

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  11/20/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for investigation of complaint #IN00118625 and #IN00118923.</p> <p>Complaint #IN00118625: Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Complaint #IN00118923: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W249.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: November 19 and 20, 2012.</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed December 3, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		
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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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W0149	<p><b>483.420(d)(1)</b> <b>STAFF TREATMENT OF CLIENTS</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 4 of 8 BDDS (Bureau of Developmental Disabilities Services) reports reviewed regarding client protection, the facility neglected to implement the facility's policy and procedure and neglected to protect and prohibit neglect for 1 of 3 sampled clients (client A) by failing to provide adequate supervision for client A's SIB (self-injurious behavior).</p> <p>Findings include:</p> <p>On 11/19/12 at 10:30 AM the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed and indicated the following:</p> <p>10/30/12: "Client was seen cutting his forearms and was stating he wanted to kill himself...". Investigation dated 10/30/12 indicated client A was discharged back to the facility. It indicated, "[client A] has a behavior support plan updated September 2012 that addresses refusals, verbal aggression, physical aggression, AWOL (Absent With Out Leave), property destruction and self-injurious behavior. Behavioral factors: [Client A] is receiving 1:1 (one-to-one) staffing as a result of repeated AWOL, SIB and somatic complaints...."</p> <p>11/15/12: "Client was threatening to kill himself. Try (sic) to jump through the window...."</p> <p>11/16/12: "Executive Director reported that resident returned to [hospital] ER (Emergency</p>	W0149	<p>W149</p> <p>I Client A's Behavior Support Plan is being reviewed and revised to include reactive strategies for Self Injurious Behavior (SIB). Client A's one on one staffing is being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her. Client A is transitioning to a placement more suitable to his/her needs on 12-20-12.</p> <p>II This potentially deficient practice would affect those residents who have self injurious behavior and those who have one to one supervision.</p> <p>III The IDTs will meet to determine if self injury is present and if it is that it is addressed in their behavior support plan with reactive strategies. Residents who have one to one supervision are being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her.</p> <p>IV Program Directors review assessments to assure self injury is addressed with a behavior support plan and that plan</p>	12/20/2012			

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	<p>Room) a second time during the early morning hours on 11/16/12...[Client A] reportedly called 911 himself at approximately 3:30 AM on 11/16/12, and was transported to [hospital] ER. He had been transferred at 11:30 PM and returned with no new orders at approximately 1:30 AM. Resident returned from ER at approximately 6:30 AM 11/16/12 with no new orders...Resident has began (sic) on a new behavior program to reinforce positive behaviors...Resident continues on 1:1 staff supervision at this time...."</p> <p>11/16/12: "[Staff #1] was [client A's] assigned 1:1 staff. [Client A] has been receiving 1:1 supervision due to escalating threats to elope, increasing attempts at self-injurious behaviors, increasing aggression and suicide threats. Overnight, [client A] put a small piece of plastic in his penis. Nursing staff were able to remove it with no injury...At about 8:00 AM, [client A] attempted to elope. [Staff #1] and [Program Director #1 (PD)] intervened. [Client A] did struggle and a 2 person escort was used to assist [client A] back to his room. [Staff #1] reports that when [client A] was in his room, he had a plastic knife and piece of broken glass and threatened to cut his [client A] throat with the plastic knife. [Staff #1] was unable to get the items away from [client A] (client A kicked staff #1 during this time) and called for assistance. The (sic) [PD #1] came back in and they pried his hand open to take away the glass. [Client A] had cut his arm and finger on the glass (not requiring more than 1st aid)...."</p> <p>Client A's record was reviewed on 11/19/12 at 2:00 PM. Client A's record contained the following dated documents:</p> <p>09/06/12: IDT (Inter-disciplinary Team) meeting indicated: "Due to an (sic) significant increase in</p>		<p>contains reactive strategies to address the self injurious behavior. Program Directors assure specific methods and strategies are present for those residents with one to one staffing and how to interact and supervise those residents and that these strategies and information is trained with the staff.</p> <p>To be completed by 12-20-12.</p>				

