Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	12G043	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA IGHWAY WAHIAWA, HI 96786

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9 000	INITIAL COMMENTS A licensure survey was conducted from 12/20/16 through 12/22/16.	9 000		
9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level. This Statute is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to aggressively implement a plan of care to meet the needs of one client, Client #3, who was experiencing a [redacted] in health and functional status. Findings include: 1) Observation of Client #3 found her in a [redacted] state of health. On the morning of 12/20/16 at approximately 10:30 A.M. Client #3 was seated in her classroom with her head down and her eyes closed. She was holding a rice cracker in her right hand and appeared to have taken a bite out of the cracker. She made occasional crying sounds. She appeared very thin, pale, weak, and sedated. Client #3 remained in the same position (eyes closed, head down, and not moving) for 30 minutes. On the afternoon of 12/20/16 at approximately 3:15 P.M. Client #3 was brought back to her home via wheelchair. A caregiver transferred Client #3 from her wheelchair to a chair in the living room. The client had a store newspaper ad in her hands. She sat on the chair with her head down and her eyes closed holding onto the	9 005	RECEIVED 2017 FEB -1 A 10: 51 STATE OF HAWAII MED-QHCA MEDICARE 1/10/2017 On 1/10/2017, the Interdisciplinary Team revised and updated client #3's, Active Treatment Training Program Plans and discussed client #3's changing health status and developed a comprehensive functional assessment. All direct care staffs received an in-service training from the QIDP and stressed the rationale and importance of consistency in implementing the active treatment training program plans for each client in the home to ensure that aggressive treatment training is provided in sufficient number and frequency, and that training goals and interventions are implemented consistently. Regular in-service training will continue to be provided by the QIDP to all direct care staffs during Tuesdays weekly caregivers meeting to ensure that aggressive active treatment training goals and interventions are implemented consistently. The QIDP will continue to monitor and actually observe direct care staffs and day program staffs in the day program daily from 10AM to 12NOON to ensure direct care staff's and day program staff's allow clients to function at their greatest physical, intellectual, social emotional and vocational level.	

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9 005	Continued From page 1	9 005		

newspaper ad. The staff attempted to get her up to the restroom to change her brief. Client #3 began making crying sounds and did not move. She required assistance to get up from her chair and walk across the living room to go to the restroom. Halfway there, the staff stopped and allowed her to sit on a chair at the desk. While seated at the desk, Client #3 was offered Boost Very High Calorie (VHC) nutritional supplement. The client began coughing. She was again offered more Boost and started coughing again.

An interview of a caregiver on the afternoon of 12/20/16 at approximately 3:45 P.M. revealed Client #3 was having difficulty with swallowing. Both of the caregivers noted Client #3 no longer ate solid food. She has experienced [redacted] twice in the past several months (July 2016 and November 2016). After the episode of [redacted] in November 2016, Client #3 experienced a significant [redacted] in nutritional intake and overall functional status.

One of the caregivers reported that Client #3 used to walk independently but now needs assistance. On the morning of 12/21/16 at approximately 7:30 A.M. the Caregiver reported that the client has [redacted] over the past several months, and now requires someone to sit next to her bed at night to ensure her safety. The Caregiver reported that Client #3 will sometimes get up in the middle of the night and will get out of bed on her own but isn't steady to walk independently. Client #3 also stopped eating solid foods and now only drinks nutritional supplements. On 12/21/16 at approximately 12:15 P.M., the facility Nurse noted Client #3's current weight was 58 pounds.

A review of Client #3's medical record revealed

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9 005	Continued From page 2	9 005		

diagnoses which included [redacted] and [redacted]. Client #3 has experienced [redacted] from her difficulty swallowing due to [redacted] A Pulmonologist note dated 9/2/16 found his assessment as "[redacted]". The Pulmonologist noted there were 2 ways to treat Client #3: 1) aggressively with GTube feedings and/or trach placement; or 2) Make client DNR (Do Not Resuscitate), perform aspiration precautions, sleep with head of bed elevated and treat [redacted] with antibiotics alone (No ICU, No intubation, etc).

A medical record review found Client #3 had a health maintenance plan titled, "Altered Nutrition: less than body requirements" and was dated 6/1/15. The plan noted Client #3 experienced weight loss of 10+ pounds. The goal was, "To increase weight to 75 pounds by June 2016". Interventions included: "Monitor caloric and nutrient intake daily. Encourage client to eat"; "Caregiver to provide nutritional food and fluid as appropriate for client. Continue intake of Ensure 4 cans daily"; and "Continue to monitor health status". The facility failed to update the plan to reflect her current health and functional status with their respective interventions and goals.

