| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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| W0000 | This visit was for a fundamental recertification and state licensure survey.<br><br>Dates of Survey: September 19, 20, 21, 22, and 26, 2011.<br><br>Facility number: 000730<br>Provider number: 15G580<br>AIM number: 100272190<br><br>Surveyors:<br>Tim Shebel, Medical Surveyor III-Team Leader<br>Paula Chika, Medical Surveyor III<br>Kathy Craig, Medical Surveyor III<br>Keith Briner, Medical Surveyor III<br>Claudia Ramirez, Public Health Nurse Surveyor III<br><br>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2.<br>Quality Review completed 10/6/11 by Ruth Shackelford, Medical Surveyor III. | W0000 | By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory oligations._____<br>_Beverly Sayre Cowart | |
| W0104 | The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>Based on observation, interview and | W0104 | For clients #8, 21, 36, 1, 5, and all other clients' utilized chairs has | 10/26/2011 |

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

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| | record review, the governing body failed 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.<br><br>Findings include:<br><br>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 were sitting in stuffed chairs which had stuffing protruding from torn areas.<br><br>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.<br><br>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 | | been initially assessed by the 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 for appropriate repairs/replacement. | |

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| | empty during this time had a dark patch of dark oval shaped stains 3 inches long, a hole on the right bottom side of chair 1 inch in diameter. There was a navy blue chair which had too many white circular stains to count on the right arm.<br><br>Interview on 9/20/11 at 7:15 AM with staff #21 indicated she thought the white stains were formula from the G-tube automatic feeding pump. There was a dark tan chair with no one sitting on it at this time, which had a patch of black stains on the right arm. Client #36 was sitting in a chair which had a tear in it on the left side 3" (inches) by 3" wide on the corner right in back with stuffing coming out of it, and a tear on the lower left side 1/2 inch.<br><br>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated any chairs used by clients which are torn should be repaired by the facility's maintenance department or replaced.<br><br>3.1-13(a) | | | |

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| W0125 | The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.<br><br>Based on observation and interview, the facility failed to allow 2 of 2 sampled clients (clients #3 and #4) and 7 additional clients (clients #17, #20, #29, #35, #37, #43, and #45) in program room five unimpeded access to active treatment supplies.<br><br>Findings include:<br><br>Clients #3, #4, #17, #20, #29, #35, #37, #43, and #45 were observed in program room five on 9/20/11 from 7:02 A.M. until 7:42 A.M.. During the observation period, client #17 tried to open the locked closet in program room five with her hands. At 7:15 A.M., staff #35 opened the closet with a key and retrieved a cause and effect device and handed it to client #29. Staff #35 then locked the closet door and put the key in her pocket.<br><br>Staff #35 was interviewed on 9/20/11 at 7:43 A.M.. Staff #35 indicated the closet held active treatment supplies for clients #3, #4, #17, #20, #29, #35, #37, #43, and #45. Staff #35 further indicated staff used a key to access items from the closet and clients were not allowed to access the supplies in the closet.<br><br>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated clients using program room five should have unimpeded access to the closet holding the active treatment supplies.<br><br>3.1-3(a)(1) | W0125 | For clients #3, 4, 17, 20,29,35, 37, 43, and 45 on 9/21/2011 the keyed lock was removed from program room five's supply closet door. Additionally, the electronic equipment housed within this closet was adapted to ensure the safety of clients accessing programmatic supplies. The personal hygiene boxes that were discovered in group five's supply closet had been placed in this closet 3 days prior to this observation. All clients' personal hygiene boxes are regularly stored in the client's bathroom of which they independently access on a routine, daily basis. Investigation noted that the shelf that normally held the clients hygiene boxes in their bathroom had broken. Maintenance personnel made an independent decision to house the boxes in the program room closet as a temporary measure until the shelf in the bathroom could be replaced.The keyed lock was removed from program room five's supply closet. No keyed locks shall be placed on any supply closet that contains items for independent client access. Personal hygiene items shall continue to be housed in each programmatic bathroom | 10/01/2011 |

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| | 3.1-3(c) | | applicable and accessible for individual client use.Future modifications or repairs that may affect client access to programmatic supplies or personal hygiene items will occur during non-programmatic time periods. If necessary, client hygiene boxes shall be placed in 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 impede client access to programmatic supplies.Prior to any necessary repairs or modifications that may restrict client access to personal hygiene or programmatic supplies, maintenance personnel shall discuss the necessary repair with supervisory staff. Supervisory staff shall make the appropriate accommodations and/or decisions to ensure that clients continue to have access to their supplies.Maintenance is responsible for repairs.The Administrator will monitor. | |
| W0136 | The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.<br><br>Based on interview and record review for 8 of 10 sampled clients (#1, #3, #5, #6, #7, #8, #9 and #10), the facility failed to ensure the clients participated in | W0136 | Community based activities (Activities that promote socialization with community members), shall be provided to Client's #1, 3, 5, 6, 7, 8, 9, and 10 as outlined in the facility policy | 10/10/2011 |

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| | activities in the community on a regular and/or ongoing basis.<br><br>Findings include:<br><br>1. Client #3's Monthly activity records from 9/10 to 9/11 were reviewed on 9/21/11 at 9:00 AM. Client #3's Monthly Activity Record indicated client #3 participated in an activity/outing in the community on 1/3/11, 2/17/11, 6/28/11, 7/20/11 and 8/15/11.<br><br>Interview with the Activity Director on 9/21/11 at 9:02 AM indicated client #3 was in school and had not participated in many community activities/outings in the past year. When asked how often clients participated in activities in the community, the Activity Director stated "once a month for school kids and two times a month for residents not in school."<br><br>2. Client #1's records were reviewed on 9/21/11 at 9:12 A.M.. A review of client #1's Monthly Activity Record from 9/19/10 to 9/19/11 indicated client #1 participated in community activities/outings on 9/22/10, 10/22/10, 11/10/10, 12/29/10, 1/6/11, 3/3/11, | | (Attachment W136 - A). The Activity Director shall implement this revised policy to incorporate client interests, level of participation and choices within the community.The Policy for community based activities shall be implemented for Clients #1, 3, 5, 6, 7, 8, 9, 10 and all other clients. The Activities Director shall maintain a log for all clients for review and tracking on a monthly basis to ensure that all clients are afforded the opportunity to participate. Documentation will address weather, illnesses, refusals, or other conditions as they occur.The facility Administrator shall review each monthly outing/activity calendar prior to the coming month. In addition, the Quarterly review Committee shall review all communty based activities specific to individual clients during their scheduled time for review.The Program Director is responsible for the Quarterly Review meetings and documenting meeting reports .The Administrator or person assigned by the Administrator will monitor the Quarterly meetings. | |

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| | 3/19/11, 7/16/11, and 7/21/11.<br><br>Activity Director was interviewed on 9/21/11 at 9:02 A.M.. Activity Director indicated client #1 was in school and had not participated in many community activities/outings in the past year. When asked how often clients participated in activities in the community, the Activity Director stated, "Once a month for school kids and two times a month for residents not in school."<br><br>3. Review on 9/21/11 at 10:15 AM of client #7's records was conducted. Client #7's monthly activity record from the December 2010 to August 2011 indicated client #7 went on an outing away from the facility on the following dates: 12/1/10, 2/21/11, 5/11/11, and 6/24/11.<br><br>4. Review on 9/21/11 at 9:20 AM of client #8's records was conducted. Client #8's monthly activity record from December 2010 to August 2011 indicated client #8 went on an outing away from the facility on the following dates: 12/13/10, 12/28/11, 3/17/11, and 4/25/11.<br><br>Activity Director was interviewed on 9/21/11 at 9:02 A.M.. Activity Director indicated client #8 was in school and had not participated in many community activities/outings in the past year. When | | | |

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| | asked how often clients participated in activities in the community, the Activity Director stated, "Once a month for school kids and two times a month for residents not in school."<br><br>5. The facility's Monthly Activity Record for 2011 was reviewed on 09/21/11 at 9:00 AM and indicated client #9's outings included the following:<br><br>01/25/11 - Dr's appointment<br>02/16/11 - Hospital evaluation<br>03/10/11 - Recycling Center Trip<br>04/01/11 - Recycling Center Trip<br>04/15/11 - Recycling Center Trip<br>05/11/11 - Shopping Trip<br>06/01/11 - Men's Club<br>06/09/11 - Walk with the Neighbors<br>07/07/11 - Nature Walk<br>08/2011 - No outings listed<br><br>An interview with Activity Director (AD) was conducted on 09/21/11 at 9:02 AM. The AD indicated the school age clients went out of the facility once a month and the others twice a month. An interview with the Qualified Mental Retardation Professional #2 (QMRP) on 09/21/11 at 1:00 PM was conducted. The QMRP #2 indicated the clients should be taken out into the community as frequently as possible. | | | |

