STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for a full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00137846. This visit resulted in an IMMEDIATE JEOPARDY. COMPLAINT #IN00137846: Substantiated. Federal/state deficiency related to the allegation is cited at W351. This survey was conducted in conjunction with the post certification revisit to a post certification revisit completed on 8/23/13 to the investigation of complaint #IN00131430 completed on 7/12/13. Dates of Survey: October 21, 22, 23, 24, 25, 28, 29, 30, and November 4 and 6, 2013. Facility number: 000730 Provider number: 15G580 AIM number: 100272190 Surveyors: Tim Shebel, LSW-TC, 10/21-10/25 and 10/28-10/30 and 11/6 Susan Eakright, QIDP, 10/21-10/25 and 10/28-10/30 Vickie Kolb, RN, 10/21-10/25 and 10/28-10/30 and 11/6 Sue Reichert, QIDP, 10/21-10/25 and 10/28-10/30 Kathy Wanner, QIDP, 10/21-10/25 and 10/30 and 11/4 The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 11/8/13 by Ruth Shackelford, QIDP and Dotty Walton, QIDP.	W 000		

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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W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, record review and interview for 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 31 additional clients (clients K, L, M, S, T, V, W, Y, AA, CC, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, AAA, BBB, CCC, and DDD), the Intermediate Care Facility failed to provide active treatment services for which the facility received payment. Findings include: Based on observation, interview and record review for 10 of 10 sampled clients (A, B,C, D, E, F, G, H, I, J) and 31 additional clients (K, L, M, S, T, V, W, Y, AA, CC, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY,	W 100		

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W 100	Continued From page 2 AAA, BBB, and DDD), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure clients received a continuous and aggressive active treatment program which addressed the training needs of each client, failed to encourage participation in the development of individual program plans, failed to ensure accurate assessments and/or re-assessments were completed as needed, failed to assess clients' vocational needs, failed to ensure specific objectives were included in Individual Program Plans, failed to ensure completion dates were accurate in individual program plans, failed to include relevant supports in Individual Program Plans, failed to ensure client opportunities for choice, failed to ensure facility staff implemented clients' program schedules, behavior and program plans, failed to ensure clients' recorded data reflected individual performance, failed to develop a recording system to document client behaviors and events, and failed to ensure the facility's Human Rights Committee reviewed, approved and monitored restrictive techniques. The facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored and/or coordinated clients' programs as needed. Please see W195.	W 100		
	3.1-13(r)			
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

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W 102	Continued From page 3 This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the governing body failed to meet the Condition of Participation: Governing Body and Management due to the severity of the citations in this report that affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD). Findings include: 1. Please refer to W104 as the governing body failed to exercise general policy and operating direction over the facility to ensure policy and procedures were implemented to promote health and safety practices for Universal Precautions and infection control measures, to ensure no commingling of the clients' medications with staff medications, to ensure all outdated medications were destroyed and to ensure all medications at the facility were properly packaged with an appropriate pharmacy label with the client's name, medication and dosage as well as visible expiration dates, and to ensure one man lifts were not conducted at the facility, to ensure precautions were taken with restraints and policies and procedures were implemented to prevent infections, for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 48 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD, EEE (a client that is no longer at the facility), and	W 102		

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W 102	Continued From page 4 XXX. 2. Please refer to W122, the Condition of Participation: Client Protections was not met as the governing body neglected to implement policies and procedures to ensure the rights of 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD). 3. Please refer to W158, the Condition of Participation: Facility Staffing due to the governing body's failure to provide sufficient staff and staff training that affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD). 4. Please refer to W195, the Condition of Participation: Active Treatment Services due to the governing body's failure to: Ensure clients received a continuous and aggressive active treatment program which addressed the training needs of each client, Encourage participation in the development of individual program plans, Ensure accurate assessments and/or re-assessments were completed as needed, Assess clients' vocational needs, Ensure specific objectives were included in Individual Program Plans, Ensure completion dates were accurate in individual program plans, Include relevant supports in Individual Program Plans, failed to	W 102		

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W 102	Continued From page 5 ensure client opportunities for choice, Ensure facility staff implemented clients' program schedules, behavior and program plans, Ensure clients recorded data reflected individual performance, Develop a recording system to document client behaviors and events, Ensure the facility's Human Rights Committee reviewed, approved and monitored restrictive techniques, and failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored and/or coordinated clients' programs as needed for 10 of 10 sampled clients (A, B,C, D, E, F, G, H, I, J) and 31 additional clients (K, L, M, S, T, V, W, Y, AA, CC, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, AAA, BBB, and DDD). 5. Please refer to W266, the Condition of Participation and Facility Practices for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 27 additional clients (clients L, M, O, Q, S, V, W, Y, Z, AA, BB, DD, EE, FF, II, JJ, NN, OO, PP, UU, VV, XX, YY, ZZ, AAA, BBB, and DDD as the facility failed to: Promote growth and dignity, ensure safeguards were in place for restraints, ensure restrictions were not used for the convenience of staff, justify the use of prone restraints, maintain a record of restraints, and to monitor the side effects of psychotropic medications. 6. Please refer to W318, the Condition of Participation, Health Care Services for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no	W 102		

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W 102	Continued From page 6 longer at the facility) as the facility failed to ensure timely, effective, and appropriate nursing care and services.	W 102		
W 104	3.1-13(a) 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility's governing body failed to exercise general policy and operating direction over the facility to ensure policy and procedures were implemented to promote health and safety practices for Universal Precautions and infection control measures, to ensure no commingling of the clients' medications with staff medications, to ensure all outdated medications were destroyed and to ensure all medications at the facility were properly packaged, with an appropriate pharmacy label with the client's name, medication and dosage as well as visible expiration dates, and to ensure one man lifts were not conducted at the facility, to ensure precautions were taken with restraints and policies and procedures were implemented to prevent infections, for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 48 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD, EEE (a client that is no longer at the facility), and XXX.	W 104		

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W 104	Continued From page 7 Findings include: 1. On 10/21/13 from 1:00 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42 AM, and on 10/22/13 from 1:40 PM until 3:00 PM, observations were conducted inside Program Group #1 where clients C, D, K, and T chewed on stained and torn clothing protectors tied around their necks. During all three observation periods Facility Staff (FS) #17 stated the clothing protectors had holes, stains, and were "worn." Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on 10/25/13 at 2:40 PM was conducted. The QIDP/PD stated she was unaware clients C, D, K, and T had clothing protectors which had holes and that were stained. Observations were conducted at the facility in program group #1 for clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW on 10/21/13 from 1:00 PM until 5:50 PM, and on 10/22/13 from 5:45 AM until 8:42 AM. During these observation periods: -Client C sat in her recliner without reclining, sat in her wheelchair, and was picked up by the facility staff #17 in a one person lift to transfer her from the recliner to her wheelchair and back to her recliner chair. -Client D sat in her wheelchair, sat in a recliner, and was picked up by facility staff #31 and #17 two separate times each in a one person lift, and placed in her wheelchair by the staff to go to the dining room for the evening meal and to go to the dining room for her breakfast meal. -Clients C and D could not get up from their recliners or wheelchairs without staff assistance. During these observation periods clients C and D were not observed to reposition themselves	W 104		

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W 104	Continued From page 8 without staff assistance. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 8/30/13 quarterly physician's orders indicated client C had diagnoses of, but not limited to, Osteoporosis (brittle bones), Seizure Disorder, Kyphosis & Scoliosis (Curving of the Spine), Contractures, Pedal Edema (Swelling of the legs/feet), Major Scoliosis Predominately in the upper Lumbar Lower Thoracic Spine measuring 36 degrees with rotation, and Arthritis. Client C's 3/28/13 ISP (Individual Support Plan) indicated client C used a wheelchair for ambulation. Client C's 3/28/13 "Annual Nursing Assessment" did not indicate client C's current PT/OT evaluations. Client C's record indicated a 3/28/13 "Adaptive Skills Assessment" completed by the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) which indicated "Ambulation Assistive Devices. [Client C] has a personal, adaptive, manual wheelchair. [Client C] does not gainfully propel her own wheelchair and requires maximum assistance from staff for movement. Her bilateral upper extremities are limited in shoulder flexion and abduction...She is unable to sit unsupported and no longer possesses the ability to perform standing transfers." Client C's undated "Functional Mobility Evaluation" completed by a Physical Therapist indicated client C used a walker and a standard manual wheelchair and that client C was a two person transfer. Client D's record was reviewed on 10/23/13 at 9:45 AM. Client D's 8/30/13 quarterly physician's orders indicated client D had diagnoses of, but not limited to, Osteoporosis, Cerebral Palsy, Club Feet, Visually Impaired due to Retinopathy of	W 104		

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W 104	Continued From page 9 Prematurity (blind), spastic Quadriplegia, Neuromuscular Scoliosis, Lumbar Spinal Fusion, Incontinence of Bowel and Bladder, Aspiration Precautions, and G Tube Placement. Client D's 5/28/13 ISP indicated client D was non-ambulatory. Client D's 5/28/13 "Annual Nursing Assessment" indicated client D was non-ambulatory, non weight bearing, and used an "Adaptive wheelchair for transport." Client D's record did not indicate she was a two person transfer. On 10/23/13 at 2:40pm, a review of clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW's Program Group #1 information book did not indicate how staff were to assist to transfer clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW. Interview with the D.O.N. (Director of Nursing) conducted on 10/25/13 at 10:15am, indicated the facility staff were to have a minimum of two (2) facility staff to transfer clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW from their recliners to their wheel chairs and from their wheelchairs back to their recliners. Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on 10/25/13 at 2:40 PM was conducted. The QIDP/PD stated the facility staff were to use a two (2) person transfer for "all clients" and a three person lift to transfer client E. The QIDP/PD stated "no" client in the facility should be a one person lift to transfer the client safely. 2. On 10/25/13 at 11 AM while doing an inspection of the medication cart at the facility in the nursing office, a medium sized crate was sitting on the desk. Below the crate was a two	W 104		

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W 104	Continued From page 10 drawer metal cabinet. The bottom drawer to the metal filing cabinet was opened. QMA #2 stated while picking up the crate of medication on the top of the desk, "Oh, this is outdated medications." QMA #2 looked in the bottom drawer and said "I have no idea where those came from" and "I think that might be staff's stuff." QMA #2 was asked, "What about the ones that have client names on them?" and the QMA stated, "Oh, I don't know about that" and walked out of the room with the crate of medications under her arm. After a few minutes QMA #2 came back into the nursing office and was asked what happens to the medications that are discontinued or expired. The QMA stated, "Oh, I destroy them." When asked why the medications in the filing cabinet were not destroyed, the QMA stated, "If they are expired I should have destroyed them. I don't know why they weren't." The QMA indicated she was the only one that destroyed expired medications and/or medications that were discontinued. On 10/25/13 at 11 AM while doing an inspection of the medication cart in the nursing office, the following was found in a metal filing cabinet in the nursing office: __A zip lock baggy with 17 white pills and Zovirax (an antiviral drug) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 30 brown pills and Singulair (a medication used to treat Asthma) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with over 200 white pills and Tylenol 325 written in black marker on the outside of the baggy. No expiration date was found on the	W 104		

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W 104	Continued From page 11 baggy. __A zip lock baggy with 24 white pills and Dallergy (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A bottle of Midol Complete with 15 pills inside. __A zip lock baggy with 15 blue pills and Tylenol PM written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 4 small white pills and 3 larger light tan colored pills and Allegra (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 small yellow pills and "allergy" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 23 white pills and "400 mg (milligrams) Motrin 600 mg" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 pink pills and over 100 pink and white capsules and Benadryl (an antihistamine) written in black marker on the outside of the baggy. __A zip lock baggy with 12 brown and tan capsules and Loperamide written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A box of over the counter AZO Urinary Pain Relief. __A box of over the counter Mucinex 1200 mg tablets for decongestant. No expiration date was found on the box. __A bottle of Maalox chewable tablets. No expiration date was found on the bottle	W 104		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 104	Continued From page 12 Clients' medications mixed in with the bags of medications not dispensed from the pharmacy were: __A card of Loratadine (an antihistamine) pills for client EEE who was no longer a client at the facility. No expiration date was found on the card. __A zip lock baggy with a pharmacy label of PRN (as needed) medication for client NN of Sudogest (a decongestant). There were 10 pills in the bag. The bag was labeled as being dispensed 8/31/12, but no expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was found on the baggy. __An Epipen (for an allergic reaction) for client V expired 12/2012. __A box of 2 Epipens for a client that was no longer at the facility. The box indicated the medication expired 12/2012. __15 white pills were randomly laying at the bottom of the box, not in a baggy. All of the above mentioned medications, along with client II's and V's Epipens, client II's Loperamide and client NN's Sudogest and client EEE's Loratadine were mixed in with all of the bags of pills in various colors, sizes and shapes with no expiration dates, not in the original store packaging and/or with a pharmacy label with clients' names and dosages. During interview with the ADON (Assistant Director of Nursing) and the Nurse Consultant on	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 13 10/25/13 at 1 PM, the ADON indicated the medications in the filing cabinet in the nursing office were for the staff. The ADON stated, "The Tylenol was mine. I had a big bottle of it at home so I just dumped some in a baggy and brought it here for the staff." When asked if that was standard of practice to have medications lying around in a drawer, not in their original packaging, no pharmacy labels and no expiration dates, the ADON indicated, "But those were for the staff." When asked what about the ones that were labeled for the clients, the ADON stated, "Those must have gotten mixed in there by mistake. They shouldn't have been in there. When is it wrong for staff to have medication here if they need it.?" The nurse consultant indicated all medications for the clients were to be packaged by the pharmacist and properly labeled. The nurse consultant indicated all outdated and discontinued medications should be disposed of immediately, the staff were not to keep/store medications at the facility and the staff were to keep all personal medications with their possessions while working and not intermingled with the clients' medications. The ADON indicated the facility did not have a policy in regard to staff keeping medications at the facility and/or for the destruction of outdated or discontinued client medications. 3. On 10/21/13 at 4:30 PM at the facility in activity room group #2, staff #57 and staff #44 picked client F up from his recliner using a 2 person lift and placed client F into his wheelchair. Staff #57 took client F to the bathroom to change his brief. Staff #57 and staff #44 again did a 2 person lift and placed client F on the changing table in the bathroom. Staff #44 returned to the activity room and staff #57 changed client F. After	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 14 changing client F, staff #57 picked client F up by himself and using a one person lift, staff #57 picked client F up from the changing table and placed client F back into his wheel chair. Staff #57 stated, "He is usually a two person lift, but it was just easier and quicker if I did it myself." At 10/22/13 at 4:35 PM in activity room group #2, staff #35 performed a one person lift and picked client FF up from his recliner and placed client FF in the wheelchair. Staff #35 indicated client FF was not a one person lift and there was no one else to help him at the time. Staff #35 indicated he had lifted client FF by himself several times. Staff #35 indicated the staff that were comfortable doing one person lifts would do them. Staff #35 stated, "I think if they weigh 90 pounds or less we can lift them." When asked if client FF was 90 pounds or less, staff #35 stated, "No, I don't know." Review of the undated Nursing Policy and Procedures "Transfer Activities" on 10/22/13 at 1 PM indicated "All evaluations shall be mindful of current guidelines recognizing that any client weighing over 99 pounds to be considered a two person transfer candidate. Those clients who have been identified through assessment or through physician's orders to require use of a sling for assisted transfers will be identified on their physician's orders and reflected on the DST (Developmental Skills Technician) treatment sheets. Professional Therapy recommendations in concurrence with staff evaluation may further determine that an individual resident may be best served as a single person transfer.... All clients will be assessed upon admission, annually and quarterly by Occupational and Physical Therapy Professionals to determine the most effective	W 104		

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W 104	Continued From page 15 method to safely and efficiently transfer clients. The assessments shall be submitted to the Interdisciplinary Team to be further integrated into each resident's Individual Program Plan. These recommendations shall indicate the methods in which a resident is to be transferred, the number of staff that may be required to perform the desired transfers and any additional instructions that may apply to an individual client." Interview with staff #28 on 10/23/13 at 11:20 AM indicated she did one person lifts on client PP because he was little. Staff #28 indicated everyone else was or should be a 2 person lift. Interview with the DON (Director of Nurses) on 10/22/13 at 5:30 PM stated she did not approve of the one man lifts being done and "I would not do a one man lift myself and I sure wouldn't ask the staff to do it either but I'm told that is the way it's done here." Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated client X's, PP's and RR's IHPs (Individual Habilitation Plans) included the use of one man lifts. Interview with Administrator (ADM) #1 on 10/23/13 at 2 PM indicated the facility did not have a mechanical lift. ADM #1 stated, "I think you can do more damage with a mechanical lift than the way we do it." 4. During observations at the facility on 10/22/13 at 2 PM, client E was sitting in her wheel chair in a semi reclining position with her upper body leaning to the right. Client E's feet were extended in front of her with both feet rotated in a fixed	W 104		

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W 104	Continued From page 16 outward position. Client E's left foot was in a fracture boot and on a pillow. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. An 8/16/13 BDDS (Bureau of Developmental Disabilities Services) report indicated "On August 15th at approximately 5:40 AM, staff entered [client E's] bedroom to prep and assist [client E] with getting for her daily routine (sic). Staff stated that they removed [client E's] covers and touched her foot. Upon touching her foot, staff stated that [client E] cried out. Reporting staff further stated that they then removed her sock in an attempt to determine what caused [client E] to cry out. [Client E] then cried out in a louder tone. Staff then stated that they left [client E] in her bed and alerted nursing personnel of the situation for further assessment. The following nursing assessment is as follows: [Client E's] left foot was noted with full range of motion capabilities. Under normal conditions, [client E's] tone and overall range of motion capabilities are minimal. Additionally, slight edema was noted to [client E's] left foot and ankle area with less than 3 seconds for cap (capillary) refill. Plan to resolve: Nursing placed a splint/rigid boot on [client E's] left foot/ankle and contacted her PCP (Primary Care Physician) for instructions. New orders were obtained to send [client E] for x-rays of [client E's] left foot and ankle area...." Client E was taken for x-rays at a nearby facility at 8 AM and returned to the facility at 10:20 AM. At 12 PM, client E's PCP called the facility with new orders for client E to "immediately" see an orthopedic surgical doctor due to x-ray results "regarding left leg fractures." The report indicated the following x-ray results: __"Acute, minimally displaced spiral fracture of the distal tibia diaphysis."	W 104		

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W 104	Continued From page 17 __"Acute, non-displaced distal fibular diaphyseal (pertaining to or affecting the shaft of a long bone) fracture." __"Diffuse bone demineralization." __"Ped planus (flat foot) deformity of the foot." The 8/16/13 BDDS report indicated client E was taken to a local hospital and another set of X-rays was completed at [name of hospital]. The findings of the x-rays were as follows: __"Non-displaced spiral fracture of the distal tibial diaphysis (the main or midsection shaft of a long bone)." __"Non-displaced spiral Weber type C fracture of the adjacent fibula with no significant joint space widening." __"Extensive bony demineralization without convincing evidence for acute fracture." The report indicated "Immediate Action Taken: New orders from [name of hospital] were to apply ice for swelling, provide Tylenol 500 mg (milligrams) Q (every) 4 hours for pain and follow up with an orthopedic consult within 6 days. On August 16th, nursing personnel scheduled an appointment with [name of doctor] for August 21st at 10:15 AM.... [Client E] has also been scheduled for a bone density diagnostic on August 30th." The 8/16/13 BDDS report indicated the facility has implemented the following measures in response to the current x-ray findings: __"[Client E's] wheelchair foot box has been widened approximately 3 additional inches to facilitate additional protection when [client E] is up in her wheelchair." __"[Client E's] recliner has been modified, in height, to allow for smooth transitioning during three man-lifting."	W 104		