After the 9/2/16 recommendation from the Pulmonologist, the facility discussed the options with the family. The facility asked for time to discuss and plan with family. As of survey date, 12/22/16, the facility had not heard from the family. According to the facility staff, the family informed them they would not use artificial methods of nutrition (GTube feedings) and further opted for "Do Not Resuscitate (DNR)" should

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9 005	Continued From page 3 Client #3 be in a life or death situation. However, the facility failed to document the conversations made with family nor did they follow up to get a solid answer on what the family wants/expects. The facility failed to address Client #3's [redacted] health and functional status thereby failing to make appropriate changes to her plan of care. 2) At approximately 7:00 A.M. the Caregiver (CG) began medication administration. Client #2 was the first to take medication. The second client was Client #3. At 7:10 A.M. Client #4's work mate came to the front door of the home to talk to Client #4. Client #4 reported she leaves for work between 7:00 and 7:30 A.M. As Client #3 was taking her medication, Client #4 began to mutter under her breath, "I gotta go to work...oh man" and she began taping the arm rest of the chair and waving her arms about. At 7:15 A.M. the client continued to comment that she was waiting for her medication and stating she is the "last one". At 7:22 A.M. Client #4 was asked to get her bin to take her medication. The client apologized for her behavior and the CG responded they will wait for you. At 7:25 A.M. the client left the home to meet her ride. The facility failed to provide Client #4 the opportunity for self-management in her daily schedule to prevent her frustration. Client #4 was concerned that she would be late for her ride to work; however, was the third client to receive her medication. Clients' #2 and #1 schedule was to leave the home at 8:00 A.M. to attend their program. 3) On 12/20/16 at 3:23 P.M. observed Client #2 seated at the dining room table for afternoon snack. The CG placed bags of chips on the	9 005	1/10/2017 On 01/10/2017, the Nurse had an in-service training with the direct care staff and caregivers and stressed the rationale and importance in the implementation of the plan of treatment for self-administration of medications for all clients in the home. The Nurse emphasized to the direct care staff's that clients in the home who are able to take their own medications can administer their own medications provided with the supervision of the caregiver. Regular in-service training will continue to be provided by the Nurse to all direct care staffs during Tuesday's weekly caregivers meetings and at least quarterly to ensure that clients are given the opportunity to be as independent as they are capable of being. The Nurse will continue to monitor direct care staffs in the house twice weekly from 7AM to 8AM to ensure that clients are provided opportunities for self-management in the administration of their own medications.	

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9 005	Continued From page 4 table. Client #2 selected the bag that she wanted and was trying to open the bag, pulling the both ends of the bag. The CG went over and state "I'll help you" and opened the bag of snacks. The CG reported it is hard for Client #2 to open the bag because of her hands. The CG did not provide the opportunity for Client #2 to open the bag or teach the client how to open the bag of snacks.	9 005	On 1/10/2017, the QIDP had an in-service training with the direct care staff and stressed the rational of providing opportunities for self- management for client #2, to do as much as possible for herself opening the bag of snacks as she is capable of being. The QIDP emphasized to the direct care staff that all clients in the home will be afforded the opportunity to do anything for themselves as they are capable of being. Regular in-service training will continue to be provided by the QIDP to all direct care staffs during weekly Tuesdays caregivers meeting and at least quarterly to ensure that clients continue to be afforded opportunities for client choice and self-management. The QIDP will continue to monitor direct care staffs twice weekly from 3PM to 4PM to ensure that clients are provided opportunities to do as much for themselves as they are capable of being.	1/10/2017
9 086	11-99-9(c)(3) DIETETIC SERVICES Modified or therapeutic diets shall be: Reviewed and adjusted, as needed, by a qualified dietitian. This Statute is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to provide a nourishing, well balanced diet for one of three clients, Client #3, reviewed. Findings include: Observation of Client #3 on the morning of 12/20/16 at approximately 10:30 A.M. found her seated in her classroom with her head down, eyes closed, and partially eaten rice cracker in her right hand. She sat for 20 minutes without moving or eating her cracker. Observation of Client #3 at the lunch meal on 12/20/16 found her seated at the dining table with the other clients. She was given Boost Very High Calorie (VHC) nutritional supplement which she sipped through a straw. She took a few sips and began coughing. The staff stopped giving the Boost when she started coughing.			

