STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G403	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAMAR SERVICES INC--BRADFORD	8835 E CR 200 S AVON, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a recertification and state licensure survey. Dates of Survey: April 28, 29, 30 and May 1, 2015 Provider Number: 15G403 Aims Number: 100249320 Facility Number: 000917 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) residing in the facility, the facility's governing body failed to exercise general policy and operating direction over the facility in regards to providing a safe and clean environment. Findings include: An observation of clients #1, #2, #3, #4,	W 0104	1.hole in wall has been patched (5.6.2015); Screen door will be replaced upon completion of deck work; discolored wood trim has been replaced (5.6) and garage door has been painted (5.6) - carpet has been replaced with vinyl (5.17). 2.All Group Homes work orders will be reviewed andoutstanding jobs will be completed. 3.Works orders submitted by staff are reviewed by Maintenance Manager and placed into categories based on	05/31/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	#5, #6, #7 and #8 (at the group home) was done on 4/28/15 from 4:04p.m. to 6:23p.m. The observation included the following environmental conditions: The den had a hole in the wall and the wood trim was discolored; the living room had ripped carpet by the door and the door was discolored and had magic marker writing on it; The screen door to the deck had a ripped screen; the back deck was splintering and a side railing was loose. Interview of staff #1 on 5/1/15 at 9:48a.m. indicated the home was in need of some remodeling and painting. Staff #1 indicated they were unsure if a work order had been placed for painting and remodeling needs. 9-3-1(a)		client safety andenvironmental damage. **Urgent** orders must be addressed withinthe closing of the day or 24 hours. Theseorders are also scan and communicated to the Maintenance Manager. Response of the plan should immediatelyfollow. **Prompt** orders are to be doneas soon as possible once any needed material and/or equipment is secured;others work orders are to be complete as soon as possible but must be completedwithin the month. Maintenance staffmembers complete a house maintenance/environmental checklist monthly (roughlyduring last week of month). 4.Daily environmental house checks are completedby staff and reviewed by Residential Manager before submitting to Dir. OfMaintenance. Work orders that have beensubmitted for a concern area are indicated on the house check form butadditional work orders may still be submitted. Additional Maintenance staff members will be hired and/or work will be contracted out to ensure timely completion of work orders.	
W 0137 Bldg. 00	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. Based on observation, interview and	W 0137	1.There continues to be a	05/31/2015

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	record review for 4 of 4 sampled clients (#1, #2, #3, #4) and 4 additional clients (#5, #6, #7, #8), the facility failed to ensure the clients had the right to keep/maintain their own personal hygiene items. Findings include: An observation was done on 4/28/15 from 4:04p.m. to 6:23p.m. at the group home. At 4:54p.m., staff #5 got client #7's toothpaste and deodorant out of a locked cabinet in the bathroom. At 5:06p.m., staff #5 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8's hygiene items were kept locked in the bathroom closet due to client behavior. Staff #5 indicated only staff had a key to the locked hygiene items. Record review for client #1 was done on 4/30/15 at 1:12p.m. Client #1's 4/16/15 admit plan did not indicate client #1's personal hygiene container would be kept locked in the office. Client #1 had no training program to address the locked personal hygiene items. Record review for client #2 was done on 4/30/15 at 1:58p.m. Client #2's 9/22/14 individual support plan (ISP) did not indicate client #2's personal hygiene container would be kept locked in the		resident that enters other rooms without permission and will remove or use items without permission. This behavior continuous although at a reduce rate. All Clients have received their individual hygiene box. Each client will determine if they would like to storage their box in their room or locked in a determined placed Those that want hygiene box in rooms will have a secure place to store Those that are wanting hygiene box locked in designated area will have this restriction addedeum to their plan 2. All Residential Managers will review homes to ensure individuals have personal hygiene boxes and are not locked unless stated in ones ISP/BSP. 3. All Residential Managers, Lead staff and staff members have been trained on resident rights and how to ensure they are in place. Emphasis placed on: a)Right to hold personal processions b)Rights to be provided with formal or informally training on skills **not custodial care** 4. All staff within all Group Homes be trained atupcoming program meeting regarding residential rights and how to ensure theyare in place (see above) Residential Manager, Lead staff and/or Dir. ofGroup Home will monitor staff performance of upholding client rights weeklywhile at the	

