

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/11/2013	
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPORT, IN 46947			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: October 2, 3, 7, 9, and 11, 2013</p> <p>Facility number: 001218 Provider number: 15G641 AIM number: 100235390</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 10/24/13 by W. Chris Greeney QIDP.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and for 3 additional clients (clients #4, #5, and #6), the facility failed to encourage and teach personal privacy during client #1, #2, #3, #4, #5, and #6's medication administration.</p> <p>Findings include:</p> <p>On 10/3/13 from 6:27am until 7:10am, clients #1, #2, #3, #5, and #6 had their morning medications administered by GHS (Group Home Staff) #3 with the medication room door open. During the medication administration time clients #1, #2, #3, #4, #5, and #6 sat at the dining room table within three feet (3') of the doorway waiting for their turn and watched medications administered by GHS #3 to the other clients. Clients #1, #2, #3, #4, #5, and #6 interrupted one another with verbal discussions between clients from the dining room table with clients who were receiving their medications inside the medication room with facility staff and without redirection. The medication door remained open during from 6:27am until 7:10am.</p>	W000130	<p>W130 Protection of Clients Rights Peak Community Services through the IDT ensures all clients rights by ensuring privacy during treatment and caring of personal needs. Peak Community Services GHS # 3 has been retrained on the need for privacy when passing medications to client #'s 1, 2,3,4,5 and 6. All Peak Community Services staff that are employed at Treen Street Group Home will be in-serviced on the need for privacy during treatment and the care of personal needs specifically medication passing. To monitor the corrective action Peak Community Services QMRP and Residential Coordinator will include medication pass privacy issues in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis. Systematically the privacy issue will be addressed at all SGL monthly staff meetings from 11.10.13 to 4.30.13 Person Responsible: Bridget Neal, Residential Coordinator Jan Adair, Residential Manager John Armstrong, QDDP</p>	11/10/2013			

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	<p>On 10/3/13 at 1pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated clients should have privacy and be taught personal privacy during their medication administration. The SDLM indicated the staff should have closed the door of the medication room when medications were administered.</p> <p>9-3-2(a)</p>				

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W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview, and record review, for 1 of 3 sampled clients (client #2) and 1 additional client (client #5) with locked personal belongings, the facility failed to allow and encourage clients #2 and #5's unimpeded access to their personal belongings.</p> <p>Findings include:</p> <p>On 10/2/13 from 3:10pm until 5:45pm, clients #2 and #5's lockers were locked and clients #2 and #5 did not have a key to access their locked snacks and personal belongings. At 3:40pm, clients #2 and #5 asked GHS (Group Home Staff) #1 and GHS #2 to open their locked lockers. At 3:40pm, GHS #1 indicated clients #2 and #5 did not have a key to their locked possessions of snacks and personal belongings. At 3:40pm, GHS #1 retrieved a key from the medication room, returned to clients #2 and #5 beside their lockers which had a key padlock, and</p>	W000137	<p>W137Peak Community Services is committed to ensure that all clients of the facility are allowed to exercise their rights as clients and as citizens of the United States. These rights include the right to retain and use appropriate personal possessions and clothing. Clients # 2 and 5 now have access to all items that were locked in the locked lockers during the time frame of the survey. The SGL staff at Treen Street will be in-serviced on the basic human rights of all clients specifically targeting the locking away of basic supplies, specifically snacks, cigarettes and pop. To monitor the corrective action Peak Community Services QMRP staff and the Residential Manager will include rights issues, such as locking away of basic supplies, in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis. Systematically the rights issue will be addressed at all SGL monthly staff meetings from 11.10.13 to 4.30.13 Person Responsible: Bridget Neal, Residential Coordinator Jan Adair, Residential Manager John</p>	11/10/2013
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	<p>unlocked client #2 and #5's locks on their individual lockers. At 3:40pm, clients #2 and #5 each removed their snacks of a bag of trail mix, their personal belongings of cigarettes, and a can of pop. At 3:40pm, clients #2 and #5 indicated they did not have a key for their lockers, clients #2 and #5 both indicated they locked their personal belongings inside their lockers, and each indicated they had to contact staff each time they wanted to get into their lockers.</p> <p>Client #2's record was reviewed on 10/3/13 at 12:40pm. Client #2's 8/21/13 CFA (Comprehensive Functional Assessment) did not indicate the identified need for locked items and indicated client #2 could use a key to access a lock.</p> <p>Client #5's record was reviewed on 10/3/13 at 12:30pm. Client #5's 2013 CFA did not indicate the identified need for locked items and indicated client #5 could use a key to access a lock.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities</p>		Armstrong, QDDP				

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	<p>Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated clients #2 and #5 had their personal belongings locked inside the lockers in the closet of the group home. Both staff indicated clients #2 and #5 did not have keys to their individual lockers and both clients #2 and #5 did not have an identified need to lock their personal belongings. Both staff indicated clients #1, #2, #3, #4, #5, and #6 had locks on their lockers to prevent problems with client #6 who stole items belonging to other clients.</p> <p>9-3-2(a)</p>				

