

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2019
NAME OF PROVIDER OR SUPPLIER HEATH AVENUE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST HEATH AVE SMITHFIELD, NC 27577		
(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 104	<p>GOVERNING BODY CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: The governing body and management failed to ensure staff followed a policy regarding cell phone usage during work hours as evidenced by observations and interviews. The finding is:</p> <p>Staff were using their personal cell phone during work hours.</p> <p>During evening observations in the home on 7/8/19 at 5:45pm, Staff A was observed to be on her personal cell phone. Further observations revealed Staff A was standing in the bedroom of a client, while the client was laying in his bed.</p> <p>During an immediate interview, Staff A confirmed they should not be on their personal cell while working.</p> <p>Review on 7/9/19 of the facility's policy Using Mobile Devices in the Workplace dated 10/1/17 stated, "...employees are expected to focus on work and should not...engage in personal use of any personal mobile device in the workplace..."</p> <p>During an interview on 7/8/19, the qualified disabilities professional (QIDP) confirmed staff should not be using their personal cell phones during working hours.</p>	W 104	<p>DHSR - Mental Health</p> <p>JUL 24 2019</p> <p>Lic. & Cert. Section</p>		
W 189	<p>STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)</p>	W 189			

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

TITLE

(X6) DATE

Robert Blue

Administrator

7/22/19

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

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W 189	<p>Continued From page 1</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to document target behaviors and documenting in the medication administration record. The findings are:</p> <p>1. Staff were not effectively trained regarding documenting target behaviors.</p> <p>During observations in the home on 7/8/19 at 5:50pm, client #4 was hitting the side of his head while he was at the dining room table. A staff person redirected him to finish eating; which he did.</p> <p>During an interview on 7/8/19, Staff A revealed she did not know if client #4 had a behavior support plan or not. Further interview revealed she normally works at another home and was working today because she was put on the schedule.</p> <p>During an interview on 7/9/19, the home manager (HM) revealed Staff A has been trained on the behavior support plans of the clients in the home, including client #4.</p> <p>2. Staff were not effectively trained regarding documenting on the MAR.</p> <p>During observations in the home on 7/9/19 at 7:21am and 7:25am, Staff B signed the MAR</p>	W 189			

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W 189	Continued From page 2 prior to clients #4 and #2 consuming their medications. During an interview on 7/9/19, Staff B confirmed she had signed off on the MAR prior to clients #4 and #2 consuming their medications. Staff B stated she was only trained to check the medications against the MAR three times before the clients consumed their medications. During an interview on 7/9/19, the HM revealed the MAR is to be signed off after the clients consume their medications. During an interview on 7/9/19, the facility's nurse stated the MAR is "absolutely" not suppose to be signed prior to the clients consuming their medications.	W 189			
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain a needed visual assessment for 1 newly admitted client (#2) no later than 30 days after admission. The finding is: The facility failed to obtain a visual examination for client #2 in a timely manner.	W 210			

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W 210	Continued From page 3 Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed a visual examination dated 12/3/18.	W 210			
W 216	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 newly admitted client (#2) received a physical within 30 days of admission. The finding is: Client #2 did not receive a physical examination within 30 days of admission. Review on 7/8/19 of client #2's record revealed a physical examination dated 10/31/18. Further review revealed client #2 was admitted to the facility on 8/28/18. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's physical examination was not completed within 30 days of admission to the facility.	W 216			
W 217	INDIVIDUAL PROGRAM PLAN	W 217			

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W 217	Continued From page 4 CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 newly admitted client (#2) nutritional assessment was completed within 30 days of admission. The finding is: The facility failed to obtain a nutritional assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review indicated client #2's nutritional assessment was completed on 5/2/19. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's nutritional assessment was not completed within 30 days of admission to the facility.	W 217			
W 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a needed sensorimotor assessment for 1 newly admitted client (#2) within 30 days of admission. The finding is:	W 218			

