STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/04/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN46260	

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W0000	This visit was for a post-certification revisit survey (PCR) to the predetermined full recertification and state licensure survey. This visit included the PCR to the investigation of Complaint #IN00094073 completed on 8/5/11. Complaint #IN00094073: Not Corrected. This visit was conducted in conjunction with a post certification revisit (PCR) to the PCR to the investigation of Complaint #IN00091282 (which resulted in an immediate jeopardy) completed on 8/5/11. This visit was conducted in conjunction with a PCR to the PCR to the PCR to the investigation of complaints #IN00082450 and #IN00082518 completed on 8/5/11. This visit was conducted in conjunction with a PCR to the PCR to the PCR to the investigation of complaint #IN00086569 completed on 8/5/11. This visit was conducted in conjunction with a PCR to the PCR to the PCR to the investigation of complaints #IN00083637 and #IN00083886 completed on 8/5/11. Dates of Survey: 9/26, 9/27, 9/28, 9/29 and 10/4/11	W0000	DISCLAIMER STATEMENT Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law. "This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."	

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

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

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	Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170 Survey Team: Paula Chika, Medical Surveyor III-Team Leader Robert Bauermeister, Medical Surveyor III (9/26/11 to 9/29/11) Keith Briner, Medical Surveyor III (9/26/11 to 9/29/11) Mark Ficklin, Medical Surveyor III (9/26/11 to 9/29/11) Claudia Ramirez, RN, Public Health Nurse Surveyor III (9/26/11 to 9/29/11) Steven Schwing, Medical Surveyor III (9/26/11 to 9/29/11) Jo Anna Scott, Medical Surveyor III (9/26/11 to 9/29/11) Dotty Walton, Medical Surveyor III (9/26/11 to 9/29/11) These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 10/14/11 by Ruth Shackelford, Medical Surveyor III.			
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.			

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	Based on observations and interview for 1 of 18 sampled clients (#6) and 6 additional clients (#109, #126, #127, #167, #129 and #155), the facility failed to ensure the rights of all clients, by not ensuring the clients had their own personal property (clothing) and had proper fitting clothing. Findings include: 1. During the observation period on 9/26/11 from 3:10 PM through 4:10 PM client #6 was observed on his unit. Client #6 was observed wearing a maroon longsleeve sweatshirt and gray sweatpants. Client #6 was observed throughout the observation period holding the waistline of his sweatpants in order to manually keep the sweatpants from falling down. Client #6 was not observed being prompted to change his clothing by CNA (Certified Nursing Assistant) #37, CNA #38 and/or QMRP (Qualified Mental Retardation Professional) #6. During the observation period on 9/27/11 from 6:50 AM through 8:00 AM client #6 was observed on his unit. At 6:50 AM client #6 exited his bedroom to enter the program room wearing the same maroon longsleeve sweatshirt and gray sweatpants as observed on 9/26/11. Client #6 wore	W0137	W 137 Protection of Clients Rights 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. I Corrective Action for Cited Clients: Social Workers have reassessed Clothing for appropriateness, quantity and fit for clients 6, 109, 126, 127, 129 and 155 in addition to clients 167, 153, 168 and 174. In addition staff will be educated to document when there are issues involving refusal to wear items that are appropriate and fit and to report when quantities are low. If needed, the client's IDT will formulate a plan or otherwise address clothing issues caused by resident behavior or preference. Also any issue of lateness of laundry or other laundry issues will be addressed including grievances or other measures as deemed necessary by administration	11/03/2011

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	the sweatshirt and sweatpants throughout the observation period. Client #6 was not observed being prompted to change his clothing by CNA #39, CNA #40 and/or QMRP #6. Interview with CNA #37 on 9/27/11 at 8:10 AM indicated client #6 had alternate clothing available to wear. CNA #37 indicated client #6 should be offered appropriate fitting clothing and prompted to daily change his clothing. 2. Observations were conducted on the 2nd floor cafeteria on 9/27/11 from 8:00 AM through 8:45 AM. Client #126 was observed in the cafeteria throughout the observation period participating in family style dining. At 8:30 AM client #126 was observed exiting the cafeteria with CNA #40. Client #126 was wearing a pair of gray sweatpants. As client #126 exited the cafeteria his sweatpants waistline slid down to his ankles. Client #126 was prompted to pull his pants up. Client #126 then manually held the sweatpants from falling down as he continued to walk/exit the cafeteria. At 8:45 AM client #126 was observed in 2 south program room with the same gray sweatpants on. Client #126 was not observed being prompted by CNA #40, CNA #39 and/or QMRP #6 to change his sweats or offered alternate clothing.		when warranted. Additionally a Resident Appearance Checklist will be posted on each unit and referred to as a reminder of appropriate appearance of residents and when education and simple reminders fail to elicit appropriate staff action it will be addressed with formal documentation including disciplinary actions. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: staff will be educated to document when there are issues involving refusal to wear items that are appropriate and fit and to report when quantities are low. If needed, the client's IDT will formulate a plan or otherwise address clothing issues caused by resident behavior or preference. Also any issue of lateness or other laundry issues will be addressed including grievances or other measures	

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	Interview with CNA #40 on 9/27/11 at 8:45 AM indicated client #126 had alternate clothing available to wear. CNA #40 indicated client #126 should be offered/trained to wear appropriate fitting clothing.		as deemed necessary by administration when warranted. Additionally a Resident Appearance Checklist will be posted on each unit and referred to as a reminder of appropriate appearance of residents and when education and simple reminders fail to elicit appropriate staff action it will be addressed with formal documentation including disciplinary actions. QMRP will audit appropriate dress and cleanliness as part of active treatment audit which is done 3 times per week. IV Monitoring Corrective Measures: Program Directors review the Active Treatment Audit for thoroughness and to assure issues are appropriately addressed. To be completed by 11-3-11.	
	3. An observation was conducted on the third floor of the facility on 9/26/11 from 3:29 PM to 6:06 PM. At 4:26 PM, client #174 was walking around the dining area holding his pants up with his left hand.			

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	The pants he was wearing were too big and when he let go of his pants with his left hand, his pants fell down. At 4:39 PM, client #167 walked into the dining room wearing a sweater. The sweater did not cover his mid-section and the arms of the sweater went to just below his elbows. An observation was conducted on the third floor of the facility on 9/27/11 from 7:26 AM to 8:52 AM. At 7:26 AM, client #153 indicated she wanted to wear pants but she did not have any pants to put on. Client #153 was wearing shorts. At 7:34 AM, staff from the laundry services department delivered one pair of pants to client #153. At 8:19 AM, client #129 entered the dining room for breakfast. Client #129's pants were low enough to expose his underwear. When client #129 sat down to eat, his buttocks were exposed due to his pants being too big and falling down. An interview with the Qualified Mental Retardation Professional (QMRP) #7 was conducted on 9/28/11 at 11:30 AM. QMRP #7 indicated the clients should have access and be encouraged to wear properly fitting clothes. 4. An observation was done at the facility (3rd floor) on 9/26/11 from 3:39p.m. to 7:00p.m. At 4:34p.m. client #168 wore a			