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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, interview, and record review for 1 of 3 sampled clients (client #2), the facility failed to initiate programming in client #2's Individual Support Plan (ISP) which addressed client #2's toileting issues.</p> <p>Findings include:</p> <p>On 10/2/13 from 3:10pm until 5:45pm, and on 10/3/13 from 6:25am from 7:50am, observation and interview was conducted at the group home. On 10/2/13 at 4:15pm, GHS (Group Home Staff) #1 and client #2 took his bed clothing from the washer and placed the blankets and sheets into the dryer. At 4:15pm, GHS #1 indicated client #2 was incontinent of urine during the night and his bedding had to be washed.</p> <p>On 10/3/13 at 12:40pm, client #2's record was reviewed. Client #2's 8/21/13 ISP (Individual Support Plan) did not indicate a toileting goal and did not indicate a toileting schedule for client #2's toileting needs. Client #2's record indicated a 10/2013 "Physicians Orders" which</p>	W000227	W227 – Individual Program Plan Peak Community Services through the IDT system will ensure that specific objectives necessary to meet the client's needs as identified by the comprehensive assessment are implemented as required. Client # 2 now has a toileting goal and specific objectives to address his incontinence. The IDT will monitor the goal and objective to assess the progress of the goal and the objectives as part of the monthly review process. This monitoring will be on-going. System wide the SGL client files will be reviewed to determine if this issue needs to be addressed. If the issue is discovered to affect other SGL clients then goals and objectives will be added to remediate this issue. Person Responsible: John Armstrong, QDDP Jan Adair, Residential Manager	11/10/2013			

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	<p>included the use of "Detrol" for incontinence medication.</p> <p>An interview with the Agency Nurse was conducted on 10/7/13 at 10:36am. The Agency Nurse indicated client #2 did not have a a toileting goal or schedule. The Agency Nurse stated client #2 was incontinent of urine and had been on the "Detrol" medication "for years" and "was not sure if [client #2] could hold his urine."</p> <p>On 10/3/13 at 1pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #2 did not have a toileting goal or a toileting schedule.</p> <p>9-3-4(a)</p>				

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients #1 and #3) who used adaptive equipment, the facility failed to develop a schedule for use of the adaptive equipment for clients #1 and #3's equipment use.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm, and on 10/3/13 from 6:25am until 7:50am. Client #1 did not wear his prescribed eye glasses and did not use his quad cane during the observations.</p> <p>Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm. Client #1 did not wear his prescribed eye glasses and did not use his prescribed quad cane. Client #1 walked independently throughout the group home, watched television, assisted with preparing the meal, walked outside the group home on the uneven pavement to the smoking area, smoked independently, counted money, fed himself, rinsed his dishes, and completed medication administration.</p>	W000240	- Individual Program PlanPeak Community Services through the IDT system will ensure that relevant interventions to support the individual toward independence are described as required by regulation are implemented. Client #' 1 and 3 have revised goals and objectives to include the wearing of and the using of adaptive equipment.The Treen Street group home staff has been in-serviced on the new objectives and has been in-serviced on the use of prompts to promote the use of prescribed adaptive devices.To monitor the corrective action Peak Community Services QMRP staff and the Residential Manager will monitor the use of staff prompting to promote the use of prescribed adaptive devices in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis.System wide the SGL client files will be reviewed to determine if this issue needs to be addressed. If the issue is discovered to affect other SGL clients then goals and objectives will be added to remediate this issue.Systematically the matter of prompting clients to utilize prescription adaptive devices will	11/10/2013	

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	<p>On 10/3/13 at 10:15am, client #1's record review was conducted. Client #1's 5/15/13 ISP (Individual Support Plan) indicated he wore prescribed eye glasses and did not include the use of a quad cane. Client #1's 10/1/12 vision evaluation indicated he wore prescribed eye glasses. Client #1's 10/2013 "Physician's Orders" and 10/11/2004 Physical Therapy recommendations indicated he wore a leg brace and used a "quad cane or walker" for walking. Client #1's ISP did not indicate a schedule for the use of his prescribed eye glasses and his quad cane.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #1 wore prescribed eye glasses and used a quad cane for walking. The SDLM indicated client #1's ISP did not include a schedule for the use of client #1's eyeglasses and quad cane.</p> <p>2. Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm, and on 10/3/13 from 6:25am until 7:50am. On 10/2/13 at 3:10pm, client #3 stepped off the facility bus</p>		be addressed at all SGL monthly staff meetings from 11.10.13 to 4.30.13 Person Responsible: John Armstrong, QDDP Jan Adair, Residential Manager		

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	<p>wearing his prescribed eye glasses. On 10/2/13 at 3:55pm, client #3 exited his room without wearing his prescribed eye glasses. From 3:55pm until 5:45pm, client #3 shaved, counted money with GHS #1, tied his shoes, watched television, completed medication administration, fed himself, rinsed his dishes, and washed dishes in the sink. Client #3 did not wear his prescribed eye glasses.</p> <p>On 10/3/13 from 6:25am until 7:50am, client #3 did not wear his prescribed eye glasses. From 6:25am until 7:50am, client #3 dressed, brushed his teeth, prepared and ate his breakfast, completed medication administration, and watched television. At 7:50am, client #3 put on his eye glasses and left for workshop.</p> <p>On 10/3/13 at 11:37am, client #3's record review was conducted. Client #3's 4/10/13 ISP indicated he wore prescribed eye glasses. Client #3's 11/4/11 vision evaluation indicated he wore prescribed eye glasses. Client #3's ISP did not indicate a schedule for the use of his prescribed eye glasses.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated client #3 wore</p>						

