptive volume and held the radio up near his right ear. His radio remained loud until 4:41 PM when he was prompted to go to his room to pick out his pajamas for the night. At 4:36 PM, staff #1 turned on the television for clients #1 and #3 who were in the same room with client #2. Staff #3 stated to staff #2 at 4:36 PM in regard to asking staff #1 to put on client #5's socks, "She can't hear me with [client #2's] radio going." At 4:43 PM, client #2 turned his radio on again to a disruptive volume.	W0227	W227 QIDP will review and revise client #2's program plan to include specific information addressing the use of his handheld radio and clients #1 and #6's program plan to include training objectives for meal prep. Staff will be trained on all revisions to program plans. QIDP or designee will observe at least monthly on a regular basis to ensure program plan objectives are being implemented. Responsible for QA: QIDP	12/22/2011

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	Client #2 turned off his radio at 4:50 PM. At 5:01 PM, client #2 turned his radio on again. At 5:16 PM, staff #3 indicated to client #3 she would remove his hearing aids so client #2's radio would not bother him and he could calm down a bit. At 5:25 PM, client #2 turned off his radio when it was time for dinner. A review of client #2's record was conducted on 11/16/11 at 11:23 AM. His Behavior Management Program plan, dated 6/5/11, and his Individual Program Plan, dated 6/11-6/12, did not address the use of his handheld radio. There was no plan in place to address client #2 using his radio in order to not disrupt his peers at the group home. On 11/16/11 at 11:32 AM, an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated there was an addendum added last year to address client #2's use of his radio. The QMRP indicated the addendum was not included in client #2's most recent plans and should be a part of his plan. 2) Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 4:00 PM, client #6 was seated on a stool at the island in			

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	15G090	A. BUILDING 00 B. WING	11/22/2011

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	the kitchen while staff #2 unloaded the dishwasher and put the dishes away. At 4:10 PM, staff #2 was rinsing dishes and putting them into the dishwasher as client #6 sat at the island. Clients #1, #3 and #4 were sitting in the living room and available to assist. At 4:16 PM, staff #2 used the can opener to open cans for dinner. Client #6 was not prompted to assist. At 4:21 PM, staff #2 cleaned off the dining room table. Client #6 was in the area but not asked to assist. At 4:22 PM, staff #2 went into the the living room area to access the second refrigerator to get bread. Clients #1, #2, #3, #4, #5 and #6 were not asked to assist and were available to assist. At 4:28 PM, staff #2 was in the kitchen without the clients cooking dinner. At 4:41 PM, staff #2 breaded the chicken; none of the clients assisted or were asked to assist. At 4:43 PM, staff #2 was washing dishes without client involvement. At 4:56 PM, staff #2 was cooking without client involvement. At 4:58 PM, staff #2 stirred the potatoes. At 5:03 PM, staff #3 obtained neck napkins for the clients who wore them without asking the clients to assist. At 5:05 PM, staff #2 was using the microwave and then took plates out of the cabinets. At 5:07 PM, staff #2 took the chicken out of the oven. At 5:18 PM, staff #2 was cutting up the chicken and put food on all the clients' plates for them.			

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	At 5:19 PM and 5:24 PM, staff #2 opened cans of peaches. At 5:24 PM, staff #2 put the can of peaches into the food processor. At 5:35 PM, staff #2 and #3 were cutting up chicken. Staff #3 carried client #1, #2, #3, #4, #5 and #6's plates to them as they sat at the dining room table. On 11/15/11 at 6:08 AM, staff #5 was in the kitchen preparing breakfast without client involvement. Clients #1, #2, #3, #5 and #6 were sitting in the living room. At 6:10 AM, staff #5 asked clients #1 and #6 if they wanted cereal or oatmeal. At 6:17 AM, client #2 signed "juice." Staff #7 went into the kitchen, poured a glass of juice and took to client #2 as he sat on the couch. At 6:21 AM, client #6 pointed to the kitchen. Staff #6 said to client #6, "He's fixing it for you." Staff #5 was in the kitchen preparing breakfast without the clients being involved. At 6:26 AM, staff #5 asked client #3 if he wanted cereal or oatmeal. At 6:30 AM, staff #5 continued to cook sausage and oatmeal while clients #1, #2, #3, #4, #5 and #6 sat in the living room. At 6:38 AM, staff #5 cut the sausage. At 6:42 AM, staff #5 continued to cut up sausage and the clients were in the living room. At 6:46 AM, staff #5 measured and then poured the clients' drinks. At 6:48 AM, staff #5 indicated breakfast was ready. Each plate had food on it. Staff #5 served each client			