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W 104	Continued From page 18 Review of client E's record on 10/22/13 at 2 PM indicated diagnoses of, but not limited to, Epilepsy, Cerebral Palsy with spastic quadriparesis (arms and legs) with associated hyperflexia (the over flexing/bending of a limb), Congenital left hip dysplasia, Bilateral Pulmonary Emboli (blood clots), incontinence of bowel and bladder, risk of aspiration, Osteopenia (low bone mineral density), fractured left distal femur and Osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density that leads to an increased risk of fracture). Client E's record indicated client E was non verbal and non-ambulatory. Client E used an adaptive wheelchair for transportation. __Client E's Radiology report of 5/21/12 indicated "Evidence of fracture which appears acute over the distal femur at the level of the femoral condyles (round projection at the end of a long bone) anterior rotation or displacement of the distal femoral metaphysis (the wide part at the end of a long bone) in relation to the diaphysis is present. Diffuse bone osteopenia (reduced bone mass) with postoperative changes stable over the proximal left femur and changes of chronic hip dysplasia." __Client E's Radiology Report of 7/16/12 indicated "Severe osteoporosis, Distal femoral fracture appears healing, could be old injury..." __Client E's 8/2/13 physician's order indicated "Send [client E] out via ambulance for stat (immediate) x-ray of her left upper leg and hip at [name of facility]." __Client E's Adaptive Skills Assessment of 10/22/12 indicated client E was a non-ambulatory female "who uses a tilt in space wheelchair with custom molded inserts pelvic stabilizer and shoe	W 104		

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W 104	Continued From page 19 holders. She can make eye contact and can turn her head. [Client E] has minimal active movement of the extremities with no attempts to roll. She can flex and rotate her head when in supine. [Client E] has decreased bilateral hip flexion in extension and rotation, ankle inversion, decreased bilateral shoulder flexion, abduction and rotation, wrist extension and forearm supination (a kind of rotation). [Client E] displays decreased muscle tone and strength in her neck and trunk. She displays decreased muscle tone in all extremities with poor muscle strength. [Client E] requires total support in all positions. [Client E] presents with a forward flexed head tilted to the right, neuromuscular scoliosis." __Client E's Osteoporosis Risk Plan of 11/7/12 indicated client E was at "Risk of injury during self repositioning, transferring from bed to chair or vice versa.... Protect client using sling to transfer from bed to wheelchair, wheelchair to recliner.... Monitor for any discomfort/pain. Use sling for all transfers...." During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM, the QIDP stated, client E had a history of breaks and "brittle bones." The QIDP indicated after client E's injury the staff were to put a pillow under client E's foot. The QIDP indicated maintenance had extended the foot box on client E's wheelchair to give her more room for her feet. The QIDP indicated client E's wheelchair had not been reassessed by the company used to repair the client's wheelchairs. Interview with maintenance staff #1 on 10/23/13 at 2 PM stated he did most of the adjustments to the wheelchairs "Like fix the breaks and stuff." Maintenance staff #1 indicated he had extended	W 104		

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W 104	Continued From page 20 client E's footbox after her fracture to try to give client E more room for her feet. Maintenance staff #1 indicated he was not qualified to do the wheelchair assessments to ensure the client was fitted properly in their wheelchair. 5. The facility's Behavior Management Policy dated 4/3/2006 with a revision date of 8/20/13 was reviewed on 10/30/13 at 10:02 A.M. The policy indicated "It is the position of Arcadia Developmental Center in con-junction with State and Federal regulations, to establish a progression of techniques, implementation of these techniques and functionally appropriate approaches to manage inappropriate client behavior. These techniques and approaches shall be designed to include positive approaches. Programs will be designed to establish techniques that progress from least restrictive to the most restrictive measures necessary. This facility will formulate the necessary behavioral guidelines to define the need for interventions. these (sic) guidelines shall be composed through documentation, review of documented events via committee, creation of needed intervention through behavioral programming or alternate means, implementation of the least restrictive methods for identified maladaptive behaviors, tracking of the effectiveness of the methods chosen and continued review or adaptations as warranted by altered behavior. These guidelines shall be implemented as a means of attempting to prevent injury prior to and/or during behavioral episodes through the application of intervention designed for individual clients. Interventions shall include review of programmatic needs to address areas of anti-social behavior, client-to-client interaction, emotional needs and other areas of	W 104		

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W 104	Continued From page 21 need identified through committee review." The policy included the following physical intervention techniques (restraints). BEARHUG: placing your arms around the client and immobilizing their arms at their sides. This is secured by grasping one of your wrists with your other hand above their elbows. Attempt to hold them until calm, up to 15 minutes in duration. However, if necessary, move to the basket hold immediately if the targeted behaviors continue. BASKETHOLD: moving from bear hug by grasping the individual's wrists and crossing them over their chest; hold this position until they are calm. This position may be employed for up to 15 minutes in duration. However, if necessary, move to the half-mat procedure immediately if needed. HALF MAT: moving from a basket hold, by pushing forward and then stepping back with one foot and placing the client slightly off balance. Place the client on the floor in a sitting position while remaining in a basket hold position. Tuck your head behind their shoulder to prevent injury from the client's head and lean them forward with your own body. hold (sic) this position until they are calm for up to 15 minutes. FULL MAT: moving from a half-mat position by rolling the individual to the side into a prone position face down. Staff should then straddle the client by placing their knees at the client's hips and over their elbows. Their hands should be placed palms down to prevent injury and scratching. Secure their head if needed to further prevent head banging or other injury to their head. Hold the client until they are calm, but for no longer than 15 minutes. This procedure will be implemented in response to emergent behavior and intervention to prevent injury from displayed behaviors. Client's Individualized behavior programs may contain revised physical	W 104		

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W 104	Continued From page 22 interventions as guided by medical, physical or other unusual circumstances/characteristics. Review of individual programs will reveal designated techniques to those identified individuals. "In addition, measures to maintain each client's physical, mental and psychosocial well being shall be ensured through emergency intervention procedures as outlined and determined by the facility's governing body...." Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client A's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP included the use of the following physical interventions (restraints) Bearhug, Basket hold, Half Mat and Full Mat. A review of the 24 hour turn around report was conducted on 11/4/13 at 12:05 P.M. The 11/2/13 report for 2nd shift indicated for client UU "Visitor asked to leave." Client UU's record was reviewed on 11/4/13 at 11:40 A.M. Client UU's record indicated he was 24 years of age, and his mother was his Health Care Representative (HCR). Client UU's record included a consent for visitation signed by his HCR on 12/4/12 indicating "Anyone can visit." A review of the nursing notes for 11/2/13 indicated "Contacted family to ask if [DCS #95] was allowed to visit. Was unable to contact mom. Was able to contact [name of dad] who said he was unaware of [DCS #95] visiting this client. He	W 104		

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W 104	Continued From page 23 stated emphatically he did not want [DCS #95] visiting. I (RN #1) confronted [DCS #95] who became angry and stated several times 'I have permission, they gave me permission.' When I pressed about who gave permission he stated '[name of Administrator] gave me permission.' I explained to him several times that when a parent says 'no to his visitation it has to be honored.' He argued several times that he has permission then left angry. Client (client UU) was seen 'pulling away' from [DCS #95] during the visit by one staff member. Client is presently in recreation room walking around. Does not appear stressed. Exhibiting usual behavior of sticking fingers in mouth and wandering. Administrator and ADON notified." A review of the Visitor's Book was completed on 11/4/13 at 2:40 P.M. the Visitor's Book indicated DCS #95 had visited client UU on 11/2/13, 9/28 (no year given), 11/1/12, 10/27/12, 9/20/12, 8/18/12 and 5/12/12. On 9/20/12, 8/18/12, 5/12/12 and 9/28 DCS #95 took client UU out of the facility. CI (confidential interview) "The person (DCS #95) was here when I got here on Saturday. The [LPN #2] had never seen him before. She asked my opinion. I told her 'He creeps me out.' [Client UU] acted fine after he (DCS #95) left, he fell asleep in the recreation room. He is creepy and weird. He used to work here before. I never saw him be violent with the clients. Sometimes [client UU] would act different around him, wouldn't want to go with him and just stay or drop to the floor. I don't know of any policy about former staff not being able to visit." CI interview "His name is [DCS #95], I don't know	W 104		

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W 104	Continued From page 24 him at all except he used to work here. He gives off a different vibe. I told [LPN #2]. I have heard he comes to visit [client UU] but I have never seen him here before. To me it seemed like he wasn't all there. He gives me a weird feeling I do not like, and [client UU] acted different after his visit. He had more behaviors than usual. If he does come to see him (client UU) I think he needs to be supervised." CI interview "I was here last Saturday. We were in the dining room for lunch. He (DCS #95) walked in and gave him (client UU) a [name of snack cake] for his birthday I guess. He then was cleaning him (client UU) up and I think he (DCS #95) changed his (client UU's) clothing, because he was wearing different outfit the next time I saw him. He worked here before. He is weird around [client UU]. [Client UU] now acts scared if you move too quickly in front of him, like he thinks you are going to hit him. He never used to act like that. His behaviors increase after [DCS #95] visits him. I think it was the first time in a few months he has come to visit him." CI interview "Yeah, he used to work here. [Client UU] does act different after visits, but I think he is over stimulated from being able to go out and do things." DCS #95's employee record was reviewed on 11/4/13 at 1:30 P.M. It indicated DCS #95 had been terminated from employment at Arcadia on 8/23/12. DCS #95 had the following discipline notes: 8/22/12 "Argued with QMA passing medication. Medications were late as result. Poor attitude towards co-workers, lack of concern for timely care for clients," 7/23/12 "Kicked open program room door, hitting client with door (client	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 104	Continued From page 25 A). Asked to write a statement for the investigation, sought out other staff and department heads. Did not follow policy. Suspended 2 days," 4/10/12 "Not changing clients," 3/14/12 "Attitude with dietary staff and group 5 staff," 2/24/12 for 2/10/12 "Left program room, leaving clients alone," 2/8/12 "Not shaving clients," and 2/1/12 "Allowing clients to go to/from program room without their shoes and socks on." A review of DCS #95's unemployment judgement paperwork indicated "...on 8/22/12 near end of shift I was approached in the nurses office. [DCS #95] brought a diaper full of feces placing it into my face nearly touching my nose. I answered his question 'No it's not C-diff (bacterial infection)." As he left he stated 'You don't know anything! I'll call [name of unknown person]!" In the hallway [unknown staff] was approached with the feces and [DCS #95] was instructed to not do this again and to properly dispose of the feces diaper. The next night I was passing med's (medication) I have a 1 hour window to get these med's passed while the kids are still up and awake in their group activity rooms (till 7:45 P.M.). At 7:30 P.M. I noticed group 5 [DCS #95's] group to be empty of children...When [DCS #95] was present at the med cart I asked him why he put group 5 to bed before they had their med's? I then showed him what time it was via the phone I carry. He said 'I go by the other clock and I will always go by that clock.' Then as I tried to finish up the residents left [DCS #95] kept telling me over and over that he was right. I tried to get him to stop trying to hash this out now since med's needed given on time. He would not. So that night I went to the kid's rooms and awakened them to take med's late. While I attempted this [DCS #95] had the supervisor paging me to her office and I also had to stop to being paged (sic) to the phone to speak	W 104		

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W 104	Continued From page 26 to the DON. All of this further delayed resident's getting med's on time." This note was signed and dated by RN #2. Administrative Staff (AS) #93 was interviewed on 11/4/13 at 1:25 P.M. AS #93 stated, "We don't have policy on visitation for past employees. I think it would sometimes depend on why they left, or what they did." The Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed on 11/4/13 at 1:15 P.M. the PD/QIDP stated, "I don't recall a specific policy on visitation. I don't remember why he (DCS #95) doesn't work here anymore. If he was terminated no it would not be a good idea for him to visit." The Administrator (ADM) was interviewed on 11/4/13 at 3:22 P.M. When asked about DCS #95 the ADM stated, "When he left it wasn't for abuse. We got mom's (client UU's) permission. She gave him permission. Last time he took him out [client UU] was kind of angry, so mom asked if he visits it should be here, not take him out. We wanted to monitor his visits and get back with mom. [DCS #95] did not let us know he was coming on Saturday. [Client UU's] parents are divorced and I could see his dad not wanting another male in his life. He probably does need a guardian, but parents are still involved, and grandmother, but she doesn't feel she is up to being guardian at her age. The parents do not talk with each other." The ADM indicated she had been unable to contact client UU's mom since the 11/2/13 visit had occurred. The ADM stated, "No, we do not have a policy on visitation for former employees." 3.1-13(s)	W 104		

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W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review, observation, and interview, the Condition of Participation: Client Protections was not met. The facility neglected to implement policies and procedures to ensure the rights of 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD). This noncompliance resulted in IMMEDIATE JEOPARDY. A Situation of IMMEDIATE JEOPARDY was identified on and had existed since October 23, 2013 at 3:32 P.M. as a result of the facility failing to implement policies and procedures to ensure the rights of all clients to be free from/prevent abuse/neglect and the potential for continued abuse/neglect. The facility's Administrator, Assistant Administrator, and Program Director/QIDP (Qualified Intellectual Disabilities Professional) were notified of the IMMEDIATE JEOPARDY on 10/24/13 at 11:05 A.M. and the facility was informed to submit a plan of corrective action to remove the IMMEDIATE JEOPARDY. On 10/24/13 at 9:00 P.M., the facility submitted the following plan to remove the IMMEDIATE JEOPARDY:	W 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 122	Continued From page 28 "The facility failed to implement a reproducible system to prevent abuse, neglect, mistreatment, or injury of unknown origin. 1) The facility has created a reproducible system to prevent abuse, neglect, mistreatment and injuries of unknown origin. The Interdisciplinary Team convened to discuss and contribute professional input in the development of potential strategies for the proposed policy and system of correction. In an effort to establish an efficient system to detect, investigate, report, review and implement follow up strategies, the facility has created a protocol that will mirror elements of facility abuse and neglect policy. Incident reporting and management will be investigated and delivered pursuant to DDRS policy management (BQIS 460 0301 008). Incidents reported to BQIS may include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual, but is not limited to guidelines set forth in the DDRS policy. The facility Incident and Accident form has been modified to include: 1) Evidence, 2) body buddy, 3) documentation for witnessed/not witnessed, 4) investigation form provide to witness/reporting staff, 5) baseline, deviation from baseline and 6) supporting documentation. All nursing personnel will be educated on the new form beginning 10/25/2013 with immediate implementation. All staff will be re-educated regarding client assessment, documentation using body buddies, the process of immediate notification for nursing personnel for assessment, their requirement to immediately identify whether they have directly witnessed a reportable deviation and their immediate responsibility to complete an	W 122		

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W 122	Continued From page 29 investigation form that will be provided to them by nursing personnel. Baseline skin assessments will be completed for all clients as an assessment tool for nursing and direct support staff. Baseline skin assessments will include, but are not limited to, existing scars, areas of discoloration, marks or other physical characteristics that are pre-existing and normal in appearance for each client. Once completed, these documents will be made available to all staff, located within their program books to allow for a continued reference point and nursing when completing an assessment. Starting on October 25th, the Social Services designee will be responsible for fielding, coordinating, investigating, reporting and completing follow up/proactive measures for all incidents, accidents and/or injuries. The Social Services designee will report all accidents and incidents to BDDS, BQIS, ISDH, and other agencies with documented proof that will be attached to all accident and incident forms. As a measure to ensure continuity among direct care services and nursing personnel, all shift supervisors will attend information exchange sessions completed between each shift. Additionally, midnight nursing personnel will document current non-baseline areas and/or injuries on the daily staffing sheet to allow for continued, current information exchange regarding noted areas of deviation for each client. To protect client from further injuries due to SIB 1) Prevention of further injuries of SIB Nursing completed an assessment for the identified client experiencing episodes of SIB.	W 122		

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W 122	Continued From page 30 Nursing personnel completed assessment of the identified client, noting client presenting with signs and symptoms of sinus infection (guarding ear, lunging at nurse, attempting to bite assessing nurse) and left otitis media. The client was placed on antibiotic treatment and nursing assessment for tracking antibiotic treatment. This client's BSP was modified to include measures to engage the client should episodes of SIB be experienced. The BSP was in-serviced on 10/25/2013, reflected by staff signatures regarding the changes to the BSP. The client's client information data sheet was also modified and inserviced regarding revisions for pain indicators. This client has also been scheduled for a psychiatric appointment dated, 10/29/2013 for psychotropic medication review, medical changes and episodes of agitation. This client has also been scheduled for an ophthalmology appointment as a proactive measure for eye health (history of retinal detachment) to ensure that the client ' s eye health is or does not contribute to the episodes of SIB. In the future, should a client exhibit SIB, nursing will assess for any medical condition. Additionally, if no medical condition is identified, the behaviorist will be consulted for alternative interventions. If the interventions are not documented as effective the client will be scheduled for a psychiatric appointment. To medically assess and implement proactive measures to protect client with history of fractures and osteoporosis. 4) Proactive measures to protect client with history of fractures Action plan for client with history of fractures and	W 122		

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W 122	Continued From page 31 diagnosed osteoporosis will include the following measures: 1) consult with PCP for Vitamin D level and supplement, 2) consult with PCP to include bone density testing yearly, 3) consult with dietician for possible increase in calcium intake through diet, 4) Continue current oral calcium supplement, 5) continue daily injection of Forteo as ordered, 6) continue strategy for alternate seating using wheeled recliner for all in facility transport to decrease the number of necessary transfers needed and to facilitate sliding transfer, 7) use of sling or turn sheet during all personal care, 8) all necessary changing will occur using her bed to assist with support and safety during care, 9) continue use of sling for all transfers, 10) consult with physician for possible order for wheelchair use for out-of-facility transport only, Additionally, the three-man lifting protocol has been modified to include pictorial steps to provide staff with specific measures to appropriately, effectively and safely move the client using prescribed sling assist. The protocol has been re-inserviced for all staff and continues to include any support staff that assists with three-man lifting. Nursing services will continue to monitor and assist with all bathing opportunities to ensure safety and appropriate handling of the affected foot. Facility failed to implement plan for weight loss: 1) On October 24th at approximately 6:30 pm,	W 122		

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W 122	Continued From page 32 The IDT assembled to discuss a plan of action regarding the identified client, weight loss and strategies to address these issues. Dr. [name], the identified client's PCP was contacted and came to this facility to assess the identified client and then met with the team to discuss a revised plan of action. The team discussed previous strategies that were formally or informally implemented in an effort to determine the antecedent for the identified client ' s weight loss. These strategies include, but are not limited to: 1) Previous review and attempt to correlate implemented psychotropic medications did not indicate a clear link to weight loss. A) Admitting weight 147.6 with documented weight loss of 6 pounds from 05/13/2013 to June 1st 140.6 pounds. B) June 1st weight 140.6 through July 1st 135.2 (Prozac 20mg ordered 5/28/2013 and implemented on 6/12/2013 after all approvals obtained from HRC and guardian) C) July 1st 135.2 through August 1st 133 D) August 1st 133 through September 1st 131.2 (Klonopin 0.5mg BID x14 days initiated on 8/2/2013) E) September 1st 131.2 through October 1st 118.2 (Trazadone xr 150mg for insomnia added 9/19/2013) An action plan for the identified client includes: 1) DC Prozac 20mg,	W 122		