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9 086	Continued From page 5 Observation of Client #3 on the afternoon of 12/20/16 at approximately 3:45 P.M. found her seated a chair in the living room of her house when she was offered Boost VHC. She sipped the liquid through a straw then began coughing. The staff stopped and waited for her to stop coughing then would resume. Client #3 sipped through the straw 4-5 times and then stopped because she started coughing. Observation of Client #3 in the evening of 12/20/16 at approximately 5:30 P.M. found her seated at the dining table with other clients. She was seated in her wheelchair with her head down and her eyes closed. The other clients were making their food but Client #3 sat in her wheelchair and occasionally made crying sounds. Observation of Client #3 on the morning of 12/21/16 at approximately 6:30 A.M. found her asleep on a chair in her bedroom. A Caregiver was seated next to her bed to watch her. The client didn't leave the room until approximately 7:40 A.M. At approximately 7:45 A.M. Client #3 was given her medications which were crushed in a small amount of water and poured into another cup with a half carton of Boost VHC in it. Client #3 was observed sipping the medication mixture but would begin coughing. She attempted to drink the medication mixture several times until she wouldn't stop coughing. The medication mixture was placed into another cup and placed back in the refrigerator. The Caregiver reported the medication mixture would be transported to the classroom where the staff there would attempt to give her the rest of the medication. A medical record review on the morning of 12/21/16 found a Nutritional Assessment dated	9 086	1/17/2017 On 1/17/2017, the Registered Dietician was consulted and recommended client #3 continues to benefit from nutritional supplements such as Boost VHC 1 carton 3x daily with meals and Ensure Plus 1 bottle/can (237ml) twice daily between meals to protect weight support and gain. Regular in-service training will continue to be provided by the Nurse to all caregivers and day program staffs during Tuesdays weekly ORI staff's meeting and at least quarterly to ensure that all clients must be provided an additional nutritional supplement if they lose weight The Nurse will continue to monitor day program staff daily from 8AM to 12NN and direct care staffs in the residence from 3PM-4PM twice weekly to ensure an accurate documenting of client's intake and the proper understanding on the client's nourishment, well-balanced diet including modified and specially-prescribed diets by the Registered Dietician. (See attached notes)	

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6/28/16 when the Contracted Registered Dietician (RD) assessed Client #3 as "more stable". The RD further noted her intake was variable but would eat during snack times. The RD noted Client #3 was receiving Boost Breeze and Boost VHC, drinking them well (1-2 cartons of each daily). The RD recommended Client #3: Continue a regular diet; Encourage intake at meals and snacks; Continue to provide and encourage nutritional supplements as ordered to support weight gain. The RD noted the weight goals was for gradual weight gain then stable at 71-86 pounds.

A review of Client #3's physician's orders noted orders dated 11/24/15 for: Boost Very High Calorie Liquid, Give 3 cans a day; and Boost Breeze Liquid, Give 3 cans a day. A review of Client #3's intake record found missing documentation for her daily intake. Client #3's intake record for the second half of November 2016 found documentation for Boost VHC given on 11/16/16, 11/17/16, and 11/18/16 at 9:00 A.M. and 12:00 P.M. which stated "1/2" in each of those boxes. The remainder of the intake record was blank. The Boost Breeze Liquid was completely blank. For the first and second halves of December 2016, some boxes were completed and others were blank.

The Nurse was interviewed on the morning of 12/21/16 regarding Client #3's intake. The Nurse was unable to explain how much of the nutritional supplements Client #3 was required to take. Additionally, the Nurse was unable to explain what she and the Caregivers were to do when/if Client #3 was not taking the recommended daily intake. Additionally, the Nurse was unable to state Client #3's nutritional goals and plans. .

