

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2011
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NAME OF PROVIDER OR SUPPLIER ARCADIA DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN46030
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W0000	<p>This visit was for a post certification revisit to a fundamental recertification and state licensure survey conducted on September 26, 2011.</p> <p>Dates of Survey: October 31, November 1 and 2, 2011.</p> <p>Facility number: 000730 Provider number: 15G580 AIM number: 100272190</p> <p>Surveyors: Tim Shebel, Medical Surveyor III-Team Leader Susan Eakright, Medical Surveyor III Sue Reichert, Medical Surveyor III Claudia Ramirez, Public Health Nurse Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 11/18/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>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 obligations. _____ __Beverly Sayre Cowart</p>	
W0104	The governing body must exercise general policy, budget, and operating direction over the facility.			

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

TITLE

(X6) DATE

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

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	Based on observation, interview and record review, the governing body failed for 1 of 1 client (client #39) whose medication needed to be destroyed, to assure that staff followed the policy and	W0104	W 104For client #39 and all other clients, all Nurses and QMA's were inserviced on 11-3-11 by the Director of Nursing regarding the Medication Destruction Policy and the proper procedure for destruction and documentation. A sharps container has been placed on each medication cart to ensure access to proper medication disposal. QMA #1 received disciplinary action as a result of her failure to follow the medication destruction policy.For client #39 and all other clients, all current Nurses and QMA's will be inserviced bi-annually and all new Nurses and QMA's will be inserviced upon hire and bi-annually there after on the medication destruction policy and procedure.A sharp's container has been placed on each medication cart to ensure proper access to medication destruction. Also, the DON or her designee will continue to perform medication pass audits on a random basis with notation if medication destruction was observed and completed correctly.The DON is responsible for compliance.The Administrator will monitor..	12/02/2011	

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	<p>procedure for medication disposal.</p> <p>Findings include:</p> <p>Observations were conducted in group room #3 on 10/31/11 from 2:20 PM until 4:05 PM. The observation included a medication pass. On 10/31/11 at 3:43 PM the QMA (Qualified Medication Assistant) #1 was observed to prepare and administer client #39's 4:00 PM oral medications to him. His medication included four 100 mg (milligram) Tegretol (for seizures) pills. One of the pills was observed to fall out of his mouth onto the floor. QMA #1 was observed to pick up the pill and place it in the open trash container which was attached to the left side of the medication cart. QMA #1 used hand sanitizer, obtained the Tegretol card out of the drawer and punched the bubble pack, which contained four pills into a medication cup, took one pill out of the cup and threw the other three Tegretol pills into the trash.</p> <p>On 11/1/11 at 3:20 PM, a record review was conducted of the facility's policy for "Medication Disposal/Contaminated Medication dated 02-20-10. The policy indicated, "Medications that are dropped or contaminated prior to administration by QMA or Nurse will not be given to the resident and replaced with a new dose.</p>				

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	<p>The QMA/Nurse administering the medication will dispose of the contaminated medication by placing the medication in sealed container or disposing of the medication by flushing using the hopper. The QMA/Nurse will dispose of the contaminated medication with another Nurse present at the time of disposal. The administering QMA/Nurse will make a notation on the back of the MAR (Medication Administration Record) that the medication was contaminated and a new dose was given."</p> <p>On 11/01/11 at 11:14 AM, an interview with the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) was conducted. The DON and the ADON both indicated QMA #1 failed to follow the facility's policy for medication disposal.</p> <p>This deficiency was cited on September 26, 2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-13(a)</p>				

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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.	W0249	02W 249For clients #3,4,5,6,7,8,9,10,30,32,35 and all other clients, staff will be trained in the appropriate techniques to facilitate client participation as designed by their individual active treatment programs and objectives. Staff interviews reflected that staff were cautious when implementing developed objectives and had rejected their usual routine for programmatic implementation. Further staff interviews revealed the need for additional training in the areas of behavioral and programmatic objective implementation. Recognizing the need for additional training, small group staff training has been implemented to address the outcome of these interviews. Topic areas and techniques to address them includes; defining active treatment, review of prompt levels, teaching strategies, review of the IPP	12/02/2011

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			<p>process, review of the data sheet and what these expectations are, review of behavior management programs and their purpose, alternate interventions, what behavior modification is and techniques to mesh active treatment with everyday events. This training will cover all direct care staff, regardless of the number of years they have worked in our facility. As a result of this training, staff will be better informed and able to implement developed objectives through activities that promote client participation and inclusion of their identified needs. For clients #3,8,35 and all other clients, all Nurses and QMA's were inserviced on 11-3-11 by the Director of Nursing regarding the implementation of medication goals to assist the clients in training toward independence in medication administration. QMA #1 received disciplinary action for her failure to use medication administration goals to promote client independence in medication administration. In regards to client #35 and his current medication goal on 10-31-11 to come to the medication cart after calling his name prior to medication administration: QMA #1 did not use his medication goal at this medication pass because the client was experiencing pain exhibited by self injurious behavior and was receiving pain medication at that</p>	