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| | 6. The facility's Monthly Activity Record for 2011 was reviewed on 09/21/11 at 9:00 AM and indicated client #10's outings included the following:<br><br>01/26/11 - Restaurant<br>02/21/11 - Dr's appointment<br>03/28/11 - Store<br>04/01/11 - Recycling Center Trip<br>04/12/11 - Restaurant<br>05/04/11 - Men's Club<br>06/01/11 - Men's Club<br>07/25/11 - Store<br>08/04/11 - Current Events Outing<br>08/12/11 - Fair<br><br>An interview with Activity Director (AD) was conducted on 09/21/11 at 9:02 AM. The AD indicated the school age clients went out of the facility once an month and the other clients twice a month. An interview with the Qualified Mental Retardation Professional #2 (QMRP) on 09/21/11 at 1:00 PM was conducted. The QMRP #2 indicated the clients should be taken out into the community as frequently as possible.<br>7. Client #5's record was reviewed on 9/21/11 at 8:42 AM. Client #5's MAR (Monthly Activity Record) January 2011 through August 2011 were reviewed. The review indicated the following community based activities:<br><br>-January 2011: No community based activities recorded.<br><br>-February 2011:Community based activity recorded | | | |

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| | on 2/18/11.<br><br>-March 2011: Community based activity recorded on 3/3/11.<br><br>-April 2011: No community based activities recorded.<br><br>-May 2011: Community based activities recorded on 5/3/11.<br><br>-June 2011: No community based activities recorded.<br><br>-July 2011: Community based activities recorded on 7/6/11, 7/16/11 and 7/21/11.<br><br>-August 2011: No community based activities recorded.<br><br>8. Client #6's record was reviewed on 9/20/11 at 2:15 PM. Client #6's MAR dated January 2011 through August 2011 were reviewed. The review indicated the following community based activities:<br><br>-January 2011: Community based activities recorded on: 1/18/11, 1/19/11.<br><br>-February 2011: No community based activities recorded.<br><br>-March 2011: No community based activities recorded.<br><br>-April 2011: No community based activities recorded.<br><br>-May 2011: No community based activities recorded.<br><br>-June 2011: Community based activity recorded on 6/13/11.<br><br>-July 2011: Community based activity recorded on 7/23/11.<br><br>-August 2011: No community based activities recorded.<br><br>The facility's Community Based Activities Policy dated 10/9/09 was reviewed on 9/21/11 at 9:00 A.M.. The policy indicated, "Each non school age client will be afforded the opportunity to participate in 1 or more | | | |

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| | community based activity each month. Each school age client will be afforded the opportunity to participate in 1 or more community based activity each month during the school year and 1 or more community based activity during non school months."<br><br>Interview the facility AD (Activity Director) on 9/20/11 at 9:00 AM indicated the school aged clients are supposed to go on 1 community based outing and non school aged clients are supposed to go out 2 times a month. AD indicated the clients' MARs (Medication Administration Records) should contain all outings and activities. When asked if medical appointments and van rides are considered outings, AD indicated they are not considered outings.<br><br>3.1-3(m)<br>3.1-3(u)(1)<br>3.1-3(u)(2) | | | |
| W0137 | The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.<br><br>Based on observation, interview and record review for 2 of 10 sampled clients (#3 and #4) and for 4 additional clients (#17, #20, #37 and #43), the facility failed to ensure the clients' personal hygiene kits | W0137 | For clients #3, 4, 17, 20, 37, and 42 on 9/21/11 the keyed lock was removed from program room five's supply closet door. Additionally, the electronic equipment housed within this closet was adapted to ensure the safety of clients accessing | 10/01/2011 |

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| | were not locked.<br><br>Findings include:<br><br>During the 9/18/11 observation period between 1:00 PM and 3:30 PM, in group 5, the supply/activity closet door was locked. At 1:10 PM, staff #2 obtained a key from a box in a wall where a phone was located. Staff #2 walked over to a locked door and unlocked the door with the key. When staff #2 opened the supply closet door, plastic containers with lids had client #3, #4, #17, #20, #37 and #43's names written on the plastic containers/boxes. Interview with staff #2 on 9/19/11 at 2:30 PM indicated clients #3, #4, #17, #20, #37 and #43's lotions, toothbrushes, brushes, Vaseline and other personal hygiene supplies were kept in the closet. Staff #2 indicated clients would have to ask the staff to get the key.<br><br>Client #3's record was reviewed on 9/21/11 at 8:42 AM. Client #3's 7/21/11 Individual Habilitation Plan (IHP) did not indicate client #3's personal hygiene supplies needed to be locked.<br><br>Client #4's record was reviewed on 9/21/11 at 10:22 AM. Client #4's 11/3/10 IHP did not indicate client #4's hygiene supplies needed to be locked. | | programmatic supplies. The personal hygiene boxes that were discovered in group five's supply closet had been placed in this closet 3 days prior to this observation. All clients' personal hygiene boxes are regularly stored in the client's bathroom of which they independently access on a routine, daily basis. Investigation noted that the shelf that normally held the clients hygiene boxes in their bathroom had broken. Maintenance personnel made an independent decision to house the boxes in the program room closet as a temporary measure until the shelf in the bathroom could be replaced.The keyed lock was removed from program room five's supply closet. No keyed locks shall be placed on any supply closet that contains items for independent client access. Personal hygiene items shall continue to be housed in each programmatic bathroom applicable and accessible for individual client use.Future modifications or repairs that may affect client access to programmatic supplies or personal hygiene items will occur during non-programmatic time periods. If necessary, client hygiene boxes shall be placed in a roll-around cart that will be housed in their respective bathrooms to assure access while repairs can be made. Electronic equipment shall be | |

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| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

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| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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| | Interview with #3 on 9/19/11 at 2:40 PM stated the activity/supply closet was kept "mostly locked." Staff #3 stated some clients would go into the activity/supply closet and "tear up book" when they had a behavior.<br><br>Interview with Qualified 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 there was no reason for client #3, #4, #17, #20, #37 and #43's hygiene supplies to be kept locked. QMRP #1 and #2 indicated the clients' hygiene supplies were only locked as the hygiene kits were stored in the closet which housed the TV box and supplies. QMRP #1 and #2 indicated the closet was kept locked due to client #43 who would try to get to the electronic equipment/TV box in the closet. QMRP #2 indicated the clients had access to the closet key which was kept with the phone.<br><br>3.1-9(a) | | placed or protected in such a manner that does not impede client access to programmatic supplies.Prior to any necessary repairs or modifications that may restrict client access to personal hygiene or programmatic supplies, maintenance personnel shall discuss the necessary repair with supervisory staff.<br>Supervisory staff shall make the appropriate accommodations and/or decisions to ensure that clients continue to have access to their supplies.Maintenane is responsible for repairs.The Administrator will monitor. | |
| W0149 | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>Based on observation, interview and record review, the facility failed: 1. To | W0149 | The facility's Abuse and Neglect Policy was revised on 10/4/2011. Mandatory all staff in-services on Abuse and Neglect are held on a | 10/26/2011 |

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| | implement its abuse/neglect policy for 1 of 2 alleged abuse incidents to ensure 1 of 1 client (client #6) was not abused, and 2. Failed to ensure staff reported all injuries of unknown origin involving 1 of 57 clients living at the facility (client #51) to the administrator in regard to 1 of 6 allegations of abuse, neglect and/or injuries of unknown origin reviewed, and 3. Failed to thoroughly investigate 2 of 5 injuries of unknown origin involving 2 of 57 clients living at the facility (clients #37 and #49.)<br><br>Findings include:<br><br>1. The facility's records were reviewed on 9/19/11 at 12:50 P.M.. A review of 1 of 2 abuse allegations from 9/19/10 to 9/19/11 indicated the following abuse allegation: "Name: [Client #6], Incident Date: 8/16/11, Narrative: [Client #6] was to be at an appointment. [Staff #77] was attempting to get him (client #6) into the bathroom to get dressed. He (client #6) did not want to go and he sat down on the floor. Another staff member (staff #78) was assisting [staff #77] with [client #6.] [Client #6] hit the other staff member (staff #78.) At that point, [staff #78] slapped [client #6] on the face and stated 'we can do this the easy way or the hard way.' She (staff #78) then proceeded to grab his (client #6's) foot and drag him | | quarterly basis. All staff are informed on what abuse is, what to look for and when and who to report abuse and neglect to. They are informed that they are to report any suspected abuse immediately. They are given a copy of the Abuse and Neglect Policy and sign off that they have read and understand the policy as it pertains to Client #6. In addition, all newly hired staff are in-serviced and given a copy of the Abuse and Neglect policy and sign off that they have read and understand the policy as it pertains to Client #6.After it was reported that Client #51 was noted to have a 1" oblong bruise to their upper left arm, nursing immediately went to assess the area. No bruise was found. However, staff were instructed to report all noted injuries, on client #51 and all other clients to nursing immediately. Nursing will immediately report all injuries to the Administator, Program Director and Director of Nursing.After the IDT reviewed the incident report for Client #49, it was determined that Client #49 had sustained the bruises in the manner described on the incident report. However, in the future, the individual will be more explicit in the verbiage used when writing the cause of the incident for Client #49.After the IDT reviewed the incident report for Client #39, it was determined that Client #39 had sustained the bruises in the | |