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	their plates with food. At 6:55 AM, staff #2 was at the island in the kitchen preparing the clients' drinks. A review of client #1's record was conducted on 11/16/11 at 11:19 AM. Client #1's Individual Program Plan (IPP), dated 5/11-5/12, indicated his culinary training objective was to prepare his lunch for the workshop. Client #1 did not have a training objective to assist during dinner and breakfast prep. A review of client #6's record was conducted on 11/16/11 at 12:57 PM. Client #6's IPP, dated 5/11-5/12, indicated he did not have a culinary training objective. The IPP indicated he needed culinary skills training however the plan did not include a training objective. The plan indicated, "[Client #6] is able to participate in some meal preparation activities. However, he can be most helpful during meal times by helping with setting the table or doing other tasks. He is not able to use kitchen appliances and must be monitored when in the kitchen to ensure his safety. He will avoid a hot stove, unless he is attempting to retrieve food." An interview with the QMRP was conducted on 11/21/11 at 12:12 PM. The QMRP indicated clients #1 and #6 should			

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	be involved with meal preparation. The QMRP indicated the clients were able to participate and their plans could be revised to include meal preparation training. 9-3-4(a)			
W0240	The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 3 non-sampled clients (#2 and #4), the facility failed to ensure their program plans included specific instructions for staff to implement their plans. Findings include: 1) An observation was conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM. On 11/14/11 at 3:58 PM, client #4 was prompted by staff #1 to put away his laundry. Client #4 stood up and staff #1 held onto client #1's right arm at the elbow. His gait belt was not observed and not used. At 4:01 PM, client #4 returned to the living room with staff #1 holding onto his left arm at the elbow. His gait belt was not observed and not used. At 4:13 PM, client #4 was prompted by staff #1 to assist her with folding laundry.	W0240	W240 QIDP will review and revise program plans to include specific instructions for staff on the use of client #2's gait belt and client #4's helmet. Staff will be trained on these plans and QIDP or designee will observe weekly for one month and at least monthly on a regular basis to ensure compliance in these areas. Responsible for QA: QIDP	12/22/2011

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	Client #4 got up and walked across the room; staff #1 did not assist and did not use his gait belt. At 4:15 PM, client #4 walked across the room and sat down in his chair. Staff #1 did not use his gait belt. At 4:16 PM, staff #3 assisted client #4 to his room. Staff #3 held onto the back of client #4's shirt and pants. His gait belt was not visible. At 4:21 PM, staff #3 assisted client #4 to his chair. Client #4's gait belt was being held by staff #3. The gait belt was on under his shirt and staff #3 was holding onto the belt and his shirt. At 4:34 PM, client #4 was prompted to go to the dining room table to decorate an ornament. Staff #3 held onto the back of his shirt. His gait belt was not observed. At 5:01 PM, client #4 stood up and took 3 steps before staff #1 held onto his gait belt. At 5:27 PM, client #4 entered the dining room from the hallway independently. Staff were not near him and none of the staff were holding his gait belt. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. His Gait Belt Usage Instructions, undated, indicated the following: "1. [Client #4] is to wear the gait belt snugly fastened around his waist below his navel. 2. Staff should walk with their hand holding onto the gait belt keeping constant contact with the belt to steady [client #4] while he			

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	is walking. 3. Staff should walk to the side of [client #4] while holding onto the gait belt. Staff should normally use their dominant hand to hold the belt but this may vary... 8. At the home [client #4] can be allowed independent walking with close supervision when in tight quarters such as the kitchen, med room, bathroom, etc." Client #4's Health/Risk Plan, dated 3/24/11, indicated the following in the prescribed treatments/medications/preventative measures section, "To wear gait belt, on in AM & off in pm." An interview with the Supported Group Living Director was conducted on 11/16/11 at 11:37 AM. The Director indicated client #4's plans should match to ensure staff know when he was to wear his gait belt. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:43 AM. The QMRP indicated the plan may need to specify the gait belt was to be worn on the outside of his clothes. 2) An observation was conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM. At 4:00 PM, client #2 was crawling on the floor of the living room. He sat up on his knees and hit himself on			

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	both thighs with his fists four times. Client #2 then bent over and banged his head on the carpeted floor ten times. Staff #2 responded by getting client #2's helmet and assisted client #2 with putting his helmet on. At 4:02 PM, client #2 was told by staff #2 he needed to wear his helmet for 15 minutes. At 4:04 PM, staff #2 told client #2 in his right ear he needed to be good and to quit hurting himself. Staff #2 indicated to client #2 his helmet could come off in 15 minutes. At 4:11 PM, client #2 took his helmet off and threw it onto the floor. Staff #1 asked staff #2 if client #2 needed to put his helmet back on. Staff #2 indicated to staff #1 he could keep his helmet off. During the remainder of the observation, client #2 was not prompted to wear his helmet. A review of client #2's record was conducted on 11/16/11 at 11:23 AM. Client #2's Behavior Management Program, dated 6/5/11, indicated he had a targeted behavior of self-injurious behavior. The plan indicated, "Self-injurious Behavior - bangs head on floor or other hard surface. Client often removes his helmet when he returns home from the [day] program. However, if he begins banging his head due to agitation staff should put his helmet on him immediately to protect his head. If he does not begin head banging he should be			