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W 218	Continued From page 5 The facility failed to obtain an occupational therapy (OT) assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed her OT assessment was completed on 12/4/18. During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's OT assessment was not completed within 30 days of admission to the facility.	W 218			
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain in a timely manner a auditory assessment for 1 newly admitted client (#2) within 30 days of admission. The finding is: The facility failed to obtain a auditory assessment for client #2 in a timely manner. Review on 7/8/19 of client #2's individual program plan (IPP) dated 10/2/18 revealed she was admitted to the facility on 8/28/18. Further review of client #2's record revealed there is no record of her initial auditory assessment.	W 221			

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W 221	Continued From page 6	W 221			
W 249	<p>During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's auditory assessment was not completed within 30 days of admission to the facility.</p> <p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#2, #4) received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas appearance, self help and dining guidelines. The findings are:</p> <p>1. Client #2 was not afforded the opportunity to wear properly fitted clothing.</p> <p>During morning observations in the home on 7/9/19 at 6:35am, client #2 stood up from a chair and her pants were hanging and loose on her hips. Further observations revealed client #2's undergarments were visible to anyone in the home. At 8:38am Staff C had client #2 change her pants. Client #2 came out of her bedroom</p>	W 249			

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W 249	<p>Continued From page 7</p> <p>wearing a different pair of pants. Upon further observations those pants were hanging and loose on her hips. Additional observations revealed client #2's undergarments were visible to anyone in the home.</p> <p>During an interview on 7/9/19, Staff C revealed a staff person on third shift had told the home manager (HM) how client #2's pants were not fitting her.</p> <p>Review on 7/8/19 of client #2's IPP dated 10/2/18 stated, "[Client 2's] appearance is important to her."</p> <p>During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's pants were banging and loose on her hips. Further interview revealed client #2 does not own belt.</p> <p>2. Client #2's meal guidelines were not followed.</p> <p>During dinner observations in the home on 7/8/19 client #2 was overstuffing her mouth with food. Further observations revealed as client #2 put more food in her mouth, there was food visible inside of her mouth that she had not swallowed. At no time was client #2 prompted to swallow her food before putting more in her mouth.</p> <p>Review on 7/9/19 of client #2's meal guidelines dated 12/12/18 stated, "...Monitor for packing her mouth...2. Encourage her to chew her foods and to not over-pack her mouth....."</p> <p>During an interview on 7/9/19, the QIDP revealed staff should have prompted client #2 not to overstuff her mouth while she was eating.</p>	W 249			

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W 249	Continued From page 8 3. Client #4's feeding guidelines were not followed. During dinner observations in the home on 7/8/19 client #4 ate his meal sixteen times with his fingers. At no times was client #4 prompted to use his spoon. Review on 7/9/19 of client #4's feeding guidelines dated 8/13/07 revealed, "...4. Provide verbal prompts as needed to encourage [Client #4] to use his spoon and redirect any attempts of inappropriate finger feeding...."	W 249			
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 3 audit clients (#4). The finding is: Data was not collected as indicated for client #4. During morning observations in the home on 7/9/19 at 6:59am, client #4 hit the side of his head	W 252			

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W 252	Continued From page 9 on seven separate occasions while he was in the kitchen. Further observations revealed a third shift staff person was also in the kitchen. Additional observations revealed no data was documented as indicated. Review on 7/9/19 of client #4's behavior support plan (BSP) dated 7/17/19 stated, "Response to Self-Injurious Behavior: Any behavior that could result in harm to self (for example...hitting himself in the face...." Further review revealed, "Documentation...: Episodes of self-injury requiring staff intervention as well as any other behaviors of clinical concern should be documented...." Review on 7/9/18 of policy for documentation procedures dated July 2003 stated, "A Behavior Support Data Sheet will be used to document the occurrence of inappropriate behavioral expression. Such documentation shall include, at a minimum, the date and time of the episode, a description of the behavior...." Further review revealed, "In addition, individual Behavior Support Plans (BSP) may require completion of data forms specific to the target behaviors identified in the plan...." During an interview on 7/9/19 the qualified intellectual disabilities professional (QIDP) confirmed staff should have documented the target behavior of client #4.	W 252			
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	W 436			

