STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 00 B. WING	10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit was done in conjunction with a PCR (Post Certification Revisit) to the investigation of complaint #IN00199891 completed on 6/10/16. Dates of Survey: 10/3/16, 10/4/16, 10/5/16 and 10/11/16. Facility Number: 000693 Provider Number: 15G157 AIMS Number: 100234510 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/28/16.	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	W 0104	**W104:** The governing body must exercise general policy, budget and operating direction over the	11/10/2016

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

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	3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the group home was clean and maintained in good repair, and the governing body failed to provide a policy for bedbugs. Findings include: 1. Observations were conducted at the group home on 10/4/16 between 6:00 AM and 8:15 AM. Clients #1, #2, #3, #4 and #5 were observed in the home throughout the observation periods; client #6 was visiting family at home. At 6:52 AM the home's kitchen stove was observed. The oven door was coming off on the bottom left side. The door had a brown substance on the front window. The oven was black on the inside and had large chunks of burned items in the bottom of it. At 7:45 AM the home's large bathroom was observed. The walk in shower had a black substance around the edges of the shower. The walk in shower contained a shower chair and underneath of the shower chair legs was a brown substance. The walk in shower caulk was coming off around the edge in the back. House Manager (HM) #1 was interviewed on 10/4/16 at 6:59 AM. HM		facility. **Corrective Action: (Specific):** The maintenance coordinator will be re-trained on timely repair and ensuring the home is in good repair. The oven will be replaced and the large bathroom shower has been cleaned and the caulk replaced. The Residential Manager will be re-trained on the process for reporting all items that need addressed by maintenance personnel. **How others will be identified: (Systemic):** The Area Supervisor will visit the home at least weekly to ensure that all items needing repair have been reported to the maintenance coordinator and have been completed timely. The Program Manager will review all maintenance requests at least weekly and ensure that timely repairs have been completed. **Measures to be put in place:** The maintenance coordinator will be re-trained on timely repair and ensuring the home is in good repair. The oven will be replaced and the large bathroom shower has been cleaned and the caulk replaced. The Residential Manager will be re-trained on the	

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	#1 indicated there was not a maintenance request to fix the stove. HM #1 indicated she would put a request in to have the stove fixed. HM #1 stated, "The home needed a new stove because the current stove was old and the oven was dirty." Program Manager (PM) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated the home should be clean and in good repair. 2. Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 10/3/16 at 12:00 PM. The 9/1/16 BDDS report for clients #1, #2, #3, #4, #5 and #6 indicated, "Bed bugs were found in [client #5's] bedroom." House Manager (HM) #1 was interviewed on 10/4/16 at 6:59 AM. HM #1 indicated bedbugs were only found in client #5's bedroom. The facility Bed Bug Policy was requested from PM #1 on 10/5/16 at 1:23 PM and 10/7/16 at 4:16 PM. Program Manager (PM) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated she would email the facility Bedbug Policy. PM #1 did not produce a policy in regard to bedbugs. PM #1 responded via electronic mail on 10/7/16		process for reporting all items that need addressed by maintenance personnel. **Monitoring of Corrective Action:** The Area Supervisor will visit the home at least weekly to ensure that all items needing repair have been reported to the maintenance coordinator and have been completed timely. The Program Manager will review all maintenance requests at least weekly and ensure that timely repairs have been completed. **Completion date: 11.10.16**	

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	at 7:21 PM, "I'm trying to get it and I will send it to you." PM #1 did not produce a policy in regard to bedbugs. 9-3-1(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to ensure clients #1, #2, #3, #4, #5 and #6's ISPs (Individual Support Plan) included training to teach clients #1, #2, #3, #4, #5 and #6 how to utilize food locked in the pantry and deep freezer. Findings include:	W 0125	**W125:** The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility and as citizens of the United States, including the right to file complaints, and the right to due process **Corrective Action: (Specific):** All staff at the home will be re-trained on the operation	11/10/2016