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	allowed a short break of 5-10 minutes and then encouraged to again wear the helmet for the remainder of the evening. Tracking of when the helmet is required will be done." His Individual Program Plan (IPP), dated 6/11-6/12, indicated the following, "[Client #2] may also bang his head when highly agitated. He has a helmet he wears to prevent injury to his head when this happens." The IPP did not indicate the staff should prompt client #2 to wear his helmet while at the group home when he was not agitated. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:30 AM. The QMRP indicated client #2's plans needed to be revised to indicate to staff the expectation for client #2 wearing his helmet. 9-3-4(a)			
W0249	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. Based on observation, interview and	W0249	W249 QIDP will retrain staff on	12/22/2011

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	record review for 3 of 6 clients living in the group home (#2, #4 and #5), the facility failed to ensure the staff implemented: 1) client #4's plan for his gait belt, 2) client #5's plan for dysphagia, 3) clients #2, #3, #4 and #5's training objectives for meals and 4) staff implemented client #1, #2, #4 and #5's training objectives for medication administration. Findings include: 1) An observation was conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM. On 11/14/11 at 3:58 PM, client #4 was prompted by staff #1 to put away his laundry. Client #4 stood up and staff #1 held onto client #1's right arm at the elbow. His gait belt was not observed and not used. At 4:01 PM, client #4 returned to the living room with staff #1 holding onto his left arm at the elbow. His gait belt was not observed and not used. At 4:13 PM, client #4 was prompted by staff #1 to assist her with folding laundry. Client #4 got up and walked across the room; staff #1 did not assist and did not use his gait belt. At 4:15 PM, client #4 walked across the room and sat down in his chair. Staff #1 did not use his gait belt. At 4:16 PM, staff #3 assisted client #4 to his room. Staff #3 held onto the back of client #4's shirt and pants. His gait belt was not visible. At 4:21 PM,		implementing program plans and providing continuous active treatment as required to include specific training in the areas cited in the survey report. QIDP or designee will observe in the home at least weekly for one month and monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP	

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	staff #3 assisted client #4 to his chair. Client #4's gait belt was being held by staff #3. The gait belt was on under his shirt and staff #3 was holding onto the belt and his shirt. At 4:34 PM, client #4 was prompted to go to the dining room table to decorate an ornament. Staff #3 held onto the back of his shirt. His gait belt was not observed. At 5:01 PM, client #4 stood up and took 3 steps before staff #1 held onto his gait belt. At 5:27 PM, client #4 entered the dining room from the hallway independently. Staff were not near him and none of the staff were holding his gait belt. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. His Gait Belt Usage Instructions, undated, indicated the following: "1. [Client #4] is to wear the gait belt snugly fastened around his waist below his navel. 2. Staff should walk with their hand holding onto the gait belt keeping constant contact with the belt to steady [client #4] while he is walking. 3. Staff should walk to the side of [client #4] while holding onto the gait belt. Staff should normally use their dominant hand to hold the belt but this may vary... 8. At the home [client #4] can be allowed independent walking with close supervision when in tight quarters such as the kitchen, med room, bathroom, etc."			

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:43 AM. The QMRP indicated client #4 had a plan for the use of his gait belt and staff should implement the plan as written. An interview with the Supported Group Living Director was conducted on 11/16/11 at 11:43 AM. The Director indicated staff should implement the plan as written. 2) Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 5:39 PM, dinner started. At 5:40 PM, client #5 had his head down, taking large, fast bites of his dinner. Client #5 held one side of his plate up with his right hand and scooped large bites of food into his mouth with his left hand. At 5:41 PM, client #5 continued eating in the same manner. At 5:44 PM, staff #3 stated in regard to clients #4 and #5, "These two are having a race." At 5:46 PM, client #5 finished his dinner. None of the staff (#1, #2 and #3) prompted client #5 to slow down, take small bites or to sit upright. None of the staff were observed to prompt client #5 to take successive dry swallows. On 11/15/11 at 6:53 AM, breakfast started.			

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	At 6:53 AM, client #5 held the corner of his plate up with his right hand and scooped/shoveled large bites into his lowered mouth quickly. Client #5 finished his breakfast at 6:55 AM. None of the staff (#5, #6 and #7) prompted client #5 to slow down, take small bites or to sit upright. None of the staff were observed to prompt client #5 to take successive dry swallows. A review of client #5's record was conducted on 11/16/11 at 12:52 PM. His Dysphagia Care Plan, dated 5/4/11, indicated client #5 was to receive cues to take small bites and sips and to slow down when eating fast. Client #5 was to sit upright in chair for meals and snacks. Staff were to prompt him to take successive dry swallows. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/18/11 at 9:40 AM. The QMRP indicated the staff should implement client #5's plan as written. An interview with the Director of Supported Group Living was conducted on 11/18/11 at 8:54 AM. The Director indicated client #5's plan should be implemented as written. 3) Observations were conducted at the			