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W 436	Continued From page 10 hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure eyeglasses were purchased for client #2. The finding is: Client #2 was not provided with eyeglasses as recommended by the ophthalmologist. Review on 7/8/19 of client #2's visual examination dated 12/3/18 revealed there was a recommendation for "new glasses". During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's eyeglasses have not been purchased as recommended by the ophthalmologist.	W 436			
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on third shift were not conducted at varied times.	W 441			

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W 441	Continued From page 11	W 441			
W 460	<p>Review of fire drill reports on 7/8/19 revealed the following:</p> <p>Two fire drills on third shift at the following times: 1am and 2am Further review revealed there were no other fire drills conducted on third shift for the twelve month time period.</p> <p>During an interview on 7/8/19, the qualified intellectual disabilities professional (QIDP) confirmed there were only two fire drill conducted on third shift for the twelve month period.</p> <p>FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of diet. This affected 2 of 3 audit clients (#2, #5). The findings are:</p> <p>1. Client #2's diet consistency were not followed.</p> <p>a. During lunch observations at the day program on 7/8/19, client #2 was observed eating a whole ham and cheese sandwich. Further observations revealed client #2 picking up the sandwich and biting undetermined pieces and consuming them. At no time was client #2 prompted to cut her</p>	W 460			

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W 460	<p>Continued From page 12 sandwich. Additional observations revealed client #2 did not cough while consuming her meal.</p> <p>b. During dinner observations in the home on 7/8/19, client #2 was observed eating pieces of beef which were larger than one inch. At no time was client #2 prompted to cut her beef. Additional observations revealed client #2 did not cough while consuming her meal.</p> <p>Review on 7/8/19 of client #2's IPP dated 10/2/19 revealed her food consistency is 1/2 - 1 inch.</p> <p>Review on 7/9/19 of client #2's nutritional evaluation dated 5/2/19 stated, "...1/2 - 1 inch consistency...."</p> <p>Review on 7/9/19 of client #2's choking prevention guidelines (on going) revealed, "Staff follow diet consistencies as ordered by the physician...."</p> <p>Review on 7/9/19 of client #2's physician's orders dated 6/26/19 - 9/30/19 indicated her diet consistency is 1/2 to 1 inch.</p> <p>During an interview on 7/9/19, the qualified intellectual disabilities professional (QIDP) revealed client #2's sandwich should have been in the correct diet consistency. Further interview revealed staff should have prompted client #2 to cut her beef to to correct consistency.</p> <p>2. Client #5's diet consistency were not followed.</p> <p>During lunch observations at the day program on 7/8/19, client #5 was observed eating a whole ham and cheese sandwich. Further observations revealed client #5 picking up the sandwich and</p>	W 460			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2019
NAME OF PROVIDER OR SUPPLIER HEATH AVENUE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST HEATH AVE SMITHFIELD, NC 27577		
(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 460	<p>Continued From page 13</p> <p>biting undetermined pieces and consuming them. At no time was client #5 prompted to cut her sandwich. Additional observations revealed client #5 did not cough while consuming her meal.</p> <p>Review on 7/8/19 of client #5's IPP dated 1/3/19 revealed her diet consistency is 1/2 to 1 inch.</p> <p>Review on 7/9/19 of client #5's meal guidelines stated, "...Assist [Client #5] with fading assistance to cut her food into 1/2 to 1 inch pieces.</p> <p>Review on 7/9/19 of client #5's nutritional evaluation dated 9/25/18 revealed her diet consistency is 1/2 to 1 inch.</p> <p>During an interview on 7/9/19, the QIDP revealed client #5's sandwich should have been in the correct diet consistency.</p>	W 460			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2019
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**HEATH AVENUE HOME
PLAN OF CORRECTIONS
For
Recertification Survey completed July 9, 2019.**

W104 GOVERNING BODY

The facility will re-in service on the use of mobile device in the workplace. QMRP will re-inservice all staff on the use of mobile device in the workplace.

