STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING 00 B. WING	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: December 12, 13, 14, 15, 16, and 20, 2022. Facility Number: 000993 Provider Number: 15G479 Aims Number: 100244950 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/5/23.	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 and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 5 additional clients (#4, #5, #6, #7 and #8), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Findings include: Observations were conducted on 12/12/22 from 3:40 pm to 5:45 pm and 12/13/22 from 6:28 am to 8:18 am. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were present throughout the observation period. 1) On the wall beside client #3's bed, the paint was worn off and the wall was not fully painted.	W 0104	**W 104** Governing Body (Standard) – The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: · All facility staff re-trained on the importance of reporting all	01/20/2023

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

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	2) In the bathroom on the left side of the hallway, the shower bar was rust colored and deteriorating. 3) In the garage there was a freezer not plugged in. Inside the freezer on the drawers and bottom there was a black substance. 4) Leading into the kitchen the half door frame of the door was rough and missing pieces of wood. An interview with staff #4 was conducted on 12/13/22 at 11:21 am. Staff #4 stated, "I don't know what happened to the wall in [client #3's] bedroom. I am not sure why the curtain rod looks like that; we don't use shower curtains. Maintenance is supposed to take the freezer in the garage and get rid of it." An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "The home should be clean. The half door in the kitchen should not be rough, it is not as smooth as it should be. Maintenance did a cheap fix. The wall in [client #3's] bedroom is from him rubbing his feet against the wall. The freezer in the garage should be discarded. We are waiting for maintenance to pick it up. We are not using it. The shower bars have rusted, they should be taken down." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "The home should be kept in good condition and repairs done as needed. Paint should not be off the walls. The curtain rods in the shower should not be rusty. If the freezer in garage is not being used it needs to be removed. The wood around the door frame should not be rough or dangerous to anyone."		maintenance concerns immediately via the Maintenance Request forms. All maintenance concerns reported are being addressed through deep cleaning as well as the completion of needed repairs by the Maintenance department. · Lead DSP and QIDP are responsible to note any broken items or maintenance needs during daily and weekly observations at the home. Lead DSP is to document concerns on monthly Site Risk Management Checklist. Maintenance Department is required to conduct a monthly inspection and note needed repairs or safety concerns. QIDP visits several times per week and is to report these concerns to Maintenance as needed. Area Director is also to visit at least quarterly to ensure that concerns are being reported as needed. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times	

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	9-3-1(a)		per week, to monitor for the overall quality of the maintenance and cleanliness of the home. In addition, Maintenance is to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately and that staff demonstrate competency in monitoring the cleanliness and safety of the home.	
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had an Individualized Support Plan (ISP) prepared, completed, and implemented within 30 days of admission. Findings include: Client #1's record was reviewed on 12/13/22 at 3:10 pm. During the record review, there was no Individualized Support Plan (ISP) to review. Client #1 was admitted to the group home on 10/28/22. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "The ISP should be completed within 30 days of admission." The PD indicated client #1's ISP meeting was held on 11/29/22. The ISP was approved on 12/14/22. An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated,	W 0226	**W 226** Individual Program Plan (Standard) – Failed to ensure client #1 had an Individualized Support Plan (ISP) prepared, completed, and implemented within 30 days of admission. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: ·The ISP for client #1 has been completed and entered into the client file. Further, the ISPs for all other individuals residing at the facility have also been audited to ensure completion and implementation. ·The QIDP is being retrained on this standard and on the	01/20/2023

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	"An ISP should be completed within 30 days and in place." 9-3-4(a)		expectation that the ISP must be developed and implemented for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence On a quarterly basis, file audits are to be completed by the QIDP in conjunction with the Area Director to ensure compliance with this standard. A checklist for all items required within the first 30 days of admission is in place and all Program Director/QIDPs are trained on this checklist.	
W 0227 Bldg. 00	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.			

