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

PRINTED: 10/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			A. BUIL	DING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/26/2011	
		15G580	B. WINC			09/20/2011	
NAME OF P	ROVIDER OR SUPPLIER			303 FRA	DDRESS, CITY, STATE, ZIP CODE		
ARCADIA	A DEVELOPMENTA	L CENTER			IA, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	MPLETION
TAG W0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DETICIENC!)		DATE
	Dates of Survey: 22, and 26, 2011. Facility number: Provider number AIM number: 10 Surveyors:	d state licensure survey.  September 19, 20, 21,  000730  15G580	WO	0000	By submitting the enclosed materials we are not admittin truth or accuracy of any specifindings or allegations as par any proceedings and submit these responses pursuant to regulatory oligations.	ific t of	
	Paula Chika, Med Kathy Craig, Med Keith Briner, Me	dical Surveyor III dical Surveyor III dical Surveyor III , Public Health Nurse					
	reflect state findi 410 IAC 16.2. Quality Review of	deral deficiencies also ngs in accordance with completed 10/6/11 by l, Medical Surveyor III.					
W0104	policy, budget, and the facility.	dy must exercise general doperating direction over attion, interview and	WO	0104	For clients #8, 21, 36, 1, 5, a other clients' utilized chairs h		/26/2011

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

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

324S11

Facility ID:

000730

If continuation sheet

NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN46030  (X5)			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULTIPLE  A. BUILDING  B. WING	00	(X3) DATE COMPI 09/26/2	LETED
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REACHONSHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CREATION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CRACTION TO THE APPROPRIATE DATE OF CROSS-NET PERCENCY OR CROSS-				STREE	FRANKLIN	•	
to exercise operating direction over the facility to maintain chairs in program room areas for 4 of 10 sampled clients (clients #1, #2, #5, and #8) plus 8 of 47 additional clients (clients #17, #20, #29, #35, #36, #37, #43, and #45) who utilized the chairs in program rooms one and four.  Findings include:  1. Clients #1, #2, #5, #17, #20, #29, #35, #37, #43, and #45 were observed in program room four on 9/19/11 from 3:00  P.M. until 4:00 P.M Clients #1 and #5  maintenance staff for the need of repair, covering or replacement. Those chairs that have tears or holes, they will be recovered or replaced. Chairs that have permanent stains will be covered by slip covers. Housekeeping will assess all chairs within the facility monthly and complete the furniture check list (Attachment 104-A). Housekeeping will turn in the furniture check list to the Maintenance Supervisor who will schedule any repairs, covering, or replacements needed. Housekeeping responsible for check sheet. Maintenance will monitor	PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION
stuffing protruding from torn areas.  Staff #33 was interviewed on 9/19/11 at 4:03 P.M Staff #33 indicated clients #1, #2, #5, #17, #20, #29, #35, #37, #43, and #45 regularly utilized the stuffed chairs in program room four.  2. Observations were conducted in program room #1 on 9/20/11 from 6:35  AM to 7:50 AM. A brown leather chair client #8 was sitting on had 22 light gray colored small stains on the left arm, one hole about an inch in diameter on the left side, and brown tape covering a tear on top of the chair on the left side. A light tan chair in program room one which was		record review, the to exercise operar facility to maintal room areas for 4 (clients #1, #2, #: additional clients #35, #36, #37, #4 the chairs in program room for P.M. until 4:00 P were sitting in stustuffing protrudir Staff #33 was int 4:03 P.M. Staff #2, #5, #17, #20, #45 regularly util program room for P.M. until 4:00 P.M. dient #8 was sitt colored small state hole about an inceside, and brown to top of the chair of the start o	the governing body failed thing direction over the plan chairs in program of 10 sampled clients 5, and #8) plus 8 of 47 (clients #17, #20, #29, #33, and #45) who utilized gram rooms one and four.  1. **Ext.** #17, #20, #29, #35, #35 were observed in pur on 9/19/11 from 3:00 P.M Clients #1 and #5 (uffed chairs which had and from torn areas.  1. **Ext.** #29, #35, #37, #43, and (lized the stuffed chairs in pur.  1. **Indicated clients #1, #29, #35, #37, #43, and (lized the stuffed chairs in pur.  1. **Indicated clients #1, #29, #35, #37, #43, and (lized the stuffed chairs in pur.  2. **Indicated clients #1, #29, #35, #37, #43, and (lized the stuffed chairs in pur.  3. **Indicated clients #1, #29, #35, #37, #43, and (lized the stuffed chairs in pur.  4. **Indicated clients #1, #29, #35, #37, #43, and (lized the stuffed chairs in pur.  5. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  6. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  6. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  8. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  8. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  9. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  1. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  1. **Indicated clients #1, #35, #37, #43, and (lized the stuffed chairs in pur.  1. **Indicated clients #1, #35, #37, #43, and #35, #37, #37, #37, #37, #37, #37, #37, #37	IAU	been initially assessed by maintenance staff for the r repair, covering or replace. Those chairs that have tea holes, they will be recover replaced. Chairs that have permanent stains will be compared by slip covers. Housekeep assess all chairs within the monthly and complete the furniture check list (Attach 104-A). Housekeeping will the furniture check list to the Maintenance Supervisor where schedule any repairs, covereplacements needed. Housekeeping responsible for check sheet. Maintenance will more for appropriate	eed of ment. rs or ed or overed oing will facility ment turn in ie ho will ering, or	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		(X2) MU A. BUIL B. WING	DING	nstruction 00	(X3) DATE ( COMPL 09/26/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
ARCADIA	A DEVELOPMENTA	AL CENTER		303 FRA	ANKLIN IA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	dark oval shaped hole on the right inch in diameter. chair which had stains to count or Interview on 9/20 staff #21 indicate stains were form automatic feedin dark tan chair withis time, which stains on the right sitting in a chair the left side 3" (i corner right in ba out of it, and a te 1/2 inch.  QMRP (Qualifie Professional) #1 9/21/11 at 1:00 Findicated any chair to responsible professional) #1 9/21/11 at 1:00 Findicated any chair to responsible professional but the professional of the professional with the professional of the professi	0/11 at 7:15 AM with ed she thought the white ula from the G-tube g pump. There was a th no one sitting on it at had a patch of black at arm. Client #36 was which had a tear in it on nches) by 3" wide on the ack with stuffing coming ear on the lower left side d Mental Retardation was interviewed on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			(X2) M A. BUII B. WIN	LDING	ONSTRUCTION  00	(X3) DATE COMPL <b>09/26/2</b>	ETED
	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ANKLIN DIA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W0125	clients. Therefore encourage individurights as clients of of the United State complaints, and the Based on observation failed to allow 2 of 2 and #4) and 7 additi #29, #35, #37, #43, unimpeded access to Findings include:  Clients #3, #4, #17, #45 were observed in 9/20/11 from 7:02 At the observation perilocked closet in program of the closet door and put to client # closet door and put to the closet door and put to the closet and clients we supplies in the closet QMRP (Qualified March Professional) #1 was 1:00 P.M QMRP # program room five supplies in control of the close to the clo		W	0125	For clients #3, 4, 17, 20,29,3 37, 43, and 45 on 9/21/2011 keyed lock was removed fror program room five's supply of door. Additionally, the electrequipment housed within this closet was adapted to ensure safety of clients accessing programmatic supplies. The personal hygiene boxes that discovered in group five's sucloset had been placed in thi closet 3 days prior to this observation. All clients' pershygiene boxes are regularly stored in the client's bathroom which they independently accondance in the client's hygiene boxes in their bathroom a routine, daily basis. Investigation noted that the sthat normally held the clients hygiene boxes in their bathroom decision to house the boxes the program room closet as a temporary measure until the in the bathroom could be replaced. The keyed lock was removed from program room five's supply closet. No keyelocks shall be placed on any supply closet that contains it for independent client access Personal hygiene items shall continue to be housed in each programmatic bathroom	the m closet onic s e the were pply s onal m of cess chelf oom dent in a shelf s ed ems s.	10/01/2011

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

PRINTED: 10/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G580	A. BUILDING B. WING		09/26/20	
	ROVIDER OR SUPPLIER		STREET 303 F	CADDRESS, CITY, STATE, ZIP CODE RANKLIN DIA, IN46030	<b>!</b>	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	<u> </u>	I	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W0136	clients. Therefore	nsure the rights of all , the facility must ensure		applicable and accessible for individual client use. Future modifications or repairs that affect client access to programmatic supplies or personal hygiene items will of during non-programmatic timperiods. If necessary, client hygiene boxes shall be place a roll-around cart that will be housed in their respective bathrooms to assure access while repairs can be made. Electronic equipment shall be placed or protected in such a manner that does not impeded client access to programmatic supplies. Prior to any necessare repairs or modifications that restrict client access to person hygiene or programmatic supplies, maintenance person shall discuss the necessary with supervisory staff. Supervisory staff. Supervisory staff shall make appropriate accommodations and/or decisions to ensure the clients continue to have access their supplies. Maintenance is responsible for repairs. The Administrator will monitor.	may  coccur ne ed in  e a e ic ary may conal connel repair the s nat ess to	
	in social, religious,	ne opportunity to participate , and community group				
	8 of 10 sampled #7, #8, #9 and #1	ew and record review for clients (#1, #3, #5, #6, 0), the facility failed to nts participated in	W0136	Community based activities (Activities that promote socialization with community members), shall be provided Client's #1, 3, 5, 6, 7, 8, 9, ar as outlined in the facility policy	to nd 10	10/10/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

324S11

Facility ID: 000730

If continuation sheet

Page 5 of 55

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150.580			ULTIPLE CO LDING	ONSTRUCTION  00	COMPLI	ETED
		15G580	B. WIN	IG		09/26/20	)11
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
4 D O 4 D I	A DEVELOPMENT	AL OFNITED			ANKLIN		
	A DEVELOPMENTA			ARCAD	01A, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<del> </del>	,		TAG	(Attachment W136 - A). The		DATE
		community on a			Activity Director shall implem		
	regular and/or	ongoing basis.			this revised policy to incorpo		
	Eta dia na in alcada.				client interests, level of		
	Findings includ	ie.			participation and choices with		
	1 Client #21s M				the community. The Policy fo community based activities s		
		onthly activity records			be implemented for Clients #		
		1 were reviewed on			5, 6, 7, 8, 9, 10 and all other		
		AM. Client #3's Monthly			clients. The Activities Direct		
	_	indicated client #3			shall maintain a log for all cli for review and tracking on a	ents	
		n activity/outing in the			monthly basis to ensure that	all	
	community on 1/3/11, 2/17/11, 6/28/11, 7/20/11 and 8/15/11.				clients are afforded the		
	//20/11 and 8/13	0/11.			opportunity to participate.		
		A .: 10 D:			Documentation will address weather, illnesses, refusals,	or	
		ne Activity Director on			other conditions as they	OI	
		AM indicated client #3			occur.The facility Administrat	tor	
		d had not participated in			shall review each monthly		
	-	y activities/outings in the			outing/activity calendar prior		
		asked how often clients			the coming month. In addition the Quarterly review Commit		
	participated in a				shall review all communty ba		
		Activity Director stated			activities specific to individua	ıl	
		or school kids and two			clients during their scheduled		
	times a month fo	or residents not in school."			time for review. The Program  Director is responsible for the		
					Quarterly Review meetings a		
					documenting meeting reports		
					.The Administrator or person		
					assigned by the Administrato		
	2 Client #1's ra	cords were reviewed on			monitor the Quarterly meetin	ys.	
		A.M A review of client					
		etivity Record from					
	1	11 indicated client #1					
	participated in co	-					
	_	s on 9/22/10, 10/22/10,					
	11/10/10, 12/29/	(10, 1/6/11, 3/3/11,					

