

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G444	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2015
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 902 N MUESSING RD INDIANAPOLIS, IN 46229
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W 0000  Bldg. 00	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: September 15, 16, 17, 18 and 24, 2015.</p> <p>Facility Number: 000958 Provider Number: 15G444 AIMS Number: 100235250</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/1/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the governing body failed to exercise general policy, budget, and operating direction over the facility: __ To ensure the clients' home was maintained and in good repair. __ To ensure all allegations of abuse were</p>	W 0104	<p>The governing body has ensured that identified repair and maintenance needs are addressed for the facility. Those specific issues noted have and will be corrected. Bids are being obtained to replace the flooring that is in need of replacement, then this work will be scheduled and completed. The agency has a new</p>	10/24/2015

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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	<p>thoroughly investigated for clients #2, #4, #5 and #6.            ___ To ensure the staff were provided training in regard to ASL (American Sign Language.)</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 9/15/15 between 4:45 PM and 7 PM. During this observation the following was observed:</p> <ul style="list-style-type: none"> <li>-The clients' home (clients #1, #2, #3, #4, #5, #6 and #7) was a single level home with small rooms.</li> <li>-The kitchen was small and shaped in the shape of a U.</li> <li>-A gas stove was built into a counter that divided the kitchen and the dining room. Approximately 20 inches of the top of the stove was exposed on the back side toward the dining room and revealed the metal sheeting, screws and sharp edges. While the staff and clients prepared the evening meal, the home became progressively hotter and the metal sheeting on the back of the stove was hot to touch.</li> <li>-The front drawer of the gas stove was rusted. The inside seal of the door was pulled away from the door and the inside of the oven was black and charred.</li> <li>-The cover of the heat duct in the kitchen</li> </ul>		<p>maintenancesupervisor who coordinates and ensures completion of needed maintenance tasks,including repairs and flooring replacement. This individual will also completethorough physical plant inspections of the facility no less than quarterly. Duringthese inspections there will be a check of prior completed work and identificationof any additional work that may be needed. The agency administrator responsiblefor the facility is also present in the home no less than twice a month. Duringthese visits the administrator will also review the physical plant of the homeand address any identified concerns with the maintenance supervisor to ensureany needed work is completed. The agency has an administrator who completes a review ofeach completed investigation regarding allegations of abuse for the agency toensure they are completed thoroughly. When reviewing each investigation this administratoris ensuring that all involved parties and those that are witness or potentiallya witness to the incident are interviewed regarding the incident beinginvestigated. The requirement to ensure investigations that are completed aredone so thoroughly has been reviewed with the professional staff that areassigned investigations. If an investigation is submitted that is not thoroughthe administrator indicates</p>	

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	<p>was rusted and in need of replacing.</p> <p>-The linoleum in the kitchen and dining room was worn. There was a hole in the flooring approximately 3 inches in diameter beside the kitchen and living room entryway.</p> <p>-In front of the sink was a two feet by two feet piece of linoleum/tile that did not match the rest of the flooring.</p> <p>-The floor beside the refrigerator and the cabinet was dark with specks of dirt, dust and pieces of unidentifiable objects.</p> <p>-In the room off of the dining room in the corner of the room with the entertainment center there was a collection of wires; electrical, telephone and speaker. The cover to the telephone wall jack was removed and there were exposed wires.</p> <p>-The molding on the corner of the wall near the entertainment center was pulled away from the wall and exposed several sharp nails.</p> <p>-The sink in the bathroom in the hallway was yellowed and stained. The plunger of the faucet was broken, didn't function and was black and rusted. A layer of black substance was behind the faucet and the faucet was scaled with a lime and mineral residue. The drains in the sink and the tub were black, rusted and scaled with water and mineral residue. The faucet handles in the tub were originally clear and now were discolored and covered with a dark substance, lime and mineral residue. The</p>		<p>an initial review that it is not thorough and it is returned to the investigating officer with the directive to gather needed information and/or complete additional interviews to complete the investigation. The administrator will ensure the completed product is thorough. These procedures will ensure that future investigations are completed thoroughly.</p> <p>The management staff for the facility are also developing and will implement a training program for staff that work in the home to provide training in American Sign Language. This will be included in the initial training for new staff that work in the home on consumer specific needs in the home. There will also be on-going training and activities provided to the staff that work in the home and the residents of the home so that all continue to learn and practice American Sign Language. The administrator will ensure that training is provided to staff that work in the facility regarding all needs of the clients in the home. When the administrator is present in the home, she will observe to ensure staff are implementing training provided regarding the consumers' needs, including the use of American Sign Language.</p> <p>Responsible Party: Area Director</p>	