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	Observations were conducted at the group home on 10/4/16 from 6:00 AM through 8:00 AM. Clients #1, #2, #3, #4 and #5 were observed throughout the observation period. At 6:50 AM the kitchen pantry was observed to have a sign on it indicating, "Pantry to remain locked at all times. Staff to supervise when clients are in pantry." The pantry door was observed to have a door lock on it. At 6:58 AM the deep freezer located in the laundry room was observed to be locked with a pad lock. House Manager (HM) #1 was interviewed at 7:03 AM. HM #1 indicated the pantry and deep freezer were locked due to client #3 having a history of stealing food. HM #1 indicated the refrigerator was unlocked and clients #1, #2, #3, #4, #5 and #6 had access to healthy snacks. Client #1's record was reviewed on 10/4/16 at 11:16 AM. Client #1's 2/17/16 Individual Support Plan (ISP) indicated client #1 did not have a training plan to get the pantry or deep freeze unlocked. Client #1's 2/17/16 ISP had HRC (Human Rights Committee) approval to lock freezer and pantry. Client #2's record was reviewed on 10/5/16 at 9:42 AM. Client #2's 7/19/16 ISP indicated client #2 did not have a training plan to get the pantry or deep		standard individual rights. The lock on the deep freeze and pantry will be removed. **How others will be identified: (Systemic):** The area supervisor will be at the home at least weekly to ensure that the pantry and the deep freeze remain unlocked and that all clients have access to these areas. All restrictions will be written in individual program plans and will be approved by the HRC. The QIDP will be at the home at least weekly to ensure that the pantry and the deep freeze remain unlocked and clients have access to these areas. The QIDP will ensure that all restrictions are written in individual program plans and have been approved by the HRC. **Measures to be put in place:** All staff at the home will be re-trained on the operation standard individual rights. The lock on the deep freezer will be removed. **Monitoring of Corrective Action:** The area supervisor will be at the home at least weekly to ensure that the pantry and the	

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	freeze unlocked. Client #2's 7/19/16 ISP had HRC approval to lock freezer and pantry. Client #3's record was reviewed on 10/4/16 at 11:16 AM. Client #3's 2/17/16 ISP indicated client #3 did not have a training plan to get the pantry or deep freeze unlocked. Client #3's 2/17/16 had HRC approval to lock freezer and pantry. Program Manager (PM) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated the deep freeze and pantry were locked due to client #3's food seeking behaviors. PM #1 indicated there should be training in place for clients to get the deep freezer and pantry unlocked. 9-3-2(a)		deep freeze remain unlocked and that all clients have access to these areas. All restrictions will be written in individual program plans and will be approved by the HRC. The QIDP will be at the home at least weekly to ensure that the pantry and the deep freeze remain unlocked and clients have access to these areas. The QIDP will ensure that all restrictions are written in individual program plans and have been approved by the HRC. **Completion date: 11.10.16**	
W 0154 Bldg. 00	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 1 of 3 allegations of abuse, neglect or mistreatment reviewed, the facility failed to ensure allegations of client to client	W 0154	**W154:** The facility must have evidence that all alleged violations are thoroughly investigated.	11/10/2016

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	abuse/mistreatment regarding client #7 were thoroughly investigated. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 10/3/16 at 12:00 PM. The review indicated the following: "[Client #8] and [client #7] were on the van on their way home from prom. [Client #8] told [client #7] to shut up, [client #7] then hit [client #8] and pushed her. Staff immediately stopped the van and separated the two individuals and checked for injuries, none noted. Individuals were redirected and returned home." The facility's Investigations were reviewed on 10/3/16 at 12:30 PM. The investigation indicated the following: "[Client #7] made a derogatory comment to another peer from [name of home]. Peer was upset and [client #8] began to take up for the upset peer. [Client #7] became increasingly verbally combative and then attempted to hit [client #8] but missed and then they grabbed each other in a bear hug into the van seat. The staff then got back to the rear of the van and		**Corrective Action: (Specific):** All staff at the home will be in-serviced on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights. The Quality Assurance manager will be retrained on ensuring that all allegations including client to client incidents are thoroughly investigated. **How others will be identified: (Systemic):** The Quality Assurance Manager and the Program manager will meet once weekly to review all investigations to ensure that all allegations have been thoroughly investigated. **Measures to be put in place:** All staff at the home will be in-serviced on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights. The Quality Assurance manager will be retrained on ensuring that all allegations including client to client incidents are thoroughly	