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W 122	Continued From page 33 2) If any meal is refused, offer preferred breakfast foods during meals and snack time opportunities, 3) continue to offer preferred high calorie snacks between/with all meals, 4) discontinue prescribed Trazadone XR 150 mg at HS, 5) implement Paxil 20 mg daily, Encourage use of wheelchair for long distances to reduce expenditure of calories pending increasing weight gain, 6) appointment scheduled with psychiatrist for medication review and potential side effects of weight loss scheduled for 10/29/2013, 7) implement weekly weight for tracking, 8) consult with dietician in one week. In the future, those clients identified with a weight loss/gain of 2% in a seven day period will result in physician notification or weight gain/loss greater than 5% in a 30 day period will result in physician notification." The 10/24/13 facility plan to remove the IMMEDIATE JEOPARDY was reviewed on 10/25/13 at 9:07 A.M.. The IMMEDIATE JEOPARDY was not removed due to the 10/24/13 plan to remove not implementing a facility system that addressed the prevention of abuse, neglect, mistreatment, and to investigate injuries of unknown origin. On 10/29/13 at 9:00 A.M., the facility submitted the following plan to remove the IMMEDIATE JEOPARDY: "In the future, the administrator will continue to receive reports of all incidents as reported to the nursing staff. The facility Incident and Accident form has been modified to include: 1) Evidence 2) Body Buddy (card that diagrams area of injury	W 122		

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W 122	Continued From page 34 to client) 3) Documentation for witnessed/not witnessed 4) Investigation form provide to witness/reporting staff 5) Supporting documentation All nursing personnel has been educated on the new form which began on 10/25/2013 with immediate implementation. All staff were re-educated regarding client assessment, documentation using body buddies, the process of immediate notification for nursing personnel for assessment, their requirement to immediately identify whether they have directly witnessed a reportable deviation and their immediate responsibility to complete an investigation form that will be provided to them by nursing personnel. As a measure to ensure continuity among direct care services and nursing personnel, all shift supervisors will attend information exchange sessions completed between each shift. Additionally, midnight nursing personnel will document injuries on the daily staffing sheet to allow for continued, current information exchange regarding noted areas of deviation for each client. To perform a double safeguard for thoroughness and accuracy of all incidents, reportable or documented, an independent review will be completed by an incident report auditor at least weekly for 90 days, contracted through [name] and Company. The auditor will perform independent reviews of all incident and accidents with autonomy. The facility has also created an incident reporting (IR) position that will function as the exclusive position for fielding, coordinating, investigating, reporting and completing follow up/proactive measures for all incidents, accidents and/or injuries. Pending training from outside	W 122		

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W 122	Continued From page 35 resources, the IR will develop a monitoring, investigating, reporting and education system for all incidents and accidents." The 10/29/13 facility plan to remove the IMMEDIATE JEOPARDY was reviewed on 10/30/13 at 11:12 A.M.. The IMMEDIATE JEOPARDY was not removed due to the 10/29/13 plan not addressing a facility system that prevented of abuse, neglect, mistreatment, and to report and investigate injuries of unknown origin. Findings include: 1. Please refer to W126 as the facility failed to: Teach and implement active treatment schedules about economics of money for 4 of 10 sampled (clients C, D, E, and G) and 9 additional clients (clients K, T, CC, HH, KK, LL, QQ, RR, and WW). 2. Please refer to W137 as the facility failed to: Provide unimpeded access to an electronic tablet (computer) for 1 of 10 sampled clients (client B). 3. Please refer to W149 as the facility neglected to: Implement its Abuse/Neglect policy/procedures which prohibited abuse/neglect of clients by failing to: A. Ensure alleged abuse was reported to the administrator and BDDS (Bureau of Developmental Disabilities Services) and investigated within a reproducible system with client safeguards in place to ensure clients were free from abuse and neglect and the potential for continued abuse and neglect which affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC,	W 122		

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W 122	Continued From page 36 DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD) living at the facility; B. Protect 1 of 10 sampled clients (K), and 2 of 46 additional clients (clients AA and HH) from further injuries from Self-Injurious Behavior; C. Implement proactive measures (programming/staff training/assessments) to protect 1 of 10 sampled clients (client E) with a fracture from further injury/pain; D. Ensure 2 of 10 sampled clients (G and H) and 3 additional clients (clients AA, HH and SS), injuries of unknown origin were reported to the administrator and BDDS and the causes thoroughly investigated; E. Ensure measures were in place to address weight loss for 1 of 46 additional clients (client DDD). F. Report and investigate client to client physical aggression resulting in injuries for 2 of 10 sampled clients (clients A and G) and 1 additional client (SS). 4. Please refer to W153 as the facility failed to: Ensure alleged abuse and injuries of unknown origin were reported to the administrator and BDDS (Bureau of Developmental Disabilities Services) which affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD) living at the facility. 5. Please refer to W154 as the facility failed to: Thoroughly investigate alleged abuse incidents and investigate injuries of unknown origin which affected 10 of 10 sampled clients (clients A, B, C,	W 122		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 122	Continued From page 37 D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD living at the facility. 6. Please refer to W155 as the facility to: Immediately suspend staff after an allegation of staff to client abuse was reported (client XX). 7. Please refer to W157 as the facility failed to: Implement sufficient corrective action to protect clients from the potential of continued client physical aggression resulting in injuries and to prevent continued unknown injuries to client K and client HH's continued SIB (Self Injurious Behaviors) for 16 of 16 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 3 additional clients (clients K, GG, and HH).	W 122		
W 126	3.1-28(a) 483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to teach and implement active treatment schedules about economics of money for 4 of 10 sampled (clients C, D, E, and G) and 9 additional clients (clients K, T, CC, HH, KK, LL, QQ, RR,	W 126		

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	15G580		C 11/06/2013

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W 126	Continued From page 38 and WW). Findings include: 1. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated an objective/goal to take a penny from staff when shown with another coin. 2. Client D's 5/28/13 IHP indicated she was blind and did not indicate a money recognition goal/objective. Client D's 5/28/13 IHP Assessment indicated she did not recognize the following: coins, penny, nickel, dime, quarter, dollar bills, putting money into a vending machine, where to obtain money, making purchases, and included client D "does not recognize coins, distinguish between coins and paper money, place money in a vending machine or display understanding for the concept of money or the need for money. Despite training to identify coins using touch." Client D's undated "(Program) Group 1 Daily Activity Schedule" did not indicate economics and/or money on the schedule and indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, sensory stim (stimulation). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity.	W 126		

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W 126	Continued From page 39 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure, communication, choice of activities, TV, parties if scheduled, movies, group activity, bathing, special events, outing if applicable, etc." An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated client D had her goals/objectives listed in her 5/28/13 ISP which did not include a money skills objective/goal. The QIDP/PD indicated client D did not recognize money and was blind. 3. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dis similar object, to select preferred DVD (movie), to respond to textured item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses as tolerated. 4. Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42	W 126		

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W 126	Continued From page 40 AM, on 10/24/13 from 8:30 AM until 9:45 AM, and on 10/24/13 from 3:25 PM until 4:00 PM, with clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW. During the observation periods clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were not taught or provided teaching/training for money skills. 5. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included an Individual Program Plan (IPP) dated 12/6/12. Client G's IPP did not include a plan to assist client G in learning money management skills. Clients C, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's undated "(Program) Group 1 Daily Activity Schedule" indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, Economics, sensory stim (stimulation). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity. 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure, communication, choice of activities, TV, parties if	W 126		

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W 126	Continued From page 41 scheduled, movies, group activity, bathing, special events, outing if applicable, etc." An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW should have received teaching and training during formal and informal opportunities to teach clients about currency and to identify coins and dollar bills. The QIDP/PD indicated money should have been used.	W 126		
W 137	3.1-6(a) 483.420(a)(12) 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. This STANDARD is not met as evidenced by: Based on observation, record review, and interview for 1 of 10 sampled clients (client B), the facility failed to provide unimpeded access to his electronic tablet. Findings include: During observations on 10/24/13 at 1:00 PM, client B walked down the hall to the social worker's office to obtain his electronic device with staff #48. The social worker did not answer his door and staff #48 walked with client B to find the social worker stating, "We have to find [social	W 137		

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W 137	Continued From page 42 worker]. He's the only one with access to your iPad (electronic device)." Client B's record was reviewed on 10/29/13 at 2:06 PM. There was no evidence of an identified need to lock his iPad, or a plan to gain access to client B's electronic device. The QIDP/(Qualified Intellectual Disabilities Professional)/Program Manager was interviewed on 10/29/13 at 3:30 PM. When asked about a plan for client B to access his electronic device, she stated, "I can't answer that," and indicated she would check into a plan. There was no additional information provided to indicate a plan was in place for client B to access his iPad.	W 137		
W 149	3.1-9(a) 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility neglected to ensure the rights of all clients by neglecting to: Implement its Abuse/Neglect policy/procedures which prohibited abuse/neglect of clients by failing to: 1. Ensure alleged abuse was reported to the administrator and BDDS (Bureau of Developmental Disabilities Services) and investigated within a reproducible system with client safeguards in place to ensure clients were free from abuse and neglect and the potential for abuse and neglect which affected 10 of 10	W 149		

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W 149	Continued From page 43 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD living at the facility; 2. Protect 1 of 10 sampled clients (K), and 2 of 46 additional clients (clients AA and HH) from further injuries from Self-Injurious Behavior; 3. Implement proactive measures (programming/staff training/assessments) to protect 1 of 10 sampled clients (client E) with a fracture from further injury/pain; 4. Ensure 2 of 10 sampled clients (A and G), and for 3 of 46 additional clients (client AA, HH and SS) injuries of unknown origin were reported to the administrator and BDDS and the causes thoroughly investigated; 5. Ensure measures were in place to address weight loss for 1 of 46 additional clients (client DDD). 6. Report and investigate client to client physical aggression resulting in injuries for 2 of 10 sampled clients (clients A and G) and 1 additional client (SS). 7. Failed to immediately suspend staff after an allegation of staff to client abuse was reported and failed to thoroughly investigate the allegation of staff to client abuse (client XX). Findings include: 1(a). Client W was interviewed on 10/22/13 at 10:55 A.M.. Client W stated, "[Direct Care Staff #12] slapped [client TT] on the bottom and yelled at the kids (clients)." When asked when this incident occurred, Client W stated, "Last week." CI (Confidential Interview) #1 was conducted. CI	W 149		

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W 149	Continued From page 44 #1 stated, "There are incidents of abuse that go on at the facility that are not reported." CI #1 further stated, "One incident happened last Friday (10/18/13). [Client W] stated (Direct Care Staff #12) had been hitting the kids (clients L and TT) on their buttocks and yelling at them. The Director of Nursing and Program Coordinator and [Nurse #7] came to the program room. The Program Coordinator paged [the Program Director] and [Administrator #1]. The Administrator played it down suggesting [client W] was making up the story to get out of group. No incident report was ever written and it (allegation of abuse) was never investigated. It's a culture here (at the facility) to not report abuse." The facility's Program Director was interviewed on 10/22/13 at 1:07 P.M. When asked if there was an allegation of abuse, an incident report, or investigation into a 10/18/13 incident involving clients L and TT being hit by Direct Care Staff #12, the Program Director stated, "No." The facility's Program Director approached this surveyor on 10/22/13 at 3:33 P.M. and stated she "misunderstood" what the surveyor had previously asked for on 10/22/13 at 1:07 P.M. The Program Director stated, "I have an incident (involving Direct Care Staff #12 hitting clients L and TT on the buttocks and yelling at them) that I investigated on the same day (10/18/13)." When asked for a copy of the incident report and investigation, the Program Director stated, "I don't have it typed up yet. I'll have it tomorrow morning." 1(b). CI (Confidential Interview) #1 was conducted. CI #1 stated, "Another incident	W 149		

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W 149	Continued From page 45 happened on September 27th (2013). [Direct Care Staff #101] alleged [Direct Care Staff #107] picked up [client Q] and "roughed her up" (shook client Q). She [Direct Care Staff #101] called the nursing staff to come and check out a big bruise on [client Q]. Nursing (Nurse #7) came down to the room and checked [client Q] out and found no bruise. This incident was never written down or investigated but [Direct Care Staff #107] was fired. [Direct Care Staff #36] knows about this." Client Q's record was reviewed on 10/22/13 at 11:56 A.M.. A review of a 9/27/13 nursing note indicated the following entry by Nurse #7: "No new skin discoloration." Program Director #1 was interviewed on 10/22/13 at 1:07 P.M.. When asked if there was an allegation of abuse, an incident report, or investigation into a 9/27/13 incident involving client Q roughed up (shaken) by Direct Care Staff #107, Program Director #1 stated, "No." The facility's records were reviewed on 10/22/13 at 1:31 P.M.. A review of Direct Care Staff #107's personnel file indicated his employment with the facility had been terminated. No date of termination was available in the record. Assistant Administrator #1 was interviewed on 10/22/13 at 1:57 P.M.. When asked why Direct Care Staff #107 was terminated, Assistant Administrator #1 stated, "We didn't like his work performance." Direct Care Staff #38 was interviewed on 10/22/13 at 2:00 P.M.. When asked if she had knowledge of a 9/27/13 incident involving Direct Care Staff #107 "roughing up" client Q, Direct	W 149		

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W 149	Continued From page 46 Care Staff #38 stated, "Yes." When asked what she did when she was made aware of the 9/27/13 incident involving Direct Care Staff #107 "roughing up" client Q, Direct Care Staff #38 stated, "I let [the Program Director] know about it." The facility's Program Director was interviewed on 10/22/13 at 2:23 P.M.. When asked again if there was any allegation of abuse, an incident report, or investigation of a 9/27/13 incident involving client Q being "roughed up" by Direct Care Staff #107, the Program Director stated, "No." This finding affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD because Direct Care Staff #107, Direct Care Staff #12, and Nurse #7 continued to work with all clients living at the facility. 2. On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes	W 149		

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W 149	Continued From page 47 were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. Client HH was not offered or encouraged activity. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self	W 149		