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| | into the bathroom. Two staff members (staff #80 and #81) witnessed the incident. One of the staff members (staff #80) immediately reported the incident to the supervisor. Plan to Resolve: As per our facility policy, the supervisor immediately asked [staff #78] to leave the facility, that there was an allegation of abuse against her. [Staff #78] left the facility. Nursing assessed [client #6] for any injuries. There were none. Myself (QMRP (Qualified Mental Retardation Professional) #1) and the Assistant Administrator began an investigation. After a thorough investigation it was determined that the allegation was founded. [Staff #78] was terminated."<br><br>QMRP #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated client #6 was abused by staff #78.<br><br>The facility's records were reviewed on 9/21/11 at 2:22 P.M.. A review of the facility's "Abuse and Neglect Policy and Procedure", dated 4/26/11, indicated in part, the following: "Staff will ensure the protection and treatment of all clients by refraining from the use of physical, verbal, sexual, or psychological abuse of any client. The facility shall act proactively to assure that clients are free from serious and immediate threat to their physical and psychological health and | | manner described on the incident report. However, in the future, the individual will be more explicit in the verbiage used when writing the cause of the incident for Client #39.However, staff was instructed to report all noted injuries, on all clients, to nursing immediately. Nursing will immediately report all injuries to the Administrator, Program Director and Director of Nursing.The IDT will review the incident reports,on a weekly basis, to determine that injuries of unknown origin are described in a manner that is appropriate and that verbiage is explicit on the incident report for all clients.All staff will continue to be in-serviced on the facility Abuse and Neglect Policy and Procedure, including reporting of injuries, on a quarterly basis or as needed to ensure that mistreatment of all clients is avoided.The IDT will review the incident reports, on a weekly basis, to determined that injuries of unknown origin are described in a manner that is appropriate and that verbiage is explicit on the incident report for all clients.All staff will continue to be in-serviced on the facility Abuse and Neglect Policy and Procedure, including reporting of injuries, on a quarterly basis or as needed to ensure that mistreatment of all clients is avoided.The facility will continue to hold mandatory all staff | |

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| | safety. The facility will further ensure that all clients are free from neglect. Neglect will include the failure to provide appropriate care, food, medical care or supervision."<br><br>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 staff #6 on 9/19/11 at 7:43 AM indicated she did not know how client #51 received the injury/bruise.<br><br>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 9/19/11 at 12:50 PM. The facility's 9/11 internal incident reports and/or reportable incident reports indicated client #51's injury of unknown origin had not been reported to the facility's administrator.<br><br>Interview with Qualified Mental Retardation Professionals (QMRPs) #1 and #2, the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Business/Office Manager on 9/21/11 at 9:53 AM indicated they had not been made aware of client #51's bruise/injury. The DON indicated the facility staff had not made her aware | | in-services on reporting of injuries immediately to nursing, on a quarterly basis or as needed. Nursing will immediately report all injuries to the Administrator, Program Director and Director of Nursing.The IDT will continue to monitor the effectiveness of the Abuse and Neglect Policy and Procedure, including reporting of injuries, quarterly or as needed to ensure that mistreatment of all clients is avoided. In addition, the IDT will continue to monitor all reporting of incidents ensuring that the Administrator has been notified of all incidents. | |

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| | of client #51's injury of unknown origin to report to the administrator.<br><br>The facility's records were reviewed on 9/21/11 at 2:22 P.M.. A review of the facility's "Abuse and Neglect Policy and Procedure", dated 4/26/11, indicated in part, the following: "This system includes: Incident and Accident reporting and investigation by the facility's Program Director, immediate reporting to the facility Administrator . . .."<br><br>3. The facility's records were reviewed on 9/19/11 at 12:50 P.M.. A review 2 of 5 incidents of unknown injuries from 9/19/10 to 9/19/11 indicated the following two unknown injuries:<br><br>A. "Name: [Client #49], Incident Date: 8/16/11, Nursing Description of Injury: Noted clusters of small fading yellow brown bruise 0.8 cm (centimeters) x (by) 1.2 cm, 0.2 cm x 0.4, 0/6 cm x 0.6 cm, 1.2 cm x 0.4 cm, 0.1 cm x 0.2 cm. All surround by 0.1 x 1.4 superficial scratch L (left) upper arm. Investigative Findings: Dry skin was noted around the area. It is believed she (client #49) scratched herself causing the area."<br><br>B. "Name: [Client #39], Incident Date: 4/20/11, Nursing Description of Injury: | | | |

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| | L (left) side neck with 6 x (by) 1.5 cm (centimeter) abrasion with scab - 0S/S of infec. (zero signs of infection.) Investigative Findings: [Client #39] was observed to be scratching himself."<br><br>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 the conclusion of client #49 scratching herself as the cause of the injury, and of client #39 scratching himself as the cause of the injury.<br><br>QMRP #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated the 8/16/11 and 4/20/11 injuries of unknown origin did not have supporting documentation to which their respective conclusions could be drawn from.<br><br>The facility's records were reviewed on 9/21/11 at 2:22 P.M.. A review of the facility's "Abuse and Neglect Policy and Procedure", dated 4/26/11, indicated in part, the following: "The Program Director will then conduct a thorough investigation . . .."<br><br>3.1.28(a) | | | |

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| W0153 | The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>Based on observation, interview and record review for 1 of 6 allegations of abuse, neglect and/or injuries of unknown origin reviewed involving client #51, the facility failed to ensure staff immediately reported all injuries of unknown origin to the administrator in accordance with state law.<br><br>Findings include:<br><br>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 staff #6 on 9/19/11 at 7:43 AM indicated she did not know how client #51 received the injury/bruise.<br><br>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 9/19/11 at 12:50 PM. The facility's 9/11 internal | W0153 | After it was reported that Client #51 was noted to have a 1" oblong bruise to their upper left arm, nursing immediately went to assess the area. No bruise was found. However, staff was instructed to report all noted injuries, on client #51 to nursing immediately. Nursing will immediately report all injuries to the Administrator, Program Director and Director of Nursing.However, staff was instructed to report all noted injuries, on all clients, to nursing immediately. Nursing will immediately report all injuries to the Administrator, Program Director and Director of Nursing.The facility will continue to hold mandatory all staff in-services on reporting of injuries immediately to nursing, on a quarterly basis or as needed. Nursing will immediately report all injuries to the Administrator, Program Director and Director of Nursing. In addition, the IDT will continue to monitor all reporting of incidents on a weekly basis as they occur, ensuring that the | 10/01/2011 |

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| | incident reports and/or reportable incident reports indicated client #51's injury of unknown origin had not been reported to the facility's administrator.<br><br>Interview with Qualified Mental Retardation Professionals (QMRPs) #1 and #2, the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Business/Office Manager on 9/21/11 at 9:53 AM indicated they had not been made aware of client #51's bruise/injury. The DON indicated the facility staff had not made her aware of client #51's injury of unknown origin to report to the administrator.<br><br>3.1-13(g)(1)<br>3.1-28(c) | | Administrator has been notified of all incidents. | |
| W0154 | The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>Based on record review and interview, the facility failed to show evidence of a thorough investigation of 2 of 5 reviewed injuries of unknown origin involving 2 of 57 clients living at the facility (clients #39 and #49.)<br><br>Findings include: | W0154 | After the IDT reviewed the incident report for Client #49, it was determined that Client #49 had sustained the bruises in the manner described on the incident report. However, in the future, the individual will be more explicit in the verbiage used when writing the cause of the incident for Client #49.After the IDT reviewed the incident report for Client #39, it was determined that Client #39 had sustained the | 10/26/2011 |