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	sweater that was too short and tight. Client #168 had his lower stomach exposed. Client #168's pants had slid down and the top half of his buttocks was exposed. Client #168 wore these clothes while in the activity room and hallway. At 5:19p.m. client #168 went into a peers room and took a white t-shirt from the peers drawer. Client #168 changed shirts while in the peers bedroom (room #337). Client #168 wore the peers t-shirt throughout the rest of the observation (7p.m.) QMRP staff #8 was interviewed on 9/28/11 at 12:10p.m. QMRP staff #8 indicated client #168 was not wearing his own clothes on 9/26/11. QMRP #8 indicated she thought some of client #168's clothes may be down in laundry. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W0189	3.1-9(a) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review for 1 of 18 sampled clients	W0189	W 189 Staff Training Program The facility must provide each employee with initial and continuing training that enables	11/03/2011

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	(#16) and for 1 additional client (#126), the facility failed to retrain staff timely on monitoring client (#16) when demonstrating a maladaptive behavior. The facility failed to ensure all staff were trained/re-trained in redirecting client #126 from others' bedrooms. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 9/27/11 at 8:20 AM. The facility's 9/15/11 reportable incident report indicated "[Client #16] was having maladaptive behaviors. She was redirected to go to her room. On her way to her room, [client #16] was physically aggressive to [client #14]. When staff separated the two there was a bloody pencil in the hand of [client #14] and he had a split bottom lip and a split tongue. [Client #16] went on to her room and would explain to staff why or what she did to [client #14] (sic). He is verbal but only says aprox (sic) two words ie (example)...Hi, Bye. He was unable to confirm to staff if [client #16] had used the pencil as a weapon to cause the extensive injury to him. [Client #14] was sent to ER (emergency room) and received sutures in his lower lip. [Client #16] was placed on 1:1 (one on one) to ensure no further aggressive actions to		the employee to perform his or her duties effectively, efficiently, and competently. I Corrective Action for Cited Clients: Training is now in place for client 16. For resident 126 staff were trained that resident must gain permission to enter a peer's room. When noting to enter without first knocking, staff will redirect to knock and a behavior incident report (BIR) written to record the issue with IDT review as appropriate. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: QMRPs were trained that after an IDT hasidentified follow up action/training, thisaction/training must be completed withinone week. IV Monitoring Corrective Measures: Program Directors are to track completionof follow up from IDTs. To be completedby 11-3-11.	

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	anyone." The facility's undated Client to Client investigative report indicated "...It is not known what triggered her aggression. The staff reported that when she (client #16) first entered the elevator she was not agitated. Then suddenly unprovoked she began trying to strike one of the clients on the elevator. The staff intervened and she did not make contact. The staff was present and reports that the client did not anything to upset [client #16]...." The undated investigative report indicated "...Staff also reported that when [client #16] gets upset she will go to her room and calm herself. She normally does not aggress upon others...." In the section entitled "Conclusion" the investigation indicated "...Staff is being trained on accompanying [client #16] to her room when she has been redirected there for agitation to prevent any physical aggressions. She has not had any further episodes of aggression....." Client #16's record was reviewed on 9/27/11 at 11:28 AM. Client #16's 5/17/11 Individual Program Plan (IPP) did not indicate the staff had been retrained in supervising/monitoring the client when redirected to her room due to agitation. Interview with Qualified Mental			

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	Retardation Professional (QMRP) #7 on 9/28/11 at 11:30 AM indicated client #16 had not been physically aggressive toward others prior to 9/15/11. QMRP #7 indicated physical aggression was added to client #16's behavior plan on 9/27/11. QMRP #7 indicated when client #16 was agitated and redirected to her bedroom, facility staff were to walk with client #16 to her bedroom to prevent aggression toward others. QMRP #7 indicated the facility staff had been retrained to monitor/supervise client #16 when she was agitated. At the time of the interview, QMRP #7 did not provide documentation of the training. Interview with administrative staff #1 on 9/29/11 at 11:40 AM indicated she thought the retraining had been completed with staff regarding the 9/15/11 incident with client #16. Administrative staff #1 indicated the QMRP did not conduct the retraining until 9/28/11 once client #16's behavior plan was approved by the facility's Human Rights Committee. Administrative staff #1 stated facility staff should have been retrained after the 9/15/11 incident as monitoring/walking with client #16 to her bedroom, when agitated, was not "restrictive." 2. During the observation period on			

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	9/27/11 from 6:50 AM through 8:00 AM client #126 was observed on the 2nd floor south unit. At 6:50 AM client #126 was observed sitting in client #118's personal recliner located in client #118 and #119's bedroom. Client #118 and client #119, female clients, were observed in their beds while client #126, male client, sat in the recliner rocking. At 7:30 AM client #126 remained in the recliner and was not observed being prompted and/or encourage to return to his own room when staff walked by and saw client #126 in the female clients' room. Interview with CNA (Certified Nursing Aide) #40 was interviewed on 9/27/11 at 8:45 AM indicated client #126 should not be sitting in the recliner and should be prompted to return to his own room. CNA #40 indicated it is not appropriate for a male client to be in the room with two female clients while they sleep. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-13(b)(2) 3.1-28(c)			

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W0227	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 18 clients in the sample (#15 and #16), the facility failed to ensure: 1) client #15 had a program plan to address refusals to participate in programming and 2) client #16 had a plan for self-protective responses to peer aggression. Findings include: 1. An observation was conducted on the third floor of the facility on 9/26/11 from 3:29 PM to 6:06 PM. From 3:29 PM to 3:56 PM, client #15 was in her bedroom with the door closed. Staff did not attempt to engage client #15 in activities. At 3:56 PM, client #15 went into the dining room. At 4:54 PM, a nurse went into the dining room and administered medications to client #15. From 4:01 PM to 4:58 PM, direct care staff did not interact or attempt to interact with client #15 while she sat in a chair looking at her fingers. At 4:58 PM after ingesting her medications, client #15 went back to her room carrying the cup of water the nurse gave her to take her medications. Client #15 spilled water from the cup from the	W0227	W 227 Individual Program Plan The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph c, 3 of this section. I Corrective Action for Cited Clients: Clients 15 and 16 have been educated on their rights. Client 159's behavior support plan has been reviewed and revised as needed. CNA staff have been trained to document refusal to participate on behavior incident reports (BIR). II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: Residents Rights have been reviewed on each unit.IDT to assess residents for need of assertivenesstraining and address as appropriate. IDTto address issues that occur three times in athirty day period. IV Monitoring Corrective Measures: Program Directors review BIR reports and assure follow up recommendations are completed for the IDT. To be completed by 11-3-11.	11/03/2011

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	dining room to her room. Several direct care staff attempted to redirect client #15 by telling her she was spilling water however client #15 did not respond to the staff and went to her room and shut the door. At 5:10 PM, client #15 went to the dining room for dinner. On 9/27/11 from 7:26 AM to 8:48 AM, client #15 was in her room with the door closed. At 8:48 AM, Certified Nursing Assistant (CNA) #22 went into client #15's bedroom to check on client #15. CNA #22 did not attempt to wake client #15 or engage her in activities. A review of client #15's record was conducted on 9/27/11 at 12:21 PM. Client #15's Behavior Support Plan, dated 9/15/10, indicated she had the following targeted maladaptive behaviors: clothes stripping, temper tantrums, hoarding and physical aggression. There was no plan to address refusals to participate in programming. An interview with CNA #22 was conducted on 9/27/11 at 8:48 AM. CNA #22 indicated client #15 refused to wake up and go to breakfast on 9/27/11. She indicated this was an on-going issue with client #15. An interview with the Qualified Mental			