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W 149	Continued From page 48 injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), which resulted in right and left black, swollen, and discolored eyes, did not meet the BDDS (Bureau of Developmental Disabilities Services) requirement for reporting. The QIDP stated client HH's injuries "did not meet the size" requirement for reporting. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication)	W 149		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 49 for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's non reportable incident report did not indicate a thorough investigation, behavioral rates, injuries caused by self injurious behaviors, client HH's right eye injury, and/or identified staff who were contacted for interviews. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's 10/21/13 BSP was not available for the facility	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 50 staff to use. No staff retraining for client HH's 10/21/13 BSP was available. Client HH's behavior data, injury information, and staff retraining were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data, injury records, BDDS reporting, investigations of injuries, and staff retraining records was given. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 51 (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 3(a). On 10/23/13 at 11:00am, client K's record was reviewed. Client K's record did not indicate a reportable incident from 10/2012 through 10/23/13. Client K's 4/25/13 ISP (Individual Support Plan) indicated client K was non verbal and the facility's Administrator was also client K's Guardian. Client K's 4/25/13 ISP and 4/25/13 CFA (Comprehensive Functional Assessment) both indicated client K did not recognize danger and could not advocate for herself. Client K's "Nurses Notes (NN)" from 10/2012 through 10/23/2013 were reviewed and included the following incidents: -On 10/2/2013 at 11:00pm, indicated "area to R (right) shoulder resolved skin sheet complete." -On 10/1/2013 at 11:00am, indicated "New Order per Dr. [Doctor Name] KUB (Diagnostic medical imaging technique of the abdomen, Kidney Ureter Bladder) Poss Abd (abdominal) Disc (discomfort) leading to agitation + (and) upset." -On 9/28/2013 at 9:00am, indicated the nurse	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 52 was "called for assessment, observed client (with) 3cm x 1cm blue discoloration to L (Left) side 2 cm x 1cm blue to R inner thigh" and the doctor and Guardian/Administrator were notified. -On 9/26/2013 at 3:00pm, indicated "Sm (Small) areas noted to top of R (Right) Shoulder 1.) 3cm x 1cm pink linear skin above 2.) pink/purple circular discoloration 2cm x 1cm, 3.) linear pink skin 2cm x 1cm, [client K was] seen gripping her shoulders, arms crossed over chest...T (Temperature) 99, Urine reported to be strong smelling but clear and yellow light (sic). wax noted to bil (bilateral) ear canals, no drainage...Guardian/Administrator notified." -On 9/25/2013 at 3:00pm, indicated "(Client K) sitting in chair in group room has purple, yellow discoloration under L (Left) eye, slightly raised." -On 9/25/2013 at 10:30am, indicated "Called to grp (group) #3 for assessment, client became agitated...Client also observed (with) .2cm x .3cm dk (dark) purple discoloration under L (Left) eye (with) 3cm x 1cm bluish yellow parameters slightly raised. [Doctor name] notified...Guardian/Administrator...notified." -On 9/24/2013 at 10:00pm, indicated "Areas to clients' LFA (Left Facial Area) (without) discoloration. Skin Sheet complete." -On 9/20/2013 at 10:00pm, indicated "L side of face (without) discoloration noted. Skin sheet complete." -On 9/19/2013 at 10:00pm, indicated "L inner thigh 3 discoloration noted. Skin Sheet complete." No further information documented. -On 9/1/2013 at 12:00pm, indicated "Discoloration to LFA (Left Facial Area) 9 x 4 + 7 x 4 (sic) purple/red, [no] edema, Guardian/Administrator notified." -On 9/2/2013 at 10:30am, indicated "Observed the following discolorations: #1.) R (Right) thigh	W 149		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 53 1cm x 1cm, #2.) L (Left) thigh 4cm x 2cm, #3.) L inner thigh 2cm x 2cm...#4.) L inner thigh 2cm x 2cm purple, #5.) L inner knee 1cm x 1cm purple discoloration. Notified [name of doctor]...Notified Guardian/Administrator." -On 9/2/2013 at 6:30am, indicated "floor staff reported multiple discolorations to inner thighs while getting client up." The NN indicated "Writer told staff since client already OOB (Out of Bed) measurements would be taken later this AM (Morning)." -On 11/11/2012 at 10:00pm, indicated client K's lower gluteal fold discoloration resolved. -On 11/7/2012 at 2:15pm, indicated the nurse was "called to group room" and "noted (with) 1cm x 5cm purple discoloration to L (Left) lower gluteal fold...Guardian/Administrator notified." -On 10/29/2012 at 10:00pm, indicated area to client K's nose "flesh colored." -On 10/25/2012 at 7:00pm, indicated the nurse was "called to the group room" and "noted a purple discoloration to tip of nose" of 2cm (centimeters). The NN indicated "Guardian/Administrator" notified. On 10/23/13 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client K was non verbal, did not recognize danger, and could not advocate for herself. The QIDP stated "each" of client K's injuries in her Nurses Notes were from SIB (Self Injurious Behavior). Client K's 4/13/2012 BSP (Behavior Support Plan) was reviewed with the QIDP. The QIDP and client K's BSP both indicated client K's targeted behavior of "SIB" was defined as "Anti Social: Chewing her clothing, pulling her shirt up, and striping her shirt." Client K's 4/25/2013 "Behavior Assessment" indicated	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 54 client K had identified behaviors of "Removing clothing/pulling shirt up...Chew on clothing." Client K's 4/25/13 "Behavior Assessment" did not indicate client K had currently and if client K had a history of self injurious behaviors which resulted in injuries (skin discolorations to face, shoulders, arms, inner thighs). The QIDP stated "No, [client K's] BSP and Behavior Assessment" did not include behaviors which "resulted in injuries." The QIDP stated "each" of client K's injuries were "self inflicted." The QIDP stated client K had a "history of putting her hands between her legs and squeezing her hands which resulted in bruises on [client K's] thighs." The QIDP indicated no documented evidence of client K's history of behaviors which included putting her hands between her legs and squeezing causing injuries (skin discolorations). The QIDP indicated "Accident/Incident Forms" for each incident were recorded. When asked if these were available for review, the QIDP stated "I can provide them." On 10/23/13 at 2:45pm, an interview with the QIDP was conducted. The QIDP indicated no BDDS (Bureau of Developmental Disabilities Services) reports, no reporting according to State Law, no thorough investigations were completed, no witness statements were documented, interview with client K was not attempted, and no reviews/revisions to client K's ISP or BSP were completed. The QIDP indicated at the time of each incident client K's injuries were not "suspicious." The QIDP indicated after discussing client K's injuries documented in her nurses notes "I can see where these would be suspicious in nature." The QIDP indicated no interviews with client K were attempted. The QIDP provided no documented Interdisciplinary Team discussions for review.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 55 On 10/23/13 at 2:45pm, the QIDP provided the following "Accident/Incident Form(s)" for client K: -Incident 9/28/13, Time: 9:00am, indicated "Nursing description of injury: 1) L side (left inner thigh) 3cm x 1cm blue green discoloration. 2) 2cm x 1cm blue green discoloration L (left). Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/26/13, Time: 3:30pm, indicated "Nursing description of injury: Nurse note area to top of R shoulder...1) Linear line of pink skin, 3cm x .1cm, 2) pink/purple above circular discoloration 2 x 1cm (sic), 3) 2cm x .1cm pink linear line below circular discoloration. Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/25/13, Time: 10:30am, indicated "Nursing description of injury: Under R eye .2cm x .3cm DK purple discoloration (with) parameters 3cm x 1cm bluish yellow discoloration slightly raised...Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -An undated investigation which indicated "After investigation, it was determined that the incidents documented for September 25, 26, and 28th (2013) should be combined following a noted trend for areas of discoloration. The area of	W 149		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 56 discoloration located under [client K's] left eye - 25th, was the result of self inflicted injury by [client K]. Behavior data collected noted observation by attending staff that witnessed [client K] to strike herself under her left eye while sitting on her bed. The area of discoloration noted to the top of her left shoulder was also created by [client K] - 26th. The areas of discoloration reflect finger grasps that melded into a cluster of discolorations. [Client K] was observed to have her arms crossed over her chest and grasping the tops of both of her shoulders firmly with her fingers prior to medical assessment completed by the D.O.N. The areas of discoloration documented to [client K's] inner thighs occurred when [client K] placed her hands between her legs and pressing - 28th. Following review of [client K's] environment, the group and bedroom, possible changes in routine, potential changes to her diet, dental visit, weights, staff discussion, medications, labs, and medical assessment, few changes were documented. Review of nurse's notes determined that revisions to her bowel medications may be contributing to [client K's] recent behavior/actions. In an effort to determine whether the recent revisions to her bowel medications is a contributing factor for [client K] recent behavior (sic), nursing will assess her current bowel sounds...[signed by D.O.N. and Administrator]." - Incident 9/15/13, Time: 11:30am, indicated "Nursing description of injury: 3cm x 2cm faint black yellow area to L side of face. Physician notified." Guardian/Administrator notified. "Investigative Findings: While engaged in a sensory stimulation activity [client K] accidentally struck the left side of her face with a tongue depressor." The report did not indicate any	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 57 measures were taken regarding the behaviors and did not indicate witnesses interviewed. -Incident 9/2/13, Time: 6:30am, indicated "Nursing description of injury: 1) R thigh 1cm x 1cm light brown discoloration, 2) L thigh 4cm x 2cm blue purple, 3) L inner thigh 2cm x 2cm purple discoloration, 4) L inner thigh 2cm x 2cm purple discoloration, 5) L inner knee 1cm x 1cm purple discoloration. Physician notified." Guardian/Administrator notified. "Investigative Findings: Areas noted are consistent with pressure placed on [client K's] hands placed between her knees. [Client K] placed her bilateral hands together, palms together, between her thighs and knees. The pressure created areas of discoloration as noted in the description undue pressure occurred during increased activity within her group." The report did not indicate witness statements and did not indicate a review/revisions of client K's plans. -Incident 11/7/12, Time: 2:15pm, indicated "Nursing description of injury: Pt. (Patient) [client K] noted (with) 1cm x 5cm purple discoloration to L lower gluteal fold. Physician Notified." Guardian/Administrator notified. The report's "Investigative Findings: Upon investigation it was reported by staff member [name] that [client K] had gone shopping earlier in the day and when she sat down on the seat of the van she accidentally sat on the seat belt clip. No injury was noted at the time." The report did not indicate witness statements and did not indicate a review by the facility leadership. -Incident 10/12/13, Time: 7:00pm, indicated "Nursing description of Injury: Tip of nose noted (with) purple discoloration, Pt. (Patient)	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 58 uncooperative (with) measurements, area approximated (at) 2cm." The "Investigative Findings" indicated a staff was placing client K's hands on her walker to go to the dining room for supper, client K "pulled her hand back," and bumped herself in the nose. The report did not indicate witness statements and did not indicate corrective action. -Incident 10/8/12, Time: (not indicated) "Nursing description of Injury: L deltoid noted with 1cm blue discoloration with pinpoint site to L of center." The report did not indicate "Investigative finding, Current Behavior Program," or review of client K's ISP/BSP. 4. On 10/21/13 at 12:20pm, client E was observed sitting in her wheel chair in the main dining room, client E was non verbal, her legs were extended outward from her wheel chair, and client E wore a fracture boot (appliance used to stabilize fracture as it healed) on her left leg. At 12:20pm, facility staff #64 stated client E fractured her fibula on her left leg "about" six (6) weeks ago. At 2:00pm, facility staff #41 and RN (Registered Nurse) #5 both indicated client E was a three person lift to transfer from her wheel chair to another location because of her left leg fracture. At 2:00pm, facility staff #31 and RN #5 checked client E's left leg. RN #5 removed client E's left leg fracture boot, stated client E had a "1 1/2cm" red area on her left inner ankle where her fracture boot had rubbed against the skin. At 3:10pm, client E was assisted back to Program Room #1 with facility staff #30, #31, and #80 entered Program Room #1 and approached client E who sat in her wheel chair on a black sling with four handles (one handle on each corner of the	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 59 sling). Facility staff #30 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #31 grasped client E's fracture boot on her left leg. Facility staff #80 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #80 stated "I pull the handles together" which he did and lifted client E with on hand holding both handles. When facility staff #80 held the sling handles together at her hips, client E's left leg moved to overlap her right leg and was squeezed in/by the sling. Client E's face wrinkled and her eyebrows connected to form a line on her forehead. Client E's face was red and watery. Client E made high a pitched vocalization when she was moved and the pitch went higher when her left leg was squeezed by the sling. During observations at the facility on 10/22/13 at 2 PM, client E was sitting in her wheel chair in a semi reclining position with her upper body leaning to the right. Client E's feet were extended in front of her with both feet rotated in a fixed outward position. Client E's left foot was in a fracture boot and on a pillow. On 10/24/13 at 8:30am, upon entering the facility at the front conference room, vocalizations were heard (crying and yelling out). At 8:30am, the surveyor followed sounds by walking down the front hallway and down the second hallway to Program Room/Group #1 located on the second hallway. The D.O.N. (Director of Nurses) was in the doorway to the entrance of the room. Inside the room was client E, who was crying and yelling out. Client E sat in a wheelchair with her left leg elevated, wore a fracture boot on her left lower leg, and client E's left foot was turned sideways	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 60 on top of a positioning pillow. At 8:30am, LPN (Licensed Practical Nurse) #7, facility staff #28, and #37 stood around client E's wheelchair. The three staff offered client E different cause/effect items which client E refused and she continued to cry and yell. At 8:30am, the D.O.N. stated client E had been crying and yelling "for about fifteen minutes" (or since 8:15 am). At 8:45am, the D.O.N. was overheard to instruct LPN #7 to administer client E's PRN (as needed) pain medication "now." From 8:30am until 8:45am, LPN #7 instructed the facility staff to transfer client E into a recliner and out of her wheelchair. At 8:45am, client E was approached by facility staff #17, #28, and #37 to transfer her into a recliner chair inside the program room. Client E sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #37 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #28 grasped client E's fracture boot on her left leg. Facility staff #17 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #17 stated "I pull the handles together" which he did and lifted client E with one hand holding both handles. When facility staff #17 held the sling handles together at her hips, client E's left leg moved together with client E's right leg, and client E's legs were squeezed together in/by the sling. Client E's face was wrinkled, her eyebrows leveled, and she continued to cry and yell. Client E's face was red. Client E made high pitched vocalizations when she was moved and the pitch went higher when her left leg was squeezed by the sling. From 8:45am until 8:48am, client E was calmer but continued to make vocalizations. At 8:50am, client E was crying and yelling again while seated	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 61 in the recliner. At 8:50am, facility staff #28 stated "She (client E) seems like (she's) in pain" and facility staff #28 held client E's hand while client E continued to cry and yell. At 8:50am, facility staff #64 entered the program room and stated to the facility staff "if the med (medication) doesn't help, come and get me." At 8:55am, facility laundry/housekeeping staff #82 entered the program room, talked to client E, and tried to reassure client E to calm her. Client E continued to thrash her head back and forth, cried and yelled, and her face was red. At 9:00am, facility laundry/housekeeping staff #82 stated "I've never seen her like this before, She's either upset or in pain." Staff #82 indicated she had been employed at the facility over nineteen years (19 years) and had a rapport with client E. At 9:00am, the D.O.N. returned to the program room and asked staff to assist client E to her bed room and for client E to go back to bed. From 9:00am until 9:10am, client E was wheeled in the recliner from the program room, down the hallways to client E's bedroom (room #36), and transferred from the recliner into her bed. At 9:10am, client E continued cry and yell and to have a red face. At 9:40am, client E was observed calm and in bed. On 10/24/13 at 3:25pm, client E was observed inside Program Room/Group #1. Client E sat in her wheelchair, softly vocalized, and her face appeared to be red and she moved her head back and forth. At 3:35pm, facility staff #31 paged for assistance from the facility nurse for group #1. At 3:35pm, facility RN #5 entered the program room, approached client E, and walked to the phone inside the program room to call the medication nurse to inquire regarding client E's use of PRN pain medication. At 3:50pm, RN #5 indicated the medication nurse was checking for	W 149		

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W 149	Continued From page 62 the availability of client E's medication. RN #5 indicated client E had been receiving her PRN pain medication today and he wanted to make sure it was time for another dose of PRN pain medication for her "breakthrough" pain. At 3:55pm, the unidentified medication nurse entered the Program Room and administered client E's PRN pain medication. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. An 8/16/13 BDDS (Bureau of Developmental Disabilities Services) report indicated "On August 15th at approximately 5:40 AM, staff entered [client E's] bedroom to prep and assist [client E] with getting for her daily routine (sic). Staff stated that they removed [client E's] covers and touched her foot. Upon touching her foot, staff stated that [client E] cried out. Reporting staff further stated that they then removed her sock in an attempt to determine what caused [client E] to cry out. [Client E] then cried out in a louder tone. Staff then stated that they left [client E] in her bed and alerted nursing personnel of the situation for further assessment. The following nursing assessment is as follow: [Client E's] left foot was noted with full range of motion capabilities. Under normal conditions, [client E's] tone and overall range of motion capabilities are minimal. Additionally, slight edema was noted to [client E's] left foot and ankle area with less than 3 seconds for cap (capillary) refill. Plan to resolve: Nursing placed a splint/rigid boot on [client E's] left foot/ankle and contacted her PCP (Primary Care Physician) for instructions. New orders were obtained to send [client E] for x-rays of [client E's] left foot and ankle area...." Client E was taken for x-rays at a nearby facility at 8 AM and returned to the facility at 10:20 AM. At 12 PM, client E's PCP	W 149		

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W 149	Continued From page 63 called the facility with new orders for client E to "immediately" see an orthopedic surgical doctor due to x-ray results "regarding left leg fractures." The report indicated the following x-ray results: __"Acute, minimally displaced spiral fracture of the distal tibia diaphysis" __"Acute, non-displaced distal fibular diaphyseal (pertaining to or affecting the shaft of a long bone) fracture." __"Diffuse bone demineralization." __"Ped planus (flat foot) deformity of the foot." The 8/16/13 BDDS report indicated client E was taken to a local hospital and another set of X-rays were completed at [name of hospital]. The findings of the x-rays were as follows: __"Non-displaced spiral fracture of the distal tibial diaphysis (the main or midsection shaft of a long bone)." __"Non-displaced spiral Weber type C fracture of the adjacent fibula with no significant joint space widening." __"Extensive bony demineralization without convincing evidence for acute fracture." The report indicated "Immediate Action Taken: New orders from [name of hospital] were to apply ice for swelling, provide Tylenol 500 mg (milligrams) Q (every) 4 hours for pain and follow up with an orthopedic consult within 6 days. On August 16th, nursing personnel scheduled an appointment with [name of doctor] for August 21st at 10:15 AM.... [Client E] has also been scheduled for a bone density diagnostic on August 30th." The 8/16/13 BDDS report indicated the facility has implemented the following measures in response to the current x-ray findings: __"[Client E's] wheelchair foot box has been	W 149		

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W 149	Continued From page 64 widened approximately 3 additional inches to facilitate additional protection when [client E] is up in her wheelchair." __"A three-man lifting protocol has been designed to ensure the protection of her [client E's] leg." __"All appropriate staff have been in-serviced regarding [client E's] current condition and on the protocol for lifting." __"[Client E's] recliner has been modified, in height, to allow for smooth transitioning during three man-lifting." Review of client E's record on 10/22/13 at 2 PM indicated diagnoses of, but not limited to, Epilepsy, Cerebral Palsy with spastic quadriparesis (arms and legs) with associated hyperflexia (overactive or over responsive reflexes), Congenital left hip dysplasia, Bilateral Pulmonary Emboli (blood clots), incontinence of bowel and bladder, risk of aspiration, Osteopenia (low bone mineral density), fractured left distal femur and Osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density that leads to an increased risk of fracture). Client E's record indicated client E was non verbal and non-ambulatory. Client E used an adaptive wheelchair for transportation. __Client E's August 2013 physician's orders indicated the following diagnosis history, but not limited to: 11/3/93 fracture of left femur above the pin, 1/30/05 blood clot removed from left breast incision, 10/4/10 left hip cellulitis (an infection of the skin), 12/5/11 acute renal failure secondary to hypotension volume depletion with history of hypokalemia (low blood potassium), 10/4/10 sepsis (a whole-body inflammation/infection) and 12/5/11 left hip cellulitis. __Client E's Radiology report of 5/21/12 indicated "Evidence of fracture which appears acute over	W 149		

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W 149	Continued From page 65 the distal femur at the level of the femoral condyles (round projection at the end of a long bone) anterior rotation or displacement of the distal femoral metaphysis (the wide part at the end of a long bone) in relation to the diaphysis is present. Diffuse bone osteopenia (reduced bone mass) with postoperative changes stable over the proximal left femur and changes of chronic hip dysplasia." __Client E's Lower Venous Duplex scan of 5/21/12 indicated client E had an "Acute deep venous thrombosis (blood clots) noted in the left distal femoral vein. Acute deep venous thrombosis noted in the left popliteal vein (veins in the leg)." __Client E's Radiology Report of 7/16/12 indicated "Severe osteoporosis, Distal femoral fracture appears healing, could be old injury..." __Client E's 8/2/13 physician's order indicated "Send [client E] out via ambulance for stat (immediate) x-ray of her left upper leg and hip at [name of facility]." __Client E's Emergency Room report of 8/7/12 indicated client E "presents to the Emergency Department with a caregiver from her living facility.... They (the facility staff) said that there was an ultrasound done of her left lower extremity venous Doppler as well as an x-ray shot on the 21st of last month. It has been 2 weeks. On the x-ray they said that there was a femur fracture and they just found out today so they bring her in here. She (client E) does not walk. She is non-verbal.... There has been no injury. She had an ultrasound because she has developed blood clots in the past." The report indicated client E's left femur shows "chronic changes as well as a healing fracture of the distal left femur.... I (ER doctor) spoke with [name of doctor] on call for orthopedics. He looked at the x-ray. He talked	W 149		

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W 149	Continued From page 66 about the patient's situation. This is not something he would surgically fix. The patient is bed ridden anyway with a long history of severe mental retardation. He also would not splint it at this point based on the patient's body habitus (appearance). They (the staff) transfer her anyway. It may be more cumbersome and be of little to no benefit at this point...." __Client E's physician's progress note of 8/21/13 indicated client E was diagnosed with cellulitis to her upper left leg. The note indicated client E was placed on antibiotics. __Client E's Social Service Quarterly Summary of 5/13 through 7/13 indicated client E is "non verbal but vocal. She will turn her head away when she does not like what is presented to her. She will fuss or cry when she is upset.... She needs total assistance with all her ADL (Adult Daily Living) care and feeding...." __Client E's physician's orders of 9/18/13 indicated client E was to "Remain in boot for left leg at all times, except may remove for skin care, etc prn (as needed)." __Client E's Adaptive Skills Assessment of 10/22/12 indicated client E was a non-ambulatory female "who uses a tilt in space wheelchair with custom molded inserts pelvic stabilizer and shoe holders. She can make eye contact and can turn her head. [Client E] has minimal active movement of the extremities with no attempts to roll. She can flex and rotate her head when in supine. [Client E] has decreased bilateral hip flexion in extension and rotation, ankle inversion, decreased bilateral shoulder flexion, abduction and rotation, wrist extension and forearm supination (a kind of rotation). [Client E] displays decreased muscle tone and strength in her neck and trunk. She displays decreased muscle tone in all extremities with poor muscle strength. [Client	W 149		

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W 149	Continued From page 67 E] requires total support in all positions. [Client E] presents with a forward flexed head tilted to the right, neuromuscular scoliosis." __Client E's Fall Fracture Risk Plan dated 10/20/12 indicated client E was at risk for falls and/or fractures. The plan indicated client E was non ambulatory and the staff were to use a "3 man lift" with transfer sling to transfer resident from bed to wheelchair to recliner. The plan indicated "Check every 2 hours." The plan indicated the staff were to monitor for client E "repositioning herself or attempting to transfer herself." The plan indicated the staff were to "Notify the nurse immediately if [client E] falls or a fracture is suspected." __Client E's Osteoporosis Risk Plan of 11/7/12 indicated client E was at "Risk of injury during self repositioning, transferring from bed to chair or vice versa.... Protect client using sling to transfer from bed to wheelchair, wheelchair to recliner.... Monitor for any discomfort/pain. Use sling for all transfers...." Client E's record indicated no PT (physical therapy) assessment in regard to the supports and equipment needed to position client E to prevent further injuries due to client E's history of fractures and diagnosis of Osteoporosis and to provide client E stability and support while in her wheelchair, recliner and/or bed. Client E's record indicated no wheelchair assessment. Client E's record indicated no positioning schedule and/or nursing care plans in regard to skin integrity and/or toileting plan. Client E's record did not indicate how and when the staff were to monitor client E in regard to pain and/or regular assessments of client E's pain. Review of the lifting protocol for client E dated	W 149		