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			time. She did not run this goal at the time as to not cause him any further pain. All Nurses and QMA's were inserviced on 11-23-11 on the importance of timely administration of pain medication. Staff will be provided with assessment strategies and training to better recognize their conduct, modeling skills and implementation strategies for active treatment for Client #3, 4, 5, 6, 7, 8, 9, 10, 30, 32, 35 and all other clients. This training shall include issues and all aspects of active treatment programming and the means to more independently recognize, initiate and implement the appropriate, intended use of programming supplies toward skills acquisition and active treatment programming strategies for all clients. Supervisory staff responsible for oversight of daily active treatment regimen shall be in-serviced to provide them the appropriate skills to further train and suggest appropriate daily active treatment. For clients #3, 8, 35 and all other clients, all current Nurses and QMA's will be inserviced bi-annually on the implementation of medication goals and the importance of timely administration of pain medication. All new Nurses and QMA's will be trained upon hire and inserviced bi-annually thereafter on the implementation of medication goals. Staff will be retrained through a Direct Care		

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			Staff 3-day training program to initially and fully address causal reasons of the behavior described and provided training to better recognize their conduct, understand the meaning behind active treatment skills and to model aspect of active treatment for all clients as outlined above. Random, bi-monthly audits will be completed by the staff trainer or designee to further ensure that these strategies are practiced and understood. All Nurses and QMA's were inserviced on 11-3-11 regarding the implementation of medication goals. They will continue to be inserviced bi-annually and all new Nurses and QMA's will be trained upon hire and inserviced bi-annually thereafter. All Nurses and QMA's were inserviced on 11-23-11 on the importance of timely administration of pain medication. They will continue to be inserviced bi-annually and all new Nurses and QMA's will be inserviced upon hire and bi-annually thereafter on the importance of timely administration of pain medication. The Quarterly Review Committee will review at least 3 times yearly and during their annual Individual Habilitation Plan meeting. QMRP's are responsible. The DON or her designee will continue to perform medication pass audits on a random basis with notation to the implementation of medication		

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	<p>Based on observation, record review and interview, the facility failed for 8 of 10 sampled clients (clients #3, #4, #5, #6, #7, #8, #9, #10), and three additional clients (clients #30, #32, and 35), to implement their identified training and behavioral objectives during formal and informal training opportunities.</p> <p>Findings include:</p> <p>1. During observation on 10/31/11 from 12:40pm until 1:40pm, and on 10/31/11 from 2:15pm until 3:40pm, in program room five (PR #5) client #6 was observed to sit in a chair and hold a yellow board. At 1:27pm, client #6 left to go with staff to the kitchen. From 2:15pm until 3:02pm, client #6 sat on a chair and held an opened magazine with the same page shown. At 3:02pm, Direct Care Staff</p>		<p>goals. The DON will continue to inservice all Nurses and QMA's bi-annually. The DON will ensure that all new Nurses and QMA's are trained on the implementation of medication goals during their orientation period by reviewing the orientation check list for documentation that training was completed and will follow up with medication goal implementation review with each new Nurse and/or QMA. The IDT will monitor Compliance</p>		

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	<p>(DCS) #21 gave client #6 a yellow colored board with laces and client #6 held the board, then flipped the laces with her hands. From 3:15pm until 3:25pm, client #6 held the same magazine. At 3:25pm, client #6 set the magazine on her chair, got up from the chair, and stated "I go potty."</p> <p>During observations on 11/1/11 from 6:45am until 7:30am in room PR #5, client #6 was alone behind the closed door in PR #5 without staff supervision. At 7:30am, DCS #23 came into PR #5 with other clients and stated she "did not know where [client #6] was" before DCS #23 entered the PR #5.</p> <p>On 11/1/11 at 9:50am, client #6's record was reviewed. Client #6's 7/14/11 ISP indicated she required staff supervision. Client #6's 6/14/11 BSP (Behavior Support Plan) indicated she had behaviors of physical aggression which included hitting, slapping, and head butting other clients and staff. Client #6's BSP indicated she had behaviors of verbal aggression, non compliance of leaving the program area without permission, resisting returning, and property theft. Client #6's BSP indicated she was self injurious which included picking of lip, face, hands, and banging her head. Client #6's ISP indicated "Daily Activity</p>				

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	<p>Schedule Group 5 (no date). 5am-7:30am, Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal. 7:30am-8am, toothbrushing, toileting, dressing, etc...12:30pm-1:30pm, Recreation, Group Activities. 1:30pm-3:30pm, Leisure, communication. 3:30pm-4pm, Toileting, handwashing, choice of activity, socializing...." Client #6's 7/14/11 ISP indicated objectives to match pictures to common objects, to select one (1) coin, to repeat counting numbers, and to place string on color boards. Client #6's 7/14/11 "Nursing Assessment" indicated she had seizure activity and staff were to monitor her for seizure activity.</p> <p>On 11/1/11 at 11am, an interview was completed with QMRP (Qualified Mental Retardation Professional) #1. QMRP #1 stated client #6 "should have had her ISP objectives implemented" during formal and informal opportunities. QMRP #1 stated facility staff "should have checked on [client #6] at least every 15 minutes." QMRP #1 indicated client #6 required twenty-four hour staff supervision.</p> <p>2. During observation on 10/31/11 from 12:40pm until 1:40pm, and on 10/31/11 from 2:15pm until 3:40pm, in PR #5 client #7 was observed to sit on the floor</p>				