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	Retardation Professional (QMRP) #7 was conducted on 9/28/11 at 11:30 AM. QMRP #7 indicated it was a known issue that client #15 did not participate in programming at the facility. He indicated this had been an on-going issue for 3 months. The QMRP indicated there was no plan in place. The QMRP indicated a plan should be in place to address refusals. 2. An observation was conducted on the third floor of the facility on 9/26/11 from 3:29 PM to 6:06 PM. At 3:48 PM, client #16 was being interviewed by the surveyor at the door to her bedroom. Client #159 exited her bedroom and approached client #16. Client #159 reached out and scratched client #16's wrist and then hit her once on each shoulder. Client #16 did not move, react or say anything to client #159. Client #159 then walked back to her room. On 9/27/11 at 7:48 AM, client #16 was in the dining room assisting with setting the tables for breakfast. Client #16 placed a container of butter and syrup at each plate. While setting the tables, client #159 approached client #16, grabbed her shirt collar and pulled on it and then hit client #16 on the right shoulder 3 times. Client #16 did not move, react and/or say anything to client #16. Although there			

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	were 4 staff in the dining room at the time, none of the staff witnessed the incident. A review of client #16's record was conducted on 9/27/11 at 11:28 AM. A review of her Individual Support Plan (ISP), dated 5/17/11 and her Behavior Support Plan, dated 5/2/11, indicated there was no plan addressing self-protective responses to peer aggression. An interview with Administrative staff (AS) #10 was conducted on 9/27/11 at 7:55 AM. AS #10 indicated client #159 did not target client #16. AS #10 indicated client #159 would hit any of the clients near her. An interview with Qualified Mental Retardation Professional (QMRP) #7 was conducted on 9/28/11 at 11:30 AM. QMRP #7 indicated there was nothing in client #16's plan addressing self-protective response to peer aggression. He indicated there should be a plan in place for client #16 to protect herself from peer aggression. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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W0249	3.1-35(a) 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. Based on observation, record review, and interview, the facility failed to assure direct care staff implemented clients' Individual Support Plans when formal and informal training opportunities existed for 7 of 18 sampled clients (clients #10, #11, #14, #15, #16, #17 and #18). Findings include: 1. During the observations at the facility on the 2 west unit on 9/26/11 from 3:05 PM until 4:51 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #10 was observed in the group room standing by the window without activity. During the observation she walked from the group room into the hall and placed her fingers on her tongue. Her pink shirt was observed to be wet from saliva. At 3:40 PM the front of her shirt was observed to be wetter than previously. Client #10 was observed to	W0249	Program Implementation 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. I Corrective Action for Cited Clients: Residents 10, 11, 14, 15, 16, 17, and 18 have had their ISPs and BSPs reviewed and revised as necessary to address sited issues. Staff have been educated on these plans. Staff have been re-educated on Infection Control. Staff have been educated on the	11/03/2011

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	stand in the hall until 4:10 PM when she returned to the group room. Staff #19 read the book, "Mickey Meets the Giants" to the clients in the group room. At 4:48 PM client #10 was observed to walk to the dining room for supper. At 5:36 PM client #10 was observed to place her hands in the mashed potatoes and put her hands into her mouth. At 5:38 PM client #10 was observed to be spoon fed her supper by CNA #18. Client #10 was not observed to participate in feeding herself and she did not pick up and use the weighted spoon located to the right of her divided dish. CNA #18 fed client #10 her entire meal. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #10 a choice of activities or implement client #10's training objectives, formally or informally. During the observations at the facility on the 2 west unit on 09/26/11 from 5:43 PM until 6:43 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #10 was observed in the hallway with the shoestring on the shoe in her mouth. Client #10 walked into the dining room and was escorted back to the hallway on the unit. At 5:56 PM client #10 was taken to her room by CNA #16 who came out of the room and		Active Treatment Audit and why it is important. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: The Active Treatment Audit has been revised to include names of staff present, accountability of staff to task and education on the "why" of active treatment and reason for the audit. QMRPs complete the Active Treatment Audit three times per week. Those staff who are not performing up to standard with education will start formal documentation including disciplinary action as warranted. IV Monitoring Corrective Measures: Program Directors complete an Active Treatment Audit weekly as well as review those completed by QMRP staff and assure appropriate follow up is completed. To be completed by 11-3-11	

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	closed the door. Client #10 remained in her room when the observation ended at 6:43 PM. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #10 a choice of activities or implement client #10's training objectives, formally or informally. Observations were conducted on the 2 west unit on 09/27/11 from 6:45 AM until 8:20 AM. Client #10's bedroom door was observed to be closed until CNA #23 went into her room at 7:20 AM and client #10 came out of her room dressed at 7:30 AM and stood in the hall. At 7:32 AM client #10 walked to the dining room and walked back to the unit. At 7:40 client #10 sat in a chair in the hall and tapped her foot. CNA #21 read a book to clients sitting in the hallway waiting for breakfast. At 8:02 AM client #10 walked to the dining room and sat in the chair. At 8:08 AM client #10 was observed to take a handful of pureed "Shape and Serve" breakfast food from client #96's plate and place it in her mouth and eat it. At 8:12 AM CNA #21 was observed to feed client #10 her entire plate of food without the assistance of client #10. Client #10 did not pick up and use the weighted spoon located to the right of her divided dish. CNAs #16, #17, #18 or #19, who were working during this observation period,			

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	did not offer client #10 a choice of activities or implement client #10's training objectives, formally or informally. Observations were conducted on the 2 west unit on 09/27/11 from 9:57 AM until 11:30 AM. CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. At 9:57 AM client #10 was observed to grab a binder on the table and pull a paper from the binder and tear and crumple the paper. Client #10 was observed to not have shoes and socks on her feet. At 10:05 AM client #10 was observed to pick up a plastic container which contained crayons and take the crayons out of the container and throw then on the floor. CNA #21 was observed to be reading the book, "Mickey Meets the Giants" in the group room to the clients in the room. At 10:17 AM client #10 was observed to go to the dining room and her shoes and socks were placed on her feet by CNA #23. CNA #24 placed large building type connecting blocks on the table in front of her. Client #10 did not touch the blocks until she picked them up and threw them on the floor at 10:33 AM. CNA #23 was observed to pick the blocks up from the floor and place them back on the table. Client #10 sat at the table until 10:45 AM when she returned to the group			

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	room and stood by the window. CNA #16 was reading a book in the group room to the clients. Client #10 remained without activity or interaction until 11:00 AM when she was escorted to the shower room. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #10 a choice of activities or implement client #10's training objectives, formally or informally. Client #10's record was reviewed on 09/27/11 at 2:30 PM. Client #10's ISP (Individual Support Plan) was dated 08/23/11 and included the following objectives: 1. "Will feed herself during mealtime... 2. Will wash her hands after brief change... 3. Will wash as much of her chest as possible... 4. Will attempt to hold her toothbrush... 5. Will pull her pants down and up when changing... 6. Will grasp objects (cup, ball, spoon)... 7. Will identify a dime... 8. Will wear her wrestling shoes with orthopedic inserts... 9. Will scoop her meds from the med cup and put them into her mouth... 10. Will open her mouth for Nurse to examine for 60 seconds 11. Will follow simple directives...".			