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	<p>[client A's] self-injurious behaviors on 9-1-12, 9-2-12, 9-3-12, 9-5-12 and many more in July and August the IDT has decided that it is necessary to update [client A's] BSP by adding self-injurious behavior to his target behaviors. Along with adding SIB the team feels that [client A] needs a search and seize restriction on any objects or materials that may be used in order for him to harm himself."</p> <p>09/06/12: Behavior Support Program (BSP) indicated client A had the following target behaviors: refusals, verbal aggression, physical aggression, AWOL, property destruction and self-injurious behavior. The BSP indicated, "due to the severity of [client A's] targeted behaviors and his threat to harm himself with objects, a room search will be completed as needed to ensure the safety of [client A] and others. Any object that has a potential to harm will be removed from his room...."</p> <p>09/21/12: IDT meeting indicated: "The IDT recommends that [client A] remain on 1:1 staffing during waking hours. If [client A] chooses to stay up later or wakes up and stays up throughout the night, then a staff will be provided for [client A]."</p> <p>09/21/12: IDT meeting indicated: "Summary of meeting [client A]: This team met to discuss the alleged incident of a pencil tip [client A] said that he stuck into his penis...For his safety, in-addition to a 1.1 (sic) staff [client A] may not use a pencil or pen without staff supervision. For his safety [client A] will be on a 'no privacy' status. This will including going to the bathroom, taking a shower, etc. The 1.1 (sic) staff will have visual sight of his every move until further notice...."</p> <p>11/16/12: IDT meeting indicated: "Team met today to discuss [client A's] ongoing escalation of</p>			

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	<p>threatening behavior towards himself and others. He remains 1:1 with supervision at this time, but it does not appear to effectively deter [client A] from attempting to harm himself and run from the facility...On 11/14/12, [client A] continued with his maladaptive behaviors of self-harm, verbal aggression, and physical aggression. He also ran from the facility down [name] street, a busy city street. On 11/15/12, [client A] continued to escalate and made a specific threat to kill himself. He was sent to the ER and returned shortly thereafter with no new orders. [Client A] also used a piece of plastic to insert into the tip of his penis, which was later safely removed by nursing staff. On 11/16/12, [client A] continued to make attempts to harm himself. In the past he has used multiple objects to cut himself, and today he refused to surrender a broken piece of glass to staff. Again, [client A] was attempting to use the glass to harm himself. Staffing was briefly elevated to 2:1 to ensure his safety, and the glass was eventually removed from his possession. While there was a brief period of calm, [client A] then later began running again from the building and making statements that he wanted to kill himself. The team has been working to find alternative placement for [client A] as he expressed he 'hates living here'...."</p> <p>The facility's policy and procedures were reviewed on 11/19/12 at 2:05 PM. The facility's 5/2001 policy and procedures entitled Reporting Alleged Violations indicated, "...neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...The facility makes reasonable efforts to determine the cause of the alleged violation and takes corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident...Appropriate steps are taken to prevent recurrence of the</p>			
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	<p>incident..."</p> <p>An interview with the PD #2 and PD #3 was conducted on 11/20/12 at 3:35 PM. Both PD#1 and PD #2 indicated client A had a history of behaviors which included AWOL and SIB. They indicated client a required 24 hour supervision and should not have been allowed to injure himself with objects. They indicated staff needed to protect the clients and staff neglected to follow the abuse/neglect policy and procedure. PD #2 indicated client A's BSP did not contain specific instructions for how staff were to deal with client A's SIB.</p> <p>3.1-28(a)</p>				