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	<p>prescribed eye glasses. The SDLM indicated client #3's ISP did not include a schedule for his prescribed eye glasses.</p> <p>9-3-4(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 2 of 3 sampled clients (clients #2 and #3) and for 1 additional client (client #5), the facility failed to teach clients about their medications when opportunities existed.</p> <p>Findings include:</p> <p>1. On 10/3/13 at 6:50am, Group Home Staff (GHS) #3 popped from a medication card into a medication cup and assembled client #2's oral medications of "Norvasc 5mg (milligrams) (for hypertension), Detrol La 4mg (for incontinence), Tricor 145 (for Hyperlipidemia/Cholesterol), Hydrochlorothiazide 20mg (for Hypertension), Sertraline HCL 100mg (for depression), Metoprolol 25mg (for Hypertension), and Hydroxyzine 50mg (for Anxiety)." Client #2 took the medication and left the medication area. No teaching or specific training about client #2's medication was completed. At 6:55am, client #2's 10/2013 MAR (Medication Administration Record) was reviewed.</p>	W000249	W249 – Program Implementation Peak Community Services through the IDT system will ensure that each client will receive a continuous active treatment program that consists of relevant interventions and services in sufficient number to support the achievement of the objectives in the individual program plan. The Treen Street group home staff has been retrained on the medication objectives for client # 2, 3, and 5 and has been retrained on the proper interventions to support all clients residing in the home. The Treen Street group home staff has been retrained on the need for active treatment throughout the client's daily routine and has been retrained on the proper interventions to support all clients residing in the home. To monitor the corrective action Peak Community Services QMRP staff and the Residential Manager will monitor the staff's implementation of active treatment in their routine residence observations that are conducted at random times during the month. This monitoring	11/10/2013			

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	<p>Client #2 10/2013 MAR included a "ISP Goal" sheet for client #2 which indicated "Medication Administration, [client #2] will be able to name the meds (medications) and the side effects of all of his medications by sight...will be asked to identify the side effects of his medications when they are being administered...."</p> <p>On 10/3/13 at 12:40pm, client #2's record was reviewed. Client #2's 8/21/13 ISP (Individual Support Plan) indicated a goal/objective "Medication Administration, [client #2] will be able to name the meds (medications) and the side effects of all of his medications by sight...will be asked to identify the side effects of his medications when they are being administered...."</p> <p>2. On 10/3/13 at 7:02am, GHS #3 popped from a medication card into a medication cup and assembled client #3's oral medications of "Acidophilus 1 tab (tablet) daily (for stomach pains), Tab A Vite 1 tab daily (for General Health), Docusate Sodium 100mg twice a day (for Constipation), Vit. (Vitamin) D3 1000units daily (for vitamin Deficiency), Ranitidine 150mg twice daily (for ulcer), and Fish Oil 1000mg three times daily (for General Health)." Client #3 took the medications and left the medication area. No teaching or specific training about</p>		will continue on a permanent basis. Systematically the issue of the need for a continuous active treatment schedule for clients will be addressed at all SGL monthly staff meetings from 11.10.13 to 4.30.13 Person Responsible: John Armstrong, QDDP Jan Adair, Residential Manager				

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	<p>client #3's medication was completed. At 7:05am, client #3's 10/2013 MAR was reviewed and included a "ISP Goal" sheet for client #3 which indicated "Medication Administration, [client #3] will learn his medications...with staff assistance [client #3] will learn the name of the meds he is taking...."</p> <p>On 10/3/13 at 11:37am, client #3's record was reviewed. Client #3's 4/10/13 ISP indicated a goal/objective "Medication Administration, [client #3] will learn his medications...with staff assistance [client #3] will learn the name of the meds he is taking...."</p> <p>3. On 10/3/13 at 6:40am, GHS #3 popped from a medication card into a medication cup and assembled client #5's oral medications of "Acedophilus with Pectin capsule, 1 cap (capsule) daily (for stomach), Lisinopril 10mg (for blood pressure), Clonazepam 0.5mg (for tremors), and Ranitidine 300mg (for stomach upset). Client #5 tood the medications and left the medication area. No teaching or specific training about client #5's medication was completed. At 6:45am, client #5's 10/2013 MAR was reviewed and included a "ISP Goal" sheet for client #5 which included "Medication Administration, [client #5] will be able to name all of his medications by sight as</p>			

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	<p>well as their side effects...[Client #5] will be asked to identify his medications and their side effects when they are being administered...."</p> <p>An interview with the Agency Nurse was conducted on 10/7/13 at 10:36am. The Agency Nurse indicated staff should have implemented client #2, #3, and #5's medication goal/objective during each opportunity.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #2, #3, and #5's medication objectives should have been implemented during each opportunity.</p> <p>9-3-4(a)</p>			