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	<p>next to client #52 who sat on a chair. From 12:40pm until 1pm, client #7 pulled client #52's hair, arms, head, and feet into her (client #7's) personal body space and against her body. No redirection was observed. At 1pm, DCS #24 offered client #7 a chair. Client #7 got up from the floor and sat in the rocking chair next to client #52. Client #7 again began to touch client #52's feet and legs. Client #7 pulled client #52's feet under her shirt and against client #7's breasts without redirection by DCS #24 who was next to client #52 placing client #36's shoes on. From 1pm until 1:20pm, client #7 continued to pull, hug to her chest area, and smile as she touched client #52 without redirection and without activity. At 1:20pm, client #7 pulled client #52's arms and legs, client #7 kissed client #52 twice, and no redirection or activity was observed. From 2:15pm until 2:45pm, client #7 was asleep sitting upright in her chair in PR #5 without activity. From 2:45pm until 3pm, client #7 laid her head back down on the arm rest of her chair and was asleep without redirection. From 3:15pm until 3:17pm, client #7 was offered a coloring pen and a piece of paper. From 3:17pm until 3:35pm, client #7 was not offered activity.</p> <p>On 11/1/11 at 10:10am, client #7's record was reviewed. Client #7's 6/17/11 ISP</p>				

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	<p>indicated "Daily Activity Schedule Group 5 (no date). 5am-7:30am, Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal. 7:30am-8am, toothbrushing, toileting, dressing, etc...12:30pm-1:30pm, Recreation, Group Activities. 1:30pm-3:30pm, Leisure, communication. 3:30pm-4pm, Toileting, handwashing, choice of activity, socializing..." Client #7's 6/17/11 ISP indicated objectives to identify coins, to make two (2) bows to tie her shoes, to identify numbers 1-3 by pointing, to match four (4) coins, to match color cards yellow, green, white, blue, and red. Client #7's 7/28/11 BSP (Behavior Support Plan) indicated she had known behaviors of bossing other clients by pushing and pulling them to get them to do what she wants them to, kissing her breasts, looking at her breasts, fondling her breasts, picking her fingers, and spitting. Client #7's BSP indicated "staff should verbally redirect her, encourage [client #7] to apologize to her victim."</p> <p>On 11/1/11 at 11am, an interview was completed with QMRP (Qualified Mental Retardation Professional) #1. QMRP #1 stated client #7 "should have had her ISP objectives implemented" during formal and informal opportunities. QMRP #1 stated facility staff "should have</p>			

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	<p>redirected" client #7 and offered client #7 an activity away from client #52.</p> <p>3. During observation on 10/31/11 from 2:30pm until 3:40pm, in PR #5 client #32 was observed to sit in a chair, held a large mechanical duck, and mouthed the ducks webbed feet and arms without redirection by facility staff DCS #21 and DCS #22. At 2:45pm, client #32 mouthed the webbed feet of the duck past his lips and teeth into client #32's mouth and DCS #22 redirected client #32 then returned the duck to client #32. Client #32 continued to mouth the same webbed feet of the duck into his mouth. At 3:02pm, DCS #21 and DCS #22 both indicated they did not know what PICA behavior (ingestion of inedible items) was and did not record client #32's mouthing a duck behavior. At 3:17pm, client #32 had drool from his mouth down the front of his shirt and continued to mouth the duck without redirection or activity offered. From 3:17pm until 3:40pm, client #32 continued to mouth the duck without redirection or activity offered.</p> <p>On 11/1/11 at 10:25am, client #32's record was reviewed. Client #32's 10/13/11 "PICA Assessment" indicated client #32 had a "diagnosis of PICA, the ingestion of inedible items." The PICA assessment indicated client #32's 3/7/09</p>				

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	<p>Diagnostic Evaluation indicated client #32 "does have to be monitored for putting inedible objects in his mouth... (Client #32's PICA assessment indicated) There is no indication that he has ingested any inedible objects in the past and there has been no ingestion of inedible objects since admission to the facility. In addition, there have been no documented incidents of mouthing objects since his admission." Client #32's 10/13/11 "PICA Protocol" indicated "if he should be observed to place objects to his mouth or chew on objects, staff should immediately redirect him...Staff should ask him to give you the object...Offer him a choice of appropriate objects to manipulate...Should staff observe him placing an inedible object in his mouth, ask him to give you the object...If he gives you the object, give him the edible. When giving him the edible, explain to him that this is what you should eat, not the object...Document all incidents of PICA and chewing on objects on a behavior card." On 11/1/11 at 10:40am, no documented behavioral cards for client #32's PICA were available for review.</p> <p>On 11/1/11 at 11am, an was completed with QMRP (Qualified Mental Retardation Professional) #1. QMRP #1 stated client #32 "should not have" been able to continue to mouth objects or the</p>				