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	broke up the hug." Client #7 was interviewed at unknown date and time. Client #7 indicated "[Client #8] had mouthed off to her and she tried to hit her but missed. They grabbed each other and then the staff broke them up." Client #8 was interviewed at unknown date and time. Client #8 indicated, "[Client #7] was telling another peer what to do and she didn't like it so I told her to stop being mean to her." Quality Assurance (QA) #1 was interviewed on 10/5/16 at 1:23 PM. QA #1 indicated there were more clients on the van. QA #1 indicated she did not interview all the clients. QA #1 indicated in client to client aggression investigations they only interview the clients who are involved. Program Manager (PM) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated all investigations should be completed thoroughly. 9-3-2(a)		investigated. **Monitoring of Corrective Action:** The Quality Assurance Manager and the Program manager will meet once weekly to review all investigations to ensure that all allegations have been thoroughly investigated. **Completion date: 11.10.16**	
W 0268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT			

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Bldg. 00	These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 2 of 3 sampled clients (#2 and #3) plus 2 additional clients (#4 and #5), the facility failed to promote the dignity of clients #2, #3, #4 and #5 regarding their appearance. Findings include: Observations were conducted at the group home on 10/4/16 from 6:00 AM through 8:15 AM. Clients #2, #3 and #5 were observed in the group home throughout the observation period. At 6:21 AM client #5 was observed in the home's dining room eating breakfast. Client #5 got up from the table and pulled up her baggy pants. Client #5 stated, "I can't keep my pants on." Client #5 was observed to have on a loose top and pants she had to keep pulling up. Client #3 did not get out of bed until time to leave for workshop. Client #3 appeared to have on a white T-shirt which was stained brown in several places on the front as she loaded the van for workshop. Observations were conducted at the Workshop on 10/4/16 from 8:20 AM through 9:20 AM. Clients #2, #3, #4 and	W 0268	**W268:** These policies and procedures must promote the growth, development and independence of the clients. **Corrective Action: (Specific):** All staff at the home will be retrained on promoting dignity of all clients in the home, ensuring that all clients are wearing clean clothes that fit and are groomed at all times. Clothing for clients #5 and #2 will be evaluated for appropriate fit and new clothing will be purchased if necessary. **How others will be identified: (Systemic):** The Residential Manager will be at the home at least five times weekly to ensure that all staff is promoting dignity for all clients, that all clients are wearing clean clothing that fits appropriately and all clients' are well groomed. The Area Supervisor will be at the home at least weekly to ensure that all staff is promoting dignity for all clients, that all clients are wearing clean clothing that fits appropriately and all clients' are well groomed.	11/10/2016

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	#5 were observed in the workshop throughout the observation period. Client #3 was observed to be sweaty and have a foul odor. Client #3 would wipe the sweat from her face off with the T-shirt she was wearing. Clients #2, #4 and #5 were observed in a separate area of the workshop at 9:00 AM. Client #2 had on tight fitting clothes and client #5 had on baggy clothes she had to keep pulling up. Workshop Staff (WS) #1 was interviewed at 9:00 AM. WS #1 indicated client #2 had been coming in lately with clothes too tight for her. WS #1 indicated client #5's clothes were too loose. WS #1 indicated stated "Friday, (9/30/16) client #4 came to workshop with oily hair and dandruff in it. It looked like she hadn't had a shower." WS #1 indicated she thought when client #5 got more clothes she was going to give her old clothes to client #2. House Manager #1 was interviewed on 10/4/16 at 6:25 AM. HM #1 indicated client #5's clothes were too big. HM #1 indicated they were going to get client #5 clothes to fit when she got some money. Program Manager (PM) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated the staff should promote the dignity of clients #2, #3, #4 and #5 in		**Measures to be put in place:** All staff at the home will be retrained on promoting dignity of all clients in the home, ensuring that all clients are wearing clean clothes that fit and are groomed at all times. Clothing for clients #5 and #2 will be evaluated for appropriate fit and new clothing will be purchased if necessary. **Monitoring of Corrective Action:** The Residential Manager will be at the home at least five times weekly to ensure that all staff is promoting dignity for all clients, that all clients are wearing clean clothing that fits appropriately and all clients' are well groomed. The Area Supervisor will be at the home at least weekly to ensure that all staff is promoting dignity for all clients, that all clients are wearing clean clothing that fits appropriately and all clients' are well groomed. **Completion date: 11.10.16**	