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	office. Client #2 had no training program to address the locked personal hygiene items. Record review for client #3 was done on 4/30/15 at 12:34p.m. Client #3's 8/20/14 ISP did not indicate client #3's personal hygiene container would be kept locked in the office. Client #3 had no training program to address the locked personal hygiene items. Record review for client #4 was done on 4/30/15 at 1:28p.m. Client #4's 1/2/15 ISP did not indicate client #4's personal hygiene container would be kept locked in the office. Client #4 had no training program to address the locked personal hygiene items. Staff #1 was interviewed on 5/1/15 at 9:48a.m. Staff #1 indicated the clients did not have access to their personal hygiene items due to client #5's behavior. Staff #1 indicated the clients did not have a program in place to address how they could access their locked personal hygiene items. 9-3-2(a)		homes. Any concerns during ones observations will beimmediately addressed with staff by retraining and/or modeling of correctbehaviors. Ongoing concerns during observations may be reviewed and communicatedby utilizing several different documentations if warrant: **a) Employee Performance Report** - completed for any repeat offenders of notshowing ability to uphold client rights. Plan may state how to correct actions; training needed and a criteria ofperformance level expected. Correctiveaction may include a written warning and/or termination for those failing tocomply. **Positive Employee Performance** report may be completed too toreinforce excellent or positive work performance. **b) Staff Memo's** – may becompleted when overall staffs are demonstrating a need to improve a behavior orto reinforce and encourage positive work performance. **1.Yearly evaluations -** with on staff's yearly evaluation. Knowing and ensuringclient rights are upheld is one of the many work behavior scored on eachevaluations. Those receiving a poorrating may be required to receive retraining by a deadline date. Thosereceiving good or excellent ratings (in all areas) will be compensated with	

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			agreater percentage of increase. **2.Staff Annual requiretraining –** annually (during January) all staff are required toreceive new and/or dated training on many areas such as, new policies, newprocedures, client rights, nutritional training and others.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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, record review and interview, the facility failed for 2 of 4 sampled clients (#3, #4) to ensure their identified dining training programs were implemented when opportunities were present. Findings include: An observation was done at the group home on 4/28/15 from 4:04p.m. to 6:23p.m. Staff #4 was observed to begin supper preparation at 4:51p.m. Staff #4 did not have any of the clients who were home at this time (#1, #2, #3, #4, #5, #6, #7, #8) in the kitchen to assist with the meal preparation. Staff #4 was observed to: heat up baked beans in the	W 0249	1.All staff have received retraining on the following: 1.Difference between formal training, informal training and custodial care. 2.Active treatment versus custodial care 3.Examples of situations or times informal training can be done 4.Review of clients ISP goals 2.Residential manager, Dir of Group Home will provide training to all staff regarding the above at upcoming program meeting. 3.All new ISP/BSP – staff will receive training and complete a competency test regarding the following but not limited to 1.Objectives and where training should occur	05/31/2015

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	microwave, heat up macaroni and cheese in the microwave, get out pudding cups and separated them, heated up green beans, put individual serving on the clients' plates and washed the dishes used during the meal preparation. The clients were given prepared plates of food and ate supper at 5:19p.m. Staff #4 was interviewed on 4/28/15 at 5:38p.m. and indicated they sometimes serve family style but didn't tonight because they had leftovers. Record review for client #3 was done on 4/30/15 at 12:34p.m. Client #3's 8/20/14 individual support plan (ISP) included a dining training program. The dining program indicated client #3 was to become more independent cooking by completing a simple recipe. Record review for client #4 was done on 4/30/15 at 1:28p.m. Client #4's 1/2/15 ISP included a dining training program. The dining program indicated client #4 was to "complete the passing of food" during a meal. Staff #1 was interviewed on 5/1/15 at 9:48a.m. Staff #1 indicated clients #3 and #4 had current dining training programs. Staff #1 indicated the dining training programs should have been implemented when opportunities were present during		2.Provide example of how to do informal training for objectives 3.Targeted behaviors definition and #of prompts permitted 4.Proactive and reactive steps 4. Residential Manager, Lead staff and/orDir. of Group Home will observe staff weekly to ensure continual understandingand demonstration of providing formal and informal training. Formal trainingdocumentation is done as scheduled within one's ISP. Weekly program incentive sheets (allowancesheets) will be revised. It will nowinclude a section to document informal training completed daily and a commentarea. Staff not performing at anacceptable level will be immediately addressed and provided retraining and/ormodeling of correct behaviors. Ongoing monitoring and documentation willbe done in the following manner: 1. **Employee Performance Report** - completed for any repeat offenders of not showing ability to upholdclient rights. Plan may state how tocorrect actions; training needed and a criteria of performance level expected. Corrective action may include a writtenwarning and/or termination for those failing to comply. **PositiveEmployee Performance** report may be completed too to	