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W 149	Continued From page 68 8/15/13 on 10/22/13 at 3 PM indicated when transferring client E from the wheelchair to the bed or from the bed to the wheelchair the staff were to: A) Ensure client E had the appropriate sling positioned under her. B) The first staff was to position themselves at client E's right side. "This should be completed as a measure to protect her feet." C) The second staff member was to be positioned on client E's left side, "firmly grasping each corner of the sling to assist with sliding [client E] into her bed." D) The third member at client E's head should control the count (1, 2, 3, lift), to ensure client E is lifted in unison. E) After client E was positioned in her bed, staff were to use the sling to move client E within her bed. F) The staff were to ensure client E's bedrails were up securely and to ensure padding over both bedrails and positioned at the bottom portion of her bed. The protocol indicated to transfer client E from/to her wheelchair to her recliner: A) The staff were to repeat steps A through F. B) The staff were to be aware of the slight drop/lift when transferring her during this time. The protocol indicated until further notice as a measure to ensure client E's safety, client E was to be provided a bed bath. Review of the facility staff training records on 10/22/13 at 3 PM indicated 5 nursing staff and 11 direct care staff that were not trained to do a 3 person lift. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM	W 149		

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W 149	Continued From page 69 indicated through investigation the exact cause of client E's injury had not been determined but was thought to be due to another client pulling at her sock on her foot. The QIDP indicated it was possible client E could have been injured when she was repositioned during the night and/or during the 2 person lift. The QIDP stated client E had a history of breaks and "brittle bones." The QIDP stated the facility did not use any mechanical lifts "The staff do the lifts." The QIDP indicated after client E's injury the facility implemented a 3 person lift until client E's leg was healed. The QIDP indicated all nursing and direct care staff were to be trained to do a 3 person lift. The QIDP indicated she had trained the first group of staff and nursing was responsible for training the rest of the staff. The QIDP stated, "Apparently that didn't happen." The QIDP indicated no positioning plan in place for client E. The QIDP stated all clients "as a rule," are to be turned or repositioned every 2 hours. The QIDP indicated after client E's injury the staff were to put a pillow under client E's foot. The QIDP indicated client E had not been assessed by physical therapy for the specific positioning supports/equipment needed to maintain client E's body and provide optimal support to ensure client E's safety due to potential of pain or further injury with healing fractures. Interview with the DON (Director of Nurses) on 10/22/13 at 5:30 PM indicated she had been with the facility as the DON for 3 months. The DON stated she did not know what happened to client E, "I think she got her foot caught or something." When asked for nursing care plans, the DON indicated the facility was not a nursing facility and did not have to do nursing care plans. The DON indicated no positioning schedule, no skin	W 149		

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W 149	Continued From page 70 integrity plan and/or toileting plan were in place for client E. The DON stated, "I think the staff do repositioning every 2 hours." The DON indicated the facility did not have a mechanical lift and the staff did the lifting. The DON indicated client E was a 3 person lift. Interview with Administrator (ADM) #1 on 10/23/13 at 2 PM indicated the facility did not have a mechanical lift. Adm #1 stated, "I think you can do more damage with a mechanical lift than the way we do it." Adm. #1 indicated the facility did not utilize a mechanical lift because a lift would not go under the tubs (bathtubs) and or the clients' chairs. 5. Observations were conducted at the facility dining room on 10/21/13 between 4 PM and 7 PM. During this time client DDD was escorted to the dining room. Client DDD did not eat or drink anything while in the dining room. The staff in the dining room did not offer client DDD a snack or a substitution for food not eaten. Client DDD's record was reviewed on 10/24/13 at 1 PM. Client DDD's record indicated client DDD was a 13 year old male who was an emergency admission to the facility on 5/13/13 due to behaviors and family problems. Client DDD had diagnoses which included, but were not limited to, Cerebral Palsy and Hydrocephalus (water on the brain) and did not take any behavior modification medications. The record indicated upon admission client DDD weighed 147.6 pounds and was 60 inches tall. Client DDD's monthly weight/height record indicated client D was 60 inches tall. The weight	W 149		

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W 149	Continued From page 71 record indicated the following weights: 5/2013 147.6 pounds (admission weight). 6/2013 140.6 pounds. 7/2013 135.2 pounds. 8/2013 133 pounds. 9/2013 131.2 pounds. 10/2013 118.2 pounds. Client DDD's monthly weight records indicated client DDD had lost 29.4 pounds since his admission to the facility. The weight record indicated the DON (Director of Nursing) and the physician were notified. __Client DDD's nutrition assessment of 6/6/13 indicated client DDD was to receive a mechanical soft diet. The assessment indicated client DDD's intake was "fair" and client DDD had no difficulty chewing and/or swallowing. The assessment indicated the dietician will monitor as client DDD was acclimated to the facility. __Client DDD's 10/8/13 Nutrition Quarterly Assessment indicated "No new diet orders, but will offer puree diet if refuses mechanical soft due to dental problems...." The report indicated client DDD had 12.6% weight loss in 90 days. Client DDD "continues to have dental problems at this time. Spoke with dietary staff about his weight loss, and the need to get any food items he may want to him." __Client DDD's Oral Food and Fluid Intake Record for August, September and October indicated client DDD refused 4 meals out of 93 in August, 39 meals out of 90 in September and 35 meals out of 68 in October. There was no evidence of supplements or food substitutes being offered. __Client DDD's dental assessment of 6/4/13 indicated no dental issues. __Client DDD's 10/2013 physician's orders indicated client DDD was now taking Prozac 20	W 149		

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W 149	Continued From page 72 milligrams a day for sexual frustration, Klonopin 1 milligram three times a day for behavior modification and Trazadone 150 milligrams at bedtime to help client DDD sleep. __Client DDD's informed consent of 8/28/13 indicated side effects of Prozac to be nervousness, anxiety, insomnia, headache, drowsiness, tremors, dizziness, nausea, diarrhea, dry mouth and anorexia (weight loss). __Client DDD's nursing notes indicated on 5/14/13 at 6 AM "Staff report client ate well having second helping of french toast." Client DDD's nursing notes indicated nursing services did not monitor client DDD's weight loss and or refusals to eat. __Client DDD's physician's order dated 10/16/13 indicated client DDD was to start Megace 4 (for appetite and added calories) milligrams twice a day to assist in gaining weight. Confidential Interview #5 stated sometimes staff did not take client DDD to the dining room for the meal because "he doesn't eat anyway." During observations on 10/23/13 from 10:35 AM until 12:50 AM, client DDD was taken to be weighed before going to dining room at 12:00 PM. Client DDD weighed 113.8 lbs. (pounds). Client DDD went to the dining room, but refused his mechanical soft chili dogs, potatoes and pears. He was then offered pureed food and also refused the pureed food. Staff #94 was interviewed on 10/23/13 at 12:30 PM and when asked if client DDD had lost weight, stated, "Yeah. He just fell off eating lately." Staff #53 and #95 were interviewed on 10/23/13	W 149		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 73 at 12:30 PM and stated client DDD had "dental problems" and nursing services was working with the dentist to resolve the problem. Interview with facility nurse #5 on 10/24/13 at 3:30 PM stated client DDD's weight was at the "low end of his weight range." The DON and ADON (Assistant DON) were interviewed on 10/23/13 at 2:00 PM. The ADON indicated the dentist had cleared client DDD of dental issues. The ADON stated, "He probably has depression," and indicated the psychiatrist prescribed Megace (appetite stimulant). The ADON indicated client DDD had previously lived in a car and stated, "He prefers junk food. When he doesn't eat at lunch, we give him a snack at 2:00 PM." The ADON indicated nursing staff did not review client DDD's snack intake. When asked if client DDD's weight was lower this week than last week, the DON indicated client DDD's weight was lower and when asked if the interventions to address client DDD's weight had been effective stated, "No." Staff #48 was interviewed on 10/24/13 at 12:50 PM. He stated client DDD "stopped eating after he started receiving Klonopin." Interview with the DON (Director of Nurses) on 10/24/13 at 3:35 PM indicated nursing had not addressed and/or monitored client DDD's weight loss. The DON indicated no nursing care plan and/or risk plan was developed to address client DDD's continued weight loss and/or refusals to eat. The DON indicated the staff were to offer client DDD snacks three times a day. The DON stated if client DDD continued to refuse his meals, client DDD's physician would "more than	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 74	W 149		

likely" want to insert a feeding tube.

Interview with the ADON (Assistant Director of Nursing) on 10/24/13 at 4:15 PM stated client DDD had lived in a car with his family prior to admission, "so they started to offer more convenience food items" as that was probably what he was used to eating prior to admission. The ADON indicated client DDD's response to the snacks was not reviewed and/or monitored by nursing. The ADON indicated client DDD did not have dental issues.

Interview with the QIDP (Qualified Intellectual Disabilities Professional), the Administrator, the DON and the ADON on 10/24/13 at 4:45 PM indicated no IDT (Interdisciplinary Team) meetings and/or notes to address client DDD's 29.4 pound weight loss over a 5 month period. The QIDP indicated client DDD's physician, client DDD's family and/or the IDT team had not convened to develop and/or implement a plan to address client DDD's refusals to eat. The QIDP indicated client DDD's physician would be notified.

3(b). During observations on 10/21/13 from 4:40 PM until 6:05 PM, client AA had 5 one quarter inch scabbed areas on his left elbow, a bump below his left elbow 1 and 1/2 inches in diameter, and 1/8 inch scabs on the top of his right index finger knuckle and knuckle of his right little finger.

Client AA's record was reviewed on 10/22/13 at 12:15 PM. There was no evidence in the nursing notes of a scabbed area on client AA's right finger. A nursing note dated 10/8/13 indicated "client has band aid on L (left) index finger knuckle. Under band aid is 1.5 cm (centimeter)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 75	W 149		

superficial opening in skin. Left open to air and cleaning with soap and water." There was no indication of the cause of client AA's skin opening. A Medical Treatment Follow-Up Form dated 10/7/13 indicated at 12 noon client #7 had fallen while ambulating to the dining room and no injuries were noted. The same form dated 10/7/13 in a section below the area where no injuries were noted indicated there was a 1.5 cm laceration to client AA's left index knuckle. There was no indication on the form as to time of day when the laceration was noted or its cause. Additional entries on the form dated 10/8/13 and 10/9/13 indicated there were no areas of concern noted. There was no additional documentation on the form to indicate the status or cause of client AA's injury to his left index finger. A Medical Treatment Follow-Up Form dated 10/19/13 indicated a flesh colored edematous (swollen) area of his left elbow. The form indicated client AA's doctor had been notified on 10/16/13 and a note dated 10/21/13 indicated the swollen area on client AA's left elbow had been "resolved." There was no evidence in client AA's record to indicate the cause of client AA's swollen elbow or of the scabbed areas on his right and left index fingers, and on his elbow.

The DON (Director of Nursing) was interviewed on 10/22/13 at 4:45 PM. She indicated nursing staff should be documenting and monitoring open skin areas. She indicated she had witnessed client AA have a behavioral incident on 10/21/13 at lunchtime with self injurious behavior and client AA had injured his left ear. She indicated the nurse on duty should have documented the injuries. She indicated client AA often has self injurious behavior of biting his hands, but nursing staff should be documenting and monitoring skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 76 breaks. She indicated client AA's physician had been contacted about client AA's bump on his elbow, but the physician did not express concern and it was unknown as to cause. The Program Director (PD) was interviewed on 10/22/13 at 5:26 PM. She stated staff should document self injurious behavior on "behavior cards." The PD reviewed behavior cards for the month of September 2013 and October 2013, but did not find any documentation of self injurious behavior for client AA. She indicated she was unaware of any injuries to client AA. 6. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. client A and client G were in the room with (direct care staff) DCS #11. Client G had a box she put clothes pins in. Client G shook the box up by her ear, and then would dump the pins on the floor. There was a movie playing on the TV in the room. Client A was not engaged in any activity. Client A attempted to leave the room but DCS #11 redirected her to put her shoes and socks on first. The QIDPD (Qualified Intellectual Disabilities Professional Designee) took client A out of the room for a walk. At 2:00 P.M. client A returned to the room with a CD player. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was returned to the room by the QIDPD at 2:24 P.M. Client A had a jump rope she was dragging around on the floor behind her. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 77 running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a loud sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors); she did not immediately offer client G her baseball hat or helmet due to intervening with client A's continued running behaviors. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:35 P.M. client A and client G were given yogurt and juice for snack. DCS #11 used a curved adaptive spoon to feed client G her yogurt. DCS #11 did not encourage client G to feed herself. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. At 2:46 P.M. client G was assisted to the recreation room to color Halloween pictures and a pumpkin. Client A was standing in the hallway with a staff (unknown) when client G went to the recreation area. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. Client A was located in the hallway. The back of her jeans were pulled down and her upper buttocks were visible. A male staff (unknown) asked her to pull up her jeans and she complied. Client SS was located in the program room watching a cartoon on the TV. Client A returned to the room at 3:37 P.M. DCS #66 assisted client A to sit at the table and had her work on cards pointing to the object the staff named. At 3:40 P.M. recreational staff assisted client G back to the program room. Client G's jeans were pulled down	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 78 in the back and half of the back of her incontinence brief was visible. Client G sat down and began to shake her box of clothes pins. Client A began to walk around the room dragging a 12 foot long piece of fabric strips tied together. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. At 4:16 PM client SS left the room to go to the dining room. At 4:45 P.M. client G entered the dining room. At 5:10 PM client A entered the dining room. Dinner observations ended at 5:43 P.M. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room preparing to have a morning snack. Client G was wearing her helmet. Client A was asleep in a chair. DCS #36 stated, "They upped her (client A's) meds (medication) yesterday. I am having trouble getting her awake. I've been wiping her face with	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 79 this cool cloth trying to wake her up." When asked what medication had been changed, DCS #36 stated, "No, I don't know about her medications you would need to ask a nurse." When client A saw the snacks she woke up and ate some snack crackers. DCS #36 assisted client A to the restroom to wash her face and hands. While DCS #36 and client A were in the restroom client G ate pieces of crackers off of the floor. At 9:45 A.M. DCS #36 stated, "No, maybe twice I have seen the clients in this room become aggressive, I have been in here a month." At 10:03 A.M. client SS asked to go get a CD player. Client SS got the CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. Client G asked if she could go to another program area and was allowed to leave room 4. At 10:15 A.M. the QIDP brought a MP3 player with headphones to the room for client A and assisted client A in putting them on. Client A smiled. A review of the behavior data cards for program room 4 for 10/21/13 for clients A and client G was completed on 10/24/13 at 3:45 P.M. The behavior	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 80 data cards indicated client G had hit herself 20 times on 10/21/13. Client A had left the program room 55 times and had hit staff and other clients 35 times on 10/21/13. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03 with a revision date of 9/2013. Client G's BMP indicated she had the targeted behaviors of Anti-Social: Self-Abuse: repeatedly hitting herself in the head and chin with her hand or toy, kicking her ankles. Physical Aggression: pull hair, scratch, hit, kick. Staff are to verbally praise her for appropriate activity, give her one-on-one time out of room once per shift after she performs an act of compliance. If self-abuse occurred, staff were to verbally interrupt the behavior, offer an item for her to manipulate,and guide her hands down and release repeating until the behavior stops. Client G's nursing notes/monthly nursing summaries were reviewed and indicated the following: 10/21/13 There was no documentation indicating client G had been assessed by nursing staff after her SIB of hitting her self in the head, banging her head on the wall or after being hit in the head/face by client A was observed to have occurred on 10/21/13. 10/1/13 Nursing note for client G: 1/3 cm (centimeter) red area to right eye sclera. 9/30/13 at 8:15 P.M. client was poked in right eye by another client. Eye lid and sclera are red. There was no documentation indicating this incident of client to client abuse had been investigated, reported to the administrator or to the Bureau of Developmental Disabilities Services (BDDS).	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 81 There was no indication the IDT (interdisciplinary team) had met to review the incident, review the client's BMP or take any corrective action to prevent further client to client abuse. 12/2012 Client G Monthly Nursing Summary: 12/24/12 laceration to lower left eye lid 0.3 x 0.2 cm and 0.8 cm x 0.3 cm on left cheek. 12/9/12 0.4 cm x 0.6 cm O/A (open area) on chest between breasts. 12/2/12 Lacerations under right eye 0.6 x0.3 cm. Under right eye 0.3cm diameter. On right cheek 1cm x 0.2 cm. Under right jaw 1 cm x 0.4 cm. There was no documentation indicating these injuries had been investigated, reported to the administrator or to BDDS. There was no indication the IDT had met to review these injuries, the client's plan or take any corrective action to prevent further injuries. 11/2012 Client G Monthly Nursing Summary: Right upper thigh 3.5 cm x 2 cm O/A. There was no documentation indicating this bruise had been investigated, reported to the administrator or to BDDS. There was no indication the IDT had met to review this injury, the client's plan or take any corrective action to prevent further injuries. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client A's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 82 noses, Stripping: Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to: photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 83 body with her hands face down between your legs and her body. Straddle her back to hold her in position. Client A's nursing notes/monthly nursing summary were reviewed and indicated the following: 10/23/13 There was no documentation indicating client A had been assessed by nursing staff after she and client SS were involved in an altercation over headphones/CD player as observed to have occurred on 10/23/13. 9/27/13 Accident /Injury Treatment Flow Sheet "Was grabbed by another resident, whose nails broke the skin two places 0.1 cm and 0.5 cm on her right upper arm." There was no documentation indicating this incident of client to client abuse had been reported to the administrator or to BDDS. There was no indication the IDT had met to review the incident, review the client's BSP or take any corrective action to prevent further client to client abuse. 8/24/13 at 12:45 P.M. Nursing Note: "Called for assessment. Per staff when coming out of bathroom with another client they observed client pulling (client G's) hair, pulling her to the floor. Causing her to bite her tongue and hitting her head. The two clients were separated." There was no documentation indicating this incident of client to client abuse had been investigated, reported to the administrator or to BDDS. There was no indication the IDT had met to review the incident, review the client's BSP or take any corrective action to prevent further client to client abuse. 5/1/13 at 11:30 P.M. Nursing Note: "Late entry for	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 84 4/22/13 client with right eye with black/blue discoloration and her left arm had three small blue discolorations." There was no documentation indicating these injuries of unknown origin had been investigated, reported to the administrator or to BDDS. 4/25/13 at 6:00 A.M. Nursing Note: "Nurse called to recreation room for assessment. Client (client A) was grabbed by her shirt by another client (client HH). Client A noted to closed (sic) red abraised areas to back of neck 4 1/2 cm and 2 cm." There was no documentation indicating this incident of client to client abuse had been reported to BDDS. There was no indication the IDT had met to review the incident, review the client's BSP or take any corrective action to prevent further client to client abuse. 1/31/13 Accident/Incident Form: "Client observed with left knee 4.5 cm x 3 cm red discoloration 2 x 2 cm red discoloration on left knee and 1 cm x 1 cm red discoloration on left knee. Upon investigation it was reported that on 1/30/13 at dinner time client A lost her balance and dropped to her knees. No injury was noted at the time." There was no documentation indicating this fall with resulting injuries was reported to BDDS. 12/14/12 at 6:45 A.M. Nursing Note: "Staff alerted nurse to new area of dark blue discoloration to right outer thigh. Area measures 1.7 cm x 3.4 cm." There was no documentation indicating this injury of unknown origin had been investigated or reported to BDDS. 12/4/12 at 7:40 P.M. Nursing Note: "During medication administration, noted 1 cm x 0.2 cm dark purple/green discoloration to upper left eye	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 149	Continued From page 85 lid." There was no documentation indicating this injury of unknown origin had been investigated or reported to BDDS. 11/26/12 at 8:45 P.M. Nursing Note: "Notified by school nurse of 5 1/2 x 5 1/2 gray-purple discoloration to right elbow." There was no documentation indicating this injury of unknown origin had been investigated or reported to BDDS. 11/12/12 at 7:30 P.M. Nursing Note: "During medication pass, pt (patient) noted with 7 cm x 4 cm faint purple discoloration to left cheek bone area." There was no documentation indicating this injury of unknown origin had been investigated or reported to BDDS. An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/24/13 at 12:45 P.M. When asked about further documentation for the injuries indicated above, the PD/QIDP stated, "I gave you everything I had. I understand sometimes the nurses see something and note it, but I am not notified." An interview was conducted with the DON on 10/24/13 at 2:48 P.M. The DON indicated direct care staff were to notify the nurses of any SIB or aggressive behaviors between clients so the nursing staff could complete an assessment. 7. The facility's reportable and investigative records were reviewed on 11/6/13 at 2 PM. The BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/13 indicated on 11/4/13 at 7:30 PM " [Client XX], a 21 year old male resident who is blind, said that staff member [staff #47] palmed him in the head where he had	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 149	Continued From page 86 surgery. [Staff #47] was immediately separated from [client XX]. [Name of police department (PD)] called to the facility to investigate. [Name of administrator], Administrator, [name of ADON (Assistant Director of Nursing)], ADON, [name of QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director)], Program Director, [name of QIDP-D (Qualified Intellectual Disabilities Professional)] and [name of AD/SSD (Activity Director/Social Services Director), AD/SSD was called and came into the facility. [Client XX] was taken to the nurse ' s office and checked. They found no injuries. [Staff #47] was questioned by [name of PD officer]. In his statement to [PD officer], [staff #47] claimed that he was talking to [client XX], another resident got between [staff #47] and [client XX] and the other resident backed up and hit [client XX ' s] head. This was again stated to this writer when I (the AD/SSD) talked with [staff #47]. [Name of PD] talked to [client XX] and asked if [staff #47] could be true, [client XX] stated, " Yes. " [Client XX] stated that he was not mad at [staff #47]. Initial verbal report from [name of PD] was that there were no charges to be filed with the prosecutor. Written report from [name of PD] will be sent when it is typed up, to Arcadia Developmental Center. Incident Investigation sheets filled out by all staff that was in the building. No indication of controversy between [staff #47] and [client XX] to substantiate abuse allegation. [Client XX] has continued his daily routine without signs or symptoms of discomfort. " The report indicated the plan to resolve was " [Client XX] will be monitored for signs of discomfort. " The report indicated the staff was not suspended and all issues were addressed. The facility records indicated written statements	W 149		