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| | The facility's records were reviewed on 9/19/11 at 12:50 P.M.. A review of 2 of 5 incidents of unknown injuries from 9/19/10 to 9/19/11 indicated the following two unknown injuries:<br><br>A. "Name: [Client #49], Incident Date: 8/16/11, Nursing Description of Injury: Noted clusters of small fading yellow brown bruise 0.8 cm (centimeters) x (by) 1.2 cm, 0.2 cm x 0.4, 0/6 cm x 0.6 cm, 1.2 cm x 0.4 cm, 0.1 cm x 0.2 cm. All surround by 0.1 x 1.4 superficial scratch L (left) upper arm. Investigative Findings: Dry skin was noted around the area. It is believed she (client #49) scratched herself causing the area."<br><br>B. "Name: [Client #39], Incident Date: 4/20/11, Nursing Description of Injury: L (left) side neck with 6 x (by) 1.5 cm (centimeter) abrasion with scab - 0S/S of infec. (zero signs of infection.) Investigative Findings: [Client #39] was observed to be scratching himself."<br><br>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 the conclusion of client #49 scratching | | bruises in the manner described on the incident report. However, in the future, the individual will be more explicit in the verbiage used when writing the cause of the incident for Client #39.The IDT will review the incident reports, on a weekly basis, to determined that injuries of unknown origin are described in a manner that is appropriate and that verbiage is explicit on the incident report for all clients. | |

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| | herself as the cause of the injury, and of client #39 scratching himself as the cause of the injury.<br><br>QMRP #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated the 8/16/11 and 4/20/11 injuries of unknown origin did not have supporting documentation to which their respective conclusions could be drawn from.<br><br>3.1-28(a) | | | |
| W0210 | Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br><br>Based on interview and record review for 1 of 10 sampled clients (#3), the facility failed to re-assess a client's behavior and/or diagnosis in regard to PICA (ingesting inedible objects/items).<br><br>Findings include:<br><br>Client #3's record was reviewed on 9/21/11 at 8:42 AM. Client #3's 8/22/11 physician's orders indicated client #3's diagnosis included, but was not limited to PICA. Client #3's 8/22/11 physician's orders indicated the client was diagnosed with PICA in 7/1/08. | W0210 | On 10/13/2011, the IDT/Behavior Management Committee discussed Client #3's diagnosis of PICA behavior. He was assessed for PICA behavior on 10/13/2011(See attachment W210-A). (This client has not exhibited PICA behavior since his admission in 2009.) A Behavior Protocol was developed for the possibility of PICA for Client #3. (See attachment W210 - B) His behaviors, including PICA will be reviewed on a quarterly basis at the scheduled Quarterly Review meetings and at his Individual Program Plan meeting annually. The Behavior Management Committee will review his behavior data as needed or at | 10/26/2011 |

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| | 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 to determine if the client actually had PICA.<br><br>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."<br><br>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's PICA behavior had not been addressed as the client had not demonstrated the behavior since he was admitted 3 to 4 years ago. QMRPs #1 and #2 indicated client #3's PICA behavior/diagnosis had not been re-assessed. | | 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 addition, all newly admitted clients will continue to be assessed for PICA upon their admission. They 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 their behavior data as needed or at least weekly.All staff will be in-serviced on PICA behavior on those clients that have PICA behavior or a history of PICA behavior on Oct. 26, 2011. They will be instructed how to document PICA behavior, what to watch for and how to intervene.All staff will closely monitor all clients with 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. The Program Director will collect and monitor the behavior data for PICA behavior. 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 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-31(a)<br>3.1-31(d) | | meeting. The Behavior Management Committee will review his behavior data as needed or at least weekly. In addition, all newly admitted clients will be assess for PICA upon their admission. They will be reviewed 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. | |
| W0249 | As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>Based on observation, record review, and interview, the facility failed to assure direct care staff provided a continuous active treatment program during times of opportunity for 8 of 10 sampled clients (clients #2, #3, #4, #5, #7, #8, #9, and #10) living in the facility.<br><br>Findings include:<br><br>1. During the 9/19/11 observation period between 1:00 PM to 3:30 PM and from 4:25 PM to 5:46 PM, in group 5, client #3 returned from school at 2:40 PM. Client | W0249 | The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on redirection to a meaningful activity/training, communication, implementation of prioritized objectives and informal opportunities for Client #3, 5, and 20 as well as all other clients. In addition, the nursing staff will be educated on the need for medication and treatment goals and when to perform them for Client #3 and for all other clients. The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on client choices, communication and socialization for Client #4.The | 10/26/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | #3 then sat in his wheelchair without an activity, sat and flapped his hands near his head/ears, sat holding a toy item in his hand, and/or sat with the toy item at/in his mouth. Facility staff #2, #7 and/or #8 not redirect the client to participate in a more meaningful activity and/or training. During the above mentioned observation period, staff did not encourage the client to answer questions nor offer the client a choice of activity to participate in as staff #7 handed client #3 an object/toy. When client #3 received his 4 PM medications at 3:10 PM, Qualified Medication Assistant #5 did not provide any medication training to client #3. At 5:02 PM, staff wheeled client #3 into the dining room to his table. Client #3 did not ambulate to the dining room with an assistive device.<br><br>Client #3's record was reviewed on 9/21/11 at 8:42 AM. Client #3's 7/21/11 IHP indicated the client had the following service objectives which facility staff did not implement when opportunities for training existed:<br><br>-encourage to stay focused on current activity for 2 minutes<br>-encourage to answer yes or no questions<br>-encourage to select a desired leisure object/item from a choice of 2 using reach/grasp | | Staff Development Coordinator will in-service all Direct Care Staff/CNA's on redirection to a meaningful activity for Client #2, 5, and all other clientsThe Staff Development Coordinator will in-service all Direct Care Staff/CNA's on Active Treatment for Client #7, 8, and all other clients. In addition, the nursing staff will be educated on the need for medication and treatment goals and when to perform them for Client #7, 8, and all other clients..The Staff Development Coordinator will in-service all Direct Care Staff/CNA's onfollowing Client #9, 10 as well as all other clients Active Treatment Schedule.The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on redirection to a meaningful activity/training, communication, implementation of prioritized objectives and informal opportunities for all clients. In addition, the nursing staff will be educated on the need for medication and treatment goals and when to perform them for all clients.The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on redirection to a meaningful activity, implementation of prioritized objectives, informal opportunities and staff interaction for all clients.The staff Development Coordinator will in-service all Direct CareStaff/CNA's onclient | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | Client #3's 7/21/11 IHP also indicated the client had objectives to sit at a table with peers for 2 minutes, to look at pictures in a magazine, maintain eye contact with staff for 10 seconds, point to 3 red items in program room, to walk to and from the dining room for meals with a gait trainer, and an objective to throw his cup in the trash after medication administration which staff did not implement when formal and/or informal training opportunities for existed.<br><br>Interview with Qualified Mental Retardation Professionals (QMRPs) #1 and #2 on 9/21/11 at 9:53 AM indicated facility staff should implement client #3's IHP and/or provide activities for the client to participate in. QMRPs #1 and #2 indicated facility staff should have used the client's gait trainer to walk to the dining room for his dinner meal on 9/19/11.<br><br>2. During the 9/20/11 observation period between 5:30 AM and 7:50 AM, when client #5 returned to program room 6, from breakfast at 7:00 AM, client #20 stood and looked out a window and/or sat on the floor holding a toy item up to his face. Staff did not interact with the client and/or offer the client a meaningful activity/training to participate in except to | | choices, communication and socialization for all clients.The Program Director, QMRP's, Shift Department Heads and Staff Development Coordinator will perform random audits daily in all training areas to ensure all clients that reside in the facility have 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. In addition, the Program Director, QMRP's and shift Department Heads will perform random audits of all training areas to ensure all clients are receiving consistent Active Treatment. The findings, if any, will be relayed to the Staff Development Coordinator. The Staff Development Coordinator will re-train in the areas of the findings. Periodic observations of medication administration will cotinue by the Director of Nursing and monthly observations of the goal sign off sheet for each client, by the Director of Nursing, will also continue. | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | place eyeglasses on the client 2 different times. Each time client #5 immediately removed the eyeglasses and threw them down to the floor. Client #5 would then place the toy item back up to the side of his head.<br><br>Client #5's record was reviewed on 9/22/11 at 8:42 AM. Client #5's 2/14/11 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 quarter and an objective to maintain eye contact with staff for 20 seconds which staff #1 and #6 did not implement when formal and/or informal opportunities for training existed.<br><br>Interview with QMRPs #1 and #2 on 9/21/11 at 9:53 AM indicated facility staff should implement client #5's IHP and/or provide activities for the client to participate in.<br><br>3. During the 9/19/11 observation period between 1:00 PM and 3:30 PM and from 4:25 PM to 5:46 PM, in group 5, client #4 sat without an activity in a lounge chair and/or was redirected to participate in game of Connect 4 with facility staff. Staff #2 did not offer the client a choice of activities to participate in. Client #4 sat holding the Connect 4 chips, and/or | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | attempted to drop the chips into the Connect 4 slots without redirection/training on how to play the game. Staff #2 would release the chips when client #4 filled the slots up and the client would start all over again. Staff #2, #7 and/or #8 did not redirect the client to participate in any other meaningful activity/training. During the above mentioned observation period, staff did not encourage client #4 to socialize with others and/or provide communication training with the non-verbal client in that the client did not speak.<br><br>Client #4's record was reviewed on 9/21/11 at 10:22 AM. Client #4's 11/3/10 IHP indicated the client had objectives to teach discrimination skills, identify the concept of more when given 2 groupings of objects, to match 4 common objects to their matching picture, to remove lids to 3 twist top containers, to match 4 coins, and to maintain her attention to a selected magazine for 5 minutes. Client #5's 11/3/10 IHP also indicated the client had a service objective for staff to encourage the client to participate in social activities to promote vocabulary and language skills, and a service objective to encourage the client to socialize with peers at a table activity which staff did not implement when formal and/or informal training opportunities existed. | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|