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	group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 4:00 PM, client #6 was seated on a stool at the island in the kitchen while staff #2 unloaded the dishwasher and put the dishes away. At 4:10 PM, staff #2 was rinsing dishes and putting them into the dishwasher as client #6 sat at the island. Clients #1, #3 and #4 were sitting in the living room and available to assist. At 4:16 PM, staff #2 used the can opener to open cans for dinner. Client #6 was not prompted to assist. At 4:21 PM, staff #2 cleaned off the dining room table. Client #6 was in the area but not asked to assist. At 4:22 PM, staff #2 went into the the living room area to access the second refrigerator to get bread. Clients #1, #2, #3, #4, #5 and #6 were not asked to assist and were available to assist. At 4:28 PM, staff #2 was in the kitchen without the clients cooking dinner. At 4:41 PM, staff #2 breaded the chicken; none of the clients assisted or were asked to assist. At 4:43 PM, staff #2 was washing dishes without client involvement. At 4:56 PM, staff #2 was cooking without client involvement. At 4:58 PM, staff #2 stirred the potatoes. At 5:03 PM, staff #3 obtained neck napkins for the clients who wore them without asked the clients to assist. At 5:05 PM, staff #2 was using the microwave and then took plates out of the			

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	cabinets. At 5:07 PM, staff #2 took the chicken out of the oven. At 5:18 PM, staff #2 was cutting up the chicken and put food on all the clients' plates for them. At 5:19 PM and 5:24 PM, staff #2 opened cans of peaches. At 5:24 PM, staff #2 put the can of peaches into the food processor. At 5:35 PM, staff #2 and #3 were cutting up chicken. Staff #3 carried client #1, #2, #3, #4, #5 and #6's plates to them as they sat at the dining room table. At 5:46 PM, staff #2 cut up client #3's chicken for him. At 5:48 PM, client #5 was prompted two times by staff #2 to carry his plate to the kitchen. At 5:49 PM, staff #2 prompted client #5 to carry plate to kitchen. Staff #2 then took client #5 his drink and picked up his plate and took to the sink. At 5:50 PM, staff #2 gave client #1 his drink. At 5:52 PM, staff #3 carried client #6's cup to the sink. Staff #2 took client #1's cup to the sink. At 5:53 PM, staff #3 started washing dishes. On 11/15/11 at 6:08 AM, staff #5 was in the kitchen preparing breakfast without client involvement. Clients #1, #2, #3, #5 and #6 were sitting in the living room. At 6:10 AM, staff #5 asked clients #1 and #6 if they wanted cereal or oatmeal. At 6:17 AM, client #2 signed "juice." Staff #7 went into the kitchen, poured a glass of juice and took to client #2 as he sat on the			

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	15G090	A. BUILDING 00 B. WING	11/22/2011

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	couch. At 6:21 AM, client #6 pointed to the kitchen. Staff #6 said to client #6, "He's fixing it for you." Staff #5 was in the kitchen preparing breakfast without the clients being involved. At 6:26 AM, staff #5 asked client #3 if he wanted cereal or oatmeal. At 6:30 AM, staff #5 continued to cook sausage and oatmeal while clients #1, #2, #3, #4, #5 and #6 sat in the living room. At 6:38 AM, staff #5 cut the sausage. At 6:42 AM, staff #5 continued to cut up sausage and the clients were in the living room. At 6:46 AM, staff #5 measured and then poured the clients' drinks. At 6:48 AM, staff #5 indicated breakfast was ready. Each plate had food on it. Staff #5 served each client their plates with food. At 6:55 AM, staff #2 was at the island in the kitchen preparing the clients' drinks. At 6:58 AM, client #5 was given his cup of orange juice by staff #5 after staff #6 prompted client #5 to take his plate to the kitchen and get his drink. At 6:59 AM, staff #5 was washing dishes. At 7:00 AM, staff #5 took a glass of milk and orange juice to client #6. At 7:01 AM, staff #5 took client #2 orange juice, milk and Ensure. Staff #5 then started washing dishes and loaded the dishwasher. At 7:07 AM, staff #5 washed dishes. A review of client #2's record was conducted on 11/16/11 at 11:23 AM.			