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	Based on interview and record review for 1 of 3 sample clients (client #1), the facility failed to ensure client #1's Individual Support Plan (ISP) included training programs and goals to address his needs. Findings include: Client #1's record was reviewed on 12/13/22 at 3:10 pm. Client #1's ISP (Individual Program Plan Summary) dated 11/29/22 did not include any goals. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "Goals should be completed within 30 days of admission. [Client #1] does not have goals." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "Goals should be in place by the 30-day mark." 9-3-4(a)	W 0227	**W 227** Individual Program Plan (Standard) - Facility failed to ensure client #1's Individual Support Plan (ISP) included training programs and goals to address his needs. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: · All ICF/I-DD QIDPs retrained on the requirement that all ISPs must outline the specific objectives necessary to meet the client's needs, as identified by the CFA. · Goals implemented for client A in conjunction with his completed CFA. · Audit completed for all individuals residing at the facility to ensure that appropriate goals are in place in the ISPs for each individual. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence On a quarterly basis, file audits are to be completed by the QIDP	01/20/2023

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			in conjunction with the Area Director to ensure compliance with this standard. A simplified audit form was created to assist the QIDP in completing this audit and reviewing that all basic domains are addressed in the ISP.	
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 for 1 of 3 sampled clients (#3), the facility failed to implement client #3's goal to feed himself. Findings include: Observation was conducted in the group home on 12/12/22 from 3:40 pm to 5:45 pm. At 4:39 pm the Program Director (PD) asked the clients to go and wash their hands. Staff #1 and #2 were in the kitchen dishing out bowls of food for the individuals. At 4:49 pm the PD began feeding client #3 his bowl of chicken and dumplings. The PD stated,"[Client #3] can eat cold food himself but not hot food." At 5:05 pm the PD gave client #3 his bowl of fruit and let him feed himself. During the dinner meal client #3 was fed his meal by the Program Director (PD).	W 0249	**W 249** Program Implementation (Standard) - Facility failed to implement client #3's goal to feed himself. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: ·All facility staff retrained on dining risk plan and self feeding goal for client #3. · The QIDP, Nurse, Area Director or other qualified designated staff are responsible to conduct active treatment observations at varying mealtimes of the day to ensure that facility staff demonstrate competency on	01/20/2023

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	Client #3's record was reviewed on 12/13/22 at 3:45 pm. Client #3's Individual Support Plan (ISP) dated 5/26/22 indicated the following: "[Client #3] will eat using utensils. ISP Program Name: Self-Feeding, Goal or Service: 1. At mealtimes, Staff will provide [client #3] with utensils. 2. [Client #3] will eat using his utensils as the meal permits. 3. Staff will redirect [client #3] to use utensils and not fingers unless it is finger foods. 3. (sic) Staff will monitor [client #3] as he eats to assure his safety and assure, he is using his utensils. 4. Staff will provide prompting as needed using least intrusive prompting first. 5. If [client #3] requires more then (sic) 1 physical prompts (sic) to use his utensils during a meal he will not make progress on this goal. 6. [Client #3] will be praised for all efforts." The goal did not indicate client #3 needed to be fed hot foods. An interview with the PD was conducted on 12/15/22 at 12:54 pm. The PD stated, "We have always fed [client #3], depending on what food he is eating. We feed him to prevent him from spilling it on himself and on floor. So, we assist him with eating properly." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD indicated she was aware staff are concerned about client #3 burning himself if the food is hot. The AD stated, "We need to make sure food is at a safe temperature. If he needs to be fed, then it should be in his plan." 9-3-4(a)		implementing the self feeding goals at mealtimes. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. <u>How facility will identify other residents potentially affected & what measures taken</u> All residents potentially are affected, and corrective measures address the needs of all clients. <u>Measures or systemic changes facility put in place to ensure no recurrence</u> QIDP to maintain a very regular presence in the facility in order to monitor continuous active treatment, coach staff on plan implementation and review staff competency on providing active treatment during family style dining.	
W 0322	483.460(a)(3) PHYSICIAN SERVICES			

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Bldg. 00	The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure client #1 had a physical exam within 30 days of admission. Findings include: Client #1's record was reviewed on 12/13/22 at 3:10 pm. No physical examination was available for review. Client #1 was admitted to the group home on 10/28/22. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "In a perfect world we would have the appointments done in 30 days." The PD indicated client #1's family indicated they would complete appointments prior to admission. An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "A physical should be completed annually and upon admission. We should have written proof that annual was completed." 9-3-6(a)	W 0322	**W 322** Physician Services (Standard) - Facility failed to ensure client #1 had a physical exam within 30 days of admission. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: ·Client #1 saw his primary care physician on 1/9/2023. Documentation of the appointment will be placed in the medical file. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no	01/20/2023