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	<p>metal hand rail in the tub was broken on one end of the rail and exposing the screws.</p> <p>-The laminate wood flooring in the bathroom in the hallway was buckled and soft between the toilet and the tub.</p> <p>-The drawer to the bathroom cabinet under the sink held five old, used crumpled tooth paste tubes. The drawer was smeared with toothpaste and gummy black, gray and white substance. The liner to the drawer was crumpled and covered with the same gummy substance. The cabinet under the sink was black and wet looking.</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/15/15 at 5:30 PM, the PQC:</p> <p>__ Indicated the home was to be maintained and in good repair at all times.</p> <p>__ Indicated the back of the stove should be covered and never exposed to the clients.</p> <p>__ Indicated the home could use a new stove/oven.</p> <p>__ Indicated the kitchen floor and the cabinets needed replaced and/or repaired.</p> <p>__ Stated, "I'm not sure but I think there might have been some water damage which would explain the dark flooring in front of the sink."</p> <p>__ Indicated the wires in the corner of the</p>			

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W 0149 Bldg. 00	<p>room by the entertainment center should be organized, straightened up and/or removed.</p> <p>__ Indicated the exposed nails under the molding on the corner of the wall were a health hazard and were to be repaired.</p> <p>__ Indicated the bathroom in the hallway would be repaired.</p> <p>2. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure all allegations of abuse were thoroughly investigated for clients #2, #4, #5 and #6. Please see W149.</p> <p>3. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility provided the staff with training in regard to ASL (American Sign Language) to be able to communicate with client #2. Please see W189.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>			

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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 4 sample clients (#2 and #4) and 2 additional clients (#5 and #6), the facility failed to implement its written policy and procedures to ensure all allegations of abuse were thoroughly investigated for clients #2, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 9/15/15 at 1 PM. The revised 10/13 facility policy entitled "Preventing Abuse and Neglect" indicated:</p> <p>___ "DSA, Inc. Prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves. DSA, Inc. asserts that sensitizing employees to the various forms that abuse and neglect may take is a primary method of prevention...." The policy indicated the definition of abuse to be, but not limited to, intentional or willful infliction of physical injury, unnecessary use of physical or chemical restraints or isolation and violation of the individual's rights. The policy indicated "Rights to be those rights guaranteed by the Constitution of the United States and the Constitution of Indiana and as set forth by IC 12-27."</p> <p>___ "Immediately upon learning of an</p>	W 0149	<p>The agency has an administrator who completes a review of each completed investigation regarding allegations of abuse for the agency to ensure they are completed thoroughly. When reviewing each investigation this administrator is ensuring that all involved parties and those that are witness or potentially a witness to the incident are interviewed regarding the incident being investigated. The requirement to ensure investigations that are completed are done so thoroughly has been reviewed with the professional staff that are assigned investigations. If an investigation is submitted that is not thorough the administrator indicates an initial review that it is not thorough and it is returned to the investigating officer with the directive to gather needed information and/or complete additional interviews to complete the investigation. The administrator will ensure the completed product is thorough. These procedures will ensure that future investigations are completed thoroughly.</p> <p>Responsible Party: Program Quality Coordinator</p>	10/24/2015

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W 0154 Bldg. 00	<p>allegation of abuse/neglect, exploitation... including injury during containment or suicidal gesture, staff are required to immediately report the incident to the Residential Director (RD) on-call." The RD on call will inform the Area Director (AD) and will "Report the incident to BQIS (Bureau of Quality Improvement Services) and any other applicable state or federal policy as required by Policy No. 8.01.01."                      ___ "Immediately upon receiving notification of the incident from the RD the AD will initiate an investigation of the allegation(s)...."</p> <p>Please see W154: For 4 of 5 allegations of abuse, the facility failed to ensure all allegations of abuse were thoroughly investigated for clients #2, #4, #5 and #6.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 5 allegations of abuse, the facility failed to ensure all allegations of abuse were thoroughly investigated for clients</p>	W 0154	The agency has an administrator who completes a review of each completed investigation regarding allegations of abuse for the agency to ensure they are completed	10/24/2015