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W0157	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 4 of 8 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility neglected to initiate and document effective corrective action to prevent further incidents of client self-harm for client A.</p> <p>Findings include:</p> <p>On 11/19/12 at 10:30 AM the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed and indicated the following:</p> <p>10/30/12: "Client was seen cutting his forearms and was stating he wanted to kill himself..." Investigation dated 10/30/12 indicated client A was discharged back to the facility. It indicated, "[client A] has a behavior support plan updated September 2012 that addresses refusals, verbal aggression, physical aggression, AWOL (Absent With Out Leave), property destruction and self-injurious behavior. Behavioral factors: [Client A] is receiving 1:1 (one-to-one) staffing as a result of repeated AWOL, SIB and somatic complaints...." No record of documented effective corrective action was available for review.</p> <p>11/15/12: "Client was threatening to kill himself. Try (sic) to jump through the window...." No new Interdisciplinary meeting notes or program revisions of documented effective corrective action were available for review.</p> <p>11/16/12: "Executive Director reported that resident returned to [hospital] ER (Emergency</p>	W0157	<p>W157</p> <p>I Client A's Behavior Support Plan is being reviewed and revised to include reactive strategies for Self Injurious Behavior (SIB). Client A's one on one staffing is being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her. Client A is transitioning to a placement more suitable to his/her needs on 12-20-12.</p> <p>II This potentially deficient practice would affect those residents who have self injurious behavior and those who have one to one supervision.</p> <p>III The IDTs will meet to determine if self injury is present and if it is that it is addressed in their behavior support plan with reactive strategies. Residents who have one to one supervision are being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her.</p> <p>IV Program Directors review assessments to assure self injury is addressed with a behavior support plan and that plan contains reactive strategies to</p>	12/20/2012			

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	<p>Room) a second time during the early morning hours on 11/16/12...[Client A] reportedly called 911 himself at approximately 3:30 AM on 11/16/12, and was transported to [hospital] ER. He had been transferred at 11:30 PM and returned with no new orders at approximately 1:30 AM. Resident returned from ER at approximately 6:30 AM 11/16/12 with no new orders...Resident has began (sic) on a new behavior program to reinforce positive behaviors...Resident continues on 1:1 staff supervision at this time...." No new Interdisciplinary meeting notes or program revisions of documented effective corrective action were available for review.</p> <p>11/16/12: "[Staff #1] was [client A's] assigned 1:1 staff. [Client A] has been receiving 1:1 supervision due to escalating threats to elope, increasing attempts at self-injurious behaviors, increasing aggression and suicide threats. Overnight, [client A] put a small piece of plastic in his penis. Nursing staff were able to remove it with no injury...At about 8:00 AM, [client A] attempted to elope. [Staff #1] and [Program Director #1 (PD)] intervened. [Client A] did struggle and a 2 person escort was used to assist [client A] back to his room. [Staff #1] reports that when [client A] was in his room, he had a plastic knife and piece of broken glass and threatened to cut his [client A] throat with the plastic knife. [Staff #1] was unable to get the items away from [client A] (client A kicked staff #1 during this time) and called for assistance. The (sic) [PD #1] came back in and they pried his hand open to take away the glass. [Client A] had cut his arm and finger on the glass (not requiring more than 1st aid)...." No new Interdisciplinary meeting notes or program revisions of documented effective corrective action were available for review.</p> <p>Client A's record was reviewed on 11/19/12 at</p>		<p>address the self injurious behavior. Program Directors assure specific methods and strategies are present for those residents with one to one staffing and how to interact and supervise those residents and that these strategies and information is trained with the staff. To be completed by 12-20-12.</p>				

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	<p>2:00 PM. Client A's record contained the following dated documents:</p> <p>09/06/12: IDT (Inter-disciplinary Team) meeting indicated: "Due to an significant increase in [client A's] self-injurious behaviors on 9-1-12, 9-2-12, 9-3-12, 9-5-12 and many more in July and August the IDT has decided that it is necessary to update [client A's] BSP by adding self-injurious behavior to his target behaviors. Along with adding SIB the team feels that [client A] needs a search and seize restriction on any objects or materials that may be used in order for him to harm himself."</p> <p>09/06/12: Behavior Support Program (BSP) indicated client A had the following target behaviors: refusals, verbal aggression, physical aggression, AWOL, property destruction and self-injurious behavior. The BSP indicated, "due to the severity of [client A's] targeted behaviors and his threat to harm himself with objects, a room search will be completed as needed to ensure the safety of [client A] and others. Any object that has a potential to harm will be removed from his room...."</p> <p>09/21/12: IDT meeting indicated: "The IDT recommends that [client A] remain on 1:1 staffing during waking hours. If [client A] chooses to stay up later or wakes up and stays up throughout the night, then a staff will be provided for [client A]." No record of staff monitoring him when he was awake was available for review.</p> <p>09/21/12: IDT meeting indicated: "Summary of meeting [client A]: This team met to discuss the alleged incident of a pencil tip [client A] said that he stuck into his penis..For his safety, in-addition to a 1.1 (sic) staff [client A] may not use a pencil or pen without staff supervision. For his safety</p>						