Interview with QMRPs #1 and #2 on 9/21/11 at 9:53 AM indicated facility staff should implement client #4's IHP and/or provide activities for the client to participate in.

4. Clients #2 and #5 were observed in program room four on 9/19/11 from 3:00 P.M. until 4:00 P.M.. From 3:00 P.M. until 4:00 P.M., client #2 sat in a chair holding a plastic object. During the same time period, client #5 sat in a chair holding a book. Staff #33 and #34 were not observed to prompt or assist clients #2 and #5 in engaging any structured activity or training program.

Client #2's record was reviewed on 9/21/11 at 10:58 A.M.. A review of the client's 10/4/10 Individual Program Plan indicated the following training objectives which could have been implemented during the 9/19/11 observation period: "1. Tolerate wearing glasses for one minute. 2. Will I.D. (identify) printed name when presented with dissimilar names. 3. Will I.D. penny by pointing and stating its name when presented with dissimilar coins. 4. Will trace the alphabet letters, A, B, C, D, E. 5. Will place 10 beads on a string."

Client #5's record was reviewed on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 9/21/11 at 12:05 A.M.. A review of the client's 2/8/11 Individual Program Plan indicated the following training objectives which could have been implemented during the 9/19/11 observation period: "1. Will roll ball with staff for 2 minutes. 2. Will place 3 shapes into a shape sorter. 3. Will hand a quarter to staff upon request. 4. Will maintain eye contact with staff for 20 seconds as staff speaks to him."<br><br>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 9/21/11 at 1:00 P.M.. QMRP #1 indicated staff are to implement client objectives during times of opportunity.<br><br>5. Observations were conducted on 9/19/11 from 1:50 PM to 4:15 PM in Program Room One. Client #7 had a shape sorter box on her tray but wasn't using. Client #8 wasn't participating in any activity. At 2:00 PM, staff #22 started reading a book to client #7. At 2:15 PM, staff #22 stopped reading to client #7 and went to client #8 and showed him a toy tambourine. Client #8 did not use them. Staff #23 asked client #7 if she wanted to play with blocks. Staff #22 took two more toys to client #8 to show him. Client #8 did not want them. At 2:25 PM, staff #23 was prompting client #8 to put shapes in the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | shape sorter box. She was handing client #8 the shapes and he put them in the box. At 2:40 PM, staff #23 started reading to client #8. Staff #24 put a cloth doll on client #7's lap. Client #7 did not respond to it. At 2:50 PM, client #8 had a book on his lap tray but was not looking at it. At 3:00 PM, staff started putting clients #7 and #8 into their wheelchairs. By 3:15 PM, clients #7 and #8 were lined up in a row in their wheelchairs awaiting their meds, along with 11 other clients in program room one. From 3:15 PM to 4:10 PM, clients were lined up in their wheelchairs. During this time, staff #24 brought in music and played it. Staff #24 went up and down the line talking to various clients. Except for clients #7 and #8 getting changed in the restroom, there was no continuous active treatment going on from 3:00 PM to 4:10 PM, when they got their meds. At 4:10 PM, client #7 was given 6 meds but there was no med training by staff #25. At 4:17 PM, client #8 was given 2 meds, but there was no med training by staff #25.<br><br>Review on 9/21/11 at 10:15 AM of client #7's records was conducted. Client #7's ISP dated 11/11/10 included the following objectives: Maintain attention to book, story, magazine by looking for 2 minutes, lift her head a few inches to accept 5 bites of her meal, raise her head to assist with | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | washing her hair, visually identify a quarter when shown with a penny, select preferred DVD from two using eye gaze, respond to text, item rubbed to hand using facial expressions, raise her head to look at staff when her name is called, and will hold an empty spoon during med administration.<br><br>Review on 9/21/11 at 9:20 AM of client #8's records was conducted. Client #8's ISP dated 2/10/11 included the following objectives: look toward staff when his name is called, remove 3 items from his lap one at a time, grasp presented item from staff within 3 seconds, attend to musical device activated for 3 seconds without interruption, maintain sitting position in recliner for 10 minutes, hold washcloth during med administration, and grasp presented item from staff with 3 seconds.<br><br>6. 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 staff (staff #24 and #25) present in the room who remained during the observation time. During the observation time a child cartoon "Sponge Bob" was on | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | TV. Client #9 was observed to sit in his wheelchair which contained a lap tray. The lap tray contained a toy car which he dropped to the floor. Client #9 put his elbows on the lap tray and placed his head in his hands. At 2:00 PM staff #25 put a wooden children's puzzle on the lap tray. Client #9 did not attempt to work the puzzle. At 2:30 PM nursing staff came into room and looked at client #9's chin. At 2:50 PM client #9 was observed to place his head back in his hands with his eyes closed. The group room TV was changed from "Sponge Bob" to "Ninja Turtles."<br><br>Observations were conducted in group room #3 on 09/22/11 from 9:15 AM until 10:45 AM. At 9:15 AM there were three staff (staff #21, #26 and #27) to 10 clients in the classroom. During observation times Mickey Mouse and Benjie the dog were on the TV. Client #9 had the following activities during the observation: sat in wheelchair with head in his hands on the lap tray; was taken to bathroom to be changed; asked if he wanted a "toy" and a child's wooden bead toy was placed on his lap tray. At 10:41 AM client #9 was taken out of the room for a Dr's appointment.<br><br>Client #9's record was reviewed on 09/21/11 at 9:45 AM. Client #9's undated | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| | active treatment schedule indicated the following for the specified time frames:<br>5:00-7:30 AM - "Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal"<br>7:30-8:00 AM - "Toothbrushing, toileting, dressing, etc"<br>8:00-9:00 AM - "Academics, Gross Motor, Sensory Stimulation"<br>9:00-10:00 AM - "Communication, Vocational Stimulation"<br>10:00-10:30 AM - "Choice of Activity (trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc."<br>10:30-11:00 AM - "Toileting, Large Group Activity"<br>11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure"<br>12:30-1:30 PM - "Recreation, Group Activity"<br>1:30-3:30 PM - "Leisure, Communication"<br>3:30-4:00 PM - "Toileting, Handwashing, Choice of Activity, Socializing"<br>4:00-5:00 PM - "Dinner, Eating, Goals, Structure Recreation"<br>5:00-7:00 PM - "Recreation, Leisure, Communication, Choice of Activities, TV, Parties If Scheduled, Movies, Group Activity, Bathing, Special Events, Outing If Applicable, Etc"<br>7:00-8:30 PM - "Snack Time, Dressing | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