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	<p>#2, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 9/15/15 at 1 PM.</p> <p>The 9/19/14 BDDS report indicated on 9/19/14 client #5 was sitting next to a male coworker at the workshop when the staff noticed the male coworker "slip his hand under the right side of her (client #5's) butox (sic) outside her clothing. Staff member asked the coworker to remove his hand which he did upon request." The report indicated client #5 was to be encouraged to report "these things when they happen. Male coworker will be counseled on the inappropriateness of such behavior. Further action to be determined at a later date."                      ___The facility records indicated no investigation was conducted.</p> <p>The 3/2/15 BDDS report indicated on 3/1/15 "[Clients #4 and #5] were having lunch at the dinner table and started to argue back and forth. [Client #4] took her plate to the sink and [client #5] followed behind her. [Client #5] threw her milk at [client #4] and [client #4] threw her water at [client #5]. [Client #5] tried to hit at</p>		<p>thoroughly. When reviewing each investigation this administrator ensuring that all involved parties and those that are witness or potentially a witness to the incident are interviewed regarding the incident being investigated. The requirement to ensure investigations that are completed are done so thoroughly has been reviewed with the professional staff that are assigned investigations. If an investigation is submitted that is not thorough the administrator indicates an initial review that it is not thorough and it is returned to the investigating officer with the directive to gather needed information and/or complete additional interviews to complete the investigation. The administrator will ensure the completed product is thorough. These procedures will ensure that future investigations are completed thoroughly.                      Responsible Party: Program Quality Coordinator</p>	

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	<p>[client #4] and [client #4] pulled [client #5's] hair and bit her (client #5) on her right wrist breaking the skin."            ___The 3/3/15 investigative summary indicated statements from one staff and clients #4 and #5.            ___The investigative summary did not indicate who was at the home at the time of the incident.            ___The investigative summary included no additional statements and/or interviews.</p> <p>The 4/11/15 BDDS report indicated on 4/10/15 "[Client #5 and client #6] became upset with one another after [client #6] requested [client #5] leave her (client #6's) bedroom. [Client #5] pulled [client #6's] hair and left some scratches on [client #6's] forehead that did not break the skin."            ___The investigative record indicated statements with one staff and clients #5 and #6.            ___The investigative summary did not indicate who (staff and clients) were in the home at the time of the incident.            ___The investigative summary included no additional statements and/or interviews.</p> <p>The 6/3/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 5/28/15 "A report was made</p>			

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	<p>to [name of work program] staff that they understood [client #2] to communicate that a DSA staff member had hit her (client #2). [Client #2] is deaf and communicates with ASL (American Sign Language) and simple written notes. DSA management immediately went to [client #2] to check on her and obtain the information that they gathered. At that time, DSA management phoned a trusted friend of [client #2] who was fluent in sign language and went to a neutral location in order to communicate the details of the allegation. [Client #2] stated that she was upset with accused staff member because she (the staff) had unpacked her boxes in her bedroom and believed that she had stole (sic) the boxes. [Client #2] stated that staff did not hit her but she actually hit her arm on the door of her bedroom when exiting the bedroom. The staff was immediately suspended until it was determined that there was no abuse. The allegation was unsubstantiated. [Client #2] had packed all of her belongings in boxes as she has been fixated on moving. She (client #2) has a guardian and there are no plans for her to move. This ideation is being addressed by her IST (Individual Support Team)."</p> <p>__The facility records indicated an investigation was conducted in regard to client #2's allegations of abuse that a staff</p>			

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	<p>had hit her. The report indicated a written statement dated 6/8/15 from the Residential Manager (RM) and an interview with client #2 on 6/10/15. The facility records indicated no additional interviews in regard to the investigation. The "Findings and Recommendations: Recommend remind [name of workshop] staff not to give [client #2] boxes to pack. Also told [client #2] not to get boxes or pack until she has a key to her new place. [Client #2] stated staff stole boxes. Staff unpacked her boxes and put belongings away and removed boxes at guardian's previous requests."</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/15/15 at 12:30 PM, the PQC:</p> <p>__ Indicated all allegations of abuse were to be thoroughly investigated.</p> <p>__ Indicated if the incident happened at the group home the investigative paperwork should include all persons in the home at the time of the incident and all persons should be interviewed.</p> <p>__ Indicated all clients and all staff present at the time of the incident should be interviewed.</p> <p>9-3-2(a)</p>			