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	<p>[client A] will be on a 'no privacy' status. This will including going to the bathroom, taking a shower, etc. The 1.1 (sic) staff will have visual sight of his every move until further notice...." No record of monitoring client A was available for review.</p> <p>11/16/12: IDT meeting indicated: "Team met today to discuss [client A's] ongoing escalation of threatening behavior towards himself and others. He remains 1:1 with supervision at this time, but it does not appear to effectively deter [client A] from attempting to harm himself and run from the facility...On 11/14/12, [client A] continued with his maladaptive behaviors of self-harm, verbal aggression, and physical aggression. He also ran from the facility down [name] street, a busy city street. On 11/15/12, [client A] continued to escalate and made a specific threat to kill himself. He was sent to the ER and returned shortly thereafter with no new orders. [Client A] also used a piece of plastic to insert into the tip of his penis, which was later safely removed by nursing staff. On 11/16/12, [client A] continued to make attempts to harm himself. In the past he has used multiple objects to cut himself, and today he refused to surrender a broken piece of glass to staff. Again, [client A] was attempting to use the glass to harm himself. Staffing was briefly elevated to 2:1 to ensure his safety, and the glass was eventually removed from his possession. While there was a brief period of calm, [client A] then later began running again from the building and making statements that he wanted to kill himself. The team has been working to find alternative placement for [client A] as he expressed he 'hates living here'...." No record of implementation of the procedures set for in the IDTs of 09/21/12 and the BSP of 09/06/12 were available for review.</p>			

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	<p>An interview with the PD #2 and the PD #3 was conducted on 11/20/12 at 3:35 PM. Both PD#1 and PD #2 indicated client A had a history of behaviors which included AWOL and SIB. They indicated client A required 24 hour supervision and should not have been allowed to injure himself with objects. PD #3 indicated the agency neglected to implement and document effective corrective action for the BDDS incidents by failing to follow his 09/06/12 BSP and failing to implement the strategies of the 09/21/12 IDTs.</p> <p>3.1-28(e)</p>			

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 3 sampled clients (client A), the client's Individual Support Plan (ISP) failed to specifically indicate what staff were to do when a client (A) threatened to harm himself/made suicidal threats.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 11/19/12 at 2:00 PM. Client A's record contained the following dated documents:</p> <p>09/06/12: IDT (Inter-disciplinary Team) meeting indicated: "Due to an significant increase in [client A's] self-injurious behaviors on 9-1-12, 9-2-12, 9-3-12, 9-5-12 and many more in July and August the IDT has decided that it is necessary to update [client A's] BSP by adding self-injurious behavior to his target behaviors. Along with adding SIB the team feels that [client A] needs a search and seize restriction on any objects or materials that may be used in order for him to harm himself."</p> <p>09/06/12: Behavior Support Program (BSP) indicated client A had the following target behaviors: refusals, verbal aggression, physical aggression, AWOL, property destruction and self-injurious behavior. The BSP indicated, "due to the severity of [client A's] targeted behaviors and his threat to harm himself with objects, a room search will be completed as needed to ensure the safety of [client A] and others. Any object that has a potential to harm will be removed from his room...." The BSP did not contain specific</p>	W0240	<p>W240</p> <p>I Client A's Behavior Support Plan is being reviewed and revised to include reactive strategies for Self Injurious Behavior (SIB). Client A's one on one staffing is being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her. Client A is transitioning to a placement more suitable to his/her needs on 12-20-12.</p> <p>II This potentially deficient practice would affect those residents who have self injurious behavior and those who have one to one supervision.</p> <p>III The IDTs will meet to determine if self injury is present and if it is that it is addressed in their behavior support plan with reactive strategies. Residents who have one to one supervision are being reviewed and revised and retrained to include specific methods and strategies of how the 1:1 staff is to interact and supervise him/her.</p> <p>IV Program Directors review assessments to assure self injury is addressed with a behavior support plan and that plan</p>	12/20/2012			