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|---|---|
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|---|---|---|---|---|
| | For Bed, Toothbrushing, Choice Of Recreation, Toileting, Medication Goal, etc"<br>Facility staff did not follow and/or implement client #9's active treatment schedule as written.<br><br>Client #9's Individual Habilitation Plan (IHP) was dated 10/28/10 and contained but was not limited to the following goals: manipulate a textured item for 5 seconds; select 1 item from a choice of 2; participate in a leisure activity for 5 minutes; when spoken to, will look at the speaker's face for 5 seconds and allow a textured item to be brushed across the palm of his hand. Client #9's IHP contained a BMP (Behavior Management Plan) dated 09/01/11. The BMP indicated, "once every 30 minutes, [client #9] will be reinforced with an edible (it can be a regular snack) including cookies, crackers, etc. or a pudding thick drinkable for refraining from biting his fingers."<br><br>On 09/21/11 at 1:00 PM an interview was conducted with the Qualified Mental Retardation Professional #2 (QMRP). The QMRP indicated client #9's goals should have been implemented and indicated staff should have been prompting the clients every 15 minutes and given them a choice of activities. | | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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| | 7. 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 staff (staff #24 and #25) present in the room who remained during the observation time. During the observation time a child cartoon "Sponge Bob" was on TV. Client #10 was observed to sit in his wheelchair which contained a lap tray. The lap tray contained Mickey Mouse cards which had colored shapes on them. Staff were observed to go from client to client asking them what color was on the cards. At 2:15 PM client #10 was given a paper with a picture of a pumpkin on it and a crayon. He was observed to make a couple of lines with the crayon and throw the paper to the floor. At 2:30 PM client #10 was moved from the table area to the TV area and Sponge Bob was on TV. Client #10 continued to sit in his wheelchair in front of the TV until the end of the observations time at 3:30 PM.<br><br>Observations were conducted in group room #3 on 09/22/11 from 9:15 AM until 10:45 AM. At 9:15 AM there were three staff (staff #21, #26 and #27) to 10 clients in the classroom. During observation times Mickey Mouse and Benjie the dog were on the TV. Client #10 had the following activities during the observation: sat in wheelchair; was asked if he wanted a "toy"; was given a | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | color crayon which he broke; was read a book entitled, "Charlie Chicken"; was given a book, "Big Bird Color Game" which he looked at upside down; and was given a children's popup toy which popped up a cat, frog, dog or bird when the button was pushed.<br><br>Client #10's record was reviewed on 09/21/11 at 11:51 AM. Client #10's undated active treatment schedule indicated the following for the specified time frames:<br>5:00-7:30 AM - "Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal"<br>7:30-8:00 AM - "Toothbrushing, toileting, dressing, etc"<br>8:00-9:00 AM - "Economics, Initiation, Fine Motor"<br>9:00-10:00 AM - "Communication, Fine Motor, Gross Motor"<br>10:00-10:30 AM - "Choice of Activity (trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc."<br>10:30-11:00 AM - "Toileting, Large Group Activity"<br>11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure"<br>12:30-1:30 PM - "Recreation, Group Activity"<br>1:30-3:30 PM - "Leisure, | | | |

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|---|---|---|---|---|
| | Communication"<br>3:30-4:00 PM - "Toileting, Handwashing, Choice of Activity, Socializing"<br>4:00-5:00 PM - "Dinner, Eating, Goals, Structure Recreation"<br>5:00-7:00 PM - "Recreation, Leisure, Communication, Choice of Activities, TV, Parties If Scheduled, Movies, Group Activity, Bathing, Special Events, Outing If Applicable, Etc"<br>7:00-8:30 PM - "Snack Time, Dressing For Bed, Toothbrushing, Choice Of Recreation, Toileting, Medication Goal, etc"<br>Facility staff did not follow and/or implement client #10's active treatment schedule as written.<br><br>Client #10's Individual Habilitation Plan (IHP) was dated 09/01/11 and contained but was not limited to the following goals: will remove the lids to three containers; will pick up 7 large items from the table one at a time; will state yes or no appropriately when shown a dime and a quarter; will maintain his attention to a selected task for 5 minutes; and will select the correct color of crayon.<br><br>On 09/21/11 at 1:00 PM an interview was conducted with Qualified Mental Retardation Professional #2 (QMRP). The QMRP indicated client #10's goals should have been implemented and | | | |

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| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | indicated staff should have been prompting the clients every 15 minutes and given them a choice of activities.<br><br>3.1-23(a)<br>3.1-32(a)<br>3.1-33(a)<br>3.1-37(a) | | | |
| W0268 | These policies and procedures must promote the growth, development and independence of the client.<br><br>Based on observation, record review, and interview, for 2 of 10 sampled clients (clients #9, #10) and 8 additional clients (clients #19, #28, #30, #33, #49, #50, #54 and #56), the facility failed to promote growth, development, independence and dignity.<br><br>Findings include:<br><br>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 staff (staff #24 and #25) present in the room who remained during the | W0268 | For Client's #9, 10, 19, 28, 30, 33, 49, 50, 54, and 56 shall be afforded the promotion of growth and independence by training staff in the craft of positive interactions, the reinforcement of skill acquisition and the awareness to recognize these opportunities. Staff will be provided assessment strategies and training to assist them in better recognizing their conduct and modeling skills toward Client #9,10, 19, 28, 30, 33, 49, 50, 54, and 56. This training shall include issues of dignity and the means to more independently correct and assist in the areas of hygiene, recognition and restitution of food spillage and soiled clothing from drooling and the correct application and the | 10/26/2011 |

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|---|---|---|---|
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|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | observation time. Observations were conducted in group room #3 on 09/22/11 from 9:15 AM until 10:45 AM. At 9:15 AM there were three staff (staff #21, #26 and #27) to 10 clients in the classroom. During the observation times children cartoons were on TV. The group room contained items which were given to the clients which included a crocodile xylophone, a top with animals, a pop-up toy with animals, a top with sea creatures, toy trucks, an animal barnyard toy, crayons, Mickey Mouse cards, and a child's puzzle. All staff were observed to go from client to client and ask how they were doing and "do you want a toy?" All of the items were toys for children and referred to as "toys" during the observation period. Clients #10, #33, #50 and #56 were all observed to be non-verbal and required total assistance from staff.<br><br>Client #9's record was reviewed on 09/21/11 at 9:30 AM. Client #9's Individual Habilitation Plan (IHP) was dated 10/28/10. The IHP indicated client #9 was over the age of 18 years old, non-verbal and required total assistance from staff for all of his needs.<br><br>Client #10's record was reviewed on 09/21/11 at 11:50 AM. Client #10's IHP dated 09/01/11 indicated client #10 was | | appropriate, intended use of programming supplies. While many of the programatic supplies may be categorized as "toys", individual clients show personal preference for these items when provided as a choice of items.Staff will be provided with assessment strategies and training to better recognize their conduct and modeling skills toward Client #9, 10, 19, 28, 30, 33, 49, 50, 54, 59 and all other clients. This training shall include issues of dignity and the means to more independently correct and assist in the areas of hygiene, recognition and restitution of food spillage and soiled clothing from drooling and the appropriate, intended use of programming supplies.Staff will be trained through an all staff in-service to initially address causal reasons of the behavior described and provided training to better recognize their conduct, and modeling skills toward all clients.Random, bi-monthly audits will be completed by the staff trainer to further ensure that these strategies are practiced and understood.The Quarterly Review Committee will review at least 3 times yearly and during their annual Individual Habilitation Plan meeting.QMRP's are responsible.Program Director will monitor. | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| | over the age of 18 years old, non-verbal and required total assistance from staff for all of his needs.<br><br>On 09/21/11 at 1:00 PM an interview was conducted with the Qualified Mental Retardation Professional #2 (QMRP). The QMRP #2 indicated it was not dignified for clients #10, #33, #50 or #56 to be drooling, not having their mouth wiped off and should not be wearing clothing wet from the drool.<br><br>On 09/21/11 at 1:00 PM an interview was conducted with the Qualified Mental Retardation Professional #2 (QMRP). The QMRP #2 indicated clients #9 and #10 were not children and staff should not be referring to or using "toys."<br><br>2. Observations were conducted in group room #3 on 09/22/11 from 9:15 AM until 10:45 AM. At 9:15 AM there were three staff (staff #21, #26 and #27) to 10 clients in the classroom. During the observation times children cartoons were on TV. The group room contained items which were given to the clients which included a crocodile xylophone, a top with animals, a pop-up toy with animals, a top with sea creatures, toy trucks, an animal barnyard toy, crayons, Mickey Mouse cards, and a child's puzzle. All staff were observed to | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