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	the supper meal on 4/28/15. 9-3-4(a)		reinforce excellent orpositive work performance. **2.Staff Memo's** – may be completed whenoverall staffs are demonstrating a need to improve a behavior or to reinforceand encourage positive work performance. **3.Yearly evaluations -** with onstaff's yearly evaluation. Knowing and ensuring client rights are upheldis one of the many work behavior scored on each evaluations. Those receiving a poor rating may be requiredto receive retraining by a deadline date. Those receiving good or excellentratings (in all areas) will be compensated with a greater percentage ofincrease. **4.Staff Annual require training –** annually (during January)all staff are required to receive new and/or dated training on many areas suchas, new policies, new procedures, client rights, nutritional training andothers.	
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 2 of 4 sampled clients	W 0262	1. All ISP/BSP and psychotropic plans have been submitted to for Human Right committee review and approve.	05/31/2015

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	(#2, #3) with behavior support plans (BSP) to ensure the clients' BSPs (including behavior medications) were reviewed/monitored within the past year. Findings include: The record of client #2 was reviewed on 4/30/15 at 1:58p.m. Client #2's 9/20/14 BSP indicated client #2's diagnoses included, but was not limited to, Autism, Depression and organic brain syndrome, for which client #2 received the medications Lexapro, Risperdal, Strattera and Trazodone. There was no documentation the BSP had been reviewed by the facility's HRC. The record of client #3 was reviewed on 4/30/15 at 12:34p.m. Client #3's 8/20/14 BSP indicated client #3's diagnosis included, but was not limited to, Attention Deficit Disorder, for which client #3 received the medications Prozac and Trazodone. There was no documentation the BSP had been reviewed by the facility's HRC. Interview of staff #1 on 5/1/15 at 9:48a.m. indicated there was no documentation the facility's HRC had reviewed client #2 and #3's restrictive BSP's during the past year.		2.Residential Managers and Lead staff will review all ISP/BSP and psychotropic plan to ensure documentation of HRC is present. Plans found to be out of compliance will be presented to HRC for approval 3.3. All consent and HRC approvals will now be attached to the original documentation and file as required. Items needed for HRC approval are submitted to HRC according to their due dates and schedule of bimonthly meetings. Procedure for emergency HRC approval are followed if approval is needed at any other times. Dir. Of Group Home and Residential Managers have been provided with the dates of all 2015 HRC meeting. Furthermore, a copy of consents and HRC approval will be kept in the Approval Note Book located in the QIDP office to ensure a copy can be secured if needed. 1.Quarterly chart checks and home checks are completed by Lead staff. Missing items such as no HRC documentation will be highlighted and corrected within the time line. Quarterly checks are submitted Quality Assurance team to verify corrections are in place. Failure to be in compliance with PQI standards (Quality Assurance) results in plan of correction implemented and monitored by Quality Assurance Director and/or Vice President	

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	9-3-4(a)			
W 0264 Bldg. 00	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) residing in the facility to review restrictive interventions: the facility practice of the use of door alarms on the facility entrance/exit doors and the locking of the clients' personal hygiene items. Findings include: During the observation on 4/28/15 from 4:04p.m to 6:23p.m., at the group home, the doors to exit the facility had working alarms. Also, clients #1, #2, #3, #4, #5, #6, #7 and #8's personal hygiene items were kept locked (only staff had a key). Record review of the facility's HRC	W 0264	1. Restriction of common items and use of alarms in common have been added to all plans. Reason for thejustification and how it's addressed are will be included in the plan, approvedby guardians and Human Rights Committee has been secured. Residents that maybe effective by the restriction(s) will have these listed in their BSP as "HouseRestriction". Resident's hygiene boxes have been returned toindividuals. Those that would like tokeep their supplies in their room will and a safe place will be provided. 2. Residential Managers andLead staff will review all ISP to ensure any "House Restriction" are included and legal guardian, HRC approval will be secured. 3. All consent and HRCapprovals will now be attached to the original documentation and file asrequired. Furthermore, a copy	05/31/2015