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	<p>instructions for how staff were to deal with client A's SIB.</p> <p>09/21/12: IDT meeting indicated: "The IDT recommends that [client A] remain on 1:1 staffing during waking hours. If [client A] chooses to stay up later or wakes up and stays up throughout the night, then a staff will be provided for [client A]."</p> <p>09/21/12: IDT meeting indicated: "Summary of meeting [client A]: This team met to discuss the alleged incident of a pencil tip [client A] said that he stuck into his penis...For his safety, in-addition to a 1.1 (sic) staff [client A] may not use a pencil or pen without staff supervision. For his safety [client A] will be on a 'no privacy' status. This will including going to the bathroom, taking a shower, etc. The 1.1 (sic) staff will have visual sight of his every move until further notice...."</p> <p>11/16/12: IDT meeting indicated: "Team met today to discuss [client A's] ongoing escalation of threatening behavior towards himself and others. He remains 1:1 with supervision at this time, but it does not appear to effectively deter [client A] from attempting to harm himself and run from the facility...On 11/14/12, [client A] continued with his maladaptive behaviors of self-harm, verbal aggression, and physical aggression. He also ran from the facility down [name] street, a busy city street. On 11/15/12, [client A] continued to escalate and made a specific threat to kill himself. He was sent to the ER and returned shortly thereafter with no new orders. [Client A] also used a piece of plastic to insert into the tip of his penis, which was later safely removed by nursing staff. On 11/16/12, [client A] continued to make attempts to harm himself. In the past he has used multiple objects to cut himself, and today he refused to surrender a broken piece of glass to</p>		<p>contains reactive strategies to address the self injurious behavior. Program Directors assure specific methods and strategies are present for those residents with one to one staffing and how to interact and supervise those residents and that these strategies and information is trained with the staff.</p> <p>To be completed by 12-20-12.</p>	

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	<p>staff. Again, [client A] was attempting to use the glass to harm himself. Staffing was briefly elevated to 2:1 to ensure his safety, and the glass was eventually removed from his possession. While there was a brief period of calm, [client A] then later began running again from the building and making statements that he wanted to kill himself. The team has been working to find alternative placement for [client A] as he expressed he 'hates living here'...."</p> <p>An interview with the PD #2 and PD #3 was conducted on 11/20/12 at 3:35 PM. Both PD#1 and PD #2 indicated client A had a history of behaviors which included AWOL and SIB. They indicated client a required 24 hour supervision and should not have been allowed to injure himself with objects. They indicated staff needed to protect the clients. PD #2 indicated client A's BSP did not contain specific instructions for how staff were to deal with client A's SIB.</p> <p>3.1-35(b)(1)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients (clients B and C) who had Dysphagia Care Plan/Mealtime Guidelines which included a dining objective, to ensure the plans and objectives were implemented per the Individualized Support Plan (ISPs).</p> <p>Findings include:</p> <p>1. On 11/20/12 from 11:30 AM until 12:00 PM observations at the facility dining room were completed. On 11/20/12 at 11:45 AM, staff #2 sat to the right of client B and fed client B his lunch. Client B's food was placed in a high-sided divided dish and he was fed with a regular sized teaspoon. Client B was fed 9 heaping spoons of pureed lasagna and was given a drink from a 6 ounce glass using a straw. Client B kept the straw in his mouth and drank 1/4 of the liquid from the glass before it was removed by staff #2. Client B was fed 6 heaping spoons of a pureed red fruit</p>	W0249	<p>W249</p> <p>I Client B and C have had their Dysphasia dining care plans revised, if needed and retrained with staff and observation completed to assure it is being followed correctly.</p> <p>II This potentially deficient practice would affect those residents who have Dysphasic dining care plans.</p> <p>III QMRPs have been educated that those residents with Dysphasic dining care plans are to have those plans present in dining books and those plans are to be trained with the staff who assist those residents with dining. Those residents with Dysphasic dining care plans have those plans in place.</p> <p>IV Program Directors assure that Dysphasic care plans are in place and trained with staff who implement them. To be completed by 12-20-12</p>	12/20/2012			