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	Client #9's Active Treatment Schedule (ATS) was dated 10/21/10 and indicated the following: "6 - 7:00 AM - wake-up/ADL's (activity of daily living) 7:00 - 8:00 AM - Breakfast/Meds 8:00 - 9:30 AM - Bath Time 8:30 - 11:00 AM - Will rotate through active treatment on leisure skills - communication skills - sensory stimulation - social skills - exercise and ADL skills. Pre-Voc 11:00 - 1 PM - Lunch/Meds 1 - 3:00 PM - Transport back to unit/toileting/hand-washing/tooth-brushin g; Rest/leisure time 3 - 3:30 PM - Wake up 3:30 - 4 PM - Will rotate through activities: softball, basketball, soccer, bowling, football and baseball 4 - 5 PM - Active Treatment/Recreational Activity 5 - 6:30 PM - Dinner/Meds 6:30 PM - 7:00 PM - Recreation and Leisure time 7:00 PM - 9:00 PM - Snack time/social and leisure time; Toileting/Hand-washing/Tooth-brushing; Flex Sleep time." Facility staff did not follow and/or implement client #10's active treatment schedule as written. QMRP #5 was interviewed on 09/28/11 at			

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	1:30 PM. The QMRP indicated client #10'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. 2. During the observations at the facility on the 2 west unit on 9/26/11 from 3:05 PM until 4:51 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #11 was observed in the group room sitting in a wheel chair drooling without activity. At 3:27 PM client #11 was observed to be rolled into the hallway as sat in his wheelchair while others had a ball attempting to put it through a hoop. Client #11 sat without activity until 4:07 PM when he was wheeled back into the group room. Staff #19 read the book, "Mickey Meets the Giants" to the clients in the group room. Client #11 continued to sit in his wheelchair without activity until 4:51 PM when the observation was completed. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #11 a choice of activities or implement client #11's training objectives, formally or informally. During the observations at the facility on			

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	the 2 west unit on 09/26/11 from 5:43 PM until 6:43 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #11 was observed in the group room without activity. CNA #19 was observed to be reading a book to the clients in the group room. Client #11 sat in his wheelchair without activity until 6:43 PM when the observation was completed. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #11 a choice of activities or implement client #11's training objectives, formally or informally. Observations were conducted on the 2 west unit on 09/27/11 from 6:45 AM until 8:20 AM. Client #11 was observed to be in bed at 6:53 AM. At 7:21 AM client #11 was wheeled from his bedroom out into the hallway. At 7:39 AM CNA #21 was observed to read, "Mickey Meets the Giant." to the clients sitting in the hallway. Client #11 continued to sit in the hallway until he was taken to the group room at 8:02 AM. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #11 a choice of activities or implement client #11's training objectives, formally or informally.			

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	Observations were conducted on the 2 west unit on 09/27/11 from 9:57 AM until 11:30 AM. CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. At 9:57 AM client #11 was observed to be in the group room in his wheelchair. CNA #21 was observed to be reading, "Mickey Meets the Giant" to the clients in the room. At 10:05 AM client #11's shirt was observed to be wet with drool in an area approximately the size of a baseball. At 10:45 AM client #11 was observed to be wearing the same shirt and was sitting in his wheelchair in his bedroom, the TV was on and no one else was in the room. At 11:07 AM client #11 was returned to the group room and sat in his wheelchair without activity. At 11:17 AM client #11 was observed to be drooling onto his shirt and the wet spot was the size of a grapefruit. He was also observed to be biting his right hand around the thumb area and the area was red and raised about the size of a quarter. Client #11 was observed to remain without activity until the observation ended at 11:30 AM. CNAs #16, #17, #18 or #19, who were working during this observation period, did not offer client #11 a choice of activities or implement client #11's training objectives, formally or informally.			

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	Client #11's record was reviewed on 09/28/11 at 10:10 AM. Client #11's ISP (Individual Support Plan) was dated 12/07/10 and included the following objectives: 1. "Will dry off his chest after shower... 2. Will attempt to hold the toothbrush while brushing... 3. Will attempt to hold his razor while shaving... 4. Will identify functional items (wheelchair and tooth brush)... 5. Will look at dollar and quarter while staff explains their value... 6. Will hold G-Tube site during flush... 7. Will open his mouth for Nurse to examine for 60 seconds... 8. Will pick up blocks and place them in a bucket...". Client #11's Active Treatment Schedule (ATS) was dated 12/7/10 and indicated the following: "6:00 AM - 7:00 AM - Wake up time/ADL's (activity of daily living) 7:00 AM - 8:00 AM - G-tube Feeding 8 - 9:30 AM - Bath time; Bathing may not take the entire time allotted. When he's finished bathing [client #11] will be directed to the appropriate activity. Medication Pass. 8:30 AM - 11:00 AM - Will rotate through active treatment on Leisure skills, Communication skills, Sensory			

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	Stimulation, Social Skills, Exercise and (nothing more written) 11 - 12:00 PM - (area was blank) 12 - 12:30 PM - ADL's Brief changing/get ready for rest time 12:30 PM - 2:00 PM - Rest Time 2:00 - 2:30 PM - ADL's Brief changing/get ready for Activity time 2:30 PM - 3:00 PM - Social time/Recreation 3:00 PM - 4:00 PM - Residents will cycle through these activities: Bowling, soccer, softball, volleyball, frisbee golf or football 4:00 PM - 5:00 PM - Goal Time/Medications 5:00 PM - 6:00 PM - (area was blank) 6:00 PM - 7:30 PM - Goal time/Leisure time 7:30 PM - 10:00 PM - Toileting/Hand-washing/tooth-brushing/Social or Leisure time; Flexible Sleep time" Facility staff did not follow and/or implement client #11's active treatment schedule as written. QMRP #5 was interviewed on 09/28/11 at 1:30 PM. The QMRP indicated client #11'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. 3. Observations of client #14 at the			

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	facility were done on 9/26/11 from 3:39p.m. to 7:00p.m. and 9/27/11 from 6:52a.m. to 9:34a.m. Client #14 was non-verbal and was not observed during any of the observation time to use sign language with direct care staff. On 9/27/11, client #14 ate breakfast at 8:08a.m. Client #14 ate 7 pancakes, 2 bowls of cereal and 2 sausage patties and half the bowl of chopped up sausage. Client #14 over filled his milk bowl and milk ran over his area and a peers area of the dining room table. Client #14 ate dry pancakes with his fingers, taking a whole pancake and biting off pieces. Staff #61 did not prompt client #14 to slow down, follow his diet, use his napkin, use sign language and to clean up his milk spill. Record review for client #14 was done on 9/28/11 at 10:28a.m. Client #14's ISP was dated 9/8/11. The ISP indicated client #14 was non-verbal. The ISP indicated client #14 had the following training programs: to slow rate of eating by using a napkin between bites and to lay down his utensil; sign work, toilet, hungry. The ISP indicated client #14 was on a regular diet with large portions. The dining room undated "Diet Book" was reviewed on 9/27/11 at 8:45a.m. indicated a large portion diet was: meat 1 1/2 times regular diet, cereal 1 1/2 times regular diet and bread 1 1/2 times regular diet. The posted			