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W 149	Continued From page 87 of interactions with client XX from the direct care staff and nursing staff that worked the evening of 11/4/13. The statements and investigative records indicated no face to face interviews of any of the direct care staff, nursing staff and/or clients. Client XX ' s record was reviewed on 11/6/13 at 12 PM. Client XX ' s record indicated a diagnosis of, but not limited to, Blindness secondary to tumor mass. Client XX ' s nursing notes for 11/4/13 indicated: __8:05 PM " While walking [client XX] to nurse ' s station from group 6 he said [staff #47] hit me on the head. He repeated that [staff #47] hit him on the side of the head and that they might have had an argument. He repeated this to [LPN (Licensed Practical Nurse) #3] who was in the hallway. [Client XX] was taken to nurses ' and shortly thereafter [staff #47] came to the station. [Staff #47] was asked to sit in the hallway which he did. All leadership notified by text. At 7:50 PM an attempt to call [name of Adm] directly was unsuccessful because the line was busy. [Name of PD] notified of allegation. " __8:10 PM " [Name of PD] here. [Staff #47] sent to break room. " __9 PM " Full head to toe body assessment completed. No signs of physical assault .... Client alert, awake and oriented to person and place. Engaged in full conversation with this nurse with appropriate answers .... [Client XX] stated ' Not that I can recall ' when asked if anything ' exciting ' happened this evening. " During interview with client XX on 11/6/13 at 11 AM, client XX stated he was arguing with staff #47 and staff #47 " palmed me on the side of my head " and took his right hand and demonstrated how staff #47 had hit him in the head with the	W 149		

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W 149	Continued From page 88 heel of his hand. Client XX stated, " It hurt. " Client XX then demonstrated to the Surveyor Supervisor the force of the hit by hitting the Surveyor Supervisor on the head as hard as client XX felt he was hit. Client XX stated, " I had surgery on my head when I was 11. " When asked why he had surgery, client XX stated, " I had a tumor by my eye and they tried to shrink it but couldn ' t so I had to have surgery. " Client XX was oriented to date and time and was able to state the name of the current President of the United States. Client XX indicated he had told the nurse what had happened and the police talked with him. Client XX indicated after the incident he returned to his room. Client XX stated staff #47 told him not to talk about food or " You ' re going to get into trouble. " Client XX indicated he calls staff #47 a J--- A-and a donkey and staff #47 calls him names. Client XX stated, " I can ' t say I ' m afraid of [staff #47], but afraid he might beat me up again." Client XX indicated since the night of the incident, no one had asked him any further questions about what had happened that night. During interview with staff #47 on 11/5/13 at 1 PM, staff #47 stated, " He [client XX] was talking about food and I had told him to be patient and was having trouble hearing him and told him to come closer when [client H] got in between him and [client XX] and they [clients XX and H] hit heads. [Client XX] said, ' You hit me. ' And that ' s when the nurse came in and took [client XX] out of the room for something. " Staff #47 indicated he didn ' t think about reporting client XX and H had bumped heads. Staff #47 indicated he was told to go to the staff break room and shortly after, his sister (the QIDP-D) came in and asked him what had happened and then the PD officer came in the room. Staff #47 indicated after talking	W 149		

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W 149	Continued From page 89 to the police and everyone left, he went back to client XX ' s bedroom to talk to client XX and to see if he was ok. Staff #47 indicated following the interview he was going to group 6 where client XX was at to continue working the evening shift. During interview with the AD/SSD on 11/6/13 at 11:30 AM, the AD/SSD indicated staff #47 and client XX were immediately separated at the time of the allegation, client XX went to the nurse ' s station and staff #47 was sent to the staff break room near the dining room. The AD/SSD indicated staff were given forms to document any interactions with client XX. The AD/SSD stated, " This was my first time of doing an investigation like this. " The AD/SSD stated protocol was " If there is reasonable doubt found during the initial statements, the staff is suspended and if not, the staff is allowed to continue to work. " The AD/SSD stated, " The police officer does this for a living and didn ' t find any evidence of abusing him (client XX). " When asked did you interview client XX, the AD/SSD stated, " After it was over that night, I asked him how he was feeling and he said he was OK. And I asked him if he still thought [staff #47] hit him and he said, ' No, I don ' t want him to get into trouble. " The AD/SSD indicated PD officer asked client XX if it was possible someone could have gotten between him and staff #47 and client XX said yes. The AD/SSD stated " In my heart I know [staff #47] had done no abuse or nothing to justify abuse. " The AD/SSD indicated staff #47 continued to work with client XX and was not suspended during the investigation. The AD/SSD stated the investigation was not complete, " I ' m waiting on the police report and I have some notes scribbled down I have to organize but otherwise is done. "	W 149		

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W 149	Continued From page 90 The facility's records were further reviewed on 10/24/13 at 7:05 P.M. Review of the facility's Abuse/Neglect policy, dated 9/3/13, indicated, in part, the following: "It is the policy of Arcadia Developmental Center, that the identification of any reportable or emergent incidents in which the reporting staff has reasonable cause to suspect that a client in their care has been subjected to abuse, sexual abuse, neglect, exploitation, or psychological abuse, through observation or discovery, must be immediately reported, protocols for client protection, properly reviewed and/or investigated, and have proper corrective actions implemented that strive to prevent and/or reduce future risk of harm to individuals."	W 149		
W 153	3.1-28(a) 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure alleged abuse and injuries of unknown origin were reported to the administrator and BDDS (Bureau of Developmental Disabilities Services) in accordance with state law which affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU,	W 153		

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W 153	Continued From page 91 VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD. Findings include: 1(a). Client W was interviewed on 10/22/13 at 10:55 A.M.. Client W stated, "[Direct Care Staff #12] slapped [client TT] on the bottom and yelled at the kids (clients)." When asked when this incident occurred, Client W stated, "Last week." CI (Confidential Interview) #1 was conducted. CI #1 stated, "There are incidents of abuse that go on at the facility that are not reported." CI #1 further stated, "One incident happened last Friday (10/18/13). [Client W] stated (Direct Care Staff #12) had been hitting the kids (clients L and TT) on their buttocks and yelling at them. The Director of Nursing and Program Coordinator and [Nurse #7] came to the program room. The Program Coordinator paged [the Program Director] and [Administrator #1]. The Administrator played it down suggesting [client W] was making up the story to get out of group. No incident report was ever written and it (allegation of abuse) was never investigated. It's a culture here (at the facility) to not report abuse." The facility's Program Director was interviewed on 10/22/13 at 1:07 P.M. When asked if there was an allegation of abuse reported in regard to a 10/18/13 incident involving clients L and TT being hit by Direct Care Staff #12, the Program Director stated, "No." The facility's Program Director approached this surveyor on 10/22/13 at 3:33 P.M. and stated she "misunderstood" what the surveyor had previously asked for on 10/22/13 at 1:07 P.M.	W 153		

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W 153	Continued From page 92 The Program Director stated, "I have an incident (involving Direct Care Staff #12 hitting clients L and TT on the buttocks and yelling at them) that I investigated on the same day (10/18/13)." When asked for a copy of the incident report and investigation, the Program Director stated, "I don't have it typed up yet. I'll have it tomorrow morning." When asked if the incident was reported to BDDS, Program Director stated, "No." 1(b). CI (Confidential Interview) #1 was conducted. CI #1 stated, "Another incident happened on September 27th (2013). [Direct Care Staff #101] alleged [Direct Care Staff #107] picked up [client Q] and "roughed her up" (shook client Q). She [Direct Care Staff #101] called the nursing staff to come and check out a big bruise on [client Q]. Nursing (Nurse #7) came down to the room and checked [client Q] out and found no bruise. This incident was never written down or investigated but [Direct Care Staff #107] was fired. [Direct Care Staff #36] knows about this." Client Q's record was reviewed on 10/22/13 at 11:56 A.M.. A review of a 9/27/13 nursing note indicated the following entry by Nurse #7: "No new skin discoloration." Program Director #1 was interviewed on 10/22/13 at 3:33 P.M.. When asked if there was an allegation of abuse reported in regard to a 9/27/13 incident involving client Q roughed up (shook) by Direct Care Staff #107, Program Director #1 stated, "No." When asked if the incident was reported to BDDS, Program Director stated, "No." This finding affected 10 of 10 sampled clients	W 153		

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W 153	Continued From page 93 (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD because Direct Care Staff #107, Direct Care Staff #12, and Nurse #7 continued to work with all clients living at the facility. 2(a). On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without	W 153		

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W 153	Continued From page 94 redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), which resulted in right and left black, swollen, and discolored eyes, did not meet the BDDS (Bureau of Developmental Disabilities Services) requirement for reporting. The QIDP stated client HH's injuries "did not meet the size" requirement for reporting. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13."	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 95 Client HH's behavior data, injury information, and staff retraining were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data, injury records, and BDDS reporting was provided. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area.	W 153		

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W 153	Continued From page 96 -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 2(b). On 10/25/13 from 10:35 AM until 11:30 AM and on 10/25/13 from 1:05 PM until 1:55 PM, client ZZ was observed in the facility Program Group #5. At 11:00 AM, client ZZ stated facility staff at the facility "hit me." When asked where she was hit, Client ZZ rubbed her right forehead and her right eye and stated she was "hit at night" by "that guy." Client ZZ was asked what "guy" because there was not a male staff person in the room. Client ZZ stated "that guy" hit her "Yes it hurt" and rubbed the same area again. At 11:30 AM, facility staff #49 stated client ZZ "tells that all the time." Facility staff (FS) #49 stated client ZZ had been telling that story to staff "today." Facility staff #49 stated she (FS #49) "had overheard other employees talking about [client ZZ] saying she was hit by that guy several days, two or three (2 or 3) days ago." FS #49 indicated she did not report client ZZ's allegation after she had overheard other staff talking about it. At 1:05 PM, FS #150 indicated client ZZ had made an allegation on 10/24/13 during the evening, it was reported, and the police were called because client ZZ said someone hit her in the face. FS #150 stated she had "overheard (other facility	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 97 staff) talking a few days before that [client ZZ] said a man hit her." FS #150 indicated she did not report the allegation. On 10/25/13 at 9:00 AM, a review of an additional BDDS report for client ZZ was conducted. The 10/24/13 BDDS report for an incident on 10/24/13 at 7:45 PM, indicated client ZZ stated "that guy just hit me." The report indicated the facility's RN (Registered Nurse) on duty "assessed the area to the left side of her face and the bridge of her nose to be red." The report indicated a police report was filed and witness statements obtained. The report indicated FS #150 stated client ZZ "had been resting the left side of her face on her hand propped up on the table just prior to staff noticing the area to her face." The report indicated the allegation was "unsubstantiated." The report did not include that the client had made the allegations previously before this incident date. Interview on 10/28/13 at 2:10pm, with the facility's Administrator was conducted. The Administrator indicated client ZZ's allegation investigation did not include her prior allegations and no other allegations or BDDS reports had been filed for client ZZ's allegations. The Administrator indicated she was not aware of any other allegations client ZZ had voiced. 3(a). On 10/23/13 at 11:00am, client K's record was reviewed. Client K's record did not indicate a reportable incident from 10/2012 through 10/23/13. Client K's "Nurses Notes (NN)" from 10/2012 through 10/23/2013 were reviewed and included the following incidents:	W 153		

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W 153	Continued From page 98 -On 10/2/2013 at 11:00pm, indicated "area to R (right) shoulder resolved skin sheet complete." -On 10/1/2013 at 11:00am, indicated "New Order per Dr. [Doctor Name] KUB (Diagnostic medical imaging technique of the abdomen, Kidney Ureter Bladder) Poss Abd (abdominal) Disc (discomfort) leading to agitation + (and) upset." -On 9/28/2013 at 9:00am, indicated the nurse was "called for assessment, observed client (with) 3cm x 1cm blue discoloration to L (Left) side 2 cm x 1cm blue to R inner thigh" and the doctor and Guardian/Administrator were notified. -On 9/26/2013 at 3:00pm, indicated "Sm (Small) areas noted to top of R (Right) Shoulder 1.) 3cm x 1cm pink linear skin above 2.) pink/purple circular discoloration 2cm x 1cm, 3.) linear pink skin 2cm x 1cm, [client K was] seen gripping her shoulders, arms crossed over chest...T (Temperature) 99, Urine reported to be strong smelling but clear and yellow light (sic). wax noted to bil (bilateral) ear canals, no drainage...Guardian/Administrator notified." -On 9/25/2013 at 3:00pm, indicated "(Client K) sitting in chair in group room has purple, yellow discoloration under L (Left) eye, slightly raised." -On 9/25/2013 at 10:30am, indicated "Called to grp (group) #3 for assessment, client became agitated...Client also observed (with) .2cm x .3cm dk (dark) purple discoloration under L (Left) eye (with) 3cm x 1cm bluish yellow parameters slightly raised. [Doctor name] notified...Guardian/Administrator...notified." -On 9/24/2013 at 10:00pm, indicated "Areas to clients' LFA (Left Facial Area) (without) discoloration. Skin Sheet complete." -On 9/20/2013 at 10:00pm, indicated "L side of face (without) discoloration noted. Skin sheet complete." -On 9/19/2013 at 10:00pm, indicated "L inner	W 153		

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W 153	Continued From page 99 thigh 3 discoloration noted. Skin Sheet complete." No further information documented. -On 9/1/2013 at 12:00pm, indicated "Discoloration to LFA (Left Facial Area) 9 x 4 + 7 x 4 (sic) purple/red, [no] edema, Guardian/Administrator notified." -On 9/2/2013 at 10:30am, indicated "Observed the following discolorations: #1.) R (Right) thigh 1cm x 1cm, #2.) L (Left) thigh 4cm x 2cm, #3.) L inner thigh 2cm x 2cm...#4.) L inner thigh 2cm x 2cm purple, #5.) L inner knee 1cm x 1cm purple discoloration. Notified [name of doctor]...Notified Guardian/Administrator." -On 9/2/2013 at 6:30am, indicated "floor staff reported multiple discolorations to inner thighs while getting client up." The NN indicated "Writer told staff since client already OOB (Out of Bed) measurements would be taken later this AM (Morning)." -On 11/11/2012 at 10:00pm, indicated client K's lower gluteal fold discoloration resolved. -On 11/7/2012 at 2:15pm, indicated the nurse was "called to group room" and "noted (with) 1cm x 5cm purple discoloration to L (Left) lower gluteal fold...Guardian/Administrator notified." -On 10/29/2012 at 10:00pm, indicated area to client K's nose "flesh colored." -On 10/25/2012 at 7:00pm, indicated the nurse was "called to the group room" and "noted a purple discoloration to tip of nose" of 2cm (centimeters). The NN indicated "Guardian/Administrator" notified. On 10/23/13 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client K was non verbal. The QIDP stated "each" of client K's injuries in her Nurses Notes were from SIB (Self Injurious Behavior).	W 153		

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W 153	Continued From page 100 Client K's 4/13/2012 BSP (Behavior Support Plan) was reviewed with the QIDP. The QIDP and client K's BSP both indicated client K's targeted behavior of "SIB" was defined as "Anti Social: Chewing her clothing, pulling her shirt up, and striping her shirt." Client K's 4/25/2013 "Behavior Assessment" indicated client K had identified behaviors of "Removing clothing/pulling shirt up...Chew on clothing." Client K's 4/25/13 "Behavior Assessment" did not indicate client K had currently and if client K had a history of self injurious behaviors which resulted in injuries (skin discolorations to face, shoulders, arms, inner thighs). The QIDP stated "No, [client K's] BSP and Behavior Assessment" did not include behaviors which "resulted in injuries." The QIDP stated "each" of client K's injuries were "self inflicted." The QIDP stated client K had a "history of putting her hands between her legs and squeezing her hands which resulted in bruises on [client K's] thighs." The QIDP indicated no documented evidence of client K's history of behaviors which included putting her hands between her legs and squeezing causing injuries (skin discolorations). The QIDP indicated "Accident/Incident Forms" for each incident were recorded. When asked if these were available for review, the QIDP stated "I can provide them." On 10/23/13 at 2:45pm, an interview with the QIDP was conducted. The QIDP indicated no BDDS (Bureau of Developmental Disabilities Services) reports for client K's unknown injuries. The QIDP indicated at the time of each incident client K's injuries were not "suspicious." The QIDP indicated after discussing client K's injuries documented in her nurses notes "I can see where these would be suspicious in nature."	W 153		