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	<p>substance followed by drinking from the glass using the straw and drank an additional 1/4 of the liquid without removing the straw from his mouth. Client B was fed 4 heaping spoons of the red substance and then staff #2 gave him the glass with the straw and he drank an additional 1/4 of the glass at one time. Client B was fed 3 heaping spoons of pureed salad and then drank the rest of the liquids in the glass using a straw. Staff #2 fed client B the entire meal. Client B was not prompted or assisted to attempt to feed himself.</p> <p>Client B's records were reviewed on 11/19/12 at 3:00 PM and contained the following dated documents:</p> <p>05/22/12: Client B's ISP dated 05/22/12 indicated client B had a, "Dining Goal - Aspiration Prevention." The rationale for goal selection indicated client B, "has been coughing and aspirating on his meals." The goal's procedure indicated the following steps: "1. Provide [client B] with his diet - smooth pureed with honey-thick liquids 2. Assist [client B] with feeding following his safe swallow strategies as follows: 3. Assist [client B] to sit/position upright during meals</p>						

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	<p>4. Alternate solids and liquids</p> <p>5. Encourage dry swallow after every bite</p> <p>6. Watch and report to nursing any signs of Dysphagia - coughing, husky voice, constant dribbling of food out of his mouth...."</p> <p>06/09/12: Client B's "Focus" page indicated, "I have swallowing difficulty as related to: Kugelberg Wielander Syndrome (spinal muscular atrophy): dysphagia...Diet as ordered Regular - Pureed - Thickened Liquids Honey - Smooth puree with Honey thick liquids via straw only. Educate patient and caregiver on the following safe swallow strategies: Single sips of liquids with straw, small bites of food. Alternate solids/liquids. Dry swallow between bites...Provide the following adaptive equipment: Divided dish, dycem mat, built-up spoon...."</p> <p>11/01/12: OT (Occupational Therapy) Evaluation: "[Client referred to OT for Eval[uation] and Tx (treatment) due to poor, impaired posture while positioned in w/c (wheelchair) during meals. Pt (patient) hospitalized from 10-29-12 to 10-31-12 for video fluoroscope swallow study due to episode of choking and coughing while eating...swallow study recommends pureed diet with honey thickened liquids. Client is fed by staff -</p>			

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	<p>swallow compensatory strategies:</p> <ol style="list-style-type: none"> <li>1. Honey thickened liquids by straw</li> <li>2. limit intake to single small bites of pureed food</li> <li>3. feed slowing taking extra time between swallows</li> <li>4. alternate solids with sips of liquids...."</li> </ol> <p>An interview with the Program Director (PD) #2 and PD #3 was conducted on 11/20/12 at 3:35 PM. Both PD #1 and PD #2 indicated client B's dining plan should have been followed.</p> <p>2. On 11/20/12 from 11:30 AM until 12:00 PM observations at the facility dining room were completed. On 11/20/12 at 11:45 AM, staff #3 sat to the right of client C and fed client C his lunch. Client C's food was placed in a high-sided divided dish and he was fed with a regular sized teaspoon. Client C was fed his entire meal by staff #3.</p> <p>Client C's records were reviewed on 11/19/12 at 4:00 PM and contained the following dated documents:</p> <p>10/18/12: Client C's ISP dated 10/18/12 indicated client C is at risk for choking and has dysphagia (difficulty swallowing). The ISP indicated he was on a pureed diet, honey thick liquids and was to use a divided plate, dycem mat, a</p>						

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	<p>baby spoon and had a Dining Goal. The rationale for goal selection indicated client C, "to improve ROM (Range of Motion) and encourage independence in feeding himself."</p> <p>The goals procedure indicated the following steps: "1. ...Using hand-to-hand prompt [client C] to serve himself his pureed diet...provide him with his built up baby spoon and explain to him he needs to participate during his feedings...."</p> <p>An interview with the PD #2 and PD #3 was conducted on 11/20/12 at 3:35 PM. Both PD #1 and PD #2 indicated client C's dining plan should have been followed.</p> <p>This federal tag relates to complaint #IN00118923.</p> <p>3.1-23(a) 3.1-32(a) 3.1-33(a) 3.1-37(a) 3.1-53(3)(B)</p>						

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