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	<p>duck. QMRP #1 stated facility staff "should have redirected" client #32 and offered client #32 an activity.</p> <p>4. During observation on 10/31/11 from 12:40pm until 1:40pm, and on 10/31/11 from 2:15pm until 3:40pm, in PR #5 client #35 was observed and no communication books, symbols, or pictures were observed to be used with the client. From 12:40pm until 1:20pm, client #35 was asleep in a chair without activity or redirection observed. At 1:20pm, client #35 scooted out of the chair and onto the floor. DCS #22 assisted him to the bathroom. At 1:35pm, client #35 was back to PR #5 and no activity was offered or encouraged. From 2:15pm until 2:45pm, client #35 walked around PR #5, laid on the floor, sat on a chair, and no activity was observed offered or encouraged. From 2:45pm until 3pm, client #35 hit himself with a closed fist in the face and head thirty-one (31) times, and made whimpering sounds without redirection or activity observed offered. At 3pm, DCS #21 stated "he usually has a head ache when he does that and yes he's (client #35) crying." At 3pm, DCS #21 called the nurse to assess client #35. From 3pm until 3:02pm, when the nurse entered the program room #5 client #35 hit himself with a closed fist an additional eleven (11) times without</p>				

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	<p>redirection or interaction by the facility staff. At 3:02pm, the nurse indicated client #35's temperature was taken, his temperature was 98 degrees, and the nurse stated the QMA (Qualified Medicine Aide) will "bring him down" later. From 3:02pm until 3:25pm, client #35 was observed to hit himself in the face and head with a closed fist an additional ten (10) times without activity or redirection offered. At 3:25pm, the QMA entered PR #5 with her medication cart. The QMA assembled client #35's oral medications of Vimpat for seizures, Prilosec for gastric upset, Sudafed for sinus, Klonopin for seizures, and "Acetaminophen 325mg (milligrams) 2 tab (tablets) q 4 (every four hours) for pain or temp (temperature)." The QMA put client #35's medications into applesauce, walked to client #35, and spoon fed him his medications without interaction. The QMA did not name, give the reason, or identify client #35's medications. At 3:35pm, the QMA stated "she did not run [client #35's] goal" for medication administration. The QMA indicated client #35's medication administration goal was to come to the medication cart when his name was called.</p> <p>Client #35's record was reviewed on 11/1/11 at 9:35am. Client #35's 1/27/11 ISP indicated a medication objective to</p>				

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	<p>hand the spoon back to the QMA after taking his medications. Client #35's ISP indicated objectives to hand dollar to staff, to identify common objects, to communicate with pictures/photo/or symbol, to select an activity, and to look at three different colors for three seconds. Client #35's 1/27/11 "Nursing Assessment" indicated he had seizures and wore a helmet to protect his head from seizures and self injurious behavior. Client #35's 7/7/11 BSP indicated he had a diagnosis of "scoliosis" and the disease "appears to have (caused) some behavior due to back pain." Client #35's BSP indicated "his behaviors of hitting his head/ears, biting his hand, punching his head, smack his head, and throwing himself backwards against a chair...Should [client #35] be observed to be self abusive, staff should verbally interrupt the behavior...allow him 10 seconds to comply. Encourage him to participate in an activity that requires the use of his hands...."</p> <p>On 11/1/11 at 11am, an interview was completed with QMRP (Qualified Mental Retardation Professional) #1. QMRP #1 stated client #35 "should not have" been able to continue to hit himself. QMRP #1 stated facility staff "should have redirected" client #35 and offered client #35 an activity.</p>			

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	5. Observations were conducted in group room #3 on 10/31/11 from from 12:40 PM until 1:40 PM and on 10/31/11 from 2:20 PM until 4:05 PM. At 12:40 PM there were 2 staff (staff #1 and #2) present in the room who remained until 1:00 PM and were replaced with 2 staff (staff #3 and #4) who remained during the remainder of the observation time. During the observation time a child cartoon "Sponge Bob" was on TV. Client #3 was observed to sit in his wheelchair which contained a lap tray. The lap tray contained colored markers and paper. At 12:56 PM client #3 was given a child's top which contained sea creatures. Client #3 was not observed to be prompted to do anything with the top. At 1:06 PM staff #3 was observed to go up to client #3 with shave cream and laugh and put some on client #3's hands and on the tip of client #3's nose. Client #3 was observed to laugh with the activity which lasted less than 1 minute. At 1:30 PM client #3 was observed to be given a children's pop-up toy which popped up a cat, frog, dog or bird when the button was pushed. Client #3 sat with the toy in his lap and was observed to sit with his eyes closed until 1:40 PM. On 10/31/11 at 2:20 PM client #3 was observed to be sitting in a recliner holding a pop-up toy. At 2:28 PM client #3 was taken into the bathroom and his	W0249	02W 249For clients #3,4,5,6,7,8,9,10,30,32,35 and all other clients, staff will be trained in the appropriate techniques to facilitate client participation as designed by their individual active treatment programs and objectives. Staff interviews reflected that staff were cautious when implementing developed objectives and had rejected their usual routine for programmatic implementation. Further staff interviews revealed the need for additional training in the areas of behavioral and programmatic objective implementation. Recognizing the need for additional training, small group staff training has been implemented to address the outcome of these interviews. Topic areas and techniques to address them includes; defining active treatment, review of prompt levels, teaching strategies, review of the IPP process, review of the data sheet and what these expectations are, review of behavior management programs and their purpose, alternate interventions, what behavior modification is and techniques to mesh active treatment with everyday events. This training will cover all direct care staff, regardless of the number of years they have worked in our facility. As a result of this training, staff will be better informed and able to implement developed objectives through	12/02/2011	