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	regard to their appearance. PM #1 indicated clients should wear clean clothes and be groomed at all times. PM #1 indicated when client #5 got a check she would get new clothes. 9-3-5(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 additional client (#4), the facility failed to ensure client #4's medication was administered without error. Findings include: 1. During the 10/3/16 observation period between 4:09 PM and 6:45 PM at the group home at the 3:00 to 5:00 PM medication pass staff #7 administered client #4's medications. Staff #7 passed oral medications only. Client #4 did not receive any external medications during the 10/3/16 observation period, and/or	W 0369	**W369:** The system for drug administration must assure that all drugs, including those that are self-administered without error. **Corrective Action: (Specific):** All staff at the home will be retrained on the medication administration policy and procedure and following all physicians' orders as written.	11/10/2016

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	was not asked to take any external medications. Review of client #4's 10/16 Medication Administration Record (MAR) on 10/3/16 at 4:45 PM indicated client #4 was to receive Ayr Saline Gel Nasal to her nostrils. Client #4's 7/21/16 physician's orders indicated client #4 was to receive "Ayr Saline Gel Nasal Use intranasally on nasal septum TID (three times a day)." Interview with staff #7 on 10/3/16 at 4:45 PM indicated she did not administer the client's Ayr Saline Nasal medication. Staff #7 stated client #4's medication was kept in her "zip lock bag." Staff #7 stated "If she wants to take it she tells us." 2. Observations were conducted at the group home on 10/4/16 at 6:00 AM through 8:00 AM. At 6:30 AM, client #4 received her morning medications which included but was not limited to Levothyroxine (thyroid), Docusate (stool softener), Aripiprazole (bipolar), Potassium (hypokalemia), Lithium Carbonate (bipolar). Client #4's Levothyroxine pharmacy label was reviewed on 10/4/16 at 6:30 AM. Client #4's Levothyroxine pharmacy label indicated, "Must be given 1 hour before		**How others will be identified: (Systemic):** The residential manager will be in the home at least five times weekly and will complete medication observations at least once weekly with staff to ensure that all medications are being administered without error. The area supervisor will be in the home at least weekly and will complete medication observations at least once weekly with staff to ensure that all medications are being administered without error. The nurse will be in the home at least weekly and will complete medication observations at least once weekly with staff to ensure that all medications are being administered without error. Medication Administration Observations that are completed will be turned into the Program Manager. **Measures to be put in place:** All staff at the home will be retrained on the medication administration policy and procedure and following all physicians' orders as written. **Monitoring of Corrective Action:** The residential manager will be in the home at least five times weekly and will complete	

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	food or any other medications." Client #4's record was reviewed on 10/4/16 at 11:35 AM. Client #4's Physician's Orders (PO) form dated 10/3/16 indicated, "Must be given 1 hour before food or any other medications." Client #4's PO indicated client #4 should have received Seroquel, Raloxifene and Fluticasone during the morning medication pass. Client #4 did not receive Seroquel (psychosis), Raloxifene (osteoporosis) and Fluticasone (allergies) during the morning medication pass. Staff #2 was interviewed on 10/4/16 at 6:40 AM. Staff #2 indicated she passed the morning medications. Staff #2 indicated this was the first time she had ever passed medications. Staff #2 indicated she was not sure if client #4 should have her Levothyroxine at a different time. Staff #2 indicated she was trained to give it to her with all of her other medications. LPN (Licensed Practical Nurse) #1 was interviewed on 10/5/16 at 1:23 PM. LPN #1 indicated medication should be administered as ordered by the physician. LPN #1 indicated Levothyroxine must be given one hour before other medications or food for it to be effective. LPN #1 indicated the staff would be retrained.		medication observations at least once weekly with staff to ensure that all medications are being administered without error. The area supervisor will be in the home at least weekly and will complete medication observations at least once weekly with staff to ensure that all medications are being administered without error. The nurse will be in the home at least weekly and will complete medication observations at least once weekly with staff to ensure that all medications are being administered without error. Medication Administration Observations that are completed will be turned into the Program Manager. **Completion date: 11.10.16**	

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	15G157	A. BUILDING 00 B. WING	10/11/2016

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	LPN #1 indicated client #4 would refuse to take the nasal gel medication. The LPN #1 indicated facility staff should offer the medication as it is a routine medication to be given three times a day. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's ISP (Individual Support Plan) included training in regard to her eye glasses.	W 0436	**W436:** The facility must furnish, maintain in good repair and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices	11/10/2016