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	breakfast menu for 9/27/11 indicated a regular diet was 4 ounces of cereal, 1 sausage and 2 pancakes. QMRP #7 was interviewed on 9/28/11 at 12:10p.m. QMRP #7 indicated client #14 had training programs to be encouraged to use sign language, use a napkin, slow his rate of eating and was on a regular large portion diet. QMRP #7 indicated staff should have implemented client #14's training programs whenever opportunities were present. 4. Observations of client #17 at the facility were done on 9/26/11 from 3:39p.m. to 7:00p.m. and 9/27/11 from 6:52a.m. to 9:34a.m. Client #17 was non-verbal and was not observed during any of the observation time to use sign language with direct care staff. On 9/26/11 client #17 sat in the corner of the activity room from 4:15p.m. to 6:21p.m. Client #17 sat in a chair with his feet up in the chair and his shirt pulled over his knees with his arms inside the shirt. The only staff interaction client #17 received during this time frame was at 5:03p.m. when QMRP #8 gave client #17 (2) sensory items to hold. At 6:21p.m. client #17 went to the dining room for supper. Client #17 received regular style whole french fries. Client #17 put a handful of french fries into his mouth without			

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	redirection. Client #17 ate his meatloaf with his fingers. Client #17 did not receive a drink during his meal. Client #17 was not prompted to use a napkin and did not use his napkin during the meal. On 9/27/11, client #17 ate breakfast at 9:02a.m. Client #17 ate 4 pancakes, 3 servings of mechanical soft sausage patties. Client #17 ate with his hands and did not use his napkin. Record review for client #17 was done on 9/28/11 at 11:03a.m. Client #17's ISP was dated 1/20/11. The ISP indicated client #14 was non-verbal. The ISP indicated client #14 had the following training programs: to put down his spoon/fork between bites; use a baby spoon to slow his food consumption; offer small group activities; verbally prompt him to remove his arms from inside his shirt and offer him an item to hold; complete steps for tooth brushing; identify pictorial objects in a book, magazine or paper; identify a penny; sign medicine; attend to task for 5 minutes. The ISP indicated client #17 was on a regular portion mechanical soft diet. The posted breakfast menu for 9/27/11 indicated a regular diet was 4 ounces of cereal, 1 sausage pattie and 2 pancakes. QMRP #8 was interviewed on 9/28/11 at 12:10p.m. QMRP #8 indicated client #17 should be prompted to participate in			

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	activities and use sensory items in when in the activity room. QMRP #8 indicated client #17 should have received french fries cut up into small pieces and was on a mechanical soft regular portion diet. QMRP #8 indicated client #17 should be prompted to remove his legs and arms from inside of his shirt. QMRP #8 indicated staff should have implemented client #17's training programs whenever opportunities were present. 5. An observation was done at the facility on 9/27/11 from 6:52a.m. to 9:34a.m. At 7:08 client #18 continually tried to trade surveyor ink pens without redirection from staff. Again, at 7:28a.m., client #18 tried to take surveyor's ink pen without redirection from staff. At 7:28a.m. staff #62 indicated client #18 always tries to trade ink pens. Record review for client #18 was done on 9/28/11 at 11:36a.m. Client #18's 10/13/10 ISP indicated client #18's behavior of wanting others pens. Staff were to prompt client #18 to stop and to redirect client #18 to an activity. QMRP #7 was interviewed on 9/28/11 at 12:10p.m. QMRP #7 indicated client #18 should be prompted to stop when asking for others' pens and should be redirected to an activity.			

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		W0249	Program Implementation 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. I Corrective Action for Cited Clients: Residents 10, 11, 14, 15, 16, 17, and 18 have had their ISPs and BSPs reviewed and revised as necessary to address sited issues. Staff have been educated on these plans. Staff have been re-educated on Infection Control. Staff have been educated on the Active Treatment Audit and why it is important. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or	11/03/2011

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	6. An observation was conducted on the third floor of the facility on 9/26/11 from 3:29 PM to 6:06 PM. From 3:29 PM to 3:56 PM, client #15 was in her bedroom with the door closed. Staff did not attempt to engage client #15 in activities. At 3:56 PM, client #15 went into the dining room. At 4:01 PM, staff went over to client #15 and attempted to talk to her.		Systemic Changes: The Active Treatment Audit has been revised to include names of staff present, accountability of staff to task and education on the "why" of active treatment and reason for the audit. QMRPs complete the Active Treatment Audit three times per week. Those staff who are not performing up to standard with education will start formal documentation including disciplinary action as warranted. IV Monitoring Corrective Measures: Program Directors complete an Active Treatment Audit weekly as well as review those completed by QMRP staff and assure appropriate follow up is completed. To be completed by 11-3-11	

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	Client #15 screamed. The staff immediately backed away. At 4:54 PM, a nurse went into the dining room and administered medications to client #15. From 4:01 PM to 4:58 PM, direct care staff did not interact or attempt to interact with client #15 while she sat in a chair looking at her fingers. At 4:58 PM after ingesting her medications, client #15 went back to her room carrying the cup of water the nurse gave her to take her medications. Client #15 spilled water from the cup from the dining room to her room. Several direct care staff attempted to redirect client #15 by telling her she was spilling water however client #15 did not respond to the staff and went to her room and shut the door. At 5:10 PM, client #15 went back to the dining room for dinner. On 9/27/11 from 7:26 AM to 8:48 AM, client #15 was in her room with the door closed. At 8:48 AM, Certified Nursing Assistant (CNA) #22 went into client #15's bedroom to check on client #15. CNA #22 did not attempt to wake client #15 or engage her in activities. A review of client #15's record was conducted on 9/27/11 at 12:21 PM. Her Individual Support Plan (ISP), dated 5/26/11, indicated she had the following training objectives: wait patiently by the med cart for her meds, pop out Keppra from its pack, stay on-task during work,			

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	wake to use the toilet, portion correctly according to family style dining protocols, identify coins and community safety signs, participate in a recreational activity with a peer, accept housekeeping coming in to her room to clean 2 times per week with no behavioral incidents, and complete her daily domestic chores. Client #16's Daily Activity Schedule, dated 5/26/11, indicated the following activities: Monday 3:30 PM to 4:00 PM - relaxation, 4:00 to 5:00 PM - formal goals/simple pleasures, meal prep, 5:15 PM to 6:15 PM - meal time and meal time clean up. 7. An observation was conducted on the third floor of the facility on 9/26/11 from 3:29 PM to 6:06 PM. At 3:56 PM, staff attempted to engage client #16 in an activity. Client #16 indicated she wanted to stay in her room. At 4:59 PM, client #16 was lying in her bed. Client #16 indicated she had been lying in her bed for the past hour resting. At 5:38 PM, staff indicated to Administrative staff (AS) #1 she did not know what the clients mealtime goals were after AS #1 asked the staff to identify the goals for mealtime. AS #1 looked in the dining book on the table and indicated to the staff that the goal for client #16 was to have her napkin in her lap. Client #16 was not prompted to put her napkin in her			