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	<p>shirt was changed. At 2:40 PM client #3 was asked if he wanted to color and a color crayon and coloring book was given back to him as he sat in his wheelchair at a table. At 2:44 PM client #3 was observed to remove a terry cloth towel which was around his neck and had a gingerbread boy on it. He tossed the towel to the floor. Client #3 sat at the table and was offered a glass of water at 2:55 PM. He remained at the table with the color book and crayon until 3:30 PM when the ADON (Assistant Director of Nursing) came into the program room dressed in costume (Halloween) and interacted with each client. At 4:01 PM client #3 received his 4:00 PM medications from the QMA (Qualified Medication Assistant) #1. No teaching/training of the names, reasons, or doses of medication was observed. At 4:03 PM client #3 was wheeled down the hall towards the dining room for supper.</p> <p>Client #3's record was reviewed on 11/01/11 at 10:24 AM. Client #3's undated active treatment schedule indicated the following for the specified time frames: 5:00-7:30 AM - "Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal" 7:30-8:00 AM - "Toothbrushing, toileting,</p>		<p>activities that promote client participation and inclusion of their identified needs. For clients #3,8,35 and all other clients, all Nurses and QMA's were inserviced on 11-3-11 by the Director of Nursing regarding the implementation of medication goals to assist the clients in training toward independence in medication administration. QMA #1 received disciplinary action for her failure to use medication administration goals to promote client independence in medication administration. In regards to client #35 and his current medication goal on 10-31-11 to come to the medication cart after calling his name prior to medication administration: QMA #1 did not use his medication goal at this medication pass because the client was experiencing pain exhibited by self injurious behavior and was receiving pain medication at that time. She did not run this goal at the time as to not cause him any further pain. All Nurses and QMA's were inserviced on 11-23-11 on the importance of timely administration of pain medication. Staff will be provided with assessment strategies and training to better recognize their conduct, modeling skills and implementation strategies for active treatment for Client #3, 4, 5, 6, 7, 8, 9, 10, 30, 32, 35 and all other clients. This training shall include issues and all aspects of</p>		

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	<p>dressings, etc"</p> <p>8:00-9:00 AM - "Economics, Initiation, Fine Motor"</p> <p>9:00-10:00 AM - "Communication, Fine Motor, Gross Motor"</p> <p>10:00-10:30 AM - "Choice of Activity (trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc."</p> <p>10:30-11:00 AM - "Toileting, Large Group Activity"</p> <p>11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure"</p> <p>12:30-1:30 PM - "Recreation, Group Activity"</p> <p>1:30-3:30 PM - "Leisure, Communication"</p> <p>3:30-4:00 PM - "Toileting, Handwashing, Choice of Activity, Socializing"</p> <p>4:00-5:00 PM - "Dinner, Eating, Goals, Structure Recreation"</p> <p>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"</p> <p>7:00-8:30 PM - "Snack Time, Dressing For Bed, Toothbrushing, Choice Of Recreation, Toileting, Medication Goal, etc"</p> <p>Facility staff did not follow and/or implement client #3's active treatment schedule as written.</p>		<p>active treatment programming and the means to more independently recognize, initiate and implement the appropriate, intended use of programming supplies toward skills acquisition and active treatment programming strategies for all clients. Supervisory staff responsible for oversight of daily active treatment regimen shall be in-serviced to provide them the appropriate skills to further train and suggest appropriate daily active treatment. For clients #3, 8, 35 and all other clients, all current Nurses and QMA's will be inserviced bi-annually on the implementation of medication goals and the importance of timely administration of pain medication. All new Nurses and QMA's will be trained upon hire and inserviced bi-annually thereafter on the implementation of medication goals. Staff will be retrained through a Direct Care Staff 3-day training program to initially and fully address causal reasons of the behavior described and provided training to better recognize their conduct, understand the meaning behind active treatment skills and to model aspect of active treatment for all clients as outlined above. Random, bi-monthly audits will be completed by the staff trainer or designee to further ensure that these strategies are practiced and understood. All Nurses and QMA's were</p>		