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G580			ΓIPLE CON NG	OO	ľ í	e survey pleted /2011
	PROVIDER OR SUPPLIER		(	303 FRA	DDRESS, CITY, STATE, ZIP ( NKLIN A, IN46030	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) and 7/21/11	PR	ID EFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Activity Director 9/21/11 at 9:02 A indicated client at not participated activities/outings asked how often activities in the oractivities in the oractivity on the foractivity on the foractivity on the foractivity on the foractivity Director 9/21/11 at 9:02 A indicated client at not participated.	r was interviewed on A.M Activity Director IIII was in school and had in many community in the past year. When clients participated in community, the Activity IIIII at 10:15 AM of IIII					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	ľ í	TE SURVEY PLETED /2011
	PROVIDER OR SUPPLIER			303 FRA	.DDRESS, CITY, STATE, ZIP ( ANKLIN IA, IN46030	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	activities in the control Director stated, "kids and two time not in school."  5. The facility's for 2011 was revenue 9:00 AM and included the following of the following of the facility of the others twice a with the Qualified Professional #2 (1:00 PM was continicated the clief	ppointment tal evaluation cling Center Trip cling Center Trip cling Center Trip cling Trip Club with the Neighbors e Walk					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G580			ULTIPLE COI LDING IG	NSTRUCTION 00		X3) DATE SI COMPLE 09/26/20	TED
NAME OF I	DROVIDED OD GUDDI IEI				DDRESS, CITY, STA	TE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			303 FRA	ANKLIN			
ARCADIA	A DEVELOPMENTA	AL CENTER		ARCADI	IA, IN46030			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PL	AN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFI	CIENCY)		DATE
	1	Monthly Activity Record						
		riewed on 09/21/11 at						
		dicated client #10's						
	outings included	the following:						
	01/06/11							
	01/26/11 - Resta							
	02/21/11 - Dr's a	* *						
	03/28/11 - Store							
	1	cling Center Trip						
	04/12/11 - Resta							
	05/04/11 - Men's							
	06/01/11 - Men's							
	07/25/11 - Store							
		ent Events Outing						
	08/12/11 - Fair							
	An interview wi	th Activity Director (AD)						
		on 09/21/11 at 9:02 AM.						
		ed the school age clients						
		acility once an month and						
		twice a month. An						
		ne Qualified Mental						
		Sessional #2 (QMRP) on						
		PM was conducted. The						
		ated the clients should be						
	taken out into th							
	frequently as pos	•						
		was reviewed on 9/21/11 at 8:42						
		(Monthly Activity Record)						
		h August 2011 were reviewed. the following community based						
	activities:	3						
	-January 2011: No corecorded.	ommunity based activities						
	-February 2011:Com	munity based activity recorded						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	324S11	Facility II	D: 000730	If continuation she	eet Page	e 9 of 55

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			LDING	ONSTRUCTION  00	(X3) DATE COMPL 09/26/2	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		303 FR	ANKLIN		
ARCADIA	A DEVELOPMENTA	AL CENTER		ARCAD	IA, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	on 2/18/11.	CESC IDENTIFTING INFORMATION)		IAG			DATE
	-March 2011: Comm 3/3/11.	unity based activity recorded on					
	-April 2011: No community based activities recorded.						
	-May 2011: Community based activities recorded on 5/3/11.						
	-June 2011: No community based activities recorded.						
	-July 2011: Community based activities recorded on 7/6/11, 7/16/11 and 7/21/11.						
	-August 2011: No community based activities recorded.						
	PM. Client #6's MAR	was reviewed on 9/20/11 at 2:15 dated January 2011 through eviewed. The review indicated the based activities:					
	-January 2011: Com on: 1/18/11, 1/19/11.	munity based activities recorded					
	-February 2011: No orecorded.	community based activities					
	-March 2011: No cor recorded.	nmunity based activities					
	-April 2011: No comr	munity based activities recorded.					
	-May 2011: No comm	nunity based activities recorded.					
	-June 2011: Commu 6/13/11.	nity based activity recorded on					
	-July 2011: Commun 7/23/11.	nity based activity recorded on					
	-August 2011: No co recorded.	mmunity based activities					
	10/9/09 was reviewe policy indicated, "Ead	unity Based Activities Policy dated d on 9/21/11 at 9:00 A.M The ch non school age client will be nity to participate in 1 or more					

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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G580	A. BUILDING B. WING		09/26/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			ANKLIN	
ARCADIA	A DEVELOPMENTA	L CENTER		NA, IN46030	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	age client will be affor participate in 1 or more each month during the community based act.  Interview the facility A at 9:00 AM indicated supposed to go on 1 oschool aged clients at month. AD indicated the Administration Record and activities. When a	ivity each month. Each school reded the opportunity to re community based activity e school year and 1 or more ivity during non school months."  AD (Activity Director) on 9/20/11 the school aged clients are community based outing and non re supposed to go out 2 times a che clients' MARs (Medication ds) should contain all outings asked if medical appointments is dered outings, AD indicated ed outings.			
W0137	clients. Therefore that clients have the appropriate person clothing.  Based on observative record review for (#3 and #4) and for (#17, #20, #37 ar	nsure the rights of all, the facility must ensure he right to retain and use hal possessions and ation, interview and 2 of 10 sampled clients for 4 additional clients and #43), the facility failed ints' personal hygiene kits	W0137	For clients #3, 4, 17, 20, 37, 42 on 9/21/11 the keyed lock removed from program room five's supply closet door. Additionally, the electronic equipment housed within this closet was adapted to ensure safety of clients accessing	was

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		15G580	B. WIN			09/26/2	011
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
				303 FR/			
ARCADI	A DEVELOPMENT	AL CENTER		ARCAD	IA, IN46030		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	were not locked.				programmatic supplies. The		
					personal hygiene boxes that		
	D: 1: : 1 1				discovered in group five's su	pply	
	Findings include	<b>:</b>			closet had been placed in thi	S	
					closet 3 days prior to this		
	During the 9/18/	11 observation period			observation. All clients' pers	onal	
		A and 3:30 PM, in group			hygiene boxes are regularly		
		ivity closet door was			stored in the client's bathroon		
		•			which they independently ac	cess	
		PM, staff #2 obtained a			on a routine, daily basis.		
	1 *	n a wall where a phone			Investigation noted that the s		
	was located. Sta	iff #2 walked over to a			that normally held the clients		
	locked door and	unlocked the door with			hygiene boxes in their bathro	oom	
		staff #2 opened the supply			had broken. Maintenance	dont	
	_				personnel made an independ		
		tic containers with lids			decision to house the boxes the program room closet as		
	had client #3, #4	, #17, #20, #37 and #43's			temporary measure until the		
	names written or	n the plastic			in the bathroom could be	SHEII	
	containers/boxes	s. Interview with staff #2			replaced.The keyed lock was	3	
		30 PM indicated clients			removed from program room		
					five's supply closet. No keye		
		, #37 and #43's lotions,			locks shall be placed on any	-	
		ushes, Vaseline and other			supply closet that contains it	ems	
	personal hygiene	e supplies were kept in the			for independent client access		
	closet. Staff #2	indicated clients would			Personal hygiene items shall		
	have to ask the s	taff to get the key.			continue to be housed in eac	h	
		Bet one nej.			programmatic bathroom		
	C1:	1 1			applicable and accessible for	r	
		d was reviewed on			individual client use.Future		
	9/21/11 at 8:42 A	AM. Client #3's 7/21/11			modifications or repairs that	may	
	Individual Habil	itation Plan (IHP) did not			affect client access to		
		3's personal hygiene			programmatic supplies or		
	supplies needed				personal hygiene items will o		
	Supplies needed	to be focked.			during non-programmatic tim	ie	
					periods. If necessary, client	nd in	
		d was reviewed on			hygiene boxes shall be place		
	9/21/11 at 10:22	AM. Client #4's 11/3/10			a roll-around cart that will be housed in their respective		
	IHP did not indi	cate client #4's hygiene			bathrooms to assure access		
	supplies needed				while repairs can be made.		
	supplies needed	to oo locked.			Electronic equipment shall be	e	
					2222 22422		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580	(X2) MULTIPLE COI A. BUILDING B. WING	NSTRUCTION 00	· ′	E SURVEY LETED 2011		
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030					
Interview with Walified Mental Retardation Professionals (QMRPs) #1 and #2 on 9/21/11 at 9:53 AM indicated the supply/activity closet was kept locked in group 5. QMRP #1 and #2 indicated the clients' hygiene supplies to be kept locked as the hygiene kits were stored in the closet which housed the TV box and supplies. QMRP #1 and #2 indicated the closet which housed the Client #43 who would try to get to the closet. QMRP #2 indicated the closet key which was kept with the phone.  3.1-9(a)	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  placed or protected manner that does not client access to program supplies. Prior to any repairs or modification restrict client access hygiene or program supplies, maintenant shall discuss the newith supervisory staff shappropriate accommand/or decisions to clients continue to his their supplies. Mainter responsible for repair Administrator will meaning the supplies of the sup	in such a ot impede grammatic y necessary ons that may so to personal matic nece personnel cessary repair off. all make the modations ensure that have access to enane is hirs. The	(X5) COMPLETION DATE		
W0149  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  Based on observation, interview and record review, the facility failed: 1. To	W0149  4811 Facility II	The facility's Abuse Policy was revised of Mandatory all staff if Abuse and Neglect D: 000730 If co	on 10/4/2011. n-services on are held on a	10/26/2011		

STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	<b>i</b> '	NUMBER: A.	(2) MULTIPLE CON BUILDING WING	o0	(X3) DATE SURVEY  COMPLETED  09/26/2011
NAME OF PROVIDER OR S		<u> </u>	STREET AD	ODRESS, CITY, STATE, ZIP CODE NKLIN A, IN46030	
PREFIX (EACH D	MARY STATEMENT OF DEI EFICIENCY MUST BE PERC ORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
of 2 alleged 1 client (c) Failed to 6 of unknown clients living the admin allegations injuries of 3. Failed injuries of 57 clients and #49.)  Findings in 1. The fact 1 fact 1 fact 1 fact 2 fact 1 fact 2 fact 1 fact 2 fact 1 fa	its abuse/neglect pod abuse incidents to ient #6) was not abust in origin involving 1 ing at the facility (clistrator in regard to 1 of abuse, neglect ar unknown origin revious thoroughly investigations from 9/19/10 in following at the facility include:  all the facility of the following abuse a client #6], Incident Is a start the facility in the following abuse a client #6], Incident Is a start the facility in the following abuse a client #6], Incident Is a start the facility in the facil	ensure 1 of sed, and 2. all injuries of 57 ent #51) to of 6 ad/or iewed, and gate 2 of 5 olving 2 of (clients #37  reviewed on ew of 1 of 2 to 9/19/11 allegation: Date: of was to be was 6) into the client #6) own on the staff #78) client #6.] nember ff #78] and stated the hard ceeded to		quarterly basis. All staff are informed on what abuse is, we to look for and when and who report abuse and neglect to. They are informed that they are given copy of the Abuse and Negle Policy and sign off that they be read and understand the policity pertains to Client #6. In addition, all newly hired staff in-serviced and given a copy the Abuse and Neglect policy sign off that they have read a understand the policy as it pertains to Client #6. After it were ported that Client #51 was noted to have a 1" oblong brown to their upper left arm, nursing immediately went to assess that area. No bruise was found. However, staff were instructed report all noted injuries, on of #51 and all other clients to nursing immediately. Nursing immediately. Nursing immediately report all injuries the Administator, Program Director and Director of Nursing. After the IDT review the incident report for Client it was determined that Client had sustained the bruises in manner described on the increport. However, in the futur the individual will be more exing the verbiage used when we the cause of the incident for Client #49. After the IDT review the incident report for Client it was determined that Client in the verbiage used when we the cause of the incident for Client #49. After the IDT review the incident report for Client it was determined that Client it was determined that Client had sustained the bruises in the verbiage used when we the cause of the incident for Client it was determined that Client had sustained the bruises in the verbiage used when we the cause of the incident for Client it was determined that Client had sustained the bruises in the verbiage used when we the cause of the incident for Client incident report for Client in the verbiage used when we the cause of the incident for Client was determined that Client had sustained the bruises in the verbiage used when we the cause of the incident for Client in the verbiage used when we the cause of the incident for Client in the verbiage used when we the cause of the in	are to are to are to are to a a ect have icy as are of y and and was uise ug the ed to lient g will s to ed #49, #49 the ident e, cplicit rriting ewed #39, #39

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION  00	(X3) DATE SUI COMPLET 09/26/201	ED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	(X5) COMPLETION DATE	
TAG	into the bathroor (staff #80 and #80 One of the staff rimmediately reposupervisor. Plan facility policy, the asked [staff #78] there was an alle her. [Staff #78] assessed [client #7 There were none (Qualified Mental Professional) #17 Administrator be After a thorough determined that the founded. [Staff in 1:00 P.M QMF was abused by staff as abused by staff in 1:00 P.M QMF was abused by staff in 1:00 P.M	m. Two staff members (31) witnessed the incident. members (staff #80) orted the incident to the to Resolve: As per our he supervisor immediately to leave the facility, that the regation of abuse against left the facility. Nursing [#6] for any injuries.  Myself (QMRP al Retardation and the Assistant regan an investigation. investigation it was the allegation was [#78] was terminated."  Meterviewed on 9/21/11 at RP #1 indicated client #6 reaff #78.  Ords were reviewed on P.M A review of the and Neglect Policy and de 4/26/11, indicated in hig: "Staff will ensure the eatment of all clients by the use of physical, in psychological abuse of		TAG	manner described on the increport. However, in the futur the individual will be more ex in the verbiage used when we the cause of the incident for Client #39. However, staff was instructed to report all noted injuries, on all clients, to nursimmediately. Nursing will immediately report all injuries the Administrator, Program Director and Director of Nursing. The IDT will review to incident reports, on a weekly basis, to determine that injur unknown origin are described manner that is appropriate at that verbiage is explicit on the incident report for all clients. As staff will continue to be in-serviced on the facility Abrand Neglect Policy and Procedure, including reporting injuries, on a quarterly basis needed to ensure that mistreatment of all clients is avoided. The IDT will review to incident reports, on a weekly basis, to determined that injured of unknown origin are described in a manner that is appropriate and that verbiage is explicit to the incident report for all clients. All staff will continue to in-serviced on the facility Abrand Neglect Policy and Procedure, including reporting in a manner that is appropriate and that verbiage is explicit of the incident report for all clients. All staff will continue to in-serviced on the facility Abrand Neglect Policy and Procedure, including reporting injuries, on a quarterly basis needed to ensure that mistreatment of all clients is avoided. The facility will continue to hold mandatory all staff	ident e, cplicit rriting as sing s to the dies of d in a nd e All use ag of or as the dries bed te on o be use ag of or as	DATE	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility II	D: 000730 If continuation sl	heet Page	15 of 55	

	ATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPL 09/26/2	ETED	
			B. WIN	_	DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			303 FRA				
ARCADIA	A DEVELOPMENTA	AL CENTER		ARCADIA, IN46030				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΓE	COMPLETION	
IAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	in-services on reporting of in	uries	DATE	
	1	ity will further ensure e free from neglect.			immediately to nursing, on a	uncs		
		ude the failure to provide			quarterly basis or as needed			
	•	•			Nursing will immediately repo			
	appropriate care, food, medical care or supervision."				injuries to the Administrator, Program Director and Director of			
	Sup Cr vision.				Nursing.The IDT will continue			
					monitor the effectiveness of	, and		
	2. During the 9/20/11 observation period between 5:30 AM and 7:50 AM, at the facility, client #51 had an 1 inch oblong shaped bruise to his upper left arm which was purple/black in color. Interview with				the Abuse and Neglect Policy Procedure, including reporting			
					injuries, quarterly or as need	ed to		
					ensure that mistreatment of a			
					clients is avoided. In addition IDT will continue to monitor a			
					reporting of incidents ensuring			
	staff #6 on 9/19/2	11 at 7:43 AM indicated			that the Administrator has be	en		
	she did not know	how client #51 received			notified of all incidents.			
	the injury/bruise.							
	The facility's inte	ornal incident reports						
	reportable incide	ernal incident reports,						
	•	ere reviewed on 9/19/11						
		ne facility's 9/11 internal						
		and/or reportable incident						
	_	client #51's injury of						
		had not been reported to						
	the facility's adm	-						
		100 136						
	Interview with Q	•						
		essionals (QMRPs) #1						
		etor of Nursing (DON),						
	the Assistant Dir	•						
	(ADON) and the							
	_	/11 at 9:53 AM indicated n made aware of client						
	1	ry. The DON indicated						
		had not made her aware						
	ine racinty start i	nua not muae not uvidie						

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION 00		X3) DATE COMPL 09/26/2	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STA NKLIN A, IN46030	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	PLAN OF CORRECTION FE ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	(X5) COMPLETION DATE
	of client #51's in report to the adm	jury of unknown origin to inistrator.						
	9/21/11 at 2:22 F facility's "Abuse Procedure", date part, the following includes: Inciderand investigation	ords were reviewed on P.M A review of the and Neglect Policy and d 4/26/11, indicated in ag: "This system and Accident reporting a by the facility's Program intereporting to the trator"						
	9/19/11 at 12:50 incidents of unkr	records were reviewed on P.M A review 2 of 5 nown injuries from 1 indicated the following turies:						
	8/16/11, Nursing Noted clusters of brown bruise 0.8 1.2 cm, 0.2 cm x cm x 0.4 cm, 0.1 surround by 0.1 (left) upper arm. Dry skin was not	ent #49], Incident Date: g Description of Injury: f small fading yellow f cm (centimeters) x (by) 0.4, 0/6 cm x 0.6 cm, 1.2 cm x 0.2 cm. All x 1.4 superficial scratch L Investigative Findings: ted around the area. It is ent #49) scratched herself						
	_	ent #39], Incident Date: g Description of Injury:						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility II	D: 000730	If continuation sh	eet Pa	ge 17 of 55

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	A. BUIL	DING	NSTRUCTION  00	l í	E SURVEY PLETED 2011
			B. WINC		DDRESS, CITY, STATE, ZIP		2011
NAME OF F	PROVIDER OR SUPPLIER			303 FR			
ARCADIA	A DEVELOPMENTA	AL CENTER		ARCAD	IA, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	DRRECTION SHOULD BE	(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
_		with 6 x (by) 1.5 cm		_			
	` ′	sion with scab - 0S/S of					
	infec. (zero signs	s of infection.)					
	_	dings: [Client #39] was					
	observed to be so	eratching himself."					
	Th. 0/1//11 ::	a contra a contra					
	The 8/16/11 injury of unknown origin involving client #49 and the 4/20/11 injury of unknown injury involving client #39 were further reviewed on 9/19/11 at 1:03 P.M The review failed to indicate documentation of interviews with staff or review of preceding activities to support						
		f client #49 scratching					
		ise of the injury, and of					
		ning himself as the cause					
	of the injury.						
	OMRP #1 was ir	nterviewed on 9/21/11 at					
	-	RP #1 indicated the					
	-	/11 injuries of unknown					
	origin did not ha	ve supporting					
		which their respective					
	conclusions coul	d be drawn from.					
	The facility's rec	cords were reviewed on					
		P.M A review of the					
		and Neglect Policy and					
	1	d 4/26/11, indicated in					
	· ·	ng: "The Program					
	Director will then	n conduct a thorough					
	investigation	."					
	2 1 29(a)						
	3.1.28(a)						

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULTI  A. BUILDIN  B. WING		00	(X3) DATE ( COMPL 09/26/20	ETED
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER			ST 30	3 FRAN	DRESS, CITY, STATE, ZIP CODE NKLIN a, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
W0153	mistreatment, neg injuries of unknow immediately to the officials in accordate established proced. Based on observative record review for abuse, neglect an origin reviewed in facility failed to reported all injurt the administrator law.  Findings include  During the 9/20/between 5:30 AM facility, client #5 shaped bruise to was purple/black staff #6 on 9/19/3 she did not know the injury/bruise.  The facility's intereportable incide investigations were	ation, interview and r 1 of 6 allegations of d/or injuries of unknown nvolving client #51, the ensure staff immediately ies of unknown origin to r in accordance with state  11 observation period M and 7:50 AM, at the 1 had an 1 inch oblong his upper left arm which in color. Interview with 11 at 7:43 AM indicated r how client #51 received	W015	3	After it was reported that Clie #51 was noted to have a 1" oblong bruise to their upper larm, nursing immediately we assess the area. No bruise found. However, staff was instructed to report all noted injuries, on client #51 to nurs immediately. Nursing will immediately report all injuries the Administrator, Program Director and Director of Nursing. However, staff was instructed to report all noted injuries, on all clients, to nurs immediately. Nursing will immediately report all injuries the Administrator, Program Director and Director of Nursing. The facility will contit to hold mandatory all staff in-services on reporting of injuries to the Administrator, Program Director and Director and Director Nursing will immediately reporting injuries to the Administrator, Program Director and Director Nursing. In addition, the IDT continue to monitor all report of incidents on a weekly bas they occur, ensuring that the	left ent to was sing s to sing s to nue juries ort all or of will sing is as	10/01/2011

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL <b>09/26/2</b>	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	reports indicated	and/or reportable incident client #51's injury of nad not been reported to inistrator.			Administrator has been notifi all incidents.	ed of	
	and #2, the Directhe Assistant Director (ADON) and the Manager on 9/21 they had not been #51's bruise/injurthe facility staff!	essionals (QMRPs) #1 tor of Nursing (DON), ector of Nursing Business/Office /11 at 9:53 AM indicated in made aware of client ry. The DON indicated had not made her aware fury of unknown origin to					
W0154	Based on record facility failed to sthorough investiginguries of unkno	ave evidence that all are thoroughly investigated.  review and interview, the show evidence of a gation of 2 of 5 reviewed wn origin involving 2 of at the facility (clients #39	W	0154	After the IDT reviewed the incident report for Clent #49, was determined that Client # had sustained the bruises in manner described on the increport. However, in the futur the individual will be more ex in the verbiage used when we the cause of the incident for Client #49. After the IDT reviewed the incident report Client #39, it was determined Client #39 had sustained the	49 the ident e, cplicit riting for	10/26/2011