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|---|---|
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|---|---|---|---|---|
| | go from client to client and ask how they were doing and "do you want a toy?" All of the items were toys for children and referred to as "toys" during the observation period. Clients #10, #33, #50 and #56 were observed to be drooling during all observation periods and their clothing contained wet spots from the drooling. Staff were not observed to prompt, assist or wipe clients #10, #33, #50 or #56's mouth or change their wet shirts.<br><br>Clients #10, #33, #50 and #56 were all observed to be non-verbal and required total assistance from staff.<br><br>On 09/21/11 at 1:00 PM an interview was conducted with the Qualified Mental Retardation Professional #2 (QMRP). The QMRP #2 indicated it was not dignified for clients #10, #33, #50 or #56 to be drooling, not having their mouth wiped off and should not be wearing clothing wet from the drool.<br><br>3.1-26(g) | | | |
| W0312 | Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. | | | |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| | Based on record review and interview, the facility failed for 1 of 5 sampled clients on behavior medication (client #7) by not having an active treatment plan to address the reason for the medication.<br><br>Findings include:<br><br>Review on 9/21/11 at 10:15 AM of client #7's records was conducted. Client #7's MAR (Medication Administration Record) dated 8/1/11 through 9/30/11, indicated client #7 was taking one 40 mg (milligrams) Celexa tablet (for depression as indicated on the August 2011 Physician's Orders). Client #7's ISP dated 11/11/10 did not include a behavior plan to address client #7's taking of Celexa for depression.<br><br>Interview on 9/21/11 at 11:20 AM with QMRP (Qualified Mental Retardation Professional) #2 was conducted. QMRP #2 indicated client #7 was on Celexa for depression but there was no plan in place to address the use of the Celexa.<br><br>3.1-26(k)<br>3.1-26(l)<br>3.1-26(m) | W0312 | Client #7 presents with a diagnostic history which includes Systemic Lupus, Spastic Quadra paresis, congenital hip dislocation, non-verbal Breast Cancer survivor and Depression. Client #7 was diagnosed and is followed by a Psychiatrist for treatment of Depression, a mental illness. Client #7 is currently prescribed a psychotropic medication to facilitate management of depressive traits. Client #7 does not present with inappropriate behaviors, but a mental illness that is managed through psychotropic medications prescribed by her Psychiatrist and monitored through the Interdisciplinary Team. In addition, Client #7 has been and will be continue to be, provided with programmatic objectives to address and/or assist with mood and affect responses. A behavioral protocol has been re-intoduced for Client #7 to afford staff and intervening staff measures to recognize and document changes affect or mood to assess the effectiveness of her currently prescrtibed psychotropic medication. (See attachment 312A)All clients' currently prescribed psychotropic medication for depression shall be reviewed by the Behavior Management Committee to ensure that the appropriate protocol and/or interventions are in place as an integral aspect of | 10/26/2011 |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | | | their active treatment plan.All clients who are prescribed psychotropic medications shall have their currently prescribed medications, dosage, Psychiatrist recommendations and last date of reduction reviewed by the Quarterly Review Committee. All recommendations and actions shall be documented on each client's Quarterly Review sheet.The Program Director shall maintain written documentation of each client's psychotropic medications and review dates. The Behavior Management Committee shall review Psychotropic medications prescribed for depression bi-annually. | |
| W0369 | The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>Based on observation, interview and record review for 1 of 52 medications administered, the facility failed to ensure client #20's medication was administered without error during a medication pass.<br><br>Findings include:<br><br>During the 9/19/11 observation period between 1:00 PM and 3:30 PM, in group 5, Qualified Medication Assistant (QMA) #5 administered 15 milliliters of Metamucil (irregular bowel) in 4 ounces | W0369 | The Metamucil orders were reviewed for client #20 and QMA #5 was instructed on the proper dosage mixture and how to prepare to ensure safe administration for all client's with the order for Metamucil.QMA #5 was counseled and a medication error form was completed.QMA #5 and all nursing staff (QMAs and Nurses) was in-serviced on the six rights of medication administration. (completed 10-10-11)The Director of Nursing will observe QMA #5 conduct a medication administration of Metamucil on 10-17-2011. Periodic medication | 10/26/2011 |

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|---|---|---|---|
| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| | of juice to client #20 at 3:15 PM.<br>Interview with QMA #5 on 9/19/11 at 3:15 PM indicated she used a 4 ounce cup with juice to mix/administer the client's Metamucil.<br><br>Client #20's record was reviewed on 9/19/11 at 5:15 PM. Client #20's 8/22/11 physician's orders indicated client #20 was to receive Metamucil "mix 15 ml (milliliters) in 8 oz (ounces) with juice or water and give TID (three times a day) for irregular bowel."<br><br>Interview with QMA #5 on 9/19/11 at 5:17 PM when asked why the QMA administered the Metamucil in 4 ounces of water versus 8 ounces, QMA #5 stated "Most orders say 4 to 8 ounces. Her (client #20's) physician orders said 8 ounces. I messed up."<br><br>Interview with the Director of Nursing (DON) on 9/21/11 at 9:53 AM indicated the QMA should have administered the Metamucil in 8 ounces of water/juice as ordered. | | administration audits will also continue for all nursing staff to assure correct procedures are followed. Director of Nursing is responsible.Administrator will monitor. | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARCADIA DEVELOPMENTAL CENTER | 303 FRANKLIN<br>ARCADIA, IN46030 |

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|---|---|---|---|---|
| W0436 | The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br>Based on observation, interview and record review for 1 of 4 clients that wore glasses, the facility failed to ensure and/or train client #5 to use his eyeglasses.<br><br>Findings include:<br><br>Observations were conducted at the facility on 9/19/11 from 11:55 AM through 12:35 PM and 3:30 PM through 5:46 PM. Client #5 was observed during the observation periods. Client #5 was not observed wearing eyeglasses.<br><br>During the 9/20/11 observation period between 5:30 AM and 7:50 AM, at the facility at 7:25 AM, an unidentified nursing staff brought client #5's eyeglasses into the group number 6 and handed his eyeglasses to staff #1. Staff #1 then placed the eyeglasses on client #5, who was sitting on the floor. Client #5 removed the eyeglasses and threw them down to the floor. A few minutes later, staff #1 picked the eyeglasses up and placed them back on client #5. Client #5 removed his eyeglasses and threw them down to the floor. | W0436 | For Clients #9, 10, 19, 28, 30, 33, 49, 50, 54, and 56 shall be afforded the promotion of growth and independence by training staff in the craft of reinforcement of skill acquisition and the awareness to recognize these opportunities. Staff will be provided assessment strategies and training to assist them in better recognizing opportunities for clients to wear personal eyeglasses, apply eyeglasses for those who display resistive behavior for wearing and the incremental times that they should attempt to apply individual eyeglasses for clients #5. This training shall include the means to more independently correct and assist in the areas of the correct application and the appropriate, intended use of eyeglasses.Staff will be provided with assessment strategies and training to better recognize opportunities for eyeglass application for all clients assessed to wear them. This training shall include the means to more independntly correct and assist in the areas of the correct application and the appropriate, intended use of eyeglassesStaff will be trained through an all staff | 10/26/2011 |

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|---|---|---|---|
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|---|---|---|---|---|
| | Observations were conducted at the facility on 9/20/11 from 10:15 AM through 11:00 AM and from 11:45 AM through 12:20 PM. Client #5 was observed through the observation periods. Client #5 was not observed wearing eyeglasses.<br><br>Interview with DON #1 (Director of Nursing) on 9/20/11 at 2:00 PM indicated client #5 should be wearing his eyeglasses.<br><br>Interview with DCS #11 (Direct Care Staff) on 9/20/11 at 2:15 PM indicated client #5 did have a pair of eyeglasses that he is supposed to wear. DCS #11 indicated client #5 does not like to wear the glasses and will refuse to wear them by throwing them. DCS #11 indicated client #5 did not have a training objective to teach him how to use the eyeglasses.<br><br>Interview with QMRP #2 (Qualified Mental Retardation Professional) on 9/21/11 at 1:45 PM indicated clients should be encouraged and/or trained to use eyeglasses.<br><br>Client #5's record was reviewed on 9/21/11 at 8:42 AM. Client #5's 2/8/11 ISP (Individual Support Plan) did not indicate a formal training and/or | | in-service to initially address causal reasons of the behavior described and provided training to better recognize and assist in the areas of the correct application and the appropriate, intended use of eyeglasses.Random, bi-monthly audits will be completed by the staff trainer to further ensure that these strategies are practiced and understood.The Quarterly Review Committee will review at least 3 times yearly and during their annual Individual Habilitation Plan meeting to police those who should wear eyeglasses.The QMRP will be responsible.The Quarterly Review Committee will monitor. | |