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	<p>Client #3'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. Client #3's medication goal indicated he was to grasp an empty spoon during medication administration.</p> <p>On 11/01/11 at 11:11 AM an interview was conducted with the Qualified Mental Retardation Professional #1 (QMRP). The QMRP indicated client #3'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.</p> <p>6. Observations were conducted in group room #3 on 10/31/11 from from 12:40 PM until 1:40 PM and on 10/31/11 from 2:20 PM until 4:05 PM. At 12:40 PM there were 2 staff (staff #1 and #2) present in the room who remained until 1:00 PM and were replaced with 2 staff (staff #3 and #4) who remained during the remainder of the observation time. During the observation time a child cartoon "Sponge Bob" was on TV. Client</p>		<p>inserviced on 11-3-11 regarding the implementation of medication goals. They will continue to be inserviced bi-annually and all new Nurses and QMA's will be trained upon hire and inserviced bi-annually thereafter. All Nurses and QMA's were inserviced on 11-23-11 on the importance of timely administration of pain medication. They will continue to be inserviced bi-annually and all new Nurses and QMA's will be inserviced upon hire and bi-annually thereafter on the importance of timely administration of pain medication. The Quarterly Review Committee will review at least 3 times yearly and during their annual Individual Habilitation Plan meeting. QMRP's are responsible. The DON or her designee will continue to perform medication pass audits on a random basis with notation to the implementation of medication goals. The DON will continue to inservice all Nurses and QMA's bi-annually. The DON will ensure that all new Nurses and QMA's are trained on the implementation of medication goals during their orientation period by reviewing the orientation check list for documentation that training was completed and will follow up with medication goal implementation review with each new Nurse and/or QMA. The IDT will monitor Compliance</p>				

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	<p>#4 was observed to sit in a recliner in the corner of the room. At 12:56 PM client #4 was given a child's Mickey Mouse toy which laid on her lap. Client #4 was not observed to be prompted to do anything with the toy and the staff did not engage her with it either. Client #4 sat with the toy in her lap until 1:40 PM. On 10/31/11 at 2:20 PM client #4 was observed to be sitting in the same recliner in the corner with the same Mickey Mouse toy. At 2:55 PM client #4 was given a wooden based beaded toy which was laid on her lap. Client #4 did not interact with the item. Client #4 was offered a glass of water at 2:55 PM. Client #4 was placed in her wheelchair at 3:11 PM and wheeled up to the table. She remained at the table without activity until 3:30 PM when the ADON (Assistant Director of Nursing) came into the program room dressed in costume (Halloween) and interacted with each client. At 4:03 PM client #4 was wheeled down the hall towards the dining room for supper.</p> <p>Client #4's record was reviewed on 11/01/11 at 10:09 AM. Client #4's undated active treatment schedule indicated the following for the specified time frames: 5:00-7:30 AM - "Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating</p>				

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	<p>goal"</p> <p>7:30-8:00 AM - "Toothbrushing, toileting, dressing, etc"</p> <p>8:00-9:00 AM - "Economics, Initiation, Fine Motor"</p> <p>9:00-10:00 AM - "Communication, Fine Motor, Gross Motor"</p> <p>10:00-10:30 AM - "Choice of Activity (trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc."</p> <p>10:30-11:00 AM - "Toileting, Large Group Activity"</p> <p>11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure"</p> <p>12:30-1:30 PM - "Recreation, Group Activity"</p> <p>1:30-3:30 PM - "Leisure, Communication"</p> <p>3:30-4:00 PM - "Toileting, Handwashing, Choice of Activity, Socializing"</p> <p>4:00-5:00 PM - "Dinner, Eating, Goals, Structure Recreation"</p> <p>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"</p> <p>7:00-8:30 PM - "Snack Time, Dressing For Bed, Toothbrushing, Choice Of Recreation, Toileting, Medication Goal, etc"</p> <p>Facility staff did not follow and/or implement client #4's active treatment</p>				

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	<p>schedule as written.</p> <p>Client #4's Individual Habilitation Plan (IHP) was dated 01/21/11 and contained but was not limited to the following goals: will complete one table activity with peers; will manipulate sensory stimulation device; will attend to selected task x 2 minutes; will match a square, circle and triangle to matching shapes; will activate a switch device by pushing the appropriate button and will reach out and grab an item from staff when presented left and right.</p> <p>On 11/01/11 at 11:11 AM an interview was conducted with the Qualified Mental Retardation Professional #1 (QMRP). The QMRP indicated client #4'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.</p> <p>7. Observations were conducted in group room #3 on 10/31/11 from from 12:40 PM until 1:40 PM and on 10/31/11 from 2:20 PM until 4:05 PM. At 12:40 PM there were 2 staff (staff #1 and #2) present in the room who remained until 1:00 PM and were replaced with 2 staff (staff #3 and #4) who remained during the remainder of the observation time. During the observation time a child</p>				