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	Findings include: Observations were conducted at the group home on 10/4/16 between 6:00 AM and 8:00 AM. Client #3 was observed at the group home throughout the observation period. Client #3 was not observed to wear eye glasses at any time during the observation periods. Client #3's record was reviewed on 10/4/16 at 11:16 AM. Client #3's ISP dated 2/17/16 indicated adaptive equipment of Glasses. Client #3's ISP dated 2/17/16 did not indicate documentation of a formal training objective or informal supports to teach client #3 use/wear her glasses. Client #3's 1/28/16 Eye Doctor Order indicated, "Update glasses/wear fulltime." PM (Program Manager) #1 was interviewed on 10/5/16 at 1:23 PM. PM #1 indicated client #3 should have training to wear her glasses. PM #1 indicated staff should prompt her to wear her glasses. 9-3-7(a)		identified by the interdisciplinary team as needed by the client. **Corrective Action: (Specific):** A formal training goal will be developed for Client #21 to wear her glasses. All staff at the home will be trained on the formal training goal and on prompting client #3 to wear her glasses as indicated in the formal training goal. **How others will be identified: (Systemic):** The QIDP will be in the home at least weekly to ensure that all client formal training goals are being implemented as written. The data for all client formal training goals will be reviewed and analyzed at least monthly to ensure the implementation and make revisions on at least a quarterly basis if indicated. **Measures to be put in place:** A formal training goal will be developed for Client #21 to wear her glasses. All staff at the home will be trained on the formal training goal and on prompting client #3 to wear her glasses as indicated in the formal training goal.	

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			Monitoring of Corrective Action: The QIDP will be in the home at least weekly to ensure that all client formal training goals are being implemented as written. The data for all client formal training goals will be reviewed and analyzed at least monthly to ensure the implementation and make revisions on at least a quarterly basis if indicated. **Completion date: 11/20/2016**	
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, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the facility failed to serve adequate amounts of food to ensure the clients were served enough food to eat per the facility's menus and/or diets. Findings include:	W 0460	**W460:** Each client must receive a nourishing well balanced diet including modified and specially prescribed diets.	11/10/2016

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	During the 10/3/16 observation period between 4:09 PM and 6:45 PM at the group home, staff #7 prepared the dinner meal with minimal assistance from clients #1 and #2. Staff #7 prepared 1 can of lima beans for 6 clients and 3 staff. Staff #7 had client #2 place 9 breaded fish on a cookie sheet for the clients to have for dinner. The breaded fish fillets were not 3 ounces of fish. Staff #7 also prepared a salad for the clients to eat as well. Clients #2 and #4 placed 1 tablespoon of lima beans on their plate and client #7 served herself lima beans as well. Client #1 took 3 lima beans and placed them on her plate. Each client had 1 serving of fish, 1 slice of bread and milk. Clients #1 and #4 did not want a salad. No alternate food/substitution was offered and/or provided to the clients. Clients #1, #2, #3, #4 and #5 also had an individual cup of vanilla ice cream for dessert. Clients #1, #2, #3, #4, and #5 were only offered 1 piece of fish. At 5:38 PM, client #3 stated "We are supposed to have 2 pieces of fish." Staff #1 stated "No you are to have 1 piece of fish." Client #3 stated "We normally get 2 pieces of fish." Staff #7 cut up client #5's fish into 4 pieces for the client to eat. At 5:41 PM, when asked if clients #1, #2, #3, #4, and #5 received 3 ounces of fish/meat, staff #1 stated "Yes." When		**Corrective Action: (Specific):** All staff in the home will be retrained on all clients' dining plans, following the menu, serving the correct portion sizes and offering substitutions. **How others will be identified: (Systemic):** The residential manager will be in the home at least three times weekly and observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The Area Supervisor will be in the home at least once weekly to observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The observations will be turned into the program manager weekly. **Measures to be put in place:** All staff in the home will be retrained on all clients' dining plans, following the menu, serving the correct portion sizes and offering substitutions.	