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	lap. Her napkin stayed on the table during dinner. On 9/27/11 at 8:01 AM, client #16 sat down for breakfast. Client #16 was not prompted to put her napkin in her lap; the napkin stayed on the table during breakfast unless client #16 was using it to wipe her face. CNA #22 did not prompt client #16 to put the napkin in her lap. A review of client #16's record was conducted on 9/27/11 at 11:28 AM. Her ISP, dated 5/17/11, indicated she had the following training objectives: distribute materials to her peers at the workshop, brush her teeth thoroughly, place napkin in her lap during meals, identify basic coins to make small purchases, read words from flashcards, participate in classroom activities, define appropriate ways to interact with others and identify Prozac. Her Active Treatment Schedule, dated 5/17/11, indicated the following for 4:00 to 5:00 PM: formal goals, simple pleasures and meal prep. An interview with the Qualified Mental Retardation Professional (QMRP) #7 was conducted on 9/28/11 at 11:30 AM. QMRP #7 indicated the direct care staff should be prompting the clients to participate in programming at least once per hour. He indicated the staff should be implementing the program plans based on the activity schedules for the clients.			

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	QMRP #7 indicated the staff should be implementing client #16's mealtime goal to place a napkin on her lap at every meal. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-32(a) 3.1-33(a) 3.1-37(a)			
W0268	These policies and procedures must promote the growth, development and independence of the client.	W0268	Conduct Toward Client These policies and procedures must promote the growth, development and independence of the client. I Corrective Action for Cited Clients: Residents 3, 10, 11, 90, 92, 93, 99, 101, 107, and 126 have had their plans reviewed by the IDT and appropriate interventions prescribed as necessary. Those plans have been retrained. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.	11/03/2011

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	Based on observation, interview and record review for 3 of 18 sampled clients		III Corrective Measures or Systemic Changes: A Resident Appearance Checklist will be posted on each unit and referred to as a reminder of appropriate appearance of residents and when education and simple reminders fail to elicit appropriate staff action it will be addressed with formal documentation including disciplinary actions. Infection Control has been re-educated with staff. The Active Treatment Audit has been revised to include a check for Infection Control practices. Staff have been educated on the Active Treatment Audit and why it is important. IV Monitoring Corrective Measures: Program Directors complete an Active Treatment Audit weekly as well as review those completed by QMRP staff and assure appropriate follow up is completed. To be completed by 11-3-11.	

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	(#3, #10 and #11) and for 7 additional clients (#90, #92, #93, #99, #101, #107 and #126), the facility failed to ensure clients changed clothes when wet,and wore clean and/or appropriate clothing to ensure the clients' dignity. Findings include: 1. During the observations at the facility on the 2 west unit on 9/26/11 from 3:05 PM until 4:51 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #11 was observed in the group room sitting in a wheel chair drooling without activity. At 3:47 PM client #92 was observed to get up from her chair in the hallway, walk approximately 5 feet, place a ball through a hoop, turn around and walk back to her chair and sit down. Her green pants were observed to be wet from the waist down the left leg to the thigh area and the hallway smelled of urine. At 3:50 PM client #93 was observed to sit in her wheelchair and was chewing on her shirt. Her shirt was observed to be wet in a spot approximately 10 inches by 3 inches. At 3:58 PM client #99 was observed sitting in the hallway eating animal crackers from a package. Client #99 dropped pieces of the crackers and was observed to reach down and move his fingers the floor			

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	until he located the piece, picked it up and ate it. At 4:07 PM client #93 was observed to still be chewing on her shirt. At 4:10 PM client #92 was observed to be taken to her room by CNA #17. Client #92 remained in her wet pants from 3:45 PM until 4:10 PM. At 4:14 PM client #93's shirt remained in her mouth and the wet area was the size of a basketball. At 6:43 PM client #101 was observed to be wearing a shirt which had an approximately four inch wet spot with food on the front of the shirt. Observations were conducted on the 2 west unit on 09/27/11 from 9:57 AM until 11:30 AM. CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. At 9:57 AM client #101 was observed to be wearing the same sweatshirt and pants as the previous day. The shirt still contained dried food. At 9:57 AM client #11 was observed to be in the group room in his wheelchair. CNA #21 was observed to be reading, "Mickey Meets the Giant" to the clients in the room. At 10:05 AM client #11's shirt was observed to be wet with drool in an area approximately the size of a baseball. At 10:07 AM client #107 was observed to raise his shirt, showing his stomach and placed the bottom of his shirt into his mouth. His shirt was wet in an area the			

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	size of a basketball. At 10:45 AM client #11 was observed to be wearing the same shirt and was sitting in his wheelchair in his bedroom, the TV was on and no one else was in the room. At 10:54 AM client #90 was observed to be drooling on his shirt and the shirt was wet in an area the size of a grapefruit. Client #93 was observed to have her wet shirt in her mouth chewing on it. At 11:07 AM client #11 was returned to the group room wearing the wet shirt and sat in his wheelchair without activity. At 11:10 AM client #10 was observed to have one sock on and two shoes, upon closer observation she had on two socks which were mismatched, one of ankle length and the other a "no show sock" which made it appear she only had on one sock. At 11:17 AM client #11 was observed to be drooling onto his shirt and the wet spot was the size of a grapefruit. He was also observed to be biting his right hand around the thumb area and the area was red and raised about the size of a quarter. At 11:25 AM client #107 was observed to have his wet shirt in his mouth chewing on it. At 2:05 PM client #90 was observed to still be wearing his food stained wet shirt. QMRP #5 was interviewed on 09/28/11 at 1:30 PM. QMRP #5 indicated staff should ensure the dignity of the clients			

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	and ensure the clients do not remain in soiled clothing. 2. During the observation period on 9/26/11 from 3:10 PM through 4:10 PM client #6 was observed on his unit. Client #6 was observed wearing a maroon longsleeve sweatshirt and gray sweatpants. Client #6 was observed throughout the observation period holding the waistline of his sweatpants in order to manually keep the sweatpants from falling down. Client #6 was not observed being prompted to change his clothing by CNA (Certified Nursing Assistant) #37, CNA #38 and/or QMRP (Qualified Mental Retardation Professional) #6. During the observation period on 9/27/11 from 6:50 AM through 8:00 AM client #6 was observed on his unit. At 6:50 AM client #6 exited his bedroom to enter the program room wearing the same maroon longsleeve sweatshirt and gray sweatpants as observed on 9/26/11. Client #6 wore the sweatshirt and sweatpants throughout the observation period. Client #6 was not observed being prompted to change his clothing by CNA #39, CNA #40 and/or QMRP #6. Interview with CNA #37 on 9/27/11 at 8:10 AM indicated client #6 had alternate clothing available to wear. CNA #37			