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| | desensitization objective to for utilization of eyeglasses.<br><br>3.1-21(h)<br>3.1-39(a) | | | |
| W0455 | There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br><br>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.<br><br>Findings include:<br><br>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 group room #3 on 09/22/11 from 9:15 AM until 10:45 AM. At 9:15 AM there | W0455 | The Direct Care Staff/CNA's will be in-serviced, by the Staff Development Coordinator, on assisting Clients #10, 33, 50, and 56 with removing drool and/or removing drool from those clients that are not capable of doing so. For clients that are able, they will be encouraged to use a klenex or dry clean wash cloth to remove drool from their face. In addition, staff will be in-serviced, by the Staff Development Coordinator, on ensuring that Clients #10, 33, 50, and 56 and all other clients have clean and dry clothing on upon becoming soiled or wet.The Staff Development Coordinator will in-service all Direct Care Staff/CNA's on monitoring all clients in the Dining Room during the meals and in the Programming areas while eating to ensure that Client #32 and Client #22 and all other clients refrain from eating food off the | 10/26/2011 |

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| | 15G580 | A. BUILDING 00<br>B. WING | 09/26/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | were three staff (staff #21, #26 and #27) to 10 clients in the classroom. Clients #10, #33, #50 and #56 were observed to be drooling during all observation periods and their clothing contained wet spots from the drooling. Staff were not observed to prompt, assist or wipe clients #10, #33, #50 or #56's mouth or change their wet shirts.<br><br>An interview on 09/21/11 at 1:00 PM with Qualified Mental Retardation Professional #2 (QMRP) was conducted. The QMRP #2 indicated it was not good hygiene for clients to be drooling and not be assisted with the drooling and wet clothes.<br><br>2. Observations were conducted at the facility dining room on 09/19/11 from 4:03 PM until 6:00 PM. At 4:50 PM client #32 was observed to lean over in his chair, pick food up from the floor, place the food in his mouth and swallow the food. At 5:50 PM client #22 was observed to lean over in his chair, pick food up from the floor, place the food in his mouth and swallow the food. Observations were conducted at the facility dining room on 09/20/11 from 11:55 AM until 1:00 PM. At 12:40 PM client #32 was observed to lean over in his chair, pick food up from the floor, place the food in his mouth and swallow | | floor, staff will be instructed to remove food from the floor as soon as witnessed by staff.The Program Director, QMRP's and shift Department Head will perform randomaudits in all programming and or all areas where clients are present daily. They will immediately inform staff of those clients that need attention. The shift Department Head will follow up to ensure that the client has been assisted.The Program Director, QMRP's and shift Department Head will perform random audits in the Dining Room and other areas where clients will be consuming food to ensure that no client eats food from the floor.The Staff Development Coordinator will in-service all staff on infection control on a quarterly basis or as needed. In addition, the Program Director, QMRP's and shift Department Head will perform daily random audits in all programming and or all areas where clients are present. They will immediately inform Direct Care Staff/CNA's of those clients that need attention. The shift Department Head will follow up to ensure that the clients have been assisted.The Department Head will assign a designated Direct Care Staff/CNA to monitor the Dining Room during mealtimes. The designated staff member will make sure that the floors are kept free from spilled food and clean it up immediately after a spill.The | |

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| | the food.<br><br>An interview on 09/21/11 at 1:00 PM with Qualified Mental Retardation Professional #2 (QMRP) was conducted. The QMRP #2 indicated it was not good hygiene for clients to be eating food from the dining room floor.<br><br>3.1-18(b)(1) | | Shift Department Head is responsible for compliance.The QMRP's will monitor. | |
| W0488 | The facility must assure that each client eats in a manner consistent with his or her developmental level.<br><br>Based on observation, interview and record review for 9 of 10 sampled clients (#1, #2, #3, #4, #5, #6, #8, #9, and #10), the facility failed to provide and/or encourage family style dining at meals. The facility failed to ensure all clients were supervised and/or redirected to take appropriate bites, used utensils and/or ate a manner consistent with their skills.<br><br>Findings include: | W0488 | This facility does provide family style dining for the evening meal for all clients assessed to functionally participate. Clients #1, 2, 3, 4, 5, and 6 participate in a family style dining atmosphere for their evening meal regularly. To further incorporate an atmosphere of family dining: clients #1, 2, 3, 4, 5, 6, and all other assessed clients will be offered introductory elements of a family dining experience during the breakfast and lunch time meals.The facility will continue to offer a family style dining | 10/26/2011 |

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| | 1. During the 9/19/11 observation period between 1:00 PM to 3:30 PM and from 4:25 PM to 5:46 PM, at the facility, staff #10 assisted client #3 to serve himself 2 meatballs with gravy onto his plate. As soon as the client placed the meatballs on his plate, staff #10 assisted a client next to client #3 to serve himself. Client #3 picked up a whole meatball with his hands and placed into his mouth. Staff #10 looked at client #3, as the client was reaching for the second meatball. Staff #10 did not redirect the client to slow down, take smaller bites of food, and/or encourage the client to use his adaptive fork to eat with as the client placed the second (whole) meatball in his mouth.<br><br>During the 9/20/11 observation period between 5:30 AM and 7:50 AM, at the facility, clients #1, #2, #3, #4, #5 and #6 ate their breakfast meal in the dining room. The clients did not eat family style as the clients' cereal, toast, eggs, milk, and juice were served to the clients on trays. Facility staff carried the clients' trays from the kitchen window to the dining tables where each client sat. The staff either removed the food items off the tray and placed the items in front of the clients and/or had the clients eat off the tray.<br><br>Client #6's record was reviewed on 9/20/11 at 2:15 PM. Client #4's 4/7/11 | | atmosphere for each client during the evening meal. Additionally, to further incorporate an atmosphere of family dining: clients #1, 2, 3, 4, 5, 6, and all other assessed clients will be offered introductory elements of a family dining experience during the breakfast and lunch time meals. Introductory elements of family style dining will include self-acquisition of napkins and utilization of salt and pepper shakers as appropriate, for each client, if the appropriate food items are served during these meals.To assure that elements of family style dining continue for the breakfast and lunch time meals, napkin dispensers and salt and pepper shakers will be placed, and remain placed, on all tables in the dining room.The Quarterly 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 dining atmosphere.QMRP will monitor. | |

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| | Individual Habilitation Plan (IHP) indicated the client participated in family style dining.<br><br>Client #3's record was reviewed on 9/21/11 at 8:42 AM. Client #3's 7/21/11 Individual Habilitation Plan (IHP) indicated the client participated in family style dining.<br><br>Client #5's record was reviewed on 9/21/11 at 8:42 AM. Client #5's 2/14/11 IHP indicated the client participated in family style dining.<br><br>Client #1's record was reviewed on 9/21/11 at 9:12 A.M.. Client #1's 4/7/11 Individual Program Plan indicated the client participated in family style dining.<br><br>Client #4's record was reviewed on 9/21/11 at 10:22 AM. Client #4's 11/3/10 IHP indicated the client participated in family style dining.<br><br>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.<br><br>Interview with Qualified Mental Retardation Professionals (QMRPs) #1 and #2, the Director of Nursing (DON), | | | |

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| | the Assistant Director of Nursing (ADON) and the Business/Office Manager on 9/21/11 at 9:53 AM indicated the facility did not do family style dining at the breakfast and lunch meals. QMRPs #1 and #2 indicated the facility did not have enough time to do family style dining at breakfast as some of the clients/kids had to go to school and the clients got up at varied times. QMRP #2 indicated the facility did not do family style dining at lunch because some clients would be sitting at a table by themselves as the other clients/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 the past for breakfast and lunch but it did not work. QMRP #1 indicated facility staff should have assisted client #51 to cut up his meatballs, encourage the client to slow down and not eat with his hands.<br><br>2. Observations were conducted at the facility on 09/20/11 from 6:00 AM to 7:00 AM.<br>At 6:25 AM client #8 was observed to be wheeled into the dining table. At 6:28 AM client #8 was observed to have his prepared food tray placed in front of him and was observed to be fed his entire meal by staff #30. | | | |

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| | An interview on 09/21/11 at 1:00 PM with Qualified Mental Retardation Professional #2 (QMRP) was conducted. The QMRP indicated client #8 should have been assisted with his food and staff should not have fed him.<br><br>Observations were conducted at the facility on 09/20/11 from 12:15 PM to 1:00 PM. At 12:15 PM client #9 was observed to be wheeled to the dining room. At 12:25 PM client #9 was observed to have his prepared food tray placed in front of him and was observed to be fed his entire meal by staff #29. At 12:43 PM client #10 was observed to wheel himself into the dining room. Staff #28 was observed to get his prepared food tray and placed it in front of him on the table. Client #10 was not observed to assist in obtaining his food or setting it up.<br><br>An interview on 09/20/11 at 1:00 PM with Qualified Mental Retardation Professional #2 (QMRP) was conducted. The QMRP #2 indicated client #10 was capable of assisting with his food and staff #28 should not have custodially fed him.<br><br>3.1-20(a) | | | |

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