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	reviews from 4/1/14 to 5/1/15 was done on 5/1/15 at 9:40a.m. There was no documentation the HRC had reviewed the facility's restrictive practices of locked personal items and activated entrance/exit door alarms for clients #1, #2, #3, #4, #5, #6, #7 and #8. Interview of staff #1 on 5/1/15 at 9:48a.m. indicated they could not find documentation the facility restrictions of locked client personal hygiene items and the use of entry/exit door alarms had been presented to and reviewed by the facility's HRC during the past year. 9-3-4(a)		of consents and HRC approval will be kept in the ApprovalNote Book located in the QIDP office. 3. All consent and HRC approvals will now be attached to the original documentation and file as required. Items needed for HRC approval are submitted to HRC according to their due dates and schedule of bimonthly meetings. Procedure for emergency HRC approval are followed if approval is needed at any other times. Dir. Of Group Home and Residential Managers have been provided with the dates of all 2015 HRC meeting. Furthermore, a copy of consents and HRC approval will be kept in the Approval Note Book located in the QIDP office to ensure a copy can be secured if needed. 1.Quarterly chart checks and home checks are completed by Lead staff. Missing items such as no HRC documentation will be highlighted and corrected within the time line. Quarterly checks are submitted Quality Assurance team to verify corrections are in place. Failure to be in compliance with PQI standards (Quality Assurance) results in plan of correction implemented and monitored by Quality Assurance Director and/or Vice President	
W 0289 Bldg. 00	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must			

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	be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview, the facility failed for 1 of 4 sample clients (#2) with a restrictive behavior management plan, to ensure that all interventions (door alarms) to manage client #2's behaviors were included in the client's individual support plan (ISP). Findings include: During the observation on 4/28/15 from 4:04p.m to 6:23p.m., at the group home, the doors to exit the facility had working alarms. Review of the record of client #2 was done on 4/30/15 at 1:58p.m. Client #2's 9/22/14 ISP indicated client #2 had the identified behavior of elopement. Client #2's ISP did not contain the use of the door alarms for her identified elopement behavior. Interview of staff #1 on 5/1/15 at 9:48a.m., indicated the facility's door alarms were for client #2's identified behavior of elopement. Staff #1 indicated client #2's program intervention (door alarms) had not been incorporated into client #2's ISP.	W 0289	1.Client #2 has a history and continues to exhibitincidents of elopement. The use of dooralarms on exterior door to alert staff when opened has been added to cilent's#2 BSP within the proactive steps 2.The use of door alarm on exterior doors has beenincluded to all resident's ISP. The usinga restrictive method that affects all living within the home has been listedas, "House Restrictive Method". LegalGuardian and HRC approval will be attained as required. 3.Residential Managers will review all ISP/BSP toensure any House Restrictive Method is included in all plans for all residentsbeing affected. The justification forthe restrictive method will be stated and the duration for the plan to be inplace will be stated. Legal Guardian andHRC approval will be attained asrequired 4.Quarterly chart checks are completed by Leadstaff. The verification of houserestriction included in all's plan has been added to the check list. Items out of compliance are corrected by theResidential Manager with the established time line. Corrections are verified by a member	05/31/2015

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	9-3-5(a)		ofQuality Assurance Team and/or Dir. of Group Home.	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, #4) and 4 non-sampled clients (#5, #6, #7, #8) to ensure the clients received all the menued items at mealtime. Findings include: An observation was done at the group home on 4/28/15 from 4:04p.m. to 6:23p.m. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were served supper at 5:13p.m. The clients were only offered water to drink with their meal. The facility menu, reviewed on 4/28/15 at 5:25p.m., indicated supper on 4/28/15 was to include 8 ounces of milk. Staff #4 was interviewed on 4/28/15 at 5:34p.m. Staff #4 indicated milk was on the menu but wasn't on the table. Staff #4 indicated if they (clients) wanted milk they would ask for it. Professional staff #1 was interviewed on 5/1/15 at 9:48a.m. Staff #1 indicated the	W 0460	1.All staff has received training regarding importance of following the menu during the May 12th program meeting. Staff(s) stated that clients prefer water therefore; they stopped putting it on the table. Clarification/retraining were given regarding client's rights to choose can only be in place when options are given. In addition – it is expected that all items on the menu be present at the table at each meal. 1.All Group Home Staff will receive training from the Residential Manager or Lead staff regarding the importance of following the menu and having items available. Group Home #1 received training on May 18th, Group Home #2 on May 19th and Group Home#4 – TBD. In addition, training was provided on ·How to make substitution on menu ·How to complete the meal counts ·Eating family style 3. Residential Manager, Lead	05/31/2015