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	indicated client #6 should be offered appropriate fitting clothing and prompted to daily change his clothing. 3. Observations were conducted on the 2nd floor cafeteria on 9/27/11 from 8:00 AM through 8:45 AM. Client #126 was observed in the cafeteria throughout the observation period participating in family style dining. At 8:30 AM client #126 was observed exiting the cafeteria with CNA #40. Client #126 was wearing a pair of gray sweatpants. As client #126 exited the cafeteria his sweatpants waistline slid down to his ankles. Client #126 was prompted to pull his pants up. Client #126 then manually held the sweatpants from falling down as he continued to walk/exit the cafeteria. At 8:45 AM client #126 was observed in 2 south program room with the same gray sweatpants on. Client #126 was not observed being prompted by CNA #40, CNA #39 and/or QMRP #6 to change his sweats or offered alternate clothing. Interview with CNA #40 on 9/27/11 at 8:45 AM indicated client #126 had alternate clothing available to wear. CNA #40 indicated client #126 should be offered/trained to wear appropriate fitting clothing. This deficiency was cited on 8/5/11. The			

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	facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-3(t)			
W0331	The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 18 sampled clients (#2, #5 and #11), and one additional client (#61), the facility's nursing services failed to ensure clients completed recommended dental procedures, had gastrointestinal and psychiatric consultations, and were adequately supervised during medication administrations. Findings include: 1. Observations were conducted at the facility on the afternoon/evening of 9/26/11 from 3:30 PM until 6:00 PM. Client #2 was observed in his dining area from 4:45 PM until 6:00 PM. Client #2 was observed to have a cough throughout the observation period. During observations on 9/27/11 from 9:30 AM until 12:15 PM client #2 was observed to cough. Review of client #2's record on 9/28/11 at 10:15 AM indicated the client's diagnoses included but were not limited to GERD	W0331	Nursing Services The facility must provide clients with nursing services in accordance with I Corrective Action for Cited Clients: Client 2 can now make his own decisions as to medical care and appointments have been scheduled for him. Client 5 no longer has the need for weekly labs. Resident 11 has an IDT which states he will have a Behavior Support Plan for Self Injurious Behavior which will be completed. The nurse for resident 61 has been re-educated on medication administration. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes:	11/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/04/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN46260	

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	(gastroesophageal reflux disease) and dysphagia. The record review indicated the client's niece was his power of attorney/POA regarding health care issues. The record review indicated on 7/01/11 client #2 had a procedure under general anesthetic to treat his chronic bilateral maxillary sinusitis. The ENT (Ears, nose and throat) surgeon indicated on 7/01/11 client #2 may require additional follow up with a Gastroenterologist to determine if his cough was due to reflux. No Gastroenterologist's consult was found in the record dated after 7/01/11. Client #2's record review indicated he had a dental consultation on 1/17/11 to treat a tooth on the lower right which "hurt whenever he eats." The dental consultation notes in client #2's record indicated upon examination the dentist found multiple missing teeth, heavy amounts of plaque and tartar, generalized inflammation, and root sensitivity. The dentist indicated the client's oral hygiene was poor and he required "gross debridement and scaling." The dentist indicated the client may need a synthetic cover and a filling on tooth number 30 to relieve pain. The dentist indicated at the time of the 1/17/11 consult client #2 indicated he was "very scared" and cried. The dentist indicated the client was afraid		Written Informed Consent will be trained at the next two Family Council meetings on why it is necessary for medical and other issues in order to care for their loved one. Social Workers will track when items are mailed for consent and will give guardian/HCR a reminder call if the item is not returned within 2 weeks, the item will be resent one time with a total time of a month to obtain consent from the Guardian/HCR. Nursing to be educated to note on the 24 hour flow sheet when a lab draw occurs and will leave it on there until the results are received. Nursing has been educated as to the new order protocol (which alerts the Program Director). Nurses have been re-educated on medication administration. IV Monitoring Corrective Measures: If consent is not obtained within the two mailings, the Social Worker will refer the	

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	because of tooth pain and recommended he return for the deep cleaning and treatment to tooth number 30 in the future with the use of an anti-anxiety medication. An appointment was set for 3/21/11 with the use of Valium 10 mg./milligrams for anxiety. Review of client #2's 8/11 medication administration record/MAR on 9/28/11 at 10:15 AM indicated on 8/08/11 a dental appointment and the use of 10 mg. of Valium on hour prior to the visit had been discontinued. The review indicated the client had not been to the dentist since 1/17/11 because no consent from his medical POA had been obtained. Interview with Administrative staff #9 on 9/28/11 at 1:15 PM indicated client #2 had not been back to the dentist since 1/17/11. The interview indicated client #2 did continue to cough and had not been re-reevaluated by a Gastroenterologist to determine if the cough was due to reflux as recommended by the ENT on 7/01/11. 2. The record review for client #5 was conducted on 9/28/11 at 10:21 AM. The daily Progress note dated 8/18/11 indicated "[Primary Care Physician] in facility and gave new order for cbc q (every) Monday until colonoscopy done" The progress note indicated the lab and been notified. Review of the lab reports		issue to the ED/DNS for further follow up. The DNS/ADNS/Designee will audit labs and lab results and follow up when issues are noted. New orders are reviewed by DNS/ADNS/Designee to assure they are carried out. Medication Pass Observation is completed by the Director of Clinical Education/Designee one time a week for four weeks, then twice a month for four weeks and then at least monthly thereafter. To be completed by 11-3-11	

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	indicated the last cbc done for client #5 was dated 8/2/11. There was no record of a cbc being conducted after the order written on 8/18/11. Interview with staff #53, Director of Nursing (DON), on 9/28/11 at 1:05 PM indicated the order had been placed with the lab, but it had not been done. Staff #53, DON, indicated the order to the lab had not been followed up. 3. During the observation period on 9/27/11 at 7:00 AM to 8:50 AM, client #61 came to dining room at 7:35 AM for breakfast. Staff # 55, Licensed Practical Nurse (LPN) gave client #61 a pill cup with pills and walked away at 7:45 AM. Client #61 held the cup in her hand and proceeded to remove one pill at a time with her other hand and take the medication. Interview with staff #55, LPN on 9/27/11 at 8:10 AM indicated client #61 did not like to take her medication all at one time and it took a long time for her to take one pill at a time. Staff #55, LPN, indicated she did not watch client #61 take her meds. Interview with staff #53, DON, on 9/28/11 at 1:05 PM indicated the nurse should watch the client take her pills to ensure they were taken.			