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			recurrence Going forward, the nurse and Program Director/QIDP will utilize the Pre/Post Admission Checklist in conjunction with the Master Medical Schedule to ensure that all required appointments are scheduled, completed, and documented in the Medical File within prescribed timeframes. The team of Nurse, PD/QIDP, Med DSP and Lead DSP are to meet weekly to review compliance with appointments, paperwork, and filing, as well as discussing the overall health and safety needs of the home.	
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure client #1 had vision and hearing exams within 30 days of admission. Findings include: Client #1's record was reviewed on 12/13/22 at 3:10 pm. No vision and hearing evaluations were available for review. Client #1 was admitted to the group home on 10/28/22. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "In a perfect world we would have the appointments done in 30 days." The PD indicated	W 0323	**W 323** Physician Services (Standard) - Facility failed to ensure client #1 had vision and hearing exams within 30 days of admission. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: ·Client #1 had an eye appointment on 12/22/2022. Documentation of the appointment	01/20/2023

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	client #1's family indicated they would complete appointments prior to admission. An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "A hearing exam is completed within the first 30 days unless we have proof of prior visit and then every 3 years. Vision exams are completed within the first 30 days and then annually or as recommended." 9-3-6(a)		will be placed in the medical file. ·The referral for the audiologist was requested from the PCP and we are working to schedule at the first available appointment. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the nurse and Program Director/QIDP will utilize the Pre/Post Admission Checklist in conjunction with the Master Medical Schedule to ensure that all required appointments are scheduled, completed, and documented in the Medical File within prescribed timeframes. The team of Nurse, PD/QIDP, Med DSP and Lead DSP are to meet weekly to review compliance with appointments, paperwork, and	

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			filing, as well as discussing the overall health and safety needs of the home.	
W 0351 Bldg. 00	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure client #1 had a dental exam within 30 days of admission. Findings include: Client #1's record was reviewed on 12/13/22 at 3:10 pm. No dental exam was available for review. Client #1 was admitted to the group home on 10/28/22. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "In a perfect world we would have the appointments done in 30 days." The PD indicated client #1's family indicated they would complete appointments prior to admission. The PD stated, "[Client #1] had a dental appointment scheduled this week but he walked out of the appointment. The dental appointment has been rescheduled to February." An interview with the Area Director (AD) was	W 0351	**W 351** Comprehensive Dental Diagnostic Service (Standard) - Facility failed to ensure client #1 had a dental exam completed within 30 days of admission. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: ·Client #1 has a dental appointment re-scheduled on 2/15/23. He had an earlier appointment, but completely refused to allow the tech to start the exam and the appointment had to be rescheduled. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team	01/20/2023

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	conducted on 12/16/22 at 2:00 pm. The AD stated, "A dental exam should be completed within the first 30 days and yearly or according to recommendations." 9-3-6(a)		in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the nurse and Program Director/QIDP will utilize the Pre/Post Admission Checklist in conjunction with the Master Medical Schedule to ensure that all required appointments are scheduled, completed, and documented in the Medical File within prescribed timeframes. The team of Nurse, PD/QIDP, Med DSP and Lead DSP are to meet weekly to review compliance with appointments, paperwork, and filing, as well as discussing the overall health and safety needs of the home.	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 4 additional clients (#4, #5, #7 and #8), the facility failed to ensure the clients' medications were stored in a secure manner. Findings include: Observation was conducted on 12/13/22 from 6:28 am to 8:18 am. Clients #1, #2, #3, #4, #5, #7 and #8 were present throughout the observation period. Client #6 was not present during observation. Client #6 was on a leave with family. At 6:31 am the medication room door was unlocked, and the medication cart was unlocked with the keys to the cart lying on top of the cart. Staff #3 was in the bathroom assisting client #1 with his shower. The cart was left unlocked until 6:48 am. At 6:48 am staff #3 stated, "The medication cart is stored locked all the time." At 7:22 am staff #3 walked out of the medication room leaving the medication cart unlocked with the keys to the cart lying on top of the cart. Staff #3 went into the other room and brought back client #4. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "Medications should be stored in the locked medication cart and keys should be on staff or hanging on key rack." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "Medications should be stored in the locked medication cart and narcotics double locked. Keys should be kept on staff or on the high shelf in the dining room, not accessible to individuals."	W 0382	**W 382** Drug Storage and Recordkeeping (Standard) - Facility failed to ensure clients' medications were stored in a secure manner. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: · All facility staff were retrained on the expectation that all medications must be secured in a locked cabinet at all times. · QIDP and nurse will be responsible to verify that medication is stored in a locked cabinet during regular, frequent visits in the home. · Staff who were responsible to have locked the med cabinet on the date of the observation receiving employee counseling in addition to the retraining for all staff. Similarly, any staff found to have left the medications unsecured during an observation will receive corrective action and/or retraining in accordance with Dungarvin policy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING 00 B. WING	12/20/2022