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	clients should have been offered the menued/diet items or an equal substitute. 9-3-8(a)		staff and/or Dir. of Group Home willobserve staff weekly to ensure continual understanding and demonstration ofproviding all items on a menu is being implemented. Staff notperforming at an acceptable level will be immediately addressed and providedretraining and/or modeling of correct behaviors. 4. Ongoing monitoring will occur and documentation of concerns may be done in the followingmanner: 1. **Employee Performance Report** - completed for any repeat offenders of not showing ability to prepare meal time as established from the menu. Plan may state how to correct actions; training needed and a criteria of performance level expected. Corrective action may include a written warning and/or termination for those failing to comply. **Positive Employee Performance** report may be completed too to reinforce excellent or positive work performance. **2.Staff Memo's** – may be completed when overall staffs are demonstrating a need to improve a behavior or to reinforce and encourage positive work performance in one or several areas **3.Yearly evaluations -** with on staff's yearly evaluation. Knowing and ensuring	

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			programs are implemented as prescribed is one of the many work behavior scored on each evaluations. Those receiving a poor rating may be required to receive retraining by a deadline date. Those receiving good or excellent ratings (in all areas) will be compensated with a greater percentage of increase. **4.Staff Annual require training –** annually (during January)all staff are required to receive new and/or dated training on many areas such as, new policies, new procedures, client rights, nutritional training and others.	
W 0481 Bldg. 00	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, #4) and 4 non-sampled clients (#5, #6, #7, #8) to ensure the clients received all the menued items at mealtime and the food substitutes that were served to the clients were documented. Findings include: An observation was done at the group home on 4/28/15 from 4:04p.m. to 6:23p.m. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were served a supper which	W 0481	1.Items presented at the meal were leftovers from the previous night cook out. Staff attempted to use the food items available instead of discarding them however, did not implement substitution of menu items the correct way. Nor, did staff correctly document the food substitution on the menu. Residential Manager, Lead staff and staff members have received training on the function of the menu during May 12th program meeting. Emphasis was placed on: ·Correct substitution of items (pork for pork; green vegetable	05/31/2015

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	consisted of hot dogs, baked beans, macaroni and cheese, green beans and a pudding cup. Interview of staff #4 at 5:38p.m., indicated the meal was leftovers from the other night. Staff #4 indicated these food items were substituted for the menued items. The posted menu for 4/28/15 was observed at 4:18p.m. The posted menu for 4/28/15 was chicken and rice, glazed carrots, peas, milk and frosted graham crackers. The substituted supper items on 4/28/15 were not documented to indicate what the clients were actually served. Professional staff #1 was interviewed on 5/1/15 at 9:47a.m. Staff #1 indicated all menu changes are to documented. 9-3-8(a)		with green vegetable, etc.) ·How to document when substitutions occur ·How to complete the menu count ·Importance of having everything on menu present to be offered ·Eating family style 2. ResidentialManagers will provide the above information at all upcoming program meeting asscheduled with each Group Home.3.. Residential Manager, Lead staff and/or Dir. of Group Home willobserve staff weekly to ensure continual understanding and demonstration ofproviding all items on a menu is being implemented. Staff notperforming at an acceptable level will be immediately addressed and providedretraining and/or modeling of correct behaviors. At the end of each month, allmenus are submitted to Dir. of Dietary for review of correct substitution documentationand other information. Corrections needed or revisions are sent back tothe home to be done. Residential Managers review the corrections to ensurecorrect and provide retraining to staff 1.Ongoingmonitoring will occur and documentation of concerns may be done in the followingmanner: 1. **Employee Performance Report** -	