Staff A will be re-in service for two consecutive months on the use of mobile device in the workplace.

Monitoring will be conducted three times a month through Interaction Assessments and direct observations. Observations are performed by QMRP, Hab. Specialist, Behavior Specialist, Vocational Coordinator, Home Manager, OT/PT Hab. Assistant, Nurses, and Administrator.

Completion date by: 9/6/2019

W189 STAFF TRAINING PROGRAM

The facility will re-in-service all staff on individuals Behavior Support Plan and RHA nursing staff will monitor each client's medication pass to ensure medications are administered without error.

Staff A will be re-inserviced on Client # 4 Behavior Support Plan.

Staff A will be re-in serviced by nursing on how to properly document on the medications administration record.

Monitoring to be accomplished at least three times per month using Interaction/Medication Assessment and direct observations completed by QMRP, Hab. Specialist, Behavior Specialist, Home Supervisor, and Nursing. Should any documentation error occur, nursing and management staff will address immediately. Assessments and results of observations will be reviewed during monthly house meeting and during Quality Assurance and Quality Improvement Team meeting.

Completion date by: 9/6/2019

W210 INDIVIDUAL PROGRAM PLAN

The facility will monitor the implementation of supports and services during the 30 – day after admission. QMRP will conduct the assessment within 30 days that the services

begin. All IDT members will be re-inserviced on requirements of a 30 day post admission assessment.

Client #2 visual examination will be reviewed by nursing for any follow -up to assessment completed.

The QMRP will conduct a chart review within 2 weeks and another review within 30 days to ensure all assessments are completed within the 30 day time frame. Any areas which are indicated as “not present” should be immediately addressed by the team and the facility Administrator notified for resolution.

Completion date by: 9/6/2019

W216 INDIVIDUAL PROGRAM PLAN

The facility will monitor the implementation of supports and services during the 30 – day after admission. QMRP will conduct the assessments within 30 days of the services beginning. All IDT members will be re-inserviced on requirements of a 30 Day Post admission assessment.

Client #2 physical examination will be reviewed by nursing for any follow up to assessment completed.

The QMRP will conduct a chart review within 2 weeks and a review within 30 days to ensure all assessments are completed within the 30 day time frame. Any areas which are indicated as “not present” should be immediately addressed by the team and the Facility Administrator notified for resolution.

Completion date by: 9/6/2019

W217 INDIVIDUAL PROGRAM PLAN

The facility will monitor the implementation of supports and supports and services during the 30 – day after admission. QMRP will conduct the assessments within 30 days of the services beginning. All IDT members will be re-inserviced on requirements of a 30 Day Post admission assessment.

Client #2 nutritional assessment will be reviewed by nursing for any follow up to assessment completed.

The QMRP will conduct a chart review within 2 weeks, and a review within 30 days to ensure all assessments are completed within the 30 day time frame. Any areas which are indicated as “not present” should be immediately addressed by the team and the facility Administrator notified for resolution.

Completion date by: 9/6/2019

W218 INDIVIDUAL PROGRAM PLAN

The facility will monitor the implementation of supports and supports and services during the 30 – day after admission. QMRP will conduct the assessments within 30 days of the services beginning. All IDT members will be re-inserviced on requirements of a 30 Day Post admission assessment.

Client #2 OT assessment will be reviewed by nursing for any follow up to assessment completed.

The QMRP will conduct a chart review within 2 weeks, and a review within 30 days to ensure all assessments are completed within the 30 day time frame. Any areas which are indicated as “not present” should be immediately addressed by the team and the facility Administrator notified for resolution.