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W 153	Continued From page 101 On 10/23/13 at 2:45pm, the QIDP provided the following "Accident/Incident Form(s)" for client K: -Incident 9/28/13, Time: 9:00am, indicated "Nursing description of injury: 1) L side (left inner thigh) 3cm x 1cm blue green discoloration. 2) 2cm x 1cm blue green discoloration L (left). Physician notified." Guardian/Administrator notified. The report did not indicate if the incident was reviewed by facility leadership. -Incident 9/26/13, Time: 3:30pm, indicated "Nursing description of injury: Nurse note area to top of R shoulder...1) Linear line of pink skin, 3cm x .1cm, 2) pink/purple above circular discoloration 2 x 1cm (sic), 3) 2cm x .1cm pink linear line below circular discoloration. Physician notified." Guardian/Administrator notified. The report did not indicate if the incident was reviewed by facility leadership. -Incident 9/25/13, Time: 10:30am, indicated "Nursing description of injury: Under R eye .2cm x .3cm DK purple discoloration (with) parameters 3cm x 1cm bluish yellow discoloration slightly raised...Physician notified." Guardian/Administrator notified. The report did not indicate if the incident was reviewed by facility leadership. -An undated investigation which indicated "After investigation, it was determined that the incidents documented for September 25, 26, and 28th (2013) should be combined following a noted trend for areas of discoloration. The area of discoloration located under [client K's] left eye - 25th, was the result of self inflicted injury by [client K]. Behavior data collected noted observation by attending staff that witnessed	W 153		

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W 153	Continued From page 102 [client K] to strike herself under her left eye while sitting on her bed. The area of discoloration noted to the top of her left shoulder was also created by [client K] - 26th. The areas of discoloration reflect finger grasps that melded into a cluster of discolorations. [Client K] was observed to have her arms crossed over her chest and grasping the tops of both of her shoulders firmly with her fingers prior to medical assessment completed by the D.O.N. The areas of discoloration documented to [client K's] inner thighs occurred when [client K] placed her hands between her legs and pressing - 28th. Following review of [client K's] environment, the group and bedroom, possible changes in routine, potential changes to her diet, dental visit, weights, staff discussion, medications, labs, and medical assessment, few changes were documented. Review of nurse's notes determined that revisions to her bowel medications may be contributing to [client K's] recent behavior/actions. In an effort to determine whether the recent revisions to her bowel medications is a contributing factor for [client K] recent behavior (sic), nursing will assess her current bowel sounds...[signed by D.O.N. and Administrator]." - Incident 9/15/13, Time: 11:30am, indicated "Nursing description of injury: 3cm x 2cm faint black yellow area to L side of face. Physician notified." Guardian/Administrator notified. "Investigative Findings: While engaged in a sensory stimulation activity [client K] accidentally struck the left side of her face with a tongue depressor." -Incident 9/2/13, Time: 6:30am, indicated "Nursing description of injury: 1) R thigh 1cm x 1cm light brown discoloration, 2) L thigh 4cm x	W 153		

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W 153	Continued From page 103 2cm blue purple, 3) L inner thigh 2cm x 2cm purple discoloration, 4) L inner thigh 2cm x 2cm purple discoloration, 5) L inner knee 1cm x 1cm purple discoloration. Physician notified." Guardian/Administrator notified. "Investigative Findings: Areas noted are consistent with pressure placed on [client K's] hands placed between her knees. [Client K] placed her bilateral hands together, palms together, between her thighs and knees. The pressure created areas of discoloration as noted in the description undue pressure occurred during increased activity within her group." -Incident 11/7/12, Time: 2:15pm, indicated "Nursing description of injury: Pt. (Patient) [client K] noted (with) 1cm x 5cm purple discoloration to L lower gluteal fold. Physician Notified." Guardian/Administrator notified. The report's "Investigative Findings: Upon investigation it was reported by staff member [name] that [client K] had gone shopping earlier in the day and when she sat down on the seat of the van she accidentally sat on the seat belt clip. No injury was noted at the time." The report did not indicate a review by the facility leadership. -Incident 10/12/13, Time: 7:00pm, indicated "Nursing description of Injury: Tip of nose noted (with) purple discoloration, Pt. (Patient) uncooperative (with) measurements, area approximated (at) 2cm." The "Investigative Findings" indicated a staff was placing client K's hands on her walker to go to the dining room for supper, client K "pulled her hand back," and bumped herself in the nose. -Incident 10/8/12, Time: (not indicated) "Nursing description of Injury: L deltoid noted with 1cm	W 153		

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W 153	Continued From page 104 blue discoloration with pinpoint site to L of center." 4. During observations on 10/21/13 from 4:40 PM until 6:05 PM, client AA had 5 one quarter inch scabbed areas on his left elbow, a bump below his left elbow 1 and 1/2 inches in diameter, and 1/8 inch scabs on the top of his right index finger knuckle and knuckle of his right little finger. Client AA's record was reviewed on 10/22/13 at 12:15 PM. There was no evidence in the nursing notes of a scabbed area on client AA's right finger. A nursing note dated 10/8/13 indicated "client has band aid on L (left) index finger knuckle. Under band aid is 1.5 cm (centimeter) superficial opening in skin. Left open to air and cleaning with soap and water." There was no indication of the cause of client AA's skin opening. A Medical Treatment Follow-Up Form dated 10/7/13 indicated at 12 noon client #7 had fallen while ambulating to the dining room and no injuries were noted. The same form dated 10/7/13 in a section below the area where no injuries were noted indicated there was a 1.5 cm laceration to client AA's left index knuckle. There was no indication on the form as to time of day when the laceration was noted or its cause. Additional entries on the form dated 10/8/13 and 10/9/13 indicated there were no areas of concern noted. There was no additional documentation on the form to indicate the status or cause of client AA's injury to his left index finger. A Medical Treatment Follow-Up Form dated 10/19/13 indicated a flesh colored edematous (swollen) area of his left elbow. The form indicated client AA's doctor had been notified on 10/16/13 and a note dated 10/21/13 indicated the swollen area on client AA's left elbow had been	W 153		

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W 153	Continued From page 105 "resolved." There was no evidence in client AA's record to indicate the cause of client AA's swollen elbow or of the scabbed areas on his right and left index fingers, and on his elbow. The DON (Director of Nursing) was interviewed on 10/22/13 at 4:45 PM. She indicated nursing staff should be documenting and monitoring open skin areas. She indicated she had witnessed client AA have a behavioral incident on 10/21/13 at lunchtime with self injurious behavior and client AA had injured his left ear. She indicated the nurse on duty should have documented the injuries. She indicated client AA often has self injurious behavior of biting his hands, but nursing staff should be documenting and monitoring skin breaks. She indicated client AA's physician had been contacted about client AA's bump on his elbow, but the physician did not express concern and it was unknown as to cause. The Program Director (PD) was interviewed on 10/22/13 at 5:26 PM. She stated staff should document self injurious behavior on "behavior cards." The PD reviewed behavior cards for the month of September 2013 and October 2013, but did not find any documentation of self injurious behavior for client AA. She indicated she was unaware of any injuries to client AA.	W 153		
W 154	3.1-28(c) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by:	W 154		

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W 154	Continued From page 106 Based on interview and record review, the facility failed to thoroughly investigate alleged abuse incidents and investigate injuries of unknown origin which affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD living at the facility. Findings include: 1(a). Client W was interviewed on 10/22/13 at 10:55 A.M.. Client W stated, "[Direct Care Staff #12] slapped [client TT] on the bottom and yelled at the kids (clients)." When asked when this incident occurred, Client W stated, "Last week." CI (Confidential Interview) #1 was conducted. CI #1 stated, "There are incidents of abuse that go on at the facility that are not reported." CI #1 further stated, "One incident happened last Friday (10/18/13). [Client W] stated (Direct Care Staff #12) had been hitting the kids (clients L and TT) on their buttocks and yelling at them. The Director of Nursing and Program Coordinator and [Nurse #7] came to the program room. The Program Coordinator paged [the Program Director] and [Administrator #1]. The Administrator played it down suggesting [client W] was making up the story to get out of group. No incident report was ever written and it (allegation of abuse) was never investigated. It's a culture here (at the facility) to not report abuse." The facility's Program Director was interviewed on 10/22/13 at 1:07 P.M. When asked if there was evidence of an investigation into a 10/18/13	W 154		

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W 154	Continued From page 107 incident involving clients L and TT being hit by Direct Care Staff #12, the Program Director stated, "No." The facility's Program Director approached this surveyor on 10/22/13 at 3:33 P.M. and stated she "misunderstood" what the surveyor had previously asked for on 10/22/13 at 1:07 P.M. The Program Director stated, "I have an incident (involving Direct Care Staff #12 hitting clients L and TT on the buttocks and yelling at them) that I investigated on the same day (10/18/13)." When asked for a copy of the incident report and investigation, the Program Director stated, "I don't have it typed up yet. I'll have it tomorrow morning." No evidence of a thorough investigation was given to the surveyor. 1(b). CI (Confidential Interview) #1 was conducted. CI #1 stated, "Another incident happened on September 27th (2013). [Direct Care Staff #101] alleged [Direct Care Staff #107] picked up [client Q] and "roughed her up" (shook client Q). She [Direct Care Staff #101] called the nursing staff to come and check out a big bruise on [client Q]. Nursing (Nurse #7) came down to the room and checked [client Q] out and found no bruise. This incident was never written down or investigated but [Direct Care Staff #107] was fired. [Direct Care Staff #36] knows about this." Client Q's record was reviewed on 10/22/13 at 11:56 A.M.. A review of a 9/27/13 nursing note indicated the following entry by Nurse #7: "No new skin discoloration." Program Director #1 was interviewed on 10/22/13 at 3:33 P.M.. When asked if there was an	W 154		

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W 154	Continued From page 108 allegation of abuse investigated in regard to a 9/27/13 incident involving client Q roughed up (shook) by Direct Care Staff #107, Program Director #1 stated, "No." This finding affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD because Direct Care Staff #107, Direct Care Staff #12, and Nurse #7 continued to work with all clients living at the facility. 2(a). On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 109 from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 154	Continued From page 110 manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), which resulted in right and left black, swollen, and discolored eyes, did not meet the BDDS (Bureau of Developmental Disabilities Services) requirement for reporting. The QIDP stated client HH's injuries "did not meet the size" requirement for reporting. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's non reportable incident report did not indicate a thorough investigation, behavioral rates, injuries caused by self injurious behaviors, client HH's right eye injury, and/or identified staff who were contacted for interviews. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14	W 154		

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W 154	Continued From page 111 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's behavior data, injury information, and incidents reported were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data, injury records, and investigations of injuries records were given. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area."	W 154		

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W 154	Continued From page 112 -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 2(b). On 10/25/13 from 10:35 AM until 11:30 AM and on 10/25/13 from 1:05 PM until 1:55 PM, client ZZ was observed in the facility Program Group #5. At 11:00 AM, client ZZ stated facility	W 154		

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W 154	Continued From page 113 staff at the facility "hit me." When asked where she was hit. Client ZZ rubbed her right forehead and her right eye and stated she was "hit at night" by "that guy." Client ZZ was asked what "guy" because there was not a male staff person in the room. Client ZZ stated "that guy" hit her "Yes it hurt" and rubbed the same area again. At 11:30 AM, facility staff #49 stated client ZZ "tells that all the time." Facility staff (FS) #49 stated client ZZ had been telling that story to staff "today." Facility staff #49 stated she (FS #49) "had overheard other employees talking about [client ZZ] saying she was hit by that guy several days, two or three (2 or 3) days ago." FS #49 indicated she did not report client ZZ's allegation after she had overheard other staff talking about it. At 1:05 PM, FS #150 indicated client ZZ had made an allegation on 10/24/13 during the evening, it was reported, and the police were called because client ZZ said someone hit her in the face. FS #150 stated she had "overheard (other facility staff) talking a few days before that [client ZZ] said a man hit her." FS #150 indicated she did not report the allegation. On 10/25/13 at 9:00 AM, a review of an additional BDDS report for client ZZ was conducted. The 10/24/13 BDDS report for an incident on 10/24/13 at 7:45 PM, indicated client ZZ stated "that guy just hit me." The report indicated the facility's RN (Registered Nurse) on duty "assessed the area to the left side of her face and the bridge of her nose to be red." The report indicated a police report was filed and witness statements obtained. The report indicated FS #150 stated client ZZ "had been resting the left side of her face on her hand propped up on the table just prior to staff noticing the area to her face." The report indicated the allegation was "unsubstantiated."	W 154		

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W 154	Continued From page 114 The report did not include that the client had made the allegations previously before this incident date. Interview on 10/28/13 at 2:10pm, with the facility's Administrator was conducted. The Administrator indicated client ZZ's allegation investigation did not include her prior allegations and no other allegations or BDDS reports had been filed for client ZZ's allegations. The Administrator indicated she was not aware of any other allegations client ZZ had voiced. 3(a). On 10/23/13 at 11:00am, client K's record was reviewed. Client K's record did not indicate a reportable incident from 10/2012 through 10/23/13. Client K's "Nurses Notes (NN)" from 10/2012 through 10/23/2013 were reviewed and included the following incidents non reported incidents and suspicious injuries: -On 10/2/2013 at 11:00pm, indicated "area to R (right) shoulder resolved skin sheet complete." -On 10/1/2013 at 11:00am, indicated "New Order per Dr. [Doctor Name] KUB (Diagnostic medical imaging technique of the abdomen, Kidney Ureter Bladder) Poss Abd (abdominal) Disc (discomfort) leading to agitation + (and) upset." -On 9/28/2013 at 9:00am, indicated the nurse was "called for assessment, observed client (with) 3cm x 1cm blue discoloration to L (Left) side 2 cm x 1cm blue to R inner thigh" and the doctor and Guardian/Administrator were notified. -On 9/26/2013 at 3:00pm, indicated "Sm (Small) areas noted to top of R (Right) Shoulder 1.) 3cm x 1cm pink linear skin above 2.) pink/purple circular discoloration 2cm x 1cm, 3.) linear pink skin 2cm x 1cm, [client K was] seen gripping her	W 154		

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W 154	Continued From page 115 shoulders, arms crossed over chest...T (Temperature) 99, Urine reported to be strong smelling but clear and yellow light (sic). wax noted to bil (bilateral) ear canals, no drainage...Guardian/Administrator notified." -On 9/25/2013 at 3:00pm, indicated "(Client K) sitting in chair in group room has purple, yellow discoloration under L (Left) eye, slightly raised." -On 9/25/2013 at 10:30am, indicated "Called to grp (group) #3 for assessment, client became agitated...Client also observed (with) .2cm x .3cm dk (dark) purple discoloration under L (Left) eye (with) 3cm x 1cm bluish yellow parameters slightly raised. [Doctor name] notified...Guardian/Administrator...notified." -On 9/24/2013 at 10:00pm, indicated "Areas to clients' LFA (Left Facial Area) (without) discoloration. Skin Sheet complete." -On 9/20/2013 at 10:00pm, indicated "L side of face (without) discoloration noted. Skin sheet complete." -On 9/19/2013 at 10:00pm, indicated "L inner thigh 3 discoloration noted. Skin Sheet complete." No further information documented. -On 9/1/2013 at 12:00pm, indicated "Discoloration to LFA (Left Facial Area) 9 x 4 + 7 x 4 (sic) purple/red, [no] edema, Guardian/Administrator notified." -On 9/2/2013 at 10:30am, indicated "Observed the following discolorations: #1.) R (Right) thigh 1cm x 1cm, #2.) L (Left) thigh 4cm x 2cm, #3.) L inner thigh 2cm x 2cm...#4.) L inner thigh 2cm x 2cm purple, #5.) L inner knee 1cm x 1cm purple discoloration. Notified [name of doctor]...Notified Guardian/Administrator." -On 9/2/2013 at 6:30am, indicated "floor staff reported multiple discolorations to inner thighs while getting client up." The NN indicated "Writer told staff since client already OOB (Out of Bed)	W 154		

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W 154	Continued From page 116 measurements would be taken later this AM (Morning)." -On 11/11/2012 at 10:00pm, indicated client K's lower gluteal fold discoloration resolved. -On 11/7/2012 at 2:15pm, indicated the nurse was "called to group room" and "noted (with) 1cm x 5cm purple discoloration to L (Left) lower gluteal fold...Guardian/Administrator notified." -On 10/29/2012 at 10:00pm, indicated area to client K's nose "flesh colored." -On 10/25/2012 at 7:00pm, indicated the nurse was "called to the group room" and "noted a purple discoloration to tip of nose" of 2cm (centimeters). The NN indicated "Guardian/Administrator" notified. On 10/23/13 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client K was non verbal, did not recognize danger, and could not advocate for herself. The QIDP stated "each" of client K's injuries in her Nurses Notes were from SIB (Self Injurious Behavior). Client K's 4/13/2012 BSP (Behavior Support Plan) was reviewed with the QIDP. The QIDP and client K's BSP both indicated client K's targeted behavior of "SIB" was defined as "Anti Social: Chewing her clothing, pulling her shirt up, and striping her shirt." Client K's 4/25/2013 "Behavior Assessment" indicated client K had identified behaviors of "Removing clothing/pulling shirt up...Chew on clothing." Client K's 4/25/13 "Behavior Assessment" did not indicate client K had currently and if client K had a history of self injurious behaviors which resulted in injuries (skin discolorations to face, shoulders, arms, inner thighs). The QIDP stated "No, [client K's] BSP and Behavior Assessment" did not include behaviors which "resulted in injuries."	W 154		

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W 154	Continued From page 117 The QIDP stated "each" of client K's injuries were "self inflicted." The QIDP stated client K had a "history of putting her hands between her legs and squeezing her hands which resulted in bruises on [client K's] thighs." The QIDP indicated no documented evidence of client K's history of behaviors which included putting her hands between her legs and squeezing causing injuries (skin discolorations). The QIDP indicated "Accident/Incident Forms" for each incident were recorded. When asked if these were available for review, the QIDP stated "I can provide them." On 10/23/13 at 2:45pm, an interview with the QIDP was conducted. The QIDP indicated no thorough investigations were completed, no witness statements were documented, interview with client K was not attempted, and no reviews/revisions to client K's ISP or BSP were completed. The QIDP indicated at the time of each incident client K's injuries were not "suspicious." The QIDP indicated after discussing client K's injuries documented in her nurses notes "I can see where these would be suspicious in nature." The QIDP indicated no interviews with client K were attempted. On 10/23/13 at 2:45pm, the QIDP provided the following "Accident/Incident Form(s)" for client K: -Incident 9/28/13, Time: 9:00am, indicated "Nursing description of injury: 1) L side (left inner thigh) 3cm x 1cm blue green discoloration. 2) 2cm x 1cm blue green discoloration L (left). Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership.	W 154		

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W 154	Continued From page 118 -Incident 9/26/13, Time: 3:30pm, indicated "Nursing description of injury: Nurse note area to top of R shoulder...1) Linear line of pink skin, 3cm x .1cm, 2) pink/purple above circular discoloration 2 x 1cm (sic), 3) 2cm x .1cm pink linear line below circular discoloration. Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/25/13, Time: 10:30am, indicated "Nursing description of injury: Under R eye .2cm x .3cm DK purple discoloration (with) parameters 3cm x 1cm bluish yellow discoloration slightly raised...Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -An undated investigation which indicated "After investigation, it was determined that the incidents documented for September 25, 26, and 28th (2013) should be combined following a noted trend for areas of discoloration. The area of discoloration located under [client K's] left eye - 25th, was the result of self inflicted injury by [client K]. Behavior data collected noted observation by attending staff that witnessed [client K] to strike herself under her left eye while sitting on her bed. The area of discoloration noted to the top of her left shoulder was also created by [client K] - 26th. The areas of discoloration reflect finger grasps that melded into a cluster of discolorations. [Client K] was observed to have her arms crossed over her chest and grasping the tops of both of her shoulders firmly with her fingers prior to medical	W 154		