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	4. Observations were conducted on the 2 west unit on 09/27/11 from 9:57 AM until 11:30 AM. At 11:17 AM client #11 was observed to be drooling onto his shirt and the wet spot was the size of a grapefruit. He was also observed to be biting his right hand around the thumb area and the area was red and raised about the size of a quarter. Client #11's record was reviewed on 09/28/11 at 10:10 AM. Client #11's Consolidated Physician Orders dated 08/27/11 indicated an order dated 06/17/11 for, "Psyceatric (sic) Consult Regarding Treatment of SIB (Self-Injurious Behavior) for Biting of Right Hand." Client #11's record did not contain a Psychiatric Consult. An interview was conducted on 09/28/11 at 12:30 PM with RN #25 and the QMRP #5. The RN indicated she had recently taken over that unit and did not believe the order had been completed. The QMRP indicated client #11 had not had a psychiatric consult. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-17(a)			

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		W0331	Nursing Services The facility must provide clients with nursing services in accordance with I Corrective Action for Cited Clients: Client 2 can now make his own decisions as to medical care and appointments have been scheduled for him. Client 5 no longer has the need for weekly labs. Resident 11 has an IDT which states he will have a Behavior Support Plan for Self Injurious Behavior which will be completed. The nurse for resident 61 has been re-educated on medication administration. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: Written Informed Consent will be trained at the next two Family Council meetings on why it is necessary for medical and other issues in order to care for their loved one.	11/03/2011

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			Social Workers will track when items are mailed for consent and will give guardian/HCR a reminder call if the item is not returned within 2 weeks, the item will be resent one time with a total time of a month to obtain consent from the Guardian/HCR. Nursing to be educated to note on the 24 hour flow sheet when a lab draw occurs and will leave it on there until the results are received. Nursing has been educated as to the new order protocol (which alerts the Program Director). Nurses have been re-educated on medication administration. IV Monitoring Corrective Measures: If consent is not obtained within the two mailings, the Social Worker will refer the issue to the ED/DNS for further follow up. The DNS/ADNS/Designee will audit labs and lab results and follow up when issues are noted. New orders are reviewed by	

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			DNS/ADNS/Designee to assure they are carried out. Medication Pass Observation is completed by the Director of Clinical Education/Designee one time a week for four weeks, then twice a month for four weeks and then at least monthly thereafter. To be completed by 11-3-11	
W0455	There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview and record review for 2 of 18 sampled clients (#10 and #11) and for 6 additional clients (#92, #93, #99, #101, #104 and #107), the facility failed to maintain personal hygiene practices for the prevention of infections and disease. Findings include: During the observations at the facility on the 2 west unit on 9/26/11 from 3:05 PM until 4:51 PM, CNAs #16, #17, #18 and #19 rotated through the group room and in and out of client rooms during the observation. Client #11 was observed in the group room sitting in a wheel chair drooling without activity. At 3:47 PM client #92 was observed to get up from	W0455	Infection Control There must be an active program for the prevention, control, and investigation of infection and communicable diseases. I Corrective Action for Cited Clients: Residents 10,11, 92, 93, 101, 104, and 107 have had their plans reviewed by the IDT and appropriate interventions prescribed as necessary. Those plans have been retrained. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes:	11/03/2011

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	her chair in the hallway, walk approximately 5 feet, place a ball through a hoop, turn around and walk back to her chair and sit down. Her green pants were observed to be wet from the waist down the left leg to the thigh area and the hallway smelled of urine. At 3:50 PM client #93 was observed to sit in her wheelchair and was chewing on her shirt. Her shirt was observed to be wet in a spot approximately 10 inches by 3 inches. At 3:58 PM client #99 was observed sitting in the hallway eating animal crackers from a package. Client #99 dropped pieces of the crackers and was observed to reach down and move his fingers the floor until he located the piece, picked it up and ate it. At 4:07 PM client #93 was observed to still be chewing on her shirt. At 4:10 PM client #92 was observed to be taken to her room by CNA #17. Client #92 remained in her wet pants from 3:45 PM until 4:10 PM. At 4:14 PM client #93's shirt remained in her mouth and the wet area was the size of a basketball. At 6:43 PM client #101 was observed to be wearing a shirt which had an approximately four inch wet spot with food on the front of the shirt. Observations were conducted on the 2 west unit on 09/27/11 from 9:57 AM until 11:30 AM. CNAs #16, #17, #18 and #19 rotated through the group room and in and		A Resident Appearance Checklist will be posted on each unit and referred to as a reminder of appropriate appearance of residents and when education and simple reminders fail to elicit appropriate staff action it will be addressed with formal documentation including disciplinary actions. Infection Control has been re-educated with staff. The Active Treatment Audit has been revised to include a check for Infection Control practices. Staff have been educated on the Active Treatment Audit and why it is important. IV Monitoring Corrective Measures: Program Directors complete an Active Treatment Audit weekly as well as review those completed by QMRP staff and assure appropriate follow up is completed. To be completed by 11-3-11	

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	out of client rooms during the observation. At 9:57 AM client #101 was observed to be wearing the same sweatshirt and pants as the previous day. The shirt still contained dried food. At 9:57 AM client #11 was observed to be in the group room in his wheelchair. CNA #21 was observed to be reading, "Mickey Meets the Giant" to the clients in the room. At 10:05 AM client #11's shirt was observed to be wet with drool in an area approximately the size of a baseball. At 10:07 AM client #107 was observed to raise his shirt, showing his stomach and placed the bottom of his shirt into his mouth. His shirt was wet in an area the size of a basketball. At 10:20 AM clients #10 and #104 were taken to the dining room. Client #104 was observed to sneeze into his hand three times and CNA #24 said, "bless you." CNA #24 did not prompt or assist client #104 to wash his hands after he sneezed. Client #104 touched items on the table in front of him after he sneezed into his hands. Client #10 was observed to throw the blocks in front of her onto the floor and CNA #23 was observed to pick them up and place them back on the table in front of client #10. Client #10 was observed to place her hand in her mouth, touch the blocks from the floor and touch her mouth again with her fingers. Client #10 was observed to take client #92's washcloths and throw			

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	them on the floor. CNA #23 was observed to pick up the washcloths and place them back on the table. Client #10 was observed to pick up a washcloth which had been on the floor and put it in her mouth. CNA #23 took the cloth from her mouth and placed it back on the table. Client #10 was observed to be chewing on a string from the washcloth and CNA #23 took it from her mouth. CNA #23 did not wash her hands during the observation. Client #10 and #104 were returned to the group room at 10:45 AM. At 10:45 AM client #11 was observed to be wearing the same shirt and was sitting in his wheelchair in his bedroom, the TV was on and no one else was in the room. At 10:54 AM client #90 was observed to be drooling on his shirt and the shirt was wet in an area the size of a grapefruit. Client #93 was observed to have her wet shirt in her mouth chewing on it. At 11:07 AM client #11 was returned to the group room wearing the wet shirt and sat in his wheelchair without activity. At 11:10 AM client #10 was observed to have one sock on and two shoes, upon closer observation she had on two socks which were mismatched, one of ankle length and the other a "no show sock" which made it appear she only had on one sock. At 11:17 AM client #11 was observed to be drooling onto his shirt and the wet spot was the size of a grapefruit. He was also			

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	observed to be biting his right hand around the thumb area and the area was red and raised about the size of a quarter. At 11:25 AM client #107 was observed to have his wet shirt in his mouth chewing on it. At 2:05 PM client #90 was observed to still be wearing his food stained wet shirt. QMRP #5 was interviewed on 09/28/11 at 1:30 PM. The QMRP #5 indicated it was not good hygiene for clients to be drooling on their clothing, or have wet pants and clients and staff should wash their hands often. This deficiency was cited on 8/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(l) 3.1-21(i)(3)			