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/26/2	ETED
NAME OF	PROVIDER OR SUPPLIEI	· R	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ARCADI	A DEVELOPMENT	AL CENTER	ARCAD	IA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	9/19/11 at 12:50 incidents of unkty 9/19/10 to 9/19/10 to 9/19/10 to 9/19/10 two unknown in A. "Name: [Cli 8/16/11, Nursin Noted clusters of brown bruise 0.8 1.2 cm, 0.2 cm x cm x 0.4 cm, 0.1 surround by 0.1 (left) upper arm. Dry skin was not believed she (cli causing the area.  B. "Name: [Cli 4/20/11, Nursin L (left) side necl (centimeter) about infec. (zero sign Investigative Firobserved to be some the side of the side o	ent #49], Incident Date: g Description of Injury: f small fading yellow g cm (centimeters) x (by) g 0.4, 0/6 cm x 0.6 cm, 1.2 cm x 0.2 cm. All x 1.4 superficial scratch L Investigative Findings: ted around the area. It is ent #49) scratched herself " ent #39], Incident Date: g Description of Injury: x with 6 x (by) 1.5 cm asion with scab - 0S/S of		bruises in the manner descion the incident report. How in the future, the individual more explicit in the verbiage when writing the cause of the incident for Client #39. The limit will review the incident report a weekly basis, to determine that injuries of unknown original described in a manner that appropriate and that verbiage explicit on the incident report all clients.	ever, will be e used ne DT rts, on ed gin are is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	i ´		(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/26/2011	
NAME OF PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030					
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
client #39 scrate of the injury.  QMRP #1 was in 1:00 P.M QMI 8/16/11 and 4/20 origin did not had ocumentation to conclusions could 3.1-28(a)  W0210  Within 30 days affinterdisciplinary to assessments or resupplement the piconducted prior to Based on intervi 1 of 10 sampled failed to re-asses and/or diagnosis (ingesting inedit Findings include Client #3's recorn 9/21/11 at 8:42 aphysician's order diagnosis include PICA. Client #3	der admission, the sam must perform accurate eassessments as needed to reliminary evaluation admission.  ew and record review for clients (#3), the facility as a client's behavior in regard to PICA ale objects/items).  der was reviewed on AM. Client #3's 8/22/11 as indicated client #3's ed, but was not limited to 1's 8/22/11 physician's the client was diagnosed 1/08.	W02	Facility IC	On 10/13/2011, the IDT/Beha Management Committee discussed Client #3's diagnor PICA behavior. He was assessed for PICA behavior 10/13/2011(See attachment W210-A). (This client has not exhibited PICA behavior since admission in 2009.) A Behavior Protocol was developed for the possibility of PICA for Client: (See attachment W210 - B) behaviors, including PICA wireviewed on a quarterly basis the scheduled Quarterly Reviewed on a quarterly Reviewed on a quarterly Reviewed program Plan meeting annual The Behavior Management Committee will review his behavior data as needed or a committee will review his data as needed or a committee will review his data as needed or a committee will review his data as needed or a committee will review his data as needed or a committee will re	sis of on ot ee his vior he #3. His II be s at iew al ally.	10/26/2011	

TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  Reast weekly. All clients with a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER  (X4) ID  PREFIX  TAG  Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA.  Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN46030  ID  PROVIDERS PLAN OF CORRECTION ARCADIA, IN46030  ID  PROVIDES PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  DEFICIENCY  PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In	TED	
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA.  Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN46030  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  I least weekly. All clients with a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In	11	
ARCADIA DEVELOPMENTAL CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA. Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Least weekly. All clients with a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In		
ARCADIA, IN46030  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG  Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA. Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  (X4) ID SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY) PREFIX (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERN CETON OF CORRECTION SHOULD BE CROSS-REFERN CETON OF CORRECTION OF CORRECTION SHOULD BE CROSS-REFERN CETON OF CORRECTION OF COR		
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CONSTITUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA.  Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  PREFIX TAG  PREFIX	(X5)	
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  DEFICIENCY)  least weekly. All clients with a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  TAG  DEFICIENCY)  least weekly. All clients with a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In	COMPLETION	
Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not address and/or indicate client #3 had a behavior plan for PICA. Client #3's 7/21/11 IHP did not indicate the facility was tracking any behaviors related to the client's PICA diagnosis, and/or re-assessed the client's PICA  diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at their Individual Program Plan meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In	DATE	
diagnosis to determine if the client actually had PICA.  Interview with school staff #4 on 9/20/11 at 9:35 AM indicated client #3 had eyeglasses but he did not wear them at school. School staff #4 stated if client #3 wore his eyeglasses, client #3 would "try to eat them."  Interview with Qualified Mental Retardation Professionals (QMRPs) #1 and #2, the Assistant Director of Nursing (ADON), the Director of Nursing (DON) on 9/21/11 at 9:53 AM indicated client #3 had a diagnosis of PICA. QMRP #1 indicated stated client #3 had a "history of PICA." QMRP #1 and #2 indicated client #3 had a "history of PICA behavior. The Shift Department head will monitor the Program Rooms on a daily basis. Direct Care Staff will document all PICA behavior on a daily basis. Direct Care Staff will document all PICA behavior on a daily basis. The Program Director will collect and monitor the behavior at a diagnosis of PICA or a history of PICA will be reviewed on a quarterly basis at the scheduled Quarterly will be reviewed on a quarterly basis at the scheduled program Plan and their individual Program Plan at their ledividual Program Plan at their ledividual Program Plan and their lindividual Program Plan and their lindividual Program Plan and their leaview on a quarterly basis at the scheduled Quarterly pasis at the scheduled clients will be reviewed on a quarterly basis at the scheduled client will be reviewed on a quarterly basis at the scheduled client will be reviewed on a quarterly pasis at the scheduled review the rile beases of their leaview their beaview meetings and at their leaview their beaview their behavior data for PICA behavior on Oct. 26, 2011. They will be instructed how to document PICA behavior on oct. 26, 2011. They will be instructed how to document PICA behavior on a daily basis. Direct Care Staff will document all PICA behavior on a daily basis. The Program Director will collect and		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULT A. BUILDI B. WING		00	(X3) DATE S COMPL 09/26/20	ETED
	PROVIDER OR SUPPLIER		S 3	303 FRAN	DRESS, CITY, STATE, ZIP CODE NKLIN 1, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
W0249	3.1-31(a) 3.1-31(d)  As soon as the interpretation of the interventions and some of the individual programmers of the individu	erdisciplinary team has 's individual program plan, eceive a continuous active consisting of needed services in sufficient ency to support the electropy objectives identified in the plan.  ation, record review, and eality failed to assure provided a continuous program during times of of 10 sampled clients 4, #5, #7, #8, #9, and a facility.	W02		meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In addition, all newly admitted of will be assess for PICA upon admission. They will be revie on a quarterly basis at the scheduled Quarterly Review meetings and at his Individual Program Plan meeting. The Behavior Management Committee will review their behavior data as needed or at least weekly.  The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on redirection to a meaningful activity/training, communicati implementation of prioritized objectives and informal opportunities for Client #3, 5, 20 as well as all other clients addition, the nursing staff will educated on the need for medication and treatment goa and when to perform them fo Client #3 and for all other clie The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on ol choices, communication and socialization for Client #4.The	lients their ewed  I  on,  and In be als r ents.	10/26/2011

000730

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G580	B. WIN	G		09/26/20	11
NAME OF E	PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE		
				303 FRA			
ARCADI/	A DEVELOPMENTA	AL CENTER		ARCADI	A, IN46030		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		wheelchair without an			Staff Development Coordinat	tor	
	activity, sat and t	flapped his hands near his			will in-service all Direct Care Staff/CNA's on redirection to	a	
	head/ears, sat hol	lding a toy item in his			meaningful activity for Client	I	
	hand, and/or sat v	with the toy item at/in his			5, and all other clientsThe Sta		
		staff #2, #7 and/or #8 not			Development Coordinator wil		
		t to participate in a more			in-service all Direct Care		
					Staff/CNA's on Active Treatm		
	meaningful activity and/or training.  During the above mentioned observation				for Client #7, 8, and all other		
	During the above mentioned observation				clients. In addition, the nursing staff will be educated on the		
	period, staff did not encourage the client				for medication and treatment	I	
	to answer questions nor offer the client a choice of activity to participate in as staff				goals and when to perform the		
	_				for Client #7, 8, and all other		
		#3 an object/toy. When			clientsThe Staff Developme		
		d his 4 PM medications			Coordinator will in-service all		
		lified Medication			Direct Care Staff/CNA's onfollowing Client #9, 10 as v	vell	
	Assistant #5 did	not provide any			as all other clients Active	WCII	
	medication traini	ing to client #3. At 5:02			Treatment Schedule.The Sta	ff	
		ed client #3 into the			Development Coordinator wil		
	-	is table. Client #3 did			in-service all Direct Care		
	_	the dining room with an			Staff/CNA's on redirection to	а	
	assistive device.				meaningful activity/training, communication, implementat	ion	
	and the device.				of prioritized objectives and	IUII	
	Client #21a	d was reviewed on			informal opportunities for all	1	
					clients. In addition, the nursi	ng	
		AM. Client #3's 7/21/11			staff will be educated on the	need	
		e client had the following			for medication and treatment		
	_	s which facility staff did			goals and when to perform the	nem	
	_	hen opportunities for			for all clients. The Staff	, [	
	training existed:				Development Coordinator wil in-service all Direct Care	"	
					Staff/CNA's on redirection to	a	
	-encourage to sta	y focused on current			meaningful activity,	1	
	activity for 2 min	-			implementation of prioritized		
	1	swer yes or no questions			objectives, informal opportun	ities	
	_	lect a desired leisure			and staff interaction for all	.	
	1	a choice of 2 using			clients. The staff Developmen Coordinator will in-service all		
	reach/grasp	a choice of 2 using			Direct CareStaff/CNA's oncli	I	
		-					
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	324S11	Facility II	D: 000730 If continuation sh	neet Page	e 25 of 55

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/26/2</b>	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	client had object peers for 2 minutes a magazine, main staff for 10 second in program room dining room for and an objective trash after medic which staff did in formal and/or into opportunities for Interview with Question and #2 on 9/21/1 facility staff shout IHP and/or provisto participate in indicated facility the client's gait to dining room for 19/19/11.  2. During the 9/19/11.  2. During the 9/19/11.  2. During the 9/19/11.	existed.			choices, communication and socialization for all clients. The Program Director, QMRP's, Separtment Heads and Staff Development Coordinator wiperform random audits daily training areas to ensure all continuous Active Treatment The Director of Nursing will in-service nursing staff on medication goals. The Program Director will schedule the in-services for the Staff Developmental Coordinator. addition, the Program Director QMRP's and shift Department Heads will perform random a of all training areas to ensure clients are receiving consistents. The finding any, will be relayed to the Staff Development Coordinator. Staff Development Coordinator. Staff Development Coordinator. Staff Development Coordinator. Staff Development Coordinator will re-train in the areas of the findings. Periodic observation medication administration wincotinue by the Director of Nursing walso continue.	In I	