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W000285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on record review, and interview, for 2 of 3 sampled clients (clients #2 and #3) who had physical interventions employed for behavior, the facility failed to have a written description of specific interventions from least restrictive to more restrictive restraint techniques for CPI (Crisis Prevention Intervention - a type of physical restraint intervention) to ensure a safeguard to prevent more restrictive restraint techniques were not used on clients #2 and #3.</p> <p>Findings include:</p> <p>1. Client #2's record review was conducted on 10/3/13 at 12:40pm. Client #2's 2/27/13 BSP (Behavior Support Plan) indicated the target behavior of "Aggression, Verbal and Physical, Defined as verbal aggression: yelling, cussing, calling names, making threatening remarks, Physical Aggression: causing harm to another individual, hitting, kicking, throwing items, pushing, etc...." Client #2's BSP indicated "CPI" techniques would be used by staff to</p>	W000285	<p>W285 – Management of Inappropriate Client Behavior Peak Community Services through the IDT system will ensure that interventions to manage inappropriate client behavior will be employed with sufficient safeguards to ensure the safety, welfare, and civil and human rights of the clients are adequately protected. Clients # 2 and 3's Behavior Support Plans (BSP) have been rewritten to include a written description of specific interventions from least restrictive to more restrictive techniques for Crisis Prevention Intervention to ensure a safeguard to prevent more restrictive restraint techniques were not used on them. These plans were submitted to the Human Rights Committee and approved. To monitor the corrective action Peak Community Services the Director of Quality and Support will review Behavior Support Plans written by Peak Community Services QDDP staff to see if they contain the appropriate safeguards to prevent more restrictive restraint techniques from being utilized. This review will be for 100% of</p>	11/10/2013	

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	<p>prevent client #2 from injuring other people during his behaviors. Client #2's BSP indicated "The risks of the behaviors compared to the risks of taking medications and use of CPI techniques have been discussed between all team members. The team is in agreement that they feel the risk of taking medication and use of CPI techniques is in the best interest of the consumer." Client #2's BSP did not include specific restraint interventions to inform staff what techniques or least restrictive for this individual were to be employed for behavior management.</p> <p>2. Client #3's record was reviewed on 10/3/13 at 11:37am. Client #3's 3/31/13 BSP (Behavior Support Plan) indicated client #3 had the target behaviors of Physical Aggression, Depression, and Hallucinations. Client #3's BSP indicated during his targeted behaviors client #3 had tried to "harm to self, others, or inanimate/property destruction." Client #3's BSP indicated "...If [Client #3] becomes physically aggressive, any observers will be removed from the room and CPI restraint techniques will be" implemented. Client #3's BSP did not include specific restraint interventions to inform staff what techniques or least restrictive for this individual were to be employed for behavior management.</p>		<p>plans written from 11.01.13 to 4.30.13. Starting 05.01.13 the reviews will be random and will include 25% of plans written until 09.30.13. Person Responsible: Connie English, Director of Quality and Support John Armstrong, QDDP</p>				

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	<p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #2 and #3 had CPI techniques implemented by the facility staff for behaviors to keep clients and staff safe. The SDLM indicated clients #2 and #3's BSP did not include specific restraint interventions to inform staff what techniques or least restrictive for clients #2 and #3 were to be employed for behavior management. The SDLM indicated the facility had a policy and a procedure however she could not locate the information.</p> <p>On 10/3/13 at 5:30pm, an undated CPI (Crisis Prevention Intervention - a type of physical restraint intervention) which were used for Behavior Modification and Training policy was reviewed. The policy indicated "C. Level Three Interventions include: 2. Physical Restraint: is defined as one or more persons physically limiting another's movements of body or limbs through hands on physical contact." The policy indicated CPI physical restraint interventions for CPI Interim Control Position, CPI Team Control Position, CPI Transport Position, CPI Applied Physical</p>						

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	<p>Training/Emergency Floor Procedure, and Four Person Physical Restraint.</p> <p>9-3-5(a)</p>			

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client #3 who received psychotropic medications, the facility failed to evaluate client #3's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/3/13 at 11:37am. Client #3's 4/10/13 ISP and client #3's 3/31/13 BSP both indicated the targeted behaviors of Depression, Physical Aggression, and Hallucinations. Client #3's plans indicated the use of Zyprexa 20mg at night for thought process and Fluoxetine 40mg at evening medication administration for depression. Client #3's 9/16/13, 5/28/13, 3/26/13, and 12/3/12 "Psych Medication Reviews" did not indicate a change in client #3's psychotropic medication or a contraindication. Client #3's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided for review.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at</p>	W000316	<p>W316 – Drug UsagePeak Community Services through the IDT system will ensure that drugs used for control of inappropriate behavior are gradually withdrawn at least annually. Client # 3's medications were reviewed at his quarterly Psychotropic Medication Review by the prescribing medical practitioner with no changes indicated at that time. At client # 3's next review scheduled for December the question of titration will be addressed specifically for psychotropic medications and if indicated by the prescribing medical practitioner a plan will be developed. Systematically the Psychotropic Medication Review form will be changed to specifically prompt the prescribing medical practitioner to address the need for continuation of the current medications and dosages or the titration of them. Once the form is completed the IDT will review the information from the medical practitioner and devise a plan accordingly if necessary. Person Responsible: Bridget Neal, Residential Coordinator Jan Adair, Residential Manager John Armstrong, QDDP</p>	11/10/2013	