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	Client #2's IPP, dated 6/11-6/12, indicated his training objective for meals was to pour liquids and to clear his place setting. A review of client #3's record was conducted on 11/16/11 at 11/16/11 at 12:47 PM. Client #3's IPP, dated 6/11-6/12, indicated his training objectives were to put silverware away and to clear the table of dishes after meals. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. Client #4's IPP, dated 6/11-6/12, indicated his culinary training objective was to clear dishes off the table and wipe off the table. A review of client #5's record was conducted on 11/16/11 at 11:13 AM. Client #5's IPP, dated 6/11-6/12, indicated his culinary training objective was to clear the dishes and wipe the table off after meals. An interview with the QMRP was conducted on 11/21/11 at 12:15 PM. The QMRP indicated the clients' training objectives should be implemented as written. 4) An observation was conducted at the group home on 11/15/11 from 6:05 AM to 8:00 AM. At 7:20 AM, client #4 received his medications			

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	(Famotidine, Lamotrigine, Levetiracetam, Topiramate, Vitamin C, Fiber Powder, Chlorhexidine, and Saline Mist) from staff #7. Staff #7 did not implement medication training to client #4. Client #4 did not obtain his own water for the med pass. An observation was conducted at the facility-operated senior day program on 11/15/11 from 10:45 AM to 12:05 PM. At 11:57 AM, client #1 received his medication (Lithium Carbonate) from day program staff #1. Client #1 was not asked to identify his medication, name side effects, med time or to identify the medication by color. At 11:58 AM, client #4 received his medication (Saline nasal spray) from staff #1. Client #4 was not provided medication training. An observation on 11/16/11 at 12:15 PM at the facility-operated day program, client #2 received medication (Risperidone) from day program staff #1. Client #2 was not provided training. At 12:19 PM, client #1 received his medication (Lithium Carbonate). Client #2 was not provided training during the med pass. At 12:23 PM, client #5 received his medication (Saline nasal spray and Simethicone). Client #5 was not provided training during the med pass. A review of client #1's record was conducted on 11/16/11 at 11:19 AM. His Individual Program Plan (IPP), dated 5/11-5/12, indicated he had a training objective to increase his self-administration of medications. The training objectives were to identify med by name, identify side effects of med, learn medication times, and identify meds by color. A review of client #2's record was conducted on 11/16/11 at 11:23 AM. His IPP, dated 6/11-6/12,			

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	indicated he had a training objective to increase his self-administration of medications. His training objectives were to get a glass of water for his evening medications and staff would review his medication side effects. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. His IPP, dated 6/11-6/12, indicated he had a training objective to increase his self-administration of medications. The training objectives was to get water for his evening medications. A review of client #5's record was conducted on 11/16/11 at 12:52 PM. His IPP, dated 6/11-6/12, indicated he had a training objective to increase his self-administration of medications. His IPP, dated 6/11-6/12, indicated he had a training objective to increase his self-administration of medications. His training objectives were to get his water to take evening medications, identify the drawer where his meds were stored, and clean his pill crusher daily. An interview with the Supported Group Living Director was conducted on 11/18/11 at 8:47 AM. The Director indicated the clients should receive training during each med pass. 9-3-4(a)			
W0331	The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 6 clients living in the	W0331	W331 The DON reviewed the medication error affecting client #5 with the	12/22/2011

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	group home (#4 and #5), the nurse failed to ensure: 1) client #5's medication administration record (MAR) was revised to reflect a change in a medication and 2) client #4's medication was scheduled to be given according to the instructions on the bottle. Findings include: 1) A review of the facility's incident/investigative reports was conducted on 11/14/11 at 1:30 PM. The BDDS report, dated 10/15/11, indicated the following, "At [client #5's] last psychiatric visit his psychotropic medication, Abilify, was increased from 7.5 mg (milligrams) to 10 mg. This medication was ordered and was added to the MAR (medication administration record). When the medication came in staff began giving it. However, for some reason, the previous order was not discontinued. Consequently [client #5] was receiving 17.5 mg of Abilify. This dosage was given from 10/5/11 until it was discovered by staff person, [staff #7], on 10/12/11." An interview with the nurse was conducted on 11/21/11 at 10:38 AM. The nurse indicated a fill-in nurse added the new order for Abilify but did not ensure the original order for Abilify was removed		agency nursing staff and retrained, specifically the nurse responsible for not removing the one order on the MAR for client #5 which resulted in the medication error. QIDP or agency nurse will retrain staff specifically on administering the medication as ordered by physician for client #4. QIDP will retrain all staff on the importance of accuracy in administering medications per medication labels. QIDP or designee will observe at least weekly for one month to ensure compliance. Random observations at least monthly will be on-going to ensure continued compliance. Responsible for QA: QIDP, DON, Agency nurse	

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	from the MAR. An interview with the Director of Nursing (DON) was conducted on 11/21/11 at 11:03 AM. The DON indicated the nurse who was filling in for the regular nurse failed to remove the original order for Abilify from the MAR. 2) An observation of client #4 receiving his medications was conducted on 11/15/11 at 7:20 AM. Staff #7 administered the medications. Client #4's Fiber Powder (Metamucil) bottle had a sticker on it that indicated the following, "Take w/ (with) plenty of water 2 hours before/after other meds." Client #4 received Famotidine, Lamotrigine, Levetiracetam, Topiramate, Vitamin C and Saline mist nasal spray at the same time he took the Fiber Powder. A review of client #4's record was conducted on 11/16/11 at 11:13 AM. His MAR, dated November 2011, indicated, "Take with plenty of water 2 hrs (hours) bef (before)/2 hrs aft (after) other meds." An interview with the nurse was conducted on 11/21/11 at 10:38 AM. The nurse indicated she did not check the medication bottle for instructions on how to administer. The nurse indicated it was technically a med error since the			