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X	(2) MULTIPLE CO			X3) DATE COMPL	
AND PLAN	OF CORRECTION	15G580	A.	BUILDING	00		09/26/2	
		100000	В.	WING			09/20/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STA	ATE, ZIP CODE		
ADCADI	A DEVELODMENTA	NI CENTED			ANKLIN			
	A DEVELOPMENTA				DIA, IN46030			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY F LLSC IDENTIFYING INFORMAT	ı	PREFIX TAG	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIATI FICIENCY)	E	COMPLETION DATE
IAU				IAU	DL.	,		DATE
	1	on the client 2 differen						
		e client #5 immediately						
		glasses and threw them						
		r. Client #5 would then	ı					
	place the toy item back up to the side of							
	his head.							
		d was reviewed on						
		AM. Client #5's 2/14/11	l					
	Individual Habilitation plan (IHP)							
	indicated the client had objectives to roll a							
	ball with staff for 2 minutes, to place three							
	shapes into a shape sorter correctly, to							
	hand staff a quar	ter and an objective to						
	1	ntact with staff for 20						
	1	taff #1 and #6 did not						
		formal and/or informal						
	-	training existed.						
	- 17							
	Interview with O	MRPs #1 and #2 on						
	`	AM indicated facility sta	aff					
		nt client #5's IHP and/or						
	provide activities		•					
	participate in.	5 for the enem to						
	participate III.							
	3 During the 0/	19/11 observation perio						
		A and 3:30 PM and from						
		PM, in group 5, client						
		ctivity in a lounge chair						
		ected to participate in						
	~	t 4 with facility staff.						
		offer the client a choice						
	-	icipate in. Client #4 sat						
	holding the Conr	nect 4 chips, and/or						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Even	it ID: 3245	S11 Facility	ID: 000730	If continuation she	eet Pa	ge 27 of 55

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

		X1) PROVIDER/SUPPLIER/O		(X2) MU	LTIPLE CON	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	Χ.	A. BUILI	DING	00			
		15G580		B. WING	_			09/26/2	UII
NAME OF F	PROVIDER OR SUPPLIER	<del></del>				DDRESS, CITY, STA	ATE, ZIP CODE		
				- [	303 FRA				
	A DEVELOPMENTA					A, IN46030			
(X4) ID		TATEMENT OF DEFICIENCE		_	ID		PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY LISC IDENTIFYING INFORM		I F	PREFIX TAG	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION DATE
IAU			millow)	<del>                                     </del>	IAU	DEF	- •		DATE
	Connect 4 slots v	p the chips into the			1			ļ	
			۵					ļ	
		ing on how to play th						İ	
	-	would release the chip	-					İ	
	when client #4 filled the slots up and the client would start all over again. Staff #2,							İ	
								İ	
		not redirect the clien	ii io					ļ	
		y other meaningful			1				
	activity/training. During the above							]	
	mentioned observation period, staff did				1				
	not encourage client #4 to socialize with							]	
	others and/or provide communication				1				
	_	non-verbal client in	that		1				
	the client did not	t speak.						ļ	
								ļ	
		d was reviewed on			1			]	
		AM. Client #4's 11/			1				
		e client had objective			1			]	
	teach discriminat	tion skills, identify th	ne					]	
	_	when given 2 groupi	_					]	
	of objects, to ma	tch 4 common object	ts to					]	
	their matching pi	icture, to remove lids	to 3					ļ	
	twist top contain	ers, to match 4 coins	, and		1				
	to maintain her a	attention to a selected	ļ		1			]	
	magazine for 5 n	ninutes. Client #5's							
	•	indicated the client	had a					İ	
		e for staff to encourage						İ	
	· ·	ate in social activities						ļ	
		lary and language ski			1			]	
	_	jective to encourage t			1				
		e with peers at a table			1				
		aff did not implemen			1				
	1	l/or informal training						]	
	opportunities exi	-						]	
EODA CO			t ID	46::		). 000==:	TC		00 1==
гокм смs-2	567(02-99) Previous Version	ons Obsolete E	Event ID: 324	4S11	Facility II	D: 000730	If continuation sh	neet Par	ge 28 of 55

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	Ì	LDING	NSTRUCTION  00	l í	e survey pleted /2011
NAME OF	PROVIDER OR SUPPLIE	R	_	STREET A	ADDRESS, CITY, STATE, ZIP CO ANKI IN	DE	
ARCADI	A DEVELOPMENT	AL CENTER			IA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Interview with (9/21/11 at 9:53 ashould impleme provide activities participate in.  4. Clients #2 an program room for P.M. until 4:00 P.M., holding a plastic time period, client holding a book. not observed to and #5 in engage or training program or training program (11 at 10:58 client's 10/4/10 at indicated the fol which could have during the 9/19/	QMRPs #1 and #2 on AM indicated facility staff nt client #4's IHP and/or es for the client to  ad #5 were observed in our on 9/19/11 from 3:00 P.M From 3:00 P.M. client #2 sat in a chair e object. During the same ent #5 sat in a chair Staff #33 and #34 were prompt or assist clients #2 ing any structured activity				PROPRIATE	
	minute. 2. Will name when pres names. 3. Will and stating its na dissimilar coins.	I.D. (identify) printed sented with dissimilar I.D. penny by pointing same when presented with 4. Will trace the A, B, C, D, E. 5. Will					
	Client #5's recor	rd was reviewed on					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		MULTIPLE CON ILDING NG	NSTRUCTION 00		COMPL 09/26/2	ETED
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	5. 11.	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
ARCADIA	A DEVELOPMENTA	AL CENTER		303 FRA ARCADI	ANKLIN A, IN46030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULI LISC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	Ē	(X5) COMPLETION DATE
	9/21/11 at 12:05 client's 2/8/11 In indicated the followhich could have during the 9/19/11. Will roll ball 2. Will place 3 start 3. Will hand a quest. 4. Will with staff for 20 him."  QMRP (Qualified Professional) #1 9/21/11 at 1:00 Findicated staff are objectives during 5. Observations 9/19/11 from 1:5 Program Room 6 shape sorter box using. Client #8 any activity. At started reading a 2:15 PM, staff #2 client #7 and we showed him a todid not use them #7 if she wanted Staff #22 took to show him. Client At 2:25 Prompting client to the start of the show him. Client was a c	A.M A review of the adividual Program Plan lowing training objectives to been implemented 11 observation period: I with staff for 2 minutes. Shapes into a shape sorter quarter to staff upon 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 2 maintain eye contact seconds as staff speaks to 2 maintain eye contact seconds as staff speaks to 2 maintain eye contact seconds as staff speaks to 2 maintain eye contact seconds as staff speaks to 2 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff speaks to 1 maintain eye contact seconds as staff upon 1 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 2 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 maintain eye contact seconds as staff upon 3 ma						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID	· 324S11	Facility II	D: 000730	If continuation she	et Pac	ge 30 of 55

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION 00		X3) DATE COMPL 09/26/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<b>1</b>	<u> </u>		DDRESS, CITY, STA	ATE, ZIP CODE		
ARCADI	A DEVELOPMENTA	AL CENTER		ARCADI	A, IN46030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	Ē	(X5) COMPLETION DATE
	shape sorter box #8 the shapes an At 2:40 PM, staff client #8. Staff # client #7's lap. O to it. At 2:50 PM his lap tray but v 3:00 PM, staff st and #8 into their PM, clients #7 ar row in their whe meds, along with program room of 4:10 PM, clients wheelchairs. Du brought in music went up and dow various clients. #8 getting chang was no continuo on from 3:00 PM got their meds. A given 6 meds bu training by staff #8 was given 2 m med training by Review on 9/21/ #7's records was ISP dated 11/11/ objectives: Main story, magazine lift her head a fe of her meal, raise	She was handing client d he put them in the box. If #23 started reading to #24 put a cloth doll on Client #7 did not respond M, client #8 had a book on was not looking at it. At tarted putting clients #7 wheelchairs. By 3:15 and #8 were lined up in a elchairs awaiting their in 11 other clients in inc. From 3:15 PM to were lined up in their uring this time, staff #24 on the line talking to Except for clients #7 and the interest was active treatment going M to 4:10 PM, when they is active treatment going M to 4:10 PM, client #7 was to there was no med #25. At 4:17 PM, client meds, but there was no staff #25.  If at 10:15 AM of client conducted. Client #7's included the following intain attention to book, by looking for 2 minutes, we inches to accept 5 bites the her head to assist with						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility II	D: 000730	If continuation she	eet Pa	ge 31 of 55

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	LDING	NSTRUCTION 00	COM	TE SURVEY  TPLETED  5/2011
	PROVIDER OR SUPPLIER		303 FRA	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	quarter when sho preferred DVD for respond to text, if facial expression at staff when her hold an empty spadministration.  Review on 9/21/#8's records was ISP dated 2/10/1 objectives: look name is called, relap one at a time from staff within musical device a without interrupt position in reclinic washcloth during	own with a penny, select from two using eye gaze, tem rubbed to hand using s, raise her head to look name is called, and will boon during med  11 at 9:20 AM of client conducted. Client #8's 1 included the following toward staff when his emove 3 items from his grasp presented item a 3 seconds, attend to ctivated for 3 seconds ion, maintain sitting ter for 10 minutes, hold g med administration, and tem from staff with 3				
	room #3 on 09/2 until 3:30 PM. A staff (staff #24 a room who remai observation time	were conducted in group 0/11 from from 1:00 PM At 1:00 PM there were 2 and #25) present in the ned during the . During the observation oon "Sponge Bob" was on				

000730

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION 00	COM	ee survey ipleted 5/2011
	PROVIDER OR SUPPLIE		•	303 FRA	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	TV. Client #9 w wheelchair which The lap tray condropped to the fleelbows on the latin his hands. At wooden children Client #9 did not puzzle. At 2:30 into room and lot At 2:50 PM client place his head be eyes closed. The changed from "S Turtles."  Observations we room #3 on 09/2 10:45 AM. At 9 staff (staff #21, in the classroom times Mickey M were on the TV. following activity observation: satin his hands on the bathroom to be ownted a "toy" at toy was placed of AM client #9 was for a Dr's appoint.	ras observed to sit in his h contained a lap tray. Itained a toy car which he oor. Client #9 put his p tray and placed his head 2:00 PM staff #25 put a ray by puzzle on the lap tray. It attempt to work the PM nursing staff came roked at client #9's chin. In the stage of the lap tray was observed to rack in his hands with his regroup room TV was by ponge Bob" to "Ninja reconducted in group 2/11 from 9:15 AM until 1:15 AM there were three 1:26 and #27) to 10 clients and Benjie the dog Client #9 had the ries during the ries during the ries during the reconducted in his lap tray. At 10:41 as taken out of the room					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		LDING	NSTRUCTION 00		X3) DATE S COMPLI <b>09/26/2</b> (	ETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STA ANKLIN IA, IN46030	ATE, ZIP CODE		
				<u> </u>	171, 1114-0000			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENC	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	Ē	(X5) COMPLETION DATE
TAG	active treatment following for the 5:00-7:30 AM - dressing for the 6 activity, medicat goal" 7:30-8:00 AM - dressing, etc" 8:00-9:00 AM - Motor, Sensory 9:00-10:00 AM - Vocational Stimu 10:00-10:30 AM (trucks, TV, puzzleisure item, gam socializing, etc." 10:30-11:00 AM Group Activity" 11:00-12:30 PM Structured Leisu 12:30-1:30 PM - Activity" 1:30-3:30 PM - Communication' 3:30-4:00 PM - Choice of Activity 4:00-5:00 PM - Structure Recrea 5:00-7:00 PM - Communication, TV, Parties If Sc Activity, Bathing If Applicable, Etc.	schedule indicated the especified time frames: "Get up, toileting, day, independent leisure ion goal, breakfast, eating "Toothbrushing, toileting, "Academics, Gross Stimulation" - "Communication, ulation" - "Choice of Activity zles, magazines, radio, nes, table activities, "I - "Toileting, Large -" Lunch, Eating Goals, re" - "Recreation, Group 'Leisure, " 'Toileting, Handwashing, ty, Socializing" 'Dinner, Eating, Goals, ation" 'Recreation, Leisure, Choice of Activities, cheduled, Movies, Group g, Special Events, Outing		TAG				DATE
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility I	D: 000730	If continuation she	et Pac	ne 34 of 55