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W 0189  Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 1 of 4 sample clients (#2), the facility failed to ensure the staff were provided training in regard to ASL (American Sign Language) to communicate with client #2.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/15/15 between 4:45 PM and 7 PM and on 9/16/15 between 6:15 AM and 7:30 AM. During both observation periods:</p> <p>__ Client #2 did not speak.</p> <p>__ Client #2 used gestures and pen and paper to communicate with the staff and those around her.</p> <p>Client #2's record was reviewed on 9/16/15 at 12:30 PM. Client #2's record indicated diagnoses of, but not limited to, Mild Intellectual Disability and Congenital (since birth) deafness.</p> <p>During interview with the Residential Manager (RM) on 9/18/15 at 11 AM, the RM:</p>	W 0189	<p>The management staff for the facility are developing and will implement a training program for staff that work in the home to providetraining in American Sign Language. This will be included in the initialtraining for new staff that work in the home on consumer specific needs in thehome. There will also be on-going training and activities provided to the staffthat work in the home and the residents of the home so that all continue tolearn and practice American Sign Language. The administrator will ensure thattraining is provided to staff that work in the facility regarding all needs of theclients in the home. The facility does have a training program in place foremployees to ensure that training is provided that enables employees to performtheir duties. This training is being added into this program. When theadministrator is present in the home, she will observe to ensure staff areimplementing training provided regarding the consumers' needs, including the useof American Sign Language.</p> <p>Responsible Party: Area Director</p>	10/24/2015
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	<p>__ Indicated client #2 was deaf and was fluent in ASL.</p> <p>__ Indicated client #2 had attended the [name of school for the deaf].</p> <p>__ Indicated client #2 had an electronic tablet but did not have the password to be able to use it.</p> <p>__ Indicated a book was placed in the home to assist the staff in to learning to sign the alphabet and to sign some of the simple gestures.</p> <p>__ Stated, "They (the staff) know how to sign some of the letters but she (client #2) goes way too fast for us to keep up with her."</p> <p>__ Indicated client #2 had a close friend who was also deaf and fluent in ASL and the friend would go with the staff and client #2 to the physician's office to interpret for client #2.</p> <p>__ Indicated if client #2's friend was not able to attend client #2's scheduled appointments, client #2 would use paper and pen to communicate her wants and needs.</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/18/15 at 11 AM, the PQC indicated no specific training had been provided to the staff in regard to ASL and being able to communicate with client #2.</p> <p>9-3-3(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 902 N MUESSING RD INDIANAPOLIS, IN 46229
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W 0322  Bldg. 00	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3 was provided a pre-cancerous screening test, a Pap test.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 9/16/15 at 2 PM. The client's record indicated:</p> <p>__ Client #3 was admitted to the facility on 4/24/08.</p> <p>__ Client #3 was over 21 years of age.</p> <p>__ No evidence client #3 was provided a Pap test, an early screening for cervical cancer, since her admission to the facility in 2008.</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/18/15 at 11 AM, the PQC:</p> <p>__ Indicated no record of client #3 having a Pap test since her admission to the facility in 2008.</p> <p>__ Stated, "I think she (client #3) has refused to have a Pap test."</p> <p>__ Indicated client #3 had a legal representative.</p>	W 0322	<p>The Individual Support Team did address that client #3 hasnot had a Pap test. The team acknowledged that she has refused to allow this testto be completed. The team determined that this shall be addressed with herphysician and will request sedation be considered to complete the test. The ISTwill ensure that this issue is addressed as recommended with the physician. Thefacility nurse will also ensure that the physician does address any refusals onthe part of the client to complete any ordered tests. The facility has a newnurse. This nurse receives all reports from physician visits. The nurse willreview with the Individual Support Team including the physician any reportedrefusals on the part of any client to have ordered testing completed such as aPap test. The nurse will review the records for each client in the home toensure all needed testing has been completed. Agency administrators alsoroutinely review medical appointment reports and records to ensure all orderedtests are done.</p> <p>Responsible Party: Facility Nurse</p>	10/24/2015

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W 0331 Bldg. 00	<p>Indicated the facility had not addressed client #3's refusal to have a Pap test with client #3's legal representative.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 sampled clients (#1 and #3), the facility failed to ensure nursing services addressed client #3's dietary recommendations from the dietician with client #3's physician and to ensure the staff followed client #1's diabetic protocol.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/16/15 at 11 AM. Client #1's record indicated a diagnosis of, but not limited to, Diabetes.</p> <p>Client #1's 7/16/15 quarterly physician's orders indicated client #1 was to receive Metformin 500 mg (milligrams) and Januvia 100 mg once a day for blood sugar control. The orders indicated the staff were to check client #1's blood sugar twice a day, 7 AM and 5 PM.</p>	W 0331	<p>The facility has a new nurse. This nurse will implement system to ensure there is documentation in the client record regarding contact received from staff regarding clients regarding client medical needs including those directed by risk plans and/or health protocols. This will ensure there is a means to verify that a nurse is contacted as specified by a client's risk plan such as client #1's diabetic protocol that directs the staff to notify the nurse when her blood sugar is outside the identified range. The administrator will routinely review records to ensure required notifications are completed and recorded as required. The reporting requirements will also be reviewed with direct care staff so as to ensure they document when they notify the nurse as directed on behalf of a client.</p> <p>The facility nurse has addressed the dietician's recommendations with client #3's physician regarding her recommendation to provide the</p>	10/24/2015