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	<p>10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #3's psychotropic medication had not been changed in over a year and no contraindication for decreasing the medication had been documented. The SDLM indicated she would look for additional written evidence for client #3. No additional information was available for review.</p> <p>9-3-5(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1), the facility failed to develop an assessment and/or a protocol to manage client #1's leg/foot pain.</p> <p>Findings include:</p> <p>On 10/3/13 from 6:25am until 7:50am, client #1 was observed at the group home and expressed to GHS (Group Home Staff) #3 he had leg pain from his brace on his leg.</p> <p>On 10/3/13 at 8:00am, client #1 was observed to sit in the cafeteria at the workshop at a table with his head down on the table. From 8:00am until 8:30am, client #1 sat in a chair in the workshop cafeteria and refused to get up to go to work because his leg hurt. At 8:30am, the workshop supervisor returned to the cafeteria with a wheel chair and prompted client #1 to sit in the wheel chair. At 8:30am, Woskhop Supervisor (WKS) #1 stated client #1 was "using a wheel chair because his brace rubs and hurts him to walk (sic)." WKS #1 stated client #1 had been complaining of leg and foot pain for "a while." WKS #1 indicated she was unaware of what was being done</p>	W000331	W331 – Nursing Services Peak Community Services IDT system ensures that Peak Community Services provides clients with nursing services in accordance with their needs. Client #1 has a written objective to notify staff when he is in pain for any of his ailments diagnosed or otherwise. Peak Community Services Treen SGL staff has been trained on the use of the Wong-Baker FACES Pain Rating Scale to be used with clients that have the cognitive ability to utilize such a scale. Using this scale staff should offer Client # 1 appropriate pain relieving medications pursuant to the protocol established by Client # 1' Primary Care Physician. Peak Community Services Treen SGL staff has been trained on the use of the Wong-Baker FACES Pain Rating Scale to be used with all residential clients that have the cognitive ability to utilize such a scale. Systematically during the quarterly nursing assessment the nurse will discuss with the staff what method they use to gauge an individual clients pain. This information will be placed on the quarterly assessment as well as placed in the client's file for staff to refer to when needed. System wide Peak Community Services SGL staff has been trained on the use of the Wong-Baker FACES	11/10/2013			

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	<p>regarding client #1's leg and foot pain. At 8:30am, client #1 complained of leg and foot pain and stated "they know it hurts me" referring to his leg brace. Client #1 stated "It hurts bad."</p> <p>On 10/3/13 at 10:15am, a record review for client #1 was conducted. Client #1's 6/17/13 Risk Assessment and Individual Support Plan (ISP) both did not indicate client #1 had leg and/or foot pain. Both client #1's plans indicated client #1 understood medical care with the assistance of an advocate. Client #1's Risk Assessment and ISP indicated client #1 had diabetes, was a fall risk, and had recurrent skin ulcers on his legs and feet. Client #1's Nursing Notes and Nursing Quarterly Assessments dated 7/21/13, 4/21/13, 2/3/13, and 11/11/12 did not indicate client #1 had problems with his skin integrity, leg/foot pain, or complained his legs/feet hurt him. Client #1's 8/14/13 "Foot and Ankle Center" report indicated "Dropfoot. Acquired...deformity, Post Traumatic Ulcer Left Leg. Ulcer risht calf/leg. Condition resolved. Tinea pedis left foot. condition has resolved. Painful onychomycosis by clinical appearance toes 1, 2, 3, 4, and 5 of both feet. Treatment plan: added offloading pad to right shoe insert..." Client #1's 2/27/13 hospital X-ray report indicated "Rad/Foot</p>		Pain Rating Scale to be used with residential clients that have the cognitive ability to utilize such a scale. Person Responsible: Bridget Neal, Residential Coordinator Jan Adair, Residential Manager Alison Harris, Program Nurse	

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	<p>Right, Right foot swelling...There is no fracture or subluxation. There is osteoarthritis of the osteopenic right foot. The abnormal position the foot is held in suggests the patient has a chronic neuromuscular abnormality like Club Foot." Client #1's record included but were not limited to diagnoses of: Diabetes. No pain assessment and no pain protocol was available for review.</p> <p>An interview with the Agency Nurse was conducted on 10/7/13 at 10:36am. The Agency Nurse stated client #2's leg and foot pain was not assessed because "I only complete general assessments not specific." The Agency Nurse indicated she was unaware client #1's leg/foot brace did not fit him correctly or caused client #1 pain.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #2 did not have an assessment completed for his leg and/or foot pain.</p> <p>9-3-6(a)</p>			