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			completed for any repeat offenders of not showing ability to prepare meal time as established from the menu. Plan may state how to correct actions; training needed and a criteria of performance level expected. Corrective action may include a written warning and/or termination for those failing to comply. **Positive Employee Performance** report may be completed too to reinforce excellent or positive work performance. **2.Staff Memo's** – may be completed when overall staffs are demonstrating a need to improve a behavior or to reinforce and encourage positive work performance in one or several areas **3.Yearly evaluations -** with on staff's yearly evaluation. Knowing and ensuring programs are implemented as prescribed is one of the many work behavior scored on each evaluations. Those receiving a poor rating may be required to receive retraining by a deadline date. Those receiving good or excellent ratings (in all areas) will be compensated with a greater percentage of increase. **4.Staff Annual require training –** annually (during January)all staff are required to receive new and/or dated training on many areas such as, new policies, new procedures, client rights, nutritional training and	

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			others.	
W 0488 Bldg. 00	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. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3, #4) and 4 additional clients (#5, #6, #7, #8), the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable. Findings include: 1. An observation was done at the group home on 4/28/15 from 4:04p.m. to 6:23p.m. Staff #4 was observed to begin supper preparation at 4:51p.m. Staff #4 did not have any of the clients who were home at this time (#1, #2, #3, #4, #5, #6, #7, #8) in the kitchen to assist with the meal preparation. Staff #4 was observed to: heat up baked beans in the microwave, heat up macaroni and cheese in the microwave, get out pudding cups and separated them, heated up green beans, put individual serving on the clients' plates and washed the dishes used during the meal preparation. The clients were given prepared plates of food and ate supper at 5:19p.m. Staff #4 was interviewed on 4/28/15 at 5:38p.m. and	W 0488	1.All staff has received training on the importance of having a resident participate in the preparation of meals. This can be done by formal or informal training. Custodial care or staff preparing the whole meal is not acceptable. In addition, all ISP objectives were reviewed to ensure understanding of when formal and informal training could be done. Emphasis was placed on discussing those who have a cooking goal to ensure understanding of times they should be implemented. House Meal Preparation schedule was also reviewed. This schedule includes days each resident is assigned to help prepare meals or another meal time duty. Family style eating was reviewed 2. Residential Managers will provide trainingat each Group Home on the importance of having a resident participate in thepreparation of meals. This can be done by formal or informal training. Custodial care or staff preparing the wholemeal is not acceptable. House Meal Preparationschedule was also reviewed. Thisschedule includes	05/31/2015

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	indicated they sometimes serve family style but didn't tonight because they had leftovers. 2. An observation was done on 5/1/15 at the group home from 5:58a.m. to 7:24a.m. At 6:07a.m., there were prepared individual plates of biscuits and gravy on the kitchen counter. Clients #7 and #8 were observed to get prepared plates and take them to the dining room table. Staff #6 was interviewed on 5/1/15 at 6:33a.m. Staff #6 indicated she had made the biscuits and gravy and put them on the individual plates for the clients. At 7:09a.m. staff #6 was observed to put scrambled eggs on clients #1 and #4's plate. Interview of staff #1 on 5/1/15 at 9:48a.m. indicated all the clients were capable of assisting with the preparation of breakfast and serving themselves (family style) with some staff assistance. Staff #1 indicated the clients should have been more involved with supper and breakfast preparation. 9-3-8(a)		days each resident is assigned to help prepare meals or anothermeal time duty. Family style eating wasreviewed 3. Residential Manager, Lead staff and/or Dir. of Group Home will observe staffweekly to ensure continual understanding and demonstration of providing allitems on a menu is being implemented. Staff not performing at an acceptablelevel will be immediately addressed and provided retraining and/or modeling ofcorrect behaviors. At the end of each month, all menus are submitted to Dir. ofDietary for review of correct substitution documentation and other information. Correctionsneeded or revisions are sent back to the home to be done. ResidentialManagers review the corrections to ensure correct and provide retraining tostaff 1.Ongoingmonitoring will occur and documentation of concerns may be done in the followingmanner: 1. **Employee Performance Report** - completed for any repeat offenders of not showing ability to prepare meal time as established from the menu. Plan may state how to correct actions; training needed and a criteria of performance level expected. Corrective action may include a written warning and/or termination	

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