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	<p>cartoon "Sponge Bob" was on TV. Client #5 was observed to squat on the floor placing plastic blocks in the bed of a toy dump truck, dumping them and putting them back again. At 1:06 PM staff #3 was observed to have shave cream and placed it on client #5's hand. She continued squatting on the floor playing with the blocks and the truck. At 1:13 PM client #5 stood up and started walking around the room. She continued walking about the room until 1:40 PM at the end of the observation time. On 10/31/11 at 2:20 PM client #5 was observed to be walking about in the room, at 2:25 PM picked up blocks from the floor and placed them in the toy dump truck on the floor. Client #5 continued to walk about the room clapping her hands at times. She returned to squat on the floor at 2:30 PM playing with the blocks and the truck until 2:55 PM when she stood up to get a cup of water that was handed to her by staff #3. Client #5 continued to walk about the program room until 3:30 PM when the ADON (Assistant Director of Nursing) came into the program room dressed in costume (Halloween) and interacted with each client. At 4:03 PM client #5 remained in the group room when the observation ended.</p> <p>Client #5's record was reviewed on 11/01/11 at 11:11 AM. Client #5's</p>				

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	<p>undated active treatment schedule indicated the following for the specified time frames:</p> <p>5:00-7:30 AM - "Get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal"</p> <p>7:30-8:00 AM - "Toothbrushing, toileting, dressing, etc"</p> <p>8:00-9:00 AM - "Economics, Initiation, Fine Motor"</p> <p>9:00-10:00 AM - "Communication, Fine Motor, Gross Motor"</p> <p>10:00-10:30 AM - "Choice of Activity (trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc."</p> <p>10:30-11:00 AM - "Toileting, Large Group Activity"</p> <p>11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure"</p> <p>12:30-1:30 PM - "Recreation, Group Activity"</p> <p>1:30-3:30 PM - "Leisure, Communication"</p> <p>3:30-4:00 PM - "Toileting, Handwashing, Choice of Activity, Socializing"</p> <p>4:00-5:00 PM - "Dinner, Eating, Goals, Structure Recreation"</p> <p>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"</p>				

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	<p>7:00-8:30 PM - "Snack Time, Dressing For Bed, Toothbrushing, Choice Of Recreation, Toileting, Medication Goal, etc"</p> <p>Facility staff did not follow and/or implement client #5's active treatment schedule as written.</p> <p>Client #5's Individual Habilitation Plan (IHP) was dated 02/03/11 and contained but was not limited to the following goals: will select a quarter from one other coin; will grasp a named item from a choice of three items; will appropriately manipulate a textured item; will answer 15 questions of a daily activity by nodding and will appropriately manipulate a selected leisure activity through completion.</p> <p>On 11/01/11 at 11:11 AM an interview was conducted with the Qualified Mental Retardation Professional #1 (QMRP). The QMRP indicated client #5'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.</p> <p>8. During observation on 10/31/11 from 1:16 PM until 1:38 PM, clients #8, #9, #10 and #30 were observed in group #1</p>				

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	<p>inside the program room with facility staff #11 and no activity other than television was observed offered or encouraged. Clients #8, #10 and #30 did not watch the cartoon television program, and were not prompted to visually watch to the television program. Client #8 sat with a towel in her mouth and was not offered alternative activity. At 1:25 PM, client #30 tapped his feet and put his hands into his mouth and bit his hands in excess of 10 times with no redirection while staff #11 had her back to the clients in the room arranging children's books, crayons and toys. At 1:30 PM, client #30 bit his hands and kept them in his mouth without redirection or alternate activity offered by staff #11. At 1:35 PM, staff #12 read a Dr. Seuss book to clients in the room. Clients #8 and #10 were shown pictures in the book but did not look at the picture and were not offered alternative activity.</p> <p>During observation on 10/31/11 from 2:20 PM until 3:35 PM, client #30 remained asleep in program room #1 throughout the observation without direction to activity. Staff were not observed to prompt him to grasp a square, accept a coin, sit at a table with peers or grasp a magazine. From 2:20 PM until 2:31 PM, client #10 pulled at her adult briefs or at threads of a towel around her neck until staff placed a manipulative toy</p>				

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	<p>on her lap at 2:31 PM. Client #10 was not offered another choice of activity during the observation period other than the cartoon television program that she did not look at. Staff were not observed to prompt client #10 to look at them when her name was called, reach out to grasp an item, identify objects, or activate a selected noise or light device. Client #9 had a book on her activity tray and was not offered other activity during the observation period. Client #8 sat with a towel in her mouth and was not offered alternative activity. Client #8 was asked to remove the towel from her mouth at 3:18 PM and at 3:20 PM but was not offered alternative activity. At 3:30 PM, client #8 was offered to get up from her chair and changed, but she shook her head "no," was not offered alternative activity, and client #8 placed the towel back in her mouth at 3:31 PM. Staff did not prompt her to maintain her attention to the TV for 30 seconds, visually focus on 3 objects, reach out a few inches to take an item from staff, grasp a desired magazine, or offer a textured item to be rubbed on her hand during the observation period.</p> <p>During observation of medication administration on 10/31/11 at 3:50 PM client #8 was given her medications of calcium carbonate (supplement), docusate sodium (constipation), Miralax</p>				