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	directions for administering the medication were not followed. An interview with the Director of Nursing (DON) was conducted on 11/21/11 at 11:03 AM. The DON indicated it was a medication error that the directions on the MAR and bottle were not implemented as written. 9-3-6(a)			
W0365	An individual medication administration record must be maintained for each client. Based on observation and interview for 1 of 3 clients (#1) observed to receive medication at the facility-operated day program, the facility failed to ensure a Medication Administration Record (MAR) was present to document the administration of his noon medication. Findings include: An observation was conducted at the facility-operated day program on 11/16/11 from 12:05 PM to 12:25 PM. At 12:19 PM, client #1 received Lithium Carbonate. After administering the medication, day program staff #1 indicated she did not have a MAR to document client #1's med pass. Staff #1 indicated the MAR was left at the new senior day program site.	W0365	W365 Group home QIDP and Day program QIDP reviewed this citation and staff were retrained on appropriate medication administration including presence of MAR for all medication administration. Day program QIDP will ensure that MAR provided by group home is present at the appropriate day program site prior to any medication administration. QIDP or designee will observe at least monthly on a regular basis to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:56 AM. The QMRP indicated the staff should have had an extra MAR at the day program or brought the MAR from the off-site senior day program to document the med pass. 9-3-6(a)			
W0381	The facility must store drugs under proper conditions of security. Based on observation and interview for 2 of 2 clients who attended the facility-operated day program (#1 and #4), the facility failed to ensure the clients' medications were secured. Findings include: An observation was conducted at the facility-operated senior day program on 11/15/11 from 10:45 AM to 12:05 PM. At 11:55 AM, day program staff #1 opened the middle desk drawer to get out client #1 and #4's medications. Staff #1 did not use a key or enter a code to open the drawer. Client #1 was then given Lithium Carbonate from the pouch staff #1 took from the drawer. Client #2 was administered Saline Mist nasal spray. An interview with the Qualified Mental	W0381	W381 Day program QIDP was notified of this failure to follow policy. Staff have been retrained on keeping medications secure as required. QIDP or designee will observe at least monthly on a regular basis to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	Retardation Professional (QMRP) was conducted on 11/16/11 at 11:56 AM. The QMRP indicated the medications should be locked at the facility-operated day program. An interview with the Supported Group Living Director was conducted on 11/16/11 at 11:56 AM. The Director indicated the medications should be locked at the facility-operated day program. 9-3-6(a)			
W0440	The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure quarterly evacuation drills were conducted for each shift. Findings include: A review of the facility's evacuation drills was conducted on 11/15/11 at 7:40 AM. There were no drills conducted during the night shift (11:00 PM to 7:00 AM) from 6/3/11 until the time of review of the drills. The drill conducted on 1/4/11 at 6:50 AM did not indicate the amount of time it took for the clients to evacuate.	W0440	W440 QIDP will retrain staff on requirements for regular evacuation drills and varied times for night shift drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this monthly at house meetings to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	An interview with the Director of Support Group Living was conducted on 11/16/11 at 11:05 AM. The Director indicated the evacuation drill documentation should indicated the time it took to evacuate. The Director indicated there should be one drill per shift per quarter. 9-3-7(a)			
W0441	The facility must hold evacuation drills under varied conditions.			
	Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure night shift evacuation drills were varied. Findings include: A review of the facility's evacuation drills was conducted on 11/15/11 at 7:40 AM. The following drills were conducted during the night shift: -Fire drill on 1/4/11 at 6:50 AM (time to evacuate was not documented). -Fire drill on 3/20/11 at 6:35 AM took 4 minutes to conduct. -Fire drill on 6/3/11 at 6:30 AM to 3 minutes to conduct. An interview with the Director of Supported Group Living was conducted	W0441	W441 QIDP will retrain staff on requirements for regular evacuation drills and varied times for night shift drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this monthly at house meetings to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	on 11/18/11 at 8:50 AM. The Director indicated the times of the drills should be varied. 9-3-7(a)			
W0448	The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure issues noted during evacuation drills were investigated. Findings include: A review of the facility's evacuation drills was conducted on 11/15/11 at 7:40 AM. There was no documentation the facility investigated issues noted with the following evacuations: -There were no drills conducted during the night shift (11:00 PM to 7:00 AM) from 6/3/11 until the time of review of the drills. -The drill conducted on 3/20/11 at 6:35 AM took 4 minutes to complete. -The drill conducted on 2/25/11 at 5:10 PM took 3 to 4 minutes to complete. -The drill conducted on 1/4/11 at 6:50 AM did not indicate the amount of time it took for the clients to evacuate. -The drill conducted on 12/10/10 at 5:25	W0448	W448 QIDP's will be trained on the regulation requiring investigation of issues noted during drills. Drill reports have been revised to include documentation of issues and reporting of issues to the QIDP. Staff have been trained on these reports. QIDP reviews drills monthly at house meetings to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	PM did not indicate the amount of time it took for the clients to evacuate. -The drill conducted on 11/15/10 at 7:05 AM did not indicate the amount of time it took for the clients to evacuate. An interview with the Director of Support Group Living was conducted on 11/16/11 at 11:05 AM. The Director indicated the evacuation drill documentation should indicated the time it took to evacuate. The Director indicated the targeted time to conduct drills was being discussed. The Director indicated she thought it was between 3 and 4 minutes. 9-3-7(a)			
W0460	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff provided/offered the clients their drinks during the meal. Findings include: Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 5:39 PM, dinner	W0460	W460 QIDP will retrain staff on ensuring clients receive a well-balanced diet by following menus and specific diet orders to include beverages as indicated on the menu. QIDP or designee will do random observations at least weekly for one month and at least monthly thereafter to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	started. Clients #1, #2, #3, #4, #5 and #6 were not provided or offered drinks until they were finished with their meal. At 5:47 PM when client #5 finished his dinner, client prompted him to take his plate to the kitchen and get his drink. At 5:49 PM, client #5 was prompted again to take his plate to the kitchen in order to get his drink. At 5:49 PM, client #1 indicated he wanted his milk; staff gave client #1 his milk. Client #6 carried his plate to the sink and got his drink. Client #4, at 5:50 PM, was prompted to go back to the table in order to get his drink. At 5:54 PM, client #2 was given his drink. At the end of the observation, client #3 was still eating his dinner and had not received his drink. On 11/15/11 at 6:53 AM, breakfast started. Clients #1, #2, #3, #4, #5 and #6 were not provided or offered drinks. At 6:58 AM, client #5 was given his orange juice after finishing his breakfast. At 6:59 AM, client #6 was given a glass of milk and orange juice after finishing his meal. At 7:01 AM, client #2 was given milk, orange juice and Ensure. At 7:03 AM, clients #1 and #4 were given orange juice. Client #3 received his drink at 7:03 AM. A review of the menu, dated 1996-1997 Fall/Winter, was conducted on 11/14/11 at 4:40 PM. The menu indicated the following was to be served for dinner: 3 ounces of baked chicken, 1/2 cup mashed			