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE COI LDING	NSTRUCTION 00		(X3) DATE COMPL	
		15G580	B. WIN				09/26/2	011
NAME OF I	DDOMDED OF GIRDING				DDRESS, CITY, STAT	TE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	X.		303 FRA				
	A DEVELOPMENT			<u> </u>	A, IN46030			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE CROSS-REFERENCED		ΓE	COMPLETION
TAG				TAG	BLITE	illi(C1)		DATE
	•	orushing, Choice Of						
	etc"	eting, Medication Goal,						
		l not follow and/or						
		t #9's active treatment						
	schedule as writ							
	Client #9's Indiv	ridual Habilitation Plan						
		10/28/10 and contained						
	` ′	ted to the following goals:						
		tured item for 5 seconds;						
	select 1 item from							
		eisure activity for 5						
	minutes; when s	poken to, will look at the						
		or 5 seconds and allow a						
	textured item to	be brushed across the						
	palm of his hand	l. Client #9's IHP						
	contained a BM	P (Behavior Management						
	Plan) dated 09/0	1/11. The BMP						
	indicated, "once	every 30 minutes, [client						
	#9] will be reinf	forced with an edible (it						
	_	snack) including cookies,						
	crackers, etc. or	a pudding thick drinkable						
	for refraining fro	om biting his fingers."						
	On 09/21/11 at 1	1:00 PM an interview was						
	conducted with	the Qualified Mental						
	Retardation Prof	fessional #2 (QMRP).						
	The QMRP indi	cated client #9's goals						
	should have been	n implemented and						
	indicated staff sl	hould have been						
	prompting the cl	lients every 15 minutes						
	and given them	a choice of activities.						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	324S11	Facility II	D: 000730	If continuation sl	neet Pa	ge 35 of 55

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00		e survey pleted /2011
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP C ANKLIN IA, IN46030	CODE	
					IA, IN40030		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	room #3 on 09/20 until 3:30 PM. A staff (staff #24 ar room who remain observation time time a child carto TV. Client #10 wheelchair which The lap tray contocards which had Staff were observations and a crayon. He couple of lines we the paper to the f #10 was moved f TV area and Spo Client #10 continuments wheelchair in froof the observation. Observations we room #3 on 09/2: 10:45 AM. At 9 staff (staff #21, # in the classroom. times Mickey Mowere on the TV. following activitions observation: sat	During the observation on "Sponge Bob" was on was observed to sit in his in contained a lap tray, ained Mickey Mouse colored shapes on them. Wed to go from client to m what color was on the M client #10 was given a ture of a pumpkin on it is was observed to make a with the crayon and throw cloor. At 2:30 PM client from the table area to the mage Bob was on TV. Intended to sit in his must of the TV until the end must time at 3:30 PM.  The conducted in group 2/11 from 9:15 AM until 1:15 AM there were three 1:26 and #27) to 10 clients During observation on the county of the the dog Client #10 had the					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		(X2) MU A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE COMPI 09/26/2	LETED	
	PROVIDER OR SUPPLIE			STREET A		•	
ARCADI	A DEVELOPMENT	AL CENTER		ARCAD	IA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TTATEMENT OF DEFICIENCIES  SCY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
IAU	color crayon wh book entitled, "G given a book, "E which he looked given a children popped up a cat, the button was p Client #10's reco 09/21/11 at 11:5 undated active to indicated the fol time frames: 5:00-7:30 AM - dressing for the activity, medicated goal" 7:30-8:00 AM - dressing, etc." 8:00-9:00 AM - Fine Motor. 9:00-10:00 AM Motor, Gross M 10:00-10:30 AM (trucks, TV, puz leisure item, gar socializing, etc.' 10:30-11:00 AM Group Activity" 11:00-12:30 PM Structured Leisure	ich he broke; was read a Charlie Chicken"; was Big Bird Color Game" I at upside down; and was I's popup toy which frog, dog or bird when bushed.  ord was reviewed on I AM. Client #10's reatment schedule lowing for the specified  "Get up, toileting, day, independent leisure tion goal, breakfast, eating  "Toothbrushing, toileting,  "Economics, Initiation,  - "Communication, Fine otor" I - "Choice of Activity szles, magazines, radio, nes, table activities, I - "Toileting, Large I - "Lunch, Eating Goals,		IAU			DATE
	1:30-3:30 PM -	"Leisure,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G580	ł	A. BUILE	DING	00		09/26/2	
		100000		B. WING				03/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	ATE, ZIP CODE		
ADCADI	A DEVELOPMENTA	AL CENTED		1	303 FRA				
					ARCADI	A, IN46030			
(X4) ID		TATEMENT OF DEFICIENCIES		_	ID		PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FU		P	REFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)  Communication"				TAG	DEI	richave ()		DATE
		'Toileting, Handwashing	5,						
	Choice of Activi	•							
		'Dinner, Eating, Goals,							
	Structure Recrea								
		'Recreation, Leisure,							
	·	, Choice of Activities,							
	TV, Parties If Sc	cheduled, Movies, Group	)						
	Activity, Bathing	g, Special Events, Outing	g						
	If Applicable, Et	te"							
	7:00-8:30 PM - "	'Snack Time, Dressing							
	For Bed, Toothb	rushing, Choice Of							
	Recreation, Toile	eting, Medication Goal,							
	etc"								
	Facility staff did	not follow and/or							
	<u>-</u>	t #10's active treatment							
	schedule as writt								
	Schedule as write	icii.							
	Client #10's Indi	vidual Habilitation Plan							
		09/01/11 and contained							
	` ′	ted to the following goal	g.						
		lids to three containers;	5.						
		arge items from the table							
	one at a time; wi	· ·							
	· ·								
		nen shown a dime and a							
	_	intain his attention to a							
		5 minutes; and will selec	ct						
	the correct color	of crayon.							
	0.00/01/11 : 1	00 DM							
	On 09/21/11 at 1:00 PM an interview was		S						
	conducted with Qualified Mental								
	Retardation Professional #2 (QMRP).								
		cated client #10's goals							
	should have beer	n implemented and							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event	ID: 324	S11	Facility II	D: 000730	If continuation sh	neet Par	ge 38 of 55

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G580	A. BUILDING B. WING		09/26/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			RANKLIN	
ARCADIA	A DEVELOPMENTA	AL CENTER		DIA, IN46030	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	indicated staff sh				
		ients every 15 minutes			
	and given them a	choice of activities.			
	3.1-23(a)				
	3.1-32(a)				
	3.1-33(a)				
	3.1-37(a)				
	()				
W0268	•	d procedures must promote pment and independence			
	or the chefft.		W0268	For Client's #9, 10, 19, 28, 30	0, 33, 10/26/2011
	Based on observa	ation, record review, and	W 0200	49, 50, 54, and 56 shall be afforded the promotion of gro	10,20,2011
	interview, for 2 c	of 10 sampled clients		and independence by training	
	(clients #9, #10)	and 8 additional clients		staff in the craft of positive	
	(clients #19, #28	, #30, #33, #49, #50, #54		interactions, the reinforceme skill acquisition and the	III OI
	and #56), the fac	ility failed to promote		awareness to recognize thes	e
	growth, developr	ment, independence and		opportunities. Staff will be provided assessment strateg	ies
	dignity.			and training to assist them in	
	Findings include	:		better recognizing their cond and modeling skills toward C #9,10, 19, 28, 30, 33, 49, 50, and 56. This training shall	lient
	1 Observations	were conducted in group		include issues of dignity and	
	1. Observations were conducted in group room #3 on 09/20/11 from from 1:00 PM until 3:30 PM. At 1:00 PM there were 2			means to more independent	-
				correct and assist in the area hygiene, recognition and	IS OT
		nd #25) present in the		restitution of food spillage an	d
	room who remain			soiled clothing from drooling	and
	Toom who remain	nea auring me		the correct application and the	e
FORM CMS-2:	567(02-99) Previous Versio	ons Obsolete Event ID: 32	24S11 Facility	ID: 000730 If continuation sl	neet Page 39 of 55

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			LDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/26/2</b>	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN46030						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	TE	(X5) COMPLETION DATE			
	conducted in gro from 9:15 AM un AM there were thand #27) to 10 cl During the obser cartoons were on contained items were clients which ince a top toy with animals toy trucks, an anicrayons, Mickey child's puzzle. A go from client to were doing and "of the items were referred to as "toy observation period and #56 were all non-verbal and refrom staff.  Client #9's record 09/21/11 at 9:30 Individual Hability dated 10/28/10. #9 was over the anon-verbal and refrom staff for all Client #10's record 09/21/11 at 11:50 Client #10's record 09/21/11 at 11:50	od. Clients #10, #33, #50 observed to be equired total assistance  d was reviewed on AM. Client #9's tation Plan (IHP) was The IHP indicated client age of 18 years old, equired total assistance			appropriate, intended use of programming supplies. Whill many of the programatic sup may be categorized as "toys' individual clients show perso preference for these items w provided as a choice of items. Staff will be provided w assessment strategies and training to better recognize the conduct and modeling skills toward Client #9, 10, 19, 28, 33, 49, 50, 54, 59 and all oth clients. This training shall indissues of dignity and the meat to more independently correct and assist in the areas of hygiene, recognition and restitution of food spillage an soiled clothing from drooling the appropriate, intended use programming supplies. Staff we be trained through an all staff in-service to initially address causal reasons of the behaving described and provided train better recognize their conduct and modeling skills toward all clients. Random, bi-monthly a will be completed by the staff trainer to further ensure that these strategies are practiced understood. The Quarterly Recommittee will review at least times yearly and during their annual Individual Habilitation meeting. QMRP's are responsible. Program Director monitor.	e plies ', nal hen vith neir 30, er clude ans ct d and e of will f or ing to ct, ll audits f d and eview st 3 f Plan			
	I.						l		