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	asked if the facility had a food scale to weigh the fish, staff #1 turned and asked staff #6. Staff #6 told staff #1 the facility's scale was broken. Facility staff did not offer any additional food and/or meat for the clients to eat. The facility's menu was reviewed on 10/3/16 at 5:40 PM. The facility's 1/8/14 menu for Tuesday's dinner meal indicated the following: "Crumb Baked Fish 3 oz (ounces) Lima Beans 1/2 C (cup) Sliced Tomatoes 3 sl (slices) Tossed Salad 1 C Salad Dressing LF (light) 2 Tbs (tablespoons) Dinner Roll 1 EA (each) Margarine 1 TSP (teaspoon) LF ice cream Skim Milk 1 C." The group home did not have the sliced tomatoes as indicated by the 1/8/14 menu. Interview with staff #7 on 10/3/16 at 5:07 PM indicated she was fixing 1 can of lima beans as no one liked lima beans. Staff #7 indicated the group home was to have stewed tomatoes, but clients #1, #2, #3, #4 and #5 did not like stewed tomatoes so she was fixing lima beans. Interview with staff #1 on 10/4/16 at 7:14		**Monitoring of Corrective Action:** The residential manager will be in the home at least three times weekly and observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The Area Supervisor will be in the home at least once weekly to observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The observations will be turned into the program manager weekly. **Completion date: 11.10.16**	

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	AM indicated clients #1, #2, #3, #4 and #5 did not get 3 ounces of fish as indicated by the facility's menu. Interview with client #3 on 10/4/16 at 8:38 AM indicated she did not get enough food to eat at the dinner meal on 10/3/16. Client #3 indicated facility staff knew it was not enough food for the clients. Client #3 indicated they ordered pizza for the clients later in the evening to eat. Client #3 indicated facility staff was trying to follow the menu as they were being surveyed. Interview with the Program Manager (PM) and the LPN on 10/5/16 at 12:21 PM indicated clients #1, #2, #3, #4 and #5 should be served what is on the menu to ensure the clients were served an adequate amount of food. 9-3-8(a)			
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, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the facility failed to	W 0488	**W488:** The facility must assure that each client eats in a manner consistent with his or her developmental level.	11/10/2016

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	ensure the clients participated in all aspects of the meal preparation as the clients demonstrated the needed skills. Findings include: During the 10/3/16 observation period between 4:09 PM and 6:45 PM at the group home, staff #7 prepared the dinner meal with minimal assistance from clients #1 and #2. Staff #7 prepared 1 can of lima beans for 6 clients and 3 staff. Staff #7 had client #2 place 9 breaded fish on a cookie sheet for the clients to have for dinner. Staff #7 custodially prepared the salad, turned the fish over, placed the food into serving dishes, set the dining room table, carried the food to the table and placed the condiments on the table. Staff #7 custodially prepared client #5's plate without allowing the client to serve herself. Client #1's record was reviewed on 10/4/16 at 11:16 AM. Client #1's 2/17/16 did not indicate a goal for food preparation. Client #2's record was reviewed on 10/5/16 at 9:42 AM. Client #2's 7/19/16 ISP did not indicate a goal for food preparation. Client #3's record was reviewed on		**Corrective Action: (Specific):** All staff in the home will be retrained on active treatment, all clients formal goals related to dining and client participation in all aspects of meal preparation and serving themselves in a manner consistent with their developmental level and plans. All client program plans will be reviewed for the development of a formal goal for meal preparation and implementation as indicated. **How others will be identified: (Systemic):** The residential manager will be in the home at least three times weekly and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves consistent with their developmental level and that all formal goals regarding meal preparation is being implemented as written. The Area Supervisor will be in the home at least weekly and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves consistent with their developmental level and that all formal goals regarding meal preparation is being	

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	10/4/16 at 11:16 AM. Client #3's 2/17/16 ISP did not indicate a goal for food preparation. Interview with the Program Manager (PM) on 10/5/16 at 12:21 PM stated clients #1, #2, #3, #4 and #5 "could do a lot for themselves." The PM indicated the clients should be involved in all aspects of the meal preparation. 9-3-8(a)		implemented as written. The observations will be turned into the program manager weekly. . **Measures to be put in place:** All staff in the home will be retrained on active treatment, all clients formal goals related to dining and client participation in all aspects of meal preparation and serving themselves in a manner consistent with their developmental level and plans. All client program plans will be reviewed for the development of a formal goal for meal preparation and implementation as indicated. **Monitoring of Corrective Action:** The residential manager will be in the home at least three times weekly and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves consistent with their developmental level and that all formal goals regarding meal preparation is being implemented as written. The Area Supervisor will be in the home at least weekly and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves consistent with their developmental level and that all formal goals regarding meal preparation is being	

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			implemented as written. The observations will be turned into the program manager weekly. . **Completion date: 11.10.16**	