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	15G090	A. BUILDING 00 B. WING	11/22/2011

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	potatoes, 2 ounces of gravy, 1/2 cup of green beans, roll/margarine, 1/2 cup of peaches and 1 cup of milk. A review of the breakfast menu, dated 1996-1997 Fall/Winter, was conducted on 11/15/11 at 6:21 AM. The menu indicated the following was to be served: 1/2 cup hot or 3/4 cup cold cereal, 1 thin toast, jelly, egg, if desired, and 1 cup of milk. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:30 AM. The QMRP indicated the clients should receive their drinks at the start of their meals. She indicated she did not know why the staff were not providing the drinks until the clients finished their meals. An interview with the Director of Supported Group Living was conducted on 11/16/11 at 1:19 PM. The Director indicated there was no reason the clients could not receive their drinks at the start of the meal. 9-3-8(a)			

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W0484	The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were provided condiments, forks and knives during meals. Findings include: Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 5:39 PM, dinner started. The clients were served chicken, mashed potatoes, gravy, green beans and peaches. Clients #1, #2, #3, #4, #5 and #6 were not provided or offered forks and knives. The clients were not provided or offered salt, pepper, ketchup or other condiments during the meal. On 11/15/11 at 6:53 AM, breakfast started. The clients were served cereal, toast, milk and juice. Clients #1, #2, #3, #4, #5 and #6 were not provided or offered forks and knives. The clients were not provided or offered salt, pepper, ketchup or other condiments during the meal. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 12:55 PM. The	W0484	W484 QIDP will retrain staff on the appropriate table service for this group home that meets the developmental needs of these clients and provision of appropriate condiments during meals. QIDP or designee will do random observations at least weekly for one month and at least monthly thereafter to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	QMRP indicated the clients should be provided forks and knives during meals. On 11/18/11 at 9:40 AM, the QMRP indicated condiments should be provided during each meal. An interview with the Director of Supported Group Living was conducted on 11/18/11 at 8:53 AM. The Director indicated condiments should be provided during each meal. 9-3-8(a)			
W0488	The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved in meal preparation and clean-up, serving themselves and eating family style during meals. Findings include: Observations were conducted at the group home on 11/14/11 from 3:51 PM to 5:56 PM and 11/15/11 from 6:05 AM to 8:00 AM. On 11/14/11 at 4:00 PM, client #6 was seated on a stool at the island in the kitchen while staff #2 unloaded the	W0488	W488 QIDP will retrain staff on ensuring clients receive a well-balanced diet by following menus and specific diet orders. QIDP or designee will do random observations at least weekly for one month and at least monthly thereafter to ensure compliance. Responsible for QA: QIDP	12/22/2011