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE ( COMPL <b>09/26/2</b> (	ETED
	NOVER		D. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			303 FRA			
ARCADI	A DEVELOPMENTA	AL CENTER		ARCADI	A, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		S years ald non yorbal		IAG	BEITELENCT		DATE
	over the age of 18 years old, non-verbal and required total assistance from staff for						
	all of his needs.	i assistance from starr for					
	an or ms needs.						
	On 09/21/11 at 1	:00 PM an interview was					
	conducted with t	he Qualified Mental					
		essional #2 (QMRP).					
	`	ndicated it was not					
	•	nts #10, #33, #50 or #56					
		ot having their mouth					
		ould not be wearing					
	clothing wet fror	n the droot.					
	On 00/21/11 at 1	:00 PM an interview was					
		he Qualified Mental					
		essional #2 (QMRP).					
		ndicated clients #9 and					
	1	ldren and staff should not					
	be referring to or	using "toys."					
	_						
		were conducted in group					
		2/11 from 9:15 AM until					
		:15 AM there were three					
		\$26 and \$27) to 10 clients					
		During the observation					
		artoons were on TV. The					
		ained items which were					
	-	onts which included a one, a top with animals, a					
		animals, a top with sea					
		animals, a top with sea acks, an animal barnyard					
	I -	ckey Mouse cards, and a					
	1 -	all staff were observed to					
	P P P P P P P P P P P P P P P P P P P						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			LDING	NSTRUCTION  00	(X3) DATE ( COMPL <b>09/26/2</b> (	ETED	
NAME OF P	ROVIDER OR SUPPLIER		D. WII.	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ARCADIA	A DEVELOPMENTA	AL CENTER		303 FRA ARCAD	ANKLIN IA, IN46030		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	go from client to client and ask how they were doing and "do you want a toy?" All						
	_	•					
		e toys for children and					
	referred to as "to	<del>-</del>					
	•	od. Clients #10, #33, #50					
		served to be drooling					
	•	ation periods and their					
	_	ed wet spots from the					
	_	vere not observed to					
		wipe clients #10, #33,					
	#50 or #56's mouth or change their wet						
	shirts.						
	Clients #10 #33	#50 and #56 were all					
		on-verbal and required					
	total assistance fi	•					
	total assistance in	Tom Starr.					
	On 09/21/11 at 1	:00 PM an interview was					
		he Qualified Mental					
		essional #2 (QMRP).					
		idicated it was not					
	,	nts #10, #33, #50 or #56					
	•	ot having their mouth					
	•	ould not be wearing					
	clothing wet from	•					
	3.1-26(g)						
W0212	Druge used for co	ntrol of inappropriate					
W0312		used only as an integral part					
		ridual program plan that is					
		ly towards the reduction of					
	and eventual elimi which the drugs ar	nation of the behaviors for employed.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G580	B. WIN			09/26/2	011
NAME OF A	DROLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	C		303 FR	ANKLIN		
	A DEVELOPMENTA	AL CENTER			01A, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	EFICIENCY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on record review and interview, the		W0312		Client #7 presents with a diagnostic history which incl	udes	10/26/2011
	-	r 1 of 5 sampled clients on			Systemic Lupus, Spastic Qu		
		tion (client #7) by not			paresis, congenital hip		
	having an active	treatment plan to address			dislocation, non-verbal Brea	st	
	the reason for th	e medication.			Cancer survivor and Depres		
	Findings include	»:			Client #7 was diagnosed and followed by a Psychiatrist for treatment of Depression, a		
	Daview on 0/21/	11 at 10:15 AM of client			mental illness. Client #7 is currently prescribed a		
					psychotropic medication to		
		conducted. Client #7's			facilitate management of		
	`	on Administration			depressive traits. Client #7		
	· /	/1/11 through 9/30/11,			not present with inappropriat		
		#7 was taking one 40 mg			behaviors, but a mental illne	SS	
	1 `	exa tablet (for depression			that is managed through psychotropic medications		
	as indicated on t	he August 2011			prescribed by her Psychiatris	st and	
	Physician's Orde	ers). Client #7's ISP dated			monitored through the		
	11/11/10 did not	include a behavior plan			Interdisciplinary Team. In		
	to address client	#7's taking of Celexa for			addition, Client #7 has been		
	depression.				will be continue to be, provid with programmatic objective:		
					address and/or assist with m		
	Interview on 9/2	1/11 at 11:20 AM with			and affect responses. A		
	QMRP (Qualifie	ed Mental Retardation			behavioral protocol has beer	1	
	, , ,	was conducted. QMRP			re-intoduced for Client #7 to		
	· · · · · · · · · · · · · · · · · · ·	nt #7 was on Celexa for			afford staff and intervening s	taff	
		nere was no plan in place			measures to recognize and document changes affect or		
	to address the us				mood to assess the effective	ness	
	to address the us	of the Colona.			of her currently prescrtibed		
	2.1.26(1-)				psychotropic medication. (S		
	3.1-26(k)				attachment 312A)All clients		
	3.1-26(1)				currently prescribed psychot medication for depression sh		
	3.1-26(m)				be reviewed by the Behavior		
					Management Committee to		
					ensure that the appropriate		
					protocol and/or interventions		
					in place as an integral aspec	t of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		(X2) MULTIPLE CO  A. BUILDING	00	r í	E SURVEY LETED 2011				
	ROVIDER OR SUPPLIER		B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030						
				,					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE Y)	(X5) COMPLETION DATE			
W0369	assure that all drug self-administered, error.  Based on observative record review for administered, the client #20's medi without error dure.  Findings include:  During the 9/19/1 between 1:00 PM 5, Qualified Med #5 administered.	11 observation period I and 3:30 PM, in group lication Assistant (QMA)	W0369	their active treatm clients who are propsychotropic medihave their currently medications, dosa recommendations of reduction review Quarterly Review recommendations shall be document client's Quarterly Faheet. The Program maintain written deeach client's psychotropic medications and recommittee shall	escribed ications shall y prescribed age, Psychiatrist and last date wed by the Committee. All and actions ted on each Review m Director shall ocumentation of hotropic eview dates. agement eview ications pression  ders were the #20 and QMA on the proper and how to safe all client's with mucil.QMA #5 d a medication empleted.QMA staff (QMAs in-serviced on edication ompleted ector of Nursing #5 conduct a distration of	10/26/2011			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			LDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/26/2</b>	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN						
	A DEVELOPMENTA			<u> </u>	IA, IN46030				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	3:15 PM indicate	#20 at 3:15 PM.  MA #5 on 9/19/11 at ed she used a 4 ounce cup d/administer the client's			administration audits will also continue for all nursing staff assure correct procedures a followed. Director of Nursing responsible. Administrator will monitor.	to re is			
	9/19/11 at 5:15 F physician's order was to receive M (milliliters) in 8 of	rd was reviewed on PM. Client #20's 8/22/11 rs indicated client #20 letamucil "mix 15 ml oz (ounces) with juice or TID (three times a day) for							
	5:17 PM when as administered the of water versus & "Most orders say	MA #5 on 9/19/11 at sked why the QMA Metamucil in 4 ounces 3 ounces, QMA #5 stated 4 to 8 ounces. Her ysician orders said 8 d up."							
	(DON) on 9/21/1 the QMA should	ne Director of Nursing 11 at 9:53 AM indicated have administered the nunces of water/juice as							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		A. BUII	LDING	NSTRUCTION  00	(X3) DATE : COMPL <b>09/26/2</b>	ETED	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			303 FRA			
ARCADIA	A DEVELOPMENTA	AL CENTER		1	IA, IN46030		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
W0436		urnish, maintain in good clients to use and to make					
	-	about the use of dentures,					
	eyeglasses, hearir						
		ids, braces, and other					
	as needed by the	by the interdisciplinary team					
		ation, interview and	W	0436	For Clients #9, 10, 19, 28, 30	). 33.	10/26/2011
		r 1 of 4 clients that wore	"	0130	49, 50, 54, and 56 shall be	,,	10/20/2011
		ity failed to ensure and/or			afforded the promotion of gro		
		use his eyeglasses.			and independence by training staff in the craft of reinforcement		
	train enem #5 to	use his cycgiasses.			of skill acquisition and the	ieni	
	Findings include	· ·			awareness to recognize thes opportunities. Staff will be provided assessment strateg		
	Observations we	re conducted at the			and training to assist them in		
	facility on 9/19/1	1 from 11:55 AM			better recognizing opportunit		
	•	M and 3:30 PM through			for clients to wear personal		
	_	#5 was observed during			eyeglasses, apply eyeglasse those who display resistive	s for	
		periods. Client #5 was not			behavior for wearing and the		
	observed wearing				incremental times that they		
	`				should attempt to apply indiv		
	During the 9/20/	11 observation period			eyeglasses for clients #5. Th		
	_	If and 7:50 AM, at the			training shall include the mea to more independently correct		
		M, an unidentified			and assist in the areas of the		
	nursing staff bro				correct application and the		
		ne group number 6 and			appropriate, intended use of	: -11	
		asses to staff #1. Staff #1			eyeglasses.Staff will be prov with assessment strategies a		
		yeglasses on client #5,			training to better recognize	iiid	
	•	on the floor. Client #5			opportunities for eyeglass		
	_	glasses and threw them			application for all clients		
	· ·	r. A few minutes later,			assessed to wear them. This training shall include the mea		
		ne eyeglasses up and			to more independntly correct		
	-	c on client #5. Client #5			assist in the areas of the corr	rect	
	_	glasses and threw them			application and the appropria		
	down to the floor				intended use of eyeglassesS will be trained through an all		
	22 10 11001	· 			wiii be trailled triiOugii ail all	JIAII	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL 09/26/2	ETED	
	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ANKLIN IA, IN46030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility on 9/20/2 through 11:00 A through 12:20 Probserved through Client #5 was not eyeglasses.  Interview with E Nursing) on 9/20 client #5 should eyeglasses.  Interview with E Staff) on 9/20/11 client #5 did have he is supposed to indicated client #5 the glasses and where the glasses and where the supposed to the client #5 did not to teach him how to teach him how Interview with C Mental Retardate 9/21/11 at 1:45 I should be encourage eyeglasses.  Client #5's recorn 9/21/11 at 8:42 A	DCS #11 (Direct Care 1 at 2:15 PM indicated 2 a pair of eyeglasses that 3 wear. DCS #11 2 does not like to wear 3 will refuse to wear them 4 m. DCS #11 indicated 4 have a training objective 5 to use the eyeglasses.  2 MRP #2 (Qualified 3 ion Professional) on 6 PM indicated clients 6 raged and/or trained to 6 d was reviewed on 6 AM. Client #5's 2/8/11 6 Support Plan) did not			in-service to initially address causal reasons of the behave described and provided train better recognize and assist is areas of the correct applicate and the appropriate, intended of eyeglasses. Random, bi-monthly audits will be completed by the staff trainer further ensure that these strategies are practiced and understood. The Quarterly R Committee will review at least times yearly and during their annual Individual Habilitation meeting to police those who should wear eyeglasses. The QMRP will be responsible. The Quarterly Review Committee monitor.	ior ing to n the on d use r to eview st 3 n Plan	