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9 086	Continued From page 7 In conclusion, the facility did not have a system or format for organizing Client #3's nutritional needs and plans. The facility failed to address Client #3's [redacted] in health status thereby failed to make adjustments to the goals and expected outcomes for her.	9 086		
9 138	11-99-13(2)(G) GOVERNING BODY AND MANAGEMENT There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the absence of any infectious disease. Each examination shall include a tuberculin skin test, as defined, or a chest x-ray. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure a pre-employment evaluation by a physician was done. Findings include: On the morning of 12/22/16 a review of the employee health was done. A review of the new employees found an employee was hired on 10/5/16; however, the health evaluation was dated 12/22/16. Interview with staff found that the facility does not have documentation of a pre-employment evaluation and the evaluation completed in 12/22/16 was the most current.	9 138	In the future, the personnel must see to it that pre-employment evaluation for all employee must be done by a physician prior to employment	1/10/2017
9 151	11-99-15(b) INFECTION CONTROL There shall be appropriate policies	9 151		

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9 151	Continued From page 8 and procedures written and implemented for the prevention and control of infections and the isolation of infectious residents. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure hand hygiene related to glove usage. Findings include: On the morning of 12/21/16 observation was made of medication administration. The Caregiver (CG) was observed preparing medication for Client #1. The CG donned a glove on her right hand, the CG did not perform hand hygiene before applying the glove. The CG wore the glove during the medication administration, holding the pen to document in the Medication Administration Record (MAR) and opening and closing the medication bottles. The CG was observed to remove the glove. No hand hygiene was observed. Subsequently the CG was observed preparing medication for Client #3. The CG donned a glove on her right hand, no hand hygiene was observed. The CG was observed to enter the kitchen, open the medication cabinet and remove a bin from the cabinet. The CG donned a glove on her left hand, no hand hygiene was performed and now wearing gloves to both the left and right hand. While wearing the gloves the CG crushed the client's medication, stood up, opened the kitchen cabinet, removed a cup and poured the crushed medications into the cup. The CG then closed the cabinet and proceeded to wash a cup at the sink while wearing the gloves. The CG removed the gloves and did not hand sanitize.	9 151	On 01/10/2017, the Nurse reminded the direct care staffs on the proper implementation of handwashing and changing gloves each time different clients are physically (touched). The Nurse had an in-service training with the case managers, caregivers and relief caregivers in sanitation and infection control with emphasis on handwashing with soap and water and changing gloves each time various articles and other items are being touched to prevent and control infection and communicable diseases. Regular in-service training will continue to be provided by the Nurse to all direct care staffs during Tuesdays weekly caregivers meetings and at least quarterly to ensure that proper sanitation and infection controls methods are properly implemented. The Nurse will continue to monitor direct care staffs in the house twice weekly from 7AM to 8AM to ensure that proper hand washing be done each time they changed gloves for the prevention of infection and communicable diseases	1/10/2017

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9 151	Continued From page 9 On 12/21/16 at 10:45 A.M. an interview was done with the Registered Nurse (RN). The observation of the morning preparation of medication was shared with the RN. The RN confirmed prior to donning a glove, hand hygiene is indicated and hand hygiene is also indicated after removal of glove.	9 151		
9 191	11-99-22(e) PHARMACEUTICAL SERVICES Only appropriately trained staff shall be allowed to administer drugs and shall be responsible for proper recording of the medication, including the route of administration. Such persons shall have satisfactorily completed a course of training in the administration of drugs, which course has been approved by the Department. Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician who ordered the drug and an incident report shall be prepared. All incident reports shall be kept available for inspection by the Director. This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure accurate documentation of drug administration and administered the medications as prescribed by the physician. Findings include: 1) On the morning of 12/21/16 the Caregiver (CG) was observed preparing Client #3's	9 191	1/10/2017 On 01/10/2017, the Nurse reminded the direct care staff's in proper procedure in the preparation of medications, proper medication administration and proper recording of all medications including signing of client #3's medication administration record if actually administered. The Nurse had an in-service training with the direct care staff's and caregivers on the importance of proper procedures/recording of medications in the home, and proper signing of each client's medication administration record if actually administered. Regular in-service training will continue to be provided by the Nurse to all direct care staffs during Tuesdays weekly caregivers meetings and at least quarterly on the proper implementation on the procedures for documenting administration of medications. The Nurse will continue to monitor direct care staffs in the residence twice weekly from 7AM to 8AM to ensure proper recording of all medications including signing of the client's medication administration record if actually administered.	