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	<p>Client #1's record indicated a 5/4/15 diabetic protocol. The protocol indicated:            ___ If client #1's blood sugar was below 60 the staff were to give client #1 something with sugar followed by a protein snack and call the nurse or nurse on call.            ___ If client #1's blood sugar was over 200 the staff were to have client #1 drink some water, encourage her to exercise and to call the nurse or nurse on call.</p> <p>Client #1's blood sugar results for 2015 indicated:            04/27/15 at 4:44 PM - 303.            05/04/15 at 2:59 PM - 226.            05/04/15 at 5:22 PM - 226.            05/07/15 at 10:18 AM - 210.            06/06/15 at 7:29 PM - 339.            07/25/15 at 6:27 PM - 210.</p> <p>Client #1's daily staff notes indicated no documentation of notifying nursing of client #1's blood sugar over 200 on 4/27/15, 5/4/15, 5/7/15, 6/6/15 and 7/25/15.</p> <p>Client #1's nursing notes indicated no documentation of notification of client #1's blood sugar over 200 on 4/27/15, 5/4/15, 5/7/15, 6/6/15 and 7/25/15.</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/18/15 at</p>		<p>client with Carnation Instant Breakfast three times daily. This recommendation is now ordered by the physician. The provision of this supplement continues to be recorded as provided on the Medication Administration Record. This is being monitored by the nurse. The nurse has reviewed all the current dietician's recommendations for all clients in the facility to ensure all recommendations have been addressed with the clients' physicians and that their orders are consistent with recommendations they agree with. When the physician does not agree with a recommendation from the dietician, the facility nurse will coordinate communication between the physician and dietician to ensure all come to consensus on how to best meet the dietary needs of the client. The administrator will routinely review medical records to ensure they are complete including a review of dietary recommendations and physician orders regarding diet to ensure orders and recommendations are consistent.            Responsible Party: Facility Nurse</p>	

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	<p>11 AM, the PQC:            ___ Indicated the staff were to call the nurse when client #1's blood sugar was over 200.            ___ Indicated the staff should document in client #1's daily notes what treatment was provided to client #1 when the client's blood sugars were under 60 or over 200 and verification that nursing was notified.            ___ Indicated she could not provide documentation the staff notified nursing of client #1's elevated blood sugars on 4/27/15, 5/4/15, 5/7/15, 6/6/15 and 7/25/15.            ___ Indicated the current RN began working in the group home on 8/3/15.</p> <p>2. Client #3's record was reviewed on 9/16/15 at 2 PM. Client #3's 7/16/15 quarterly physician's orders indicated client #3 was to receive a regular diet with seconds and if client #3 consumed less than 50% of her meal she was to have 8 ounces of CIB (Carnation Instant Breakfast - a dietary supplement drink.)</p> <p>Client #3's Nutrition Assessments from the dietician indicated:            ___ 2/27/15 client #3 weighed 92.6 pounds and was "underweight for ht (height)."            The assessment indicated recommendations for client #3 to have whole milk with meals and CIB made with 8 ounces of whole milk with her</p>						

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	<p>evening snack.</p> <p>__5/29/15 client #3 weighed 90.6 pounds. The assessment indicated "Recommend to provide CIB BID (twice a day) Brk (Breakfast) and HS (bedtime) snack for wt (weight) maintenance."</p> <p>__8/14/15 client #3 weighed 91 pounds. The assessment indicated recommendations to increase client #3's "CIB to TID (three times a day) from BID at Brk, dinner and Hs for weight."</p> <p>During interview with the Program Quality Coordinator (PQC) on 9/18/15 at 11 AM, the PQC:</p> <p>__ Indicated the previous RN failed to address client #3's dietary recommendations made by the dietician.</p> <p>__ Indicated the current RN began working in the group home on 8/3/15.</p> <p>__ Indicated on 9/1/15 the RN added the CIB to be given TID to client #3's MAR (Medication Administration Record) but had not addressed the recommendations with client #3's physician.</p> <p>__ Indicated the RN will address the recommendations of the CIB made by the dietician with the physician.</p> <p>9-3-6(a)</p>			