AND PLAN OF CORRECTION IDENTIFI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULTIPI A. BUILDING B. WING		NSTRUCTION  00	(X3) DATE : COMPL <b>09/26/2</b>	ETED
	ROVIDER OR SUPPLIER		STR: 303	FRA	DDRESS, CITY, STATE, ZIP CODE NKLIN A, IN46030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	desensitization of of eyeglasses.  3.1-21(h) 3.1-39(a)	bjective to for utilization					
W0455	There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  Based on observation, and interview for 4 of 4 clients (clients #10, #33, #50 and #56) in program room 3 who were drooling and not cleaned and for 2 of 2 clients (clients #22 and #32) observed to pick up food from the dining room floor and placing it into their mouths, the facility failed to maintain proper hygiene practices.  Findings include:  1. Observations were conducted in group room #3 on 09/20/11 from 1:00 PM until 3:30 PM. At 1:00 PM there were 2 staff (staff #24 and #25) present in the room who remained during the observation time. Observations were conducted in		W0455		The Direct Care Staff/CNA's be in-serviced, by the Staff Development Coordinator, or assisting Clients #10, 33, 50, 56 with removing drool and/oremoving drool from those clithat are not capable of doing For clients that are able, they be encouraged to use a klendry clean wash cloth to remodrool from their face. In addistaff will be in-serviced, by the Staff Development Coordination ensuring that Clients #10, 50, and 56 and all other client have clean and dry clothing oupon becoming soiled or wet Staff Development Coordinativill in-service all Direct Care Staff/CNA's on monitoring all clients in the Dining Room duthe meals and in the Programming areas while eat to ensure that Client #32 and Client #22 and all other client refrain from eating food off the	and and are sents so. will ex or ve tion, e cor, 33, ts on .The cor uring ting	10/26/2011

000730

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580			BUILDING WING  MULTIPLE CONSTRUCTION  00  WING		(X3) DATE SURVEY COMPLETED 09/26/2011		
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	were three staff of to 10 clients in the to 10 clients in the #10, #33, #50 and be drooling during and their clothing from the drooling observed to prome #10, #33, #50 or their wet shirts.  An interview on with Qualified M. Professional #2 of The QMRP #2 in hygiene for client be assisted with clothes.  2. Observations facility dining roughly dining	(staff #21, #26 and #27) ne classroom. Clients d #56 were observed to ng all observation periods g contained wet spots g. Staff were not npt, assist or wipe clients #56's mouth or change  09/21/11 at 1:00 PM Mental Retardation (QMRP) was conducted. ndicated it was not good ats to be drooling and not the drooling and wet  were conducted at the som on 09/19/11 from 00 PM. At 4:50 PM beserved to lean over in sod up from the floor, his mouth and swallow 0 PM client #22 was over in his chair, pick e floor, place the food in		TAG	floor, staff will be instructed to remove food from the floor as soon as witnessed by staff. The Program Director, QMRP's as shift Department Head will perform randomaudits in all programming and or all areas where clients are present dather the will immediately inform of those clients that need attention. The shift Department Head will follow up to ensure the client has been assisted. Program Director, QMRP's as shift Department Head will perform random audits in the Dining Room and other areas where clients will be consumfood to ensure that no client food from the floor. The Staff Development Coordinator wis in-service all staff on infection control on a quarterly basis of needed. In addition, the Prodirector, QMRP's and shift Department Head will perform daily random audits in all programming and or all areas where clients are present. The will immediately inform Directors are Staff/CNA's of those clients are present. The will immediately inform Director Staff/CNA's of those clients are present. The will assign a designated Director Staff/CNA to monitor the Dining Room during mealtim The designated staff members are from spilled food and clean the floors are from spilled food and clean the floors are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are from spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled food and clean the floor are spilled floor and clean the floor are spilled floor and clean the floor are spilled floor and clean the floor are spilled floor and clean the fl	s he and s lily. staff ent that The sing eats II n or as gram m s hey staft up to been eat will except each each each each each each each each	DATE	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility I	D: 000730 If continuation s	heet Pac	ge 49 of 55	

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  . DUM DDIG 00			(X3) DATE SURVEY  COMPLETED			
11.12 12.11 01 00.1112011011		15G580	A. BUII	DING		09/26/2011			
		130300	B. WIN			03/20/20	711		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE				
ARCADIA DEVELOPMENTAL CENTER			303 FRANKLIN ARCADIA, IN46030						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE		
	with Qualified M Professional #2 ( The QMRP #2 in	09/21/11 at 1:00 PM Iental Retardation QMRP) was conducted. Idicated it was not good ts to be eating food from floor.			Shift Department Head is responsible for compliance.T QMRP's will monitor.	he			
W0488	in a manner consist developmental lev  Based on observative for (#1, #2, #3, #4, #4) the facility failed encourage family. The facility failed were supervised appropriate bites.	ation, interview and r 9 of 10 sampled clients 5, #6, #8, #9, and #10), to provide and/or restyle dining at meals. d to ensure all clients and/or redirected to take , used utensils and/or ate ent with their skills.	W	0488	This facility does provide fam style dining for the evening m for all clients assessed to functionally participate. Clier #1, 2, 3, 4, 5, and 6 participate a family style dining atmosph for their evening meal regular. To further incorporate an atmosphere of family dining: clients #1, 2, 3, 4, 5, 6, and a other assessed clients will be offered introductory elements family dining experience during the breakfast and lunch time meals. The facility will continuoffer a family style dining	neal  ats te in ere rly.  Il s of a ang	10/26/2011		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE SI COMPLE <b>09/26/20</b>	TED			
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER			p. 1111	STREET ADDRESS, CITY, STATE, ZIP CODE  303 FRANKLIN  ARCADIA, IN46030						
	SUMMARY S' (EACH DEFICIEN REGULATORY OR  1. During the 9/ between 1:00 PM 4:25 PM to 5:46 #10 assisted clien meatballs with gr soon as the clien his plate, staff #1 client #3 to serve picked up a whole hands and placed #10 looked at cli reaching for the staff with the second (whole) r  During the 9/20/ between 5:30 AM facility, clients # ate their breakfast room. The client	<u> </u>	B. WIN	STREET A	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  atmosphere for each client d the evening meal. Additional further incorporate an atmosphere of family dining: clients #1, 2, 3, 4, 5, 6, and a other assessed clients will be offered introductory elements family dining experience durithe breakfast and lunch time meals. Introductory element family style dining will include self-acquisition of napkins ar utilization of salt and pepper shakers as appropriate, for eclient, if the appropriate food items are served during thes meals. To assure that elemer family style dining continue for breakfast and lunch time meanapkin dispensers and salt a pepper shakers will be place and remain placed, on all tabin the dining room. The Quart Review Committee will review each client's dining placement objective and programmatic participation to ensure each client's participation and/or exposure to the family style of	uring lly, to ll e s of a ng s of e nd ach e nts of or the als, nd d, oles erly w nt,	(X5) COMPLETION DATE			
	juice were served Facility staff care the kitchen wind where each clien removed the food placed the items and/or had the cl	d to the clients on trays. ried the clients' trays from ow to the dining tables t sat. The staff either d items off the tray and in front of the clients ients eat off the tray.  d was reviewed on			atmosphere.QMRP will moni	tor.				
FORM CMS-2	9/20/11 at 2:15 F	PM. Client #4's 4/7/11 ons Obsolete Event ID:	324S11	Facility II	D: 000730 If continuation sl	neet Page	e 51 of 55			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING COMPLETED					
		15G580	B. WING			09/26/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARCADIA DEVELOPMENTAL CENTER				303 FRA	ANKLIN IA, IN46030		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  I SC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
1710	REGULATORY OR LSC IDENTIFYING INFORMATION)  Individual Habilitation Plan (IHP)			1710	<u> </u>		DATE
	indicated the clie	ent participated in family					
	style dining.						
	Client #3's record	d was reviewed on					
	9/21/11 at 8:42 A	AM. Client #3's 7/21/11					
		itation Plan (IHP)					
	indicated the cliestyle dining.	ent participated in family					
	style uning.						
	Client #5's record was reviewed on						
	9/21/11 at 8:42 AM. Client #5's 2/14/11						
	family style dining	e client participated in					
	family style dimi	ng.					
	Client #1's record	d was reviewed on					
		A.M Client #1's 4/7/11					
		am Plan indicated the d in family style dining.					
	enent participate	d in failing style diffing.					
	Client #4's record	d was reviewed on					
		AM. Client #4's 11/3/10					
	IHP indicated the client participated in family style dining.  Client #2's record was reviewed on 9/21/11 at 10:58 A.M Client #2's 10/6/10 Individual Program Plan indicated the client participated in family						
	style dining.	an participated in family					
	, , <del></del>						
	Interview with Q	•					
		essionals (QMRPs) #1					
	and #2, the Direc	ctor of Nursing (DON),					

000730

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

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE CON			(X3) DATE SURVEY COMPLETED			
		15G580		LDING	00		09/26/2011			
		100000	B. WIN				09/20/2	011		
NAME OF I	ROVIDER OR SUPPLIER				DDRESS, CITY, STAT	ΓE, ZIP CODE				
ΔΡΟΛΟΙΑ	A DEVELOPMENTA	VI CENTER		303 FRANKLIN ARCADIA, IN46030						
	DIA DEVELOPMENTAL CENTER			<u> </u>	, , , , , , , , , , , , , , , , , , ,			are:		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5)		
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCEL DEFIC	E	COMPLETION DATE			
1710	the Assistant Dir			1710				DITTE		
		Business/Office								
	` ′	/11 at 9:53 AM indicated								
	_									
	I	ot do family style dining								
		and lunch meals. QMRPs								
		ted the facility did not								
		e to do family style								
	_	ist as some of the								
		to go to school and the								
	0 1	varied times. QMRP #2								
		ility did not do family								
		nch because some clients								
	_	at a table by themselves								
	as the other clien	nts/kids were at school.								
	QMRP #2 stated	the clients would not								
	have anyone to "	socialize with." QMRP								
	#2 indicated the	facility attempted family								
	style dining in th	e past for breakfast and								
	lunch but it did r	not work. QMRP #1								
		staff should have								
		of 1 to cut up his meatballs,								
		ient to slow down and not								
	eat with his hand									
	2 01	rroma a am drosta dost ato.								
		were conducted at the								
	facility on 09/20/11 from 6:00 AM to 7:00									
	AM.									
		nt #8 was observed to be								
		dining table. At 6:28								
		s observed to have his								
		ay placed in front of him								
	and was observe	d to be fed his entire meal								
	by staff #30.									
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	324S11	Facility ID	000730	If continuation sh	neet Par	ge 53 of 55		

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G580		A. BUII	LDING	NSTRUCTION  00	(X3) DATE COMPL 09/26/2	ETED	
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER				STREET A		<u> </u>	
	An interview on with Qualified M Professional #2 (The QMRP indicated in the proof of the proof o	AL CENTER  TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)  09/21/11 at 1:00 PM Mental Retardation (QMRP) was conducted. cated client #8 should ed with his food and staff	B. WIN	STREET A			(X5) COMPLETION DATE
	with Qualified M Professional #2 of The QMRP #2 in capable of assist	09/20/11 at 1:00 PM Mental Retardation (QMRP) was conducted. Indicated client #10 was ing with his food and not have custodially fed					

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

PRINTED: 10/26/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY MPLETED 6/2011
NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER			303 FR	ADDRESS, CITY, STATE, Z ANKLIN DIA, IN46030	TIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO 1 DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE

000730