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AMENDED POC	12G043	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA IGHWAY WAHIAWA, HI 96786

(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) COMPLETE DATE
9 191	Continued From page 10 medication. The medications were placed in a pill cup then transferred to a pill crusher container. The CG was observed initialing the "Medication Administration Record" (MAR) to indicate the medication was given. The CG was observed to go into the kitchen and remove another pill crusher container. The medication was placed in the second container. The medication was crushed and placed in a tall glass, while in the kitchen the CG added water to the cup. This mixture was placed in another cup with a handle and a liquid dietary supplement was added to the water mixture. The Reliever assisted the client to drink some of the mixture. Client #3 took a few sips of the mixture and the Reliever informed the client that if she unable to finish, she can drink it later in the classroom. At 7:55 A.M. the remainder of the medication mixture was placed in the refrigerator. On 12/21/16 at 10:45 A.M. an interview was done with the Registered Nurse (RN). The observation of the medication administration was shared with the RN. The RN confirmed the medication was not given and the CG needs to observe the medication was taken before signing the MAR. 2) Observation of medication pass for Client #2 on the morning of 12/21/16 at approximately 7:00 A.M. found the Caregiver giving her a [redacted]. The physician's orders read, "[redacted] 100 mg capsule, Take 1 capsule orally twice a day as needed for constipation". The Caregiver did not assess whether or not Client #2 was constipated. A review of the Medication Administration Record (MAR) for Client #2 found the Caregiver was	9 191	On 01/11/2017, the Medical Doctor was consulted on the proper dosages of [redacted] 100mg capsule for client # 2. Since the Medical Director alleged that client needs the [redacted] twice daily for constipation, he changed the order from taking [redacted] 100mg capsule orally twice daily as needed for constipation **to read**: take 1 capsule orally twice daily. (See attached Physician's order. In the future, the facility ensures that the staff member will continue to follow physician's orders for medication administration for the client involved and for the other clients.	1/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[illegible]	12G043	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA IGHWAY WAHIAWA, HI 96786

(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) COMPLETE DATE
9 191	Continued From page 11 providing the medication to her twice daily for the month of December 2016. A review of Client #2's output indicated she had bowel movements daily for the month of December 2016. An interview of the Nurse on the morning of 12/21/16 at approximately 11:00 A.M. revealed that she spoke with the Caregiver about giving Client #2 a [redacted] twice daily despite assessment of bowel movements. The Caregiver informed the Nurse that Client #2 remained regular from being on the [redacted] daily. Therefore the Caregiver gave the medication twice daily despite the physician's order for "as needed for constipation". The facility failed to follow the physician's orders for Client #2 to receive a [redacted] on an as needed basis.	9 191		
9 202	11-99-22(h)(3) PHARMACEUTICAL SERVICES There shall be written policies and procedures governing resident self-administration of drugs. These shall include at least the following: Provision for appropriate storage of drugs. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a system for drug administration which assured that drugs used by clients were labeled in accordance with State law. Findings include: 1) An observation of medication pass for Client #1 on the morning of 12/21/16 at 7:10 A.M. found	9 202	1/10/2017 On 01/10/2017, the Nurse reminded the direct care staff's in proper storage of client #1 & #2's unused half pill medications back in their respective pill container.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
CORRECTED FOR	12G043	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA IGHWAY WAHIAWA, HI 96786

(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) COMPLETE DATE
9 279	Continued From page 13 and individuality, including privacy in treatment and in care. This Statute is not met as evidenced by: Based on observation, the facility failed to promote positive interaction between clients for 1 (Client #3) of 4 clients in the home. Finding include: On 12/20/16 at approximately 3:15 P.M. three clients returned home from their program. The Caregiver (CG) and Reliever were observed attempting and assisting Client #3 to the bathroom. At 3:22 P.M. the CG was heard telling Client #3 to "change your diaper". At 3:50 P.M. the Reliever was heard telling Client #3 that "you have to change your diaper, it is all wet". During this period of time, the CG and Reliever were heard intermittently prompting Client #3 to walk for "diaper" change. Clients #2 and #4 were observed walking through the living area and at times Client #2 was seated in the living room. On 12/21/16 at 8:00 A.M. the CG informed the clients that they needed to get their snacks. At this time, Client #1 whispered to the surveyors that the snack cabinet is filled with "diapers".	9 279	On 01/10/2017, the QIDP had an in-service training to all caregivers on the protection of client rights and privacy and emphasized the importance of choice of word to be uttered in front of clients. All direct care staffs were reminded to follow the policies and procedures on each client protection and privacy rights in the home. Regular in-service training will continue to be provided by the QIDP to all direct care staffs during weekly Tuesdays caregivers meeting and at least quarterly to ensure that clients rights and privacy are properly implemented. The QIDP will continue to monitor direct care staffs in the house twice weekly from 3PM to 34PM to ensure training is properly implemented and the protection of client's rights and well-being is properly observed at all times.	1/10/2017