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 3 of 3 sampled clients (clients #1, #2, and #3), the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 10/2/13 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 9/2012 through 10/2/13 and indicated the following for clients #1, #2, and #3:</p> <p>-A 6/27/13 BDDS report for a medication error on 6/5/13 at 11am, indicated client #1 was given 10mg of Abilify (for behaviors) "when he should have been taking a 5mg dose as prescribed. The error occurred from 6/5/13 to 6/26/13. Staff failed to match the MAR (Medication Administration Record) to the medication packaging."</p> <p>-A 9/19/12 BDDS report for a medication error on 9/16/12 at 9pm, indicated staff gave client #2 "1 Hydroxyzine HCL 50mg and the order is written give 2</p>	W000368	W368 – Drug AdministrationPeak Community Services system for drug administration assures that all drugs, including those that are self-administered, are administered in compliance with the physician's orders. The staff who committed the errors mentioned in the Survey have been retrained in the appropriate administration of medications according to Med Core A and B. They have been observed passing medication by their direct supervisor.As part of Peak Community Service's continuous competency observation system the SGL staff working in the Treen Street home will have a medication pass as part of their observation. The continuous competency observation system calls for a minimum of three (3) staff observations within Fiscal Year 2014 which will run through June 2014.System wide Peak Community Services SGL will have a medication pass observation as part of their Continuous Competency observation.Person Responsible:Bridget Neal, SGL CoordinatorJan Adair, Manager of SGL	11/10/2013			

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	<p>Hydroxyzine HCL 50mg 3 times a day" for anxiety.</p> <p>-A 9/19/12 BDDS report for a medication error on 9/16/12 at 8pm, indicated staff gave client #3 "1 Olanzapine 20mg on 9/16/12 at 8:00pm and the order called for 2 Olanzapine 20mg tabs (tablets) orally one time a day at bedtime" for depression.</p> <p>-A 10/1/12 BDDS report for a medication error on 9/30/12 at 8:00am, indicated client #3 was not administered his medications of Acidophilus for stomach pains, Docusate Sodium 100mg for constipation, Fish Oil 1000mg for general health, Ranitidine 150mg for ulcer, Vitamin D3 1000units for vitamin deficiency, and Tab A Vite for general health.</p> <p>On 10/3/13 at 10:15am, client #1's record was reviewed. Client #1's 10/2013 "Physician's Orders" indicated "Abilify 5mg 1 tab in AM (morning)" for behaviors.</p> <p>On 10/3/13 at 12:40pm, client #2's record was reviewed. Client #2's 10/2013 "Physician's Orders" indicated 2 tablets of "Hydroxyzine HCL 50mg 3 times a day" for anxiety.</p> <p>On 10/3/13 at 11:37am, client #3's record</p>						

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	<p>was reviewed. Client #3's 10/2013 "Physician's Orders" indicated Acidophilus for stomach pains, Docusate Sodium 100mg for constipation, Fish Oil 1000mg for general health, Ranitidine 150mg for ulcer, Vitamin D3 1000units for vitamin deficiency, and Tab A Vite for general health.</p> <p>On 10/3/13 at 11:15am, a record review was completed of the undated facility's policy and procedures indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 10/2/13 at 1:25pm, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>An interview with the Agency Nurse was conducted on 10/7/13 at 10:36am. The Agency Nurse indicated staff should follow physician's orders when administering medications to clients #1, #2, and #3.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of</p>			

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	<p>Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated staff did not follow physician's orders.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) with adaptive equipment, the facility failed to teach and encourage clients #1 and #3 to use their equipment and failed to ensure client #2's wheel chair was in good repair.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm, and on 10/3/13 from 6:25am until 7:50am. Client #1 did not wear his prescribed eye glasses and did not use his quad cane during the observations.</p> <p>Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm. Client #1 did not wear his prescribed eye glasses and did not use his prescribed quad cane. Client #1 walked independently throughout the group home, watched television, assisted with preparing the meal, walked outside the group home on the uneven pavement to the smoking area, smoked independently,</p>	W000436	<p>W436Peak Community Services through the IDT is committed to ensuring that all clients are furnished, dentures, eye glasses, hearing aids, other communication aids, braces, and other devices identified by the IDT as needed by the client. In addition Peak Community Services is committed to ensuring these items are maintained in good repair and the client is trained to use them and make informed choices about them. Client # 1 and 3 has revised goals and objectives to include the wearing of and the using of adaptive equipment. Client number 2's wheelchair is being replaced. Peak Community Services Supervised Group Living staff has been in-serviced on recognizing adaptive devices in disrepair and how to report such to the appropriate person. Peak Community Services Supervised Group Living staff including GGS #'s 1 and 2, has been in-serviced on the new objectives and has been in-serviced on the use of prompts to promote the use of prescribed adaptive devices. To</p>	11/10/2013

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	<p>counted money, fed himself, rinsed his dishes, and completed medication administration. GHS (Group Home Staff) #1 and #2 did not prompt client #1 to wear his eye glasses and did not prompt him to use his quad cane.</p> <p>On 10/3/13 at 10:15am, client #1's record review was conducted. Client #1's 5/15/13 ISP (Individual Support Plan) indicated he wore prescribed eye glasses. Client #1's 10/1/12 vision evaluation indicated he wore prescribed eye glasses. Client #1's 10/2013 "Physician's Orders" and 10/11/2004 Physical Therapy recommendations indicated he wore a leg brace and used a "quad cane or walker" for walking.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated client #1 wore prescribed eye glasses and used a quad cane for walking. The SDLM indicated client #1 should have been taught and encouraged to wear his prescribed eye glasses and to use his quad cane at the group home.</p> <p>2. Observations were conducted at the group home on 10/2/13 from 3:10pm until</p>		<p>monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of staff prompting to promote the use of prescribed adaptive devices in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis. Systematically the matter of prompting clients to utilize prescription adaptive devices will be addressed at SGL monthly staff meetings from 11.10.13 to 4.30.13. Staff will also be re-trained on the need to indentify adaptive equipment that may need repair. Person Responsible: John Armstrong, QDDP Bridget Neal, Residential Coordinator Jan Adair, Residential Manager</p>		