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	dishwasher and put the dishes away. At 4:10 PM, staff #2 was rinsing dishes and putting them into the dishwasher as client #6 sat at the island. Clients #1, #3 and #4 were sitting in the living room and available to assist. At 4:16 PM, staff #2 used the can opener to open cans for dinner. Client #6 was not prompted to assist. At 4:21 PM, staff #2 cleaned off the dining room table. Client #6 was in the area but not asked to assist. At 4:22 PM, staff #2 went into the the living room area to access the second refrigerator to get bread. Clients #1, #2, #3, #4, #5 and #6 were not asked to assist and were available to assist. At 4:28 PM, staff #2 was in the kitchen without the clients cooking dinner. At 4:41 PM, staff #2 breaded the chicken; none of the clients assisted or were asked to assist. At 4:43 PM, staff #2 was washing dishes without client involvement. At 4:56 PM, staff #2 was cooking without client involvement. At 4:58 PM, staff #2 stirred the potatoes. At 5:03 PM, staff #3 obtained neck napkins for the clients who wore them without asked the clients to assist. At 5:05 PM, staff #2 was using the microwave and then took plates out of the cabinets. At 5:07 PM, staff #2 took the chicken out of the oven. At 5:18 PM, staff #2 was cutting up the chicken and put food on all the clients' plates for them. At 5:19 PM and 5:24 PM, staff #2 opened			

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	cans of peaches. At 5:24 PM, staff #2 put the can of peaches into the food processor. At 5:35 PM, staff #2 and #3 were cutting up chicken. Staff #3 carried client #1, #2, #3, #4, #5 and #6's plates to them as they sat at the dining room table. At 5:46 PM, staff #2 cut up client #3's chicken for him. At 5:48 PM, client #5 was prompted two times by staff #2 to carry his plate to the kitchen. At 5:49 PM, staff #2 prompted client #5 to carry plate to kitchen. Staff #2 then took client #5 his drink and picked up his plate and took to the sink. At 5:50 PM, staff #2 gave client #1 his drink. At 5:52 PM, staff #3 carried client #6's cup to the sink. Staff #2 took client #1's cup to the sink. At 5:53 PM, staff #3 started washing dishes. The clients did not serve themselves food or drinks during the meal. There were no serving bowls or pitchers on the table. On 11/15/11 at 6:08 AM, staff #5 was in the kitchen preparing breakfast without client involvement. Clients #1, #2, #3, #5 and #6 were sitting in the living room. At 6:10 AM, staff #5 asked clients #1 and #6 if they wanted cereal or oatmeal. At 6:17 AM, client #2 signed "juice." Staff #7 went into the kitchen, poured a glass of juice and took to client #2 as he sat on the couch. At 6:21 AM, client #6 pointed to the kitchen. Staff #6 said to client #6,			

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	"He's fixing it for you." Staff #5 was in the kitchen preparing breakfast without the clients being involved. At 6:26 AM, staff #5 asked client #3 if he wanted cereal or oatmeal. At 6:30 AM, staff #5 continued to cook sausage and oatmeal while clients #1, #2, #3, #4, #5 and #6 sat in the living room. At 6:38 AM, staff #5 cut the sausage. At 6:42 AM, staff #5 continued to cut up sausage and the clients were in the living room. At 6:46 AM, staff #5 measured and then poured the clients' drinks. At 6:48 AM, staff #5 indicated breakfast was ready. Each plate had food on it. Staff #5 served each client their plates with food. At 6:55 AM, staff #2 was at the island in the kitchen preparing the clients' drinks. At 6:58 AM, client #5 was given his cup of orange juice by staff #5 after staff #6 prompted client #5 to take his plate to the kitchen and get his drink. At 6:59 AM, staff #5 was washing dishes. At 7:00 AM, staff #5 took a glass of milk and orange juice to client #6. At 7:01 AM, staff #5 took client #2 orange juice, milk and Ensure. Staff #5 then started washing dishes and loaded the dishwasher. At 7:07 AM, staff #5 washed dishes. The clients did not serve themselves food or drinks during the meal. There were no serving bowls or pitchers on the table. An interview with staff #5 was conducted			

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	on 11/15/11 at 7:45 AM. Staff #5 indicated client #6 could assist with putting out napkins, wiping off the table and cutting toast. He indicated client #1 could wipe off the table. Staff #5 indicated none of the clients were involved with cooking (using stove or microwave). An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/16/11 at 11:52 AM. The QMRP indicated the clients should be involved in all aspects of meal preparation and clean-up. The QMRP indicated the clients should serve themselves family style, as much as possible. 9-3-8(a)			