Completion date by: 9/6/2019

W221 INDIVIDUAL PROGRAM PLAN

The facility will monitor the implementation of supports and supports and services during the 30 – day after admission. QMRP will conduct the assessments within 30 days of the services beginning. All IDT members will be re-inserviced on requirements of a 30 Day post admission assessment.

Client #2 auditory functional assessment will be obtained by Nursing and follow up to assessment completed.

The QMRP will conduct a chart review within 2 weeks, and a review within 30 days to ensure all assessments are completed within the 30 day time frame. Any areas which are indicated as “not present” should be immediately addressed by the team and the facility Administrator notified for resolution.

Completion date by: 9/6/2019

W249 PROGRAM IMPLEMENTATION

The facility will implement the Individual Program Plan (IPP) as written to ensure continuous active treatment. The QMRP will re-insevice all IPP’S. The Home Supervisor, Habilitation Specialist and the OT/PT Habilitation Assistant will re-inservice

staff on how to support individuals in the areas of appearance, self-help and dining guidelines.

Client #2 will purchase clothing that fit properly.

Client # 2 feeding guidelines will be re-inservice to staff.

Client # 4 formal guidelines for eating will be re-inserviced to staff

Monitoring will occur with at least three times per month; using the Meal Time/Appearance checklist assessments; assessments are conducted by QMRP, Hab. Spec., Home Supervisor, OT/PT Hab Asst, Voc Coordinator, and/or Behavior Specialist. Staff will receive immediate feedback/correction on assessment results. Assessment results will be reviewed at monthly house meetings.

Completion date by: 9/6/2019

W252 PROGRAM DOCUMENTATION

The facility will review all IPPs by the QMRP for the level of support needed in all domains.

Staff will be in-serviced on the needs and strengths of all clients.

Clients #4 behavior support plan will be re-inserviced by Behavior Specialist.

Monitoring to be accomplished at least three times per month using Interaction/Engagement assessments and direct observations/assessments done by QMRP, Habilitation Specialist, Behavior Analyst, Home Manager, and OT/PT Habilitation. Assessments and results of observations will be reviewed during monthly Core Team meeting and house meetings and during Quality Assurance & Quality Improvement Team meetings.

Completion date by: 9/6/2019

W436 SPACE AND EQUIPMENT

The facility will ensure all adaptive equipment is current. QMRP and/or OT/PT Habilitation Assistant to re-inservice all individual's Adaptive Equipment in the home.

Client # 2 glasses will receive eyeglasses as recommended by the ophthalmologist.

Monitoring to be done daily by direct support staff through the use of appearance checklist and reviewed weekly by QMRP. Anything found out of compliance will be addressed immediately. QMRP and Habilitations Specialist will conduct chart reviews monthly to ensure all recommendations are completed.

Completion date by: 9/6/2019

W441 EVAUCATION DRILLS

The Facility will monitor fire drills under varied conditions. The QMRP will re-in service a calendar assigning which shift that will re-in service a calendar assigning which shift will at varied times conduct fire drills.

QP and Home Manager will review on a monthly basis. Further discussion will occur at the monthly Quality Assurance/Safety Meeting to ensure drills were conducted at the appropriately. If any errors are found, a make – up drill will be ran to ensure quarterly requirement is maintained.

Completion date by: 9/6/2019

W460 FOOD AND NUTRITION SERVICES

The Facility will re-in service all staff on individuals feeding guidelines, food consistency and diets by OT/PT Habilitation Assistant.

Client # 2 diet consistency will be re-in serviced to staff by OT/PT Habilitation Assistant.
Client # 5 diet consistency will be re-in-serviced to staff by OT/PT Habilitation Assistant.

Monitoring to be accomplished at least three times per month using Mealtime/assessments by QMRP, Habilitation Specialist, Home Supervisor, and OT/PT Assistant. Assessments and results of observations will be reviewed during monthly Core Team and house meetings.

Completion date by: 9/6/2019