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	<p>5:45pm, and on 10/3/13 from 6:25am until 7:50am. Client #2 sat in a wheel chair and the seat was torn two inches (2"). On 10/2/13 at 3:35pm, GHS #1 indicated client #2 sat in a wheel chair and the seat was torn two inches.</p> <p>On 10/3/13 at 12:40pm, client #2's record review was conducted. Client #2's 8/21/13 ISP indicated he used a wheel chair for safety to access the group home.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated client #2 used a wheel chair to access the group home safely and both indicated they did not know client #2's wheel chair seat was torn.</p> <p>3. Observations were conducted at the group home on 10/2/13 from 3:10pm until 5:45pm, and on 10/3/13 from 6:25am until 7:50am. On 10/2/13 at 3:10pm, client #3 stepped off the facility bus wearing his prescribed eye glasses. On 10/2/13 at 3:55pm, client #3 exited his room without wearing his prescribed eye glasses and was not encouraged or taught to wear them. From 3:55pm until 5:45pm, client #3 shaved, counted money with GHS #1, tied his shoes, watched television, completed medication</p>						

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	<p>administration, fed himself, rinsed his dishes, and washed dishes in the sink. Client #3 did not wear his prescribed eye glasses and no eye glasses were taught.</p> <p>On 10/3/13 from 6:25am until 7:50am, client #3 did not wear his prescribed eye glasses. From 6:25am until 7:50am, client #3 dressed, brushed his teeth, prepared and ate his breakfast, completed medication administration, and watched television. At 7:50am, client #3 put on his eye glasses and left for workshop.</p> <p>On 10/3/13 at 11:37am, client #3's record review was conducted. Client #3's 4/10/13 ISP indicated he wore prescribed eye glasses. Client #3's 11/4/11 vision evaluation indicated he wore prescribed eye glasses.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated client #3 wore prescribed eye glasses. The SDLM indicated client #3 should have been taught and encouraged to wear his prescribed eye glasses.</p> <p>9-3-7(a)</p>						

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the facility failed for clients #1, #2, #3, #4, #5, and #6 to wash the dining room table before snacks/supper.</p> <p>Findings include:</p> <p>On 10/2/13 from 3:10pm until 5:45pm, clients #1, #2, #3, #4, #5, and #6 were at the group home. At 3:10pm, clients unpacked their lunch boxes on the dining room table, sorted CDs, and counted money. At 3:40pm, clients #1, #2, #3, #4, #5, and #6 obtained their personal snacks from their individual treat lockers at the group home. Clients #1, #2, #3, #4, #5, and #6 sat at the dining room table, poured trail mix onto a paper plate and onto the table. Clients scooped up the trail mixture with their fingers, placed it on their plates, and ate the mixture. No washing of the dining room table was observed from 3:10pm until 3:40pm. From 3:40pm until 5:45pm, clients #1, #2, #3, #4, #5, and #6 looked at the newspaper, sorted money, colored on paper, and folded laundry at the dining</p>	W000454	<p>W454 – Infection ControlPeak Community Services through the IDT system will ensure that it provides a sanitary environment to avoid sources and transmissions of infections.Peak Community Services Supervised Group Living staff has been in-serviced on the need to wash all surfaces used in the preparing and serving of meals and snacks. Specifically they have been re-trained on the need to wash the dining room table prior to serving the evening snack and/or meal.To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper sanitary procedures in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis.Systematically the need to maintain sanitary condition in the SGL residence will be addressed at SGL monthly staff meetings from 11.10.13 to 4.30.13.Person Responsible:John Armstrong, QDDPBridget Neal, Residential CoordinatorJan Adair, Residential Manager</p>	11/10/2013			

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	<p>room table. At 5:25pm, clients #1, #2, #3, #4, #5, and #6 sat down at the unwashed dining room table for supper and consumed their meal. No washing of the dining room table was completed and was not redirected by GHS #2.</p> <p>On 10/2/13 at 1:25pm, a record review of the undated facility's policy and procedure for infection control indicated the facility staff should encourage sanitary methods at the group home.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated clients #1, #2, #3, #4, #5, and #6 should be taught and encouraged to wash the dining room table before eating off the table.</p> <p>9-3-7(a)</p>				