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	9-3-6(a)		Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on the policy on drug storage and transference as part of new staff orientation. All staff are required to complete annual retraining on Medication Administration which covers med storage. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who leave the med closet unsecured. Nurse will also report any violations to the PD/QIDP for follow up.	
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 4 additional clients (#4, #5, #7 and #8), the facility failed to ensure clients did not have access to the medication room keys. Findings include: Observation was conducted on 12/13/22 from 6:28 am to 8:18 am. Clients #1, #2, #3, #4, #5, #7 and #8 were present throughout the observation period. Client #6 was not present during observation. Client #6 was on a leave with family. At 6:31 am the medication room door was unlocked, and the medication cart was unlocked with the keys to the cart lying on top of the cart. Staff #3 was in the bathroom assisting client #1 with his shower. The cart was left unlocked until	W 0383	**W 383** Drug Storage and Recordkeeping (Standard) - Facility failed to ensure clients did not have access to the medication room keys. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: · All facility staff will be retrained on the expectation that the keys to the med cart and medication room are to be stored securely where the clients do not have access to them.	01/20/2023

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	6:48 am. At 6:48 am staff #3 stated, "The medication cart is stored locked all the time." At 7:22 am staff #3 walked out of the medication room leaving the medication cart unlocked with the keys to the cart lying on top of the cart. Staff #3 went into the other room and brought back client #4. An interview with the Program Director (PD) was conducted on 12/15/22 at 12:54 pm. The PD stated, "Medications should be stored in the locked medication cart and keys should be on staff or hanging on key rack." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "Medications should be stored in the locked medication cart and narcotics double locked. Keys should be kept on staff or on the high shelf in the dining room, not accessible to individuals." 9-3-6(a)		· QIDP and nurse will be responsible to verify that keys are secured safely at all times during regular, frequent visits in the home. · Staff who were responsible to have secured the med room keys on the date of the observation receiving employee counseling in addition to the retraining for all staff. Similarly, any staff found to have left the med room keys unsecured during an observation will receive corrective action and/or retraining in accordance with Dungarvin policy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on the policy on drug storage and transference as part of new staff orientation. All staff are required to complete annual retraining on Medication Administration which covers med storage. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who leave the med closet unsecured. Nurse will also report	

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			any violations to the PD/QIDP for follow up.	
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 3 of 3 sampled clients (clients #1, #2, and #3) plus 4 additional clients (clients #4, #5, #7 and #8), the facility failed to ensure the clients assisted with meal preparation and served themselves at dinner. Findings include: Observation was conducted in the group home on 12/12/22 from 3:40 pm to 5:45 pm. Clients #1, #2, #3, #4, #5, #7 and #8 were present throughout the observation period. At 4:39 pm the Program Director (PD) asked the clients to go and wash their hands. Staff #1 and #2 were in the kitchen dishing out bowls of food for clients #1, #2, #3, #4, #5, #7 and #8. Staff #1 and #2 dished out a bowl of chicken and dumplings and another bowl of fruit cocktail for each client. At 4:49 pm staff #1 and staff #2 served each client a bowl of fruit and drink. Staff #1 and #2 then gave each client a bowl of chicken and dumplings. Clients #1, #2, #3, #4, #5, #7 and #8 were not prompted to serve themselves. An interview with staff #1 was conducted on 12/12/22 at 5:25 pm. Staff #1 stated, "If we do family style dining then [client #3] and [client #1] will snatch food." An interview with the Program Director (PD) was conducted on 12/15/22 at 2:01 pm. The PD stated,	W 0488	**W 488** Dining Areas and Service (Standard) - Facility failed to ensure the clients assisted with meal preparation and served themselves t dinner. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS11 will be fully implemented, including the following specifics: · All facility staff receiving re-training regarding the expectations of family style dining at all meals as well as the importance of using all teaching opportunities during meal preparation, while eating at the table, and while cleaning up after a meal. · The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on promoting independence for all individuals while dining.	01/20/2023

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	"Individuals don't serve themselves. In this house we do not do family style due to risk of injury to individuals. Clients could serve themselves with hand over hand assistance." An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "Meals should be served family style, to each person participating to their ability." 9-3-8(a)		How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on active treatment and family style dining expectations in the ICF-IDD setting. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the PD/QIDP for follow up.	