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	<p>(constipation) and protein supplement by Licensed Practical Nurse #2 without observation of training to promote independence in medication administration.</p> <p>LPN #2 was interviewed on 10/31/11 at 4:10 PM. When asked about client #8's goal to increase independence in medication administration, she stated, "I don't know. I've only been here 3 weeks."</p> <p>During observation at dinner on 10/31/11 from 4:10 PM until 4:55 PM, client #10 ate her meal with staff feeding her with a spoon. Client #10 was not encouraged to assist in feeding herself or to place her hand on staff's forearm during the observation period.</p> <p>During observation at breakfast on 11/1/11 from 5:40 AM until 6:04 AM, client #10 ate her meal with staff feeding her with a spoon. Client #10 was not encouraged to assist in feeding herself or to place her hand on staff's forearm during the observation period.</p> <p>During the observation period on 11/1/11 from 6:25 AM until 7:30 AM, clients #8 and #10 listened to the same book read to them on 10/31/11 by staff #13 from 6:25 AM until 6:40 AM. At 6:58 AM, client #8 sat with a towel in her mouth and did</p>				

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	<p>not look at or watch to the cartoon television program. At 7:00 AM, staff #13 removed the towel from client #8's mouth, but didn't offer alternative activity. At 7:05 AM, client #10 manipulated the same toy she manipulated during the observation periods on 10/31/11 and was not offered alternative activity during the remainder of the observation period until 7:22 AM when staff #13 offered her a shaker which client #10 dropped. No alternative activity was offered. From 7:05 AM until 7:22 AM, client #8 sat with her head down and eyes closed with no activity offered.</p> <p>Client #8's records were reviewed on 11/1/11 at 9:30 AM. Client #8's Individual Program Plan (IHP) indicated objectives "grabs washcloth during medication administration, make eye contact, attempt to take magazine from staff, respond to texture items, maintain attention to TV for 5 seconds, visually focus on 3 specific objects for 5 seconds: musical toy/object, stuffed object, mirror." Client #8's daily activity schedule (no date) indicated from 5:00 AM until 7:30 AM, get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast eating goal. From 12:30 PM to 1:30 PM, recreation, group activities. From 3:30 PM until 4:00 PM, toileting, handwashing, choice of</p>				

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	<p>activity, socializing. Client #8's records indicated she was NPO (nothing by mouth).</p> <p>Client #10's record was reviewed on 11/1/11 at 10:05 AM. Client #10's 12/16/10 IHP indicated objectives to "look in the direction of staff when her name is called, reach toward staff to grasp item, squeeze lotion bottle, place hand on staff's forearm to assist with at least three bites of her meal, activate a selected noise or light device, identify by reaching for/grasping hairbrush, identify by reaching for/grasping mirror, identify by reaching for/grasping stuffed object." Client #10's daily activity schedule indicated from 5:00 AM until 7:30 AM, get up, toileting, dressing for the day, independent leisure activity, medication goal, breakfast, eating goal. From 12:30 PM until 1:30 PM, recreation, group activities. From 3:30 PM until 4:00 PM, toileting, handwashing, choice of activity, socializing."</p> <p>Client #9's record was reviewed on 11/1//11 at 11/1/11 at 10:25 AM. Client #9's 3/15/11 IHP indicated objectives to "move 5 objects from one side of her tray to the other side of her tray, match a given coin, state current address, extend both arms out away from her body, verbally name flash cards for common objects,</p>				

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	<p>verbally name 4 informational signs when provided, point to a preferred leisure activity." Client #9's daily activity schedule (no date) indicated from 12:30 PM to 1:30 PM, recreation, group activities. From 1:30 PM until 3:30 PM, leisure, communication, personal. From 3:30 PM until 4:00 PM, toileting, handwashing, choice of activity, socializing.</p> <p>Client #30's record was reviewed on 11/1/11 at 11:02 AM. Client #30's 8/25/11 IHP indicated objectives to "grasp square, accept coin, sit at the table with peers, grasp magazine." His 9/2/11 Behavior Management Plan included target behaviors of "self abuse, defined as head banging and biting finger, kicking himself in the head, slapping his face, causing himself to vomit." The plan indicated staff were to verbally interrupt client #30 when he engaged in the targeted behavior, and if he continued, staff should guide his hands down and release. Client #30's daily activity schedule indicated from 12:30-1:30 PM, recreation, group activities. From 1:30-3:30, leisure, communication. From 3:30-4:00 PM, toileting, handwashing, choice of activity, socializing.</p> <p>QMRP #1 (Qualified Mental Retardation Professional) was interviewed on 11/1/11</p>			

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	<p>at 11:11 AM. QMRP #1 indicated clients's goals to increase independence in medication administration should be implemented during informal and formal opportunities.</p> <p>QMRP was interviewed again on 11/1/11 at 11:35 AM and indicated clients #8, #9, #10 and #30's IHP goals should be implemented during formal and informal opportunities by facility staff.</p> <p>This deficiency was cited on September 26, 2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-32(a) 3.1-33(a) 3.1-37(a)</p>				