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and for 3 additional clients (clients #4, #5, and #6), the facility failed to teach personal hygiene practices for the prevention of infection control and a maintain a sanitary environment when opportunities existed.</p> <p>Findings include:</p> <p>On 10/2/13 from 3:10pm until 5:45pm, clients #1, #2, #3, #4, #5, and #6 were at the group home. At 3:40pm, clients #1, #2, #3, #4, #5, and #6 obtained their personal snacks from their individual treat lockers at the group home. Clients #1, #2, #3, #4, #5, and #6 sat at the dining room table, poured trail mix onto a paper plate and onto the table. Clients scooped up the trail mixture with their fingers, placed it on their plates, and ate the mixture with their fingers. No handwashing was observed from 3:10pm until 3:40pm. From 3:40pm until 5:45pm, clients #1, #2, #3, #4, #5, and #6 looked at the newspaper, sorted money, colored on paper, and folded laundry at the dining room table. From 4:15pm until 5:25pm, client #6 smoked outside the</p>	W000455	<p>W455 – Infection Control Peak Community Services through the IDT system will ensure that it provides a sanitary environment to avoid sources and transmissions of infections. Clients # 1, 2,3,4,5 and 6 have new or revised goals and objectives to wash their hands after performing any task where germs might be transmitted from person to person or person to food stuffs. Peak Community Services Supervised Group Living staff has been in-serviced on the need to prompt all clients to wash their hands after engaging in routine daily activities such as reading the newspaper, smoking, using the toilet, sorting money, taking out the trash, doing laundry, shaking hands with other residents, coloring on paper, and any other task where germs might be transmitted from person to person or person to food stuffs. Residential Coordinator to provide training to the clients on sanitary issues in the home. To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper sanitary procedures in their routine residence observations that are conducted at random</p>	11/10/2013
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	<p>back door of the group home, re entered the group home, washed his hands, began cooking supper, pulled wrappers out of the trash, and did not re wash his hands. Client #6 without re washing his hands went back to the stove, floured meat, and placed the floured meat onto a sheet for the stove to cook. At 5:25pm, clients #2, #3, and #6 sat down at the dining room table for supper without washing their hands and consumed their meal. No handwashing was not redirected by GHS #2. From 3:10pm until 5:25pm, clients #1, #5, and #6 exited and re entered the group home from smoking and were not prompted or encouraged to wash their hands.</p> <p>On 10/2/13 at 1:25pm, a record review of the undated facility's policy and procedure for infection control indicated the facility staff should encourage sanitary methods at the group home.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at 10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated clients #1, #2, #3, #4, #5, and #6 should be taught and encouraged to wash their hands.</p> <p>9-3-7(a)</p>		<p>times during the month. This monitoring will continue on a permanent basis. Systematically the need to maintain sanitary condition in the SGL residence will be addressed at SGL monthly staff meetings from 11.10.13 to 4.30.13. Person Responsible: John Armstrong, QDDPBridget Neal, Residential Coordinator Jan Adair, Residential Manager</p>				

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the group home, the facility staff failed to teach and encourage clients the use dining utensils.</p> <p>Findings include:</p> <p>On 10/2/13 from 3:10pm until 5:45pm, clients #1, #2, #3, #4, #5, and #6 were at the group home. From 4:10pm until 5:25pm, clients #6 set the table with eight (8) place setting of 1 plate, 1 fork, 1 spoon, 1 knife, 1 napkin, and 1 glass. At 5:25pm, clients #1, #2, #3, #4, #5, and #6 sat down at the dining room table for supper and consumed their meal of Bread and Butter, Pork Chop, Scallop Potatoes, and Spinach. At 5:25pm, clients #1, #2, #3, #4, #5, and #6 served themselves each butter and bread and set the bread with butter on the dining room table. No plate was provided or encouraged. From 5:25pm until 5:45pm, clients #1, #2, #3, #5, and #6 ate their pork chops with their fingers and no knife use was encouraged or taught by GHS (Group Home Staff) #1 and GHS #2.</p> <p>On 10/3/13 at 1:00pm, and on 10/7/13 at</p>	W000488	W 488 – Dining Areas and ServicePeak Community Services through the IDT is committed to ensuring that each client eats in a manner consistent with their developmental level. Peak Community Services QDDP staff will review client’s # 1, 2,3,4,5 and 6 Comprehensive Functional Analysis document to ascertain the client’s level of cutlery usage, specifically a knife to cut meat. A dining goal with specific knife usage objectives will be implemented for those clients who do not have the skills to use a knife specifically to cut meat. SGL staff, specifically GHS 1 and 2, have be retrained on client’s # 1,2,3,4,5,6, need to use a knife as to enable each client to reach their maximum independence level when it comes to their abilities at meal time. To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of cutlery usage and staff prompting in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis.Systematically the need for staff to monitor the clients therefore ensuring that each	11/10/2013			

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	<p>10:45am, an interview the QIDP and the SDLM was conducted. The QIDP and the SDLM both indicated clients #1, #2, #3, #4, #5, and #6 should have had a plate or napkin for their bread with butter. The QIDP and the SDLM both indicated clients #1, #2, #3, #4, #5, and #6 should have been taught and encouraged to use a knife to cut their pork chops into bite size pieces during the meal by the staff.</p> <p>9-3-8(a)</p>		<p>client eats in a manner consistent with their developmental level in SGL residences will be addressed at SGL monthly staff meetings from 11.10.13 to 4.30.13. Person Responsible: John Armstrong, QDDP Bridget Neal, Residential Coordinator Jan Adair, Residential Manager</p>	