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W 154	Continued From page 119 assessment completed by the D.O.N. The areas of discoloration documented to [client K's] inner thighs occurred when [client K] placed her hands between her legs and pressing - 28th. Following review of [client K's] environment, the group and bedroom, possible changes in routine, potential changes to her diet, dental visit, weights, staff discussion, medications, labs, and medical assessment, few changes were documented. Review of nurse's notes determined that revisions to her bowel medications may be contributing to [client K's] recent behavior/actions. In an effort to determine whether the recent revisions to her bowel medications is a contributing factor for [client K] recent behavior (sic), nursing will assess her current bowel sounds...[signed by D.O.N. and Administrator]." - Incident 9/15/13, Time: 11:30am, indicated "Nursing description of injury: 3cm x 2cm faint black yellow area to L side of face. Physician notified." Guardian/Administrator notified. "Investigative Findings: While engaged in a sensory stimulation activity [client K] accidentally struck the left side of her face with a tongue depressor." The report did not indicate any measures were taken regarding the behaviors and did not indicate witnesses interviewed. -Incident 9/2/13, Time: 6:30am, indicated "Nursing description of injury: 1) R thigh 1cm x 1cm light brown discoloration, 2) L thigh 4cm x 2cm blue purple, 3) L inner thigh 2cm x 2cm purple discoloration, 4) L inner thigh 2cm x 2cm purple discoloration, 5) L inner knee 1cm x 1cm purple discoloration. Physician notified." Guardian/Administrator notified. "Investigative Findings: Areas noted are consistent with pressure placed on [client K's] hands placed	W 154		

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W 154	Continued From page 120 between her knees. [Client K] placed her bilateral hands together, palms together, between her thighs and knees. The pressure created areas of discoloration as noted in the description undue pressure occurred during increased activity within her group." The report did not indicate witness statements and did not indicate a review/revisions of client K's plans. -Incident 11/7/12, Time: 2:15pm, indicated "Nursing description of injury: Pt. (Patient) [client K] noted (with) 1cm x 5cm purple discoloration to L lower gluteal fold. Physician Notified." Guardian/Administrator notified. The report's "Investigative Findings: Upon investigation it was reported by staff member [name] that [client K] had gone shopping earlier in the day and when she sat down on the seat of the van she accidentally sat on the seat belt clip. No injury was noted at the time." The report did not indicate witness statements and did not indicate a review by the facility leadership. -Incident 10/12/13, Time: 7:00pm, indicated "Nursing description of Injury: Tip of nose noted (with) purple discoloration, Pt. (Patient) uncooperative (with) measurements, area approximated (at) 2cm." The "Investigative Findings" indicated a staff was placing client K's hands on her walker to go to the dining room for supper, client K "pulled her hand back," and bumped herself in the nose. The report did not indicate witness statements and did not indicate corrective action. -Incident 10/8/12, Time: (not indicated) "Nursing description of Injury: L deltoid noted with 1cm blue discoloration with pinpoint site to L of center." The report did not indicate "Investigative	W 154		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 121 finding, Current Behavior Program," or review of client K's ISP/BSP. 4. The facility's BDDS reports from 5/1/13-6/30/13 were reviewed on 10/21/13 at 2:20 PM. A BDDS report dated 5/12/13 indicated on 5/12/13 at approximately 4:00 AM, "nursing observed a 9.5 cm (centimeter) x 3 cm bluish/yellow discoloration to [client CC's] right breast. After investigation, it was determined that the noted area was the result of her bra riding up over her chest, with the lower portion of her bra situated on the top portion of her breast....[client CC] has a diagnosis of vitamin K deficiency with clotting disorder, which often contributes to most documented areas of discoloration." An attached Accident/Incident Form dated 5/12/13 included Investigative Findings as listed in the BDDS report, but failed to include witness statements or a dates of the investigation and conclusion. The form indicated staff #56, #64, #496 and staff #24 had been interviewed, but failed to indicate if client CC had been interviewed regarding the bruises to her breast. The Program Director was interviewed on 10/29/13 at 4:40 PM and indicated there was no additional information regarding the investigation into client CC's bruises and indicated statements should be included in the investigation. 5. The facility's reportable and investigative records were reviewed on 11/6/13 at 2 PM. The BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/13 indicated on 11/4/13 at 7:30 PM " [Client XX], a 21 year old male resident who is blind, said that staff member [staff #47] palmed him in the head where he had surgery. [Staff #47] was immediately separated	W 154		

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W 154	Continued From page 122 from [client XX]. [Name of police department (PD)] called to the facility to investigate. [Name of administrator], Administrator, [name of ADON (Assistant Director of Nursing)], ADON, [name of QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director)], Program Director, [name of QIDP-D (Qualified Intellectual Disabilities Professional)] and [name of AD/SSD (Activity Director/Social Services Director), AD/SSD was called and came into the facility. [Client XX] was taken to the nurse ' s office and checked. They found no injuries. [Staff #47] was questioned by [name of PD officer]. In his statement to [PD officer], [staff #47] claimed that he was talking to [client XX], another resident got between [staff #47] and [client XX] and the other resident backed up and hit [client XX ' s] head. This was again stated to this writer when I (the AD/SSD) talked with [staff #47]. [Name of PD] talked to [client XX] and asked if [staff #47] could be true, [client XX] stated, " Yes. " [Client XX] stated that he was not mad at [staff #47]. Initial verbal report from [name of PD] was that there were no charges to be filed with the prosecutor. Written report from [name of PD] will be sent when it is typed up, to Arcadia Developmental Center. Incident Investigation sheets filled out by all staff that was in the building. No indication of controversy between [staff #47] and [client XX] to substantiate abuse allegation. [Client XX] has continued his daily routine without signs or symptoms of discomfort. " The report indicated the plan to resolve was " [Client XX] will be monitored for signs of discomfort. " The report indicated the staff was not suspended and all issues were addressed. The facility records indicated written statements of interactions with client XX from the direct care	W 154		

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W 154	Continued From page 123 staff and nursing staff that worked the evening of 11/4/13. The statements and investigative records indicated no face to face interviews of the direct care staff, nursing staff and/or clients. The facility records failed to indicate evidence of a thorough investigation. During interview with client XX on 11/6/13 at 11 AM, client XX stated he was arguing with staff #47 and staff #47 " palmed me on the side of my head " and took his right hand and demonstrated how staff #47 had hit him in the head with the heel of his hand. Client XX stated, " It hurt. " Client XX then demonstrated to the Surveyor Supervisor the force of the hit by hitting the Surveyor Supervisor on the head as hard as client XX felt he was hit. Client XX stated, " I had surgery on my head when I was 11. " When asked why he had surgery, client XX stated, " I had a tumor by my eye and they tried to shrink it but couldn ' t so I had to have surgery. " Client XX was oriented to date and time and was able to state the name of the current President of the United States. Client XX indicated he had told the nurse what had happened and the police talked with him. Client XX indicated after the incident he returned to his room. Client XX stated staff #47 told him not to talk about food or " You ' re going to get into trouble. " Client XX indicated he calls staff #47 a J--- A-and a donkey and staff #47 calls him names. Client XX stated, " I can ' t say I ' m afraid of [staff #47], but afraid he might beat me up again." Client XX indicated since the night of the incident, no one had asked him any further questions about what had happened that night. During interview with staff #47 on 11/5/13 at 1 PM, staff #47 stated, " He [client XX] was talking about food and I had told him to be patient and	W 154		

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W 154	Continued From page 124 was having trouble hearing him and told him to come closer when [client H] got in between him and [client XX] and they [clients XX and H] hit heads. [Client XX] said, ' You hit me. ' And that ' s when the nurse came in and took [client XX] out of the room for something. " Staff #47 indicated he didn ' t think about reporting client XX and H had bumped heads. Staff #47 indicated he was told to go to the staff break room and shortly after, his sister (the QIDP-D) came in and asked him what had happened and then the PD officer came in the room. Staff #47 indicated after talking to the police and everyone left, he went back to client XX ' s bedroom to talk to client XX and to see if he was ok. During interview with the AD/SSD on 11/6/13 at 11:30 AM, the AD/SSD indicated staff were given forms to document any interactions with client XX on the evening of 11/4/13. The AD/SSD stated, " This was my first time of doing an investigation like this. " The AD/SSD stated, " The police officer does this for a living and didn ' t find any evidence of abusing him (client XX). " When asked did you interview client XX, the AD/SSD stated, " After it was over that night, I asked him how he was feeling and he said he was OK. And I asked him if he still thought [staff #47] hit him and he said, ' No, I don ' t want him to get into trouble. " The AD/SSD indicated PD officer asked client XX if it was possible someone could have gotten between him and staff #47 and client XX said yes. The AD/SSD stated " In my heart I know [staff #47] had done no abuse or nothing to justify abuse. " The AD/SSD stated the investigation was not complete, " I ' m waiting on the police report and I have some notes scribbled down I have to organize, but otherwise is done. "	W 154		

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W 154	Continued From page 125 3.1-28(d)	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review for 1 of 6 allegations of abuse, neglect and/or exploitation reviewed, the facility failed to immediately suspend a staff in regard to an allegation of physical abuse for client XX. Findings include: The facility's reportable and investigative records were reviewed on 11/6/13 at 2 PM. The BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/13 indicated on 11/4/13 at 7:30 PM " [Client XX], a 21 year old male resident who is blind, said that staff member [staff #47] palmed him in the head where he had surgery. [Staff #47] was immediately separated from [client XX]. [Name of police department (PD)] called to the facility to investigate. [Name of administrator], Administrator, [name of ADON (Assistant Director of Nursing)], ADON, [name of QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director)], Program Director, [name of QIDP-D (Qualified Intellectual Disabilities Professional)] and [name of AD/SSD (Activity Director/Social Services Director), AD/SSD was called and came into the facility. [Client XX] was taken to the nurse ' s office and checked. They found no injuries. [Staff #47] was questioned by [name of PD officer]. In his statement to [PD officer], [staff #47] claimed that	W 155		

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W 155	Continued From page 126 he was talking to [client XX], another resident got between [staff #47] and [client XX] and the other resident backed up and hit [client XX ' s] head. This was again stated to this writer when I (the AD/SSD) talked with [staff #47]. [Name of PD] talked to [client XX] and asked if [staff #47] could be true, [client XX] stated, " Yes. " [Client XX] stated that he was not mad at [staff #47]. Initial verbal report from [name of PD] was that there were no charges to be filed with the prosecutor. Written report from [name of PD] will be sent when it is typed up, to Arcadia Developmental Center. Incident Investigation sheets filled out by all staff that was in the building. No indication of controversy between [staff #47] and [client XX] to substantiate abuse allegation. [Client XX] has continued his daily routine without signs or symptoms of discomfort. " The report indicated the plan to resolve was " [Client XX] will be monitored for signs of discomfort. " The report indicated the staff was not suspended and all issues were addressed. During interview with staff #47 on 11/5/13 at 1 PM, staff #47 indicated after talking to the police and everyone had left, he went back to client XX ' s bedroom to talk to client XX to see if he was ok. Staff #47 indicated following this interview he was going back to work in group 6 where client XX was presently at. During interview with the AD/SSD on 11/6/13 at 11:30 AM, the AD/SSD indicated staff #47 and client XX were immediately separated at the time of the allegation, client XX went to the nurse ' s station and staff #47 was sent to the staff break room near the dining room. The AD/SSD stated, " This was my first time of doing an investigation like this. " The AD/SSD stated abuse allegation	W 155		

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W 155	Continued From page 127 protocol to be " If there is reasonable doubt found during the initial statements, the staff is suspended and if not, the staff is allowed to continue to work. " The AD/SSD stated, " The police officer does this for a living and didn ' t find any evidence of abusing him (client XX). " When asked did you interview client XX, the AD/SSD stated, " After it was over that night, I asked him how he was feeling and he said he was OK. And I asked him if he still thought [staff #47] hit him and he said, ' No, I don ' t want him to get into trouble. " The AD/SSD indicated the PD officer asked client XX if it was possible someone could have gotten between him and staff #47 and client XX said yes. The AD/SSD stated " In my heart I know [staff #47] had done no abuse or nothing to justify abuse. " The AD/SSD indicated staff #47 continued to work with client XX and was not suspended during the investigation. The AD/SSD stated the investigation was not complete, " I ' m waiting on the police report and I have some notes scribbled down I have to organize but otherwise is done. "	W 155		
	3.1-28(d)			
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed, for 16 of 16 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 3 additional clients (clients K, GG, and HH), the facility failed to implement sufficient corrective action to protect clients from	W 157		

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W 157	Continued From page 128 the potential of continued client physical aggression resulting in injuries and to prevent continued unknown injuries to client K and client HH's continued SIB (Self Injurious Behaviors). Findings include: 1. Incident reports and nursing notes for client GG were reviewed on 10/24/13 at 10:05 A.M. The review indicated client GG suffered the following falls: -10/20/13 incident report: "On October 20th, at approximately 5:05pm, [Client GG] fell in program room after returning from [hospital] one hour prior. Preliminary nursing assessment noted moderate size hematoma (blood/fluid filled bruise) to the right side of [client GG's] suture line at the top of her head. Large amount of blood noted with [client GG] uncooperative for complete assessment. New orders were received from [client GG's] PCP (primary care physician) to send to [hospital] for evaluation and possible treatment. Plan to Resolve: [Client GG] was transported to [hospital] via facility van and the assistance of two staff members. [Client GG] received IV (intravenous) Depakote (anti-seizure medication) during her stay at [hospital] and returned to this facility at approximately 9:10pm. No new medications were prescribed for [client GG] for seizure activity, but will complete an appointment with her neurologist sometime next week. [Client GG] was placed on 15 minute checks for additional monitoring throughout the night. [Client GG] returned to her normal group of peers this AM (morning) and attended a community outing without difficulty." -10/19/13 incident report: "On October 19th, at	W 157		

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W 157	Continued From page 129 approximately 10:00 A.M., [client GG] was independently ambulating in her program room walking toward the group room closet. One of her peers scooted their chair out into her (client GG's) path. [Client GG] caught the toe of her shoe on the inside corner of her peer's chair leg. [Client GG] fell forward, without any attempt to break her fall. Plan to Resolve: New orders were taken to send [client GG] to [hospital] for evaluation. [Client GG] returned with staples closing the laceration to the top of her head at approximately 1:00PM. A CT (diagnostic x-ray scan) was completed during her evaluation with no negative findings from the scan. [Client GG] consumed 75% of her afternoon meal and returned to her group of peers. Nursing has started a 48 hour neurological monitoring sheet." -10/12/13 nursing note: "Slipped and fell in program room. 0 (no) injury." -9/25/13 nursing note: "Outside with peers and fell. 3cm (centimeter) x(by) 2cm abrasion." -9/1/13 incident report: "At approximately 5:00PM on September 1, [client GG] was being assisted with her evening routine of putting on her pajamas. [Client GG] experienced a seizure, falling forward as staff broke her forward motion. [Client GG] struck her head on the handrail located next to the toilet without redness, discoloration or other areas noted to her head. Plan to Resolve: Nursing personnel initiated neurological checks. [Client GG] continued her routine of assisting with putting on her pajamas for the evening without further incident." -8/10/13 nursing note: "[Client GG] fell from chair to floor in group room."	W 157		

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W 157	Continued From page 130 -8/9/13 incident report: "On August 9, 2013 at about 8:00 pm [client GG] experienced a drop seizure landing on her tailbone. She now has an 8cm x 9 cm bruise at that sight. She is not showing any signs or symptoms of pain or discomfort. She was able to sleep her normal manner during the night hours. She has resumed her normal daily routine. The DON (Director of Nursing), Program Director, Physician, Guardian and Administrator were notified on 8-9-13. Plan to Resolve: Nursing will continue to monitor her seizure activity and report to Neuro physician. Nursing will also monitor her vital signs and watch for any discomfort or signs of ain. A skin sheet had been itiated (sic) to monitor the bruise until healed." -6/26/13 nursing note: "[Client GG] fell in group room. No injury." -4/29/13 nursing note: "Seizure, [client GG] fell, hit head, 2cm laceration stapled." Client GG's record was further reviewed on 10/24/13 at 1:12 P.M.. The review indicated the client had a diagnosis, which included but was not limited to, seizure disorder. Further review indicated the client had a risk plan for falls dated 6/27/13. The risk plan for falls indicated the following interventions which should be implemented to reduce the risk of client GG falling: "a. Make certain that objects are cleared from the floor/adequate lighting, b. Check each time she (client GG) gets up to walk. c. Inservice current and new staff and prn [staff]." The Program Director was interviewed on 10/25/13 at 10:41 A.M.. When asked if the	W 157		

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W 157	Continued From page 131 implementation of client GG's 6/27/13 risk plan for falls had been effective in reducing client GG's falls or injuries from falls, the Program Director stated, "No, not apparently." 2. On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in	W 157		

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W 157	Continued From page 132 the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), which resulted in right and left black, swollen, and discolored eyes, did not meet the BDDS (Bureau of Developmental Disabilities Services) requirement for reporting. The QIDP stated client	W 157		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 133 HH's injuries "did not meet the size" requirement for reporting. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's non reportable incident report did not indicate behavioral rates, injuries caused by self injurious behaviors, and client HH's right eye injury. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 134 resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's 10/21/13 BSP was not available for the facility staff to use. No staff retraining for client HH's 10/21/13 BSP was available. The QIDP indicated no corrective measures were implemented. Client HH's behavior data, injury information, and staff retraining were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data, injury records, and staff retraining records was given. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area."	W 157		

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	15G580		C 11/06/2013

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W 157	Continued From page 135 -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 3. On 10/23/13 at 11:00am, client K's record was reviewed. Client K's record did not indicate a reportable incident from 10/2012 through 10/23/13. Client K's 4/25/13 ISP (Individual Support Plan) indicated client K was non verbal and the facility's Administrator was also client K's Guardian. Client K's 4/25/13 ISP and 4/25/13 CFA (Comprehensive Functional Assessment)	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 136 both indicated client K did not recognize danger and could not advocate for herself. Client K's "Nurses Notes (NN)" from 10/2012 through 10/23/2013 were reviewed and included the following incidents: -On 10/2/2013 at 11:00pm, indicated "area to R (right) shoulder resolved skin sheet complete." -On 10/1/2013 at 11:00am, indicated "New Order per Dr. [Doctor Name] KUB (Diagnostic medical imaging technique of the abdomen, Kidney Ureter Bladder) Poss Abd (abdominal) Disc (discomfort) leading to agitation + (and) upset." -On 9/28/2013 at 9:00am, indicated the nurse was "called for assessment, observed client (with) 3cm x 1cm blue discoloration to L (Left) side 2 cm x 1cm blue to R inner thigh" and the doctor and Guardian/Administrator were notified. -On 9/26/2013 at 3:00pm, indicated "Sm (Small) areas noted to top of R (Right) Shoulder 1.) 3cm x 1cm pink linear skin above 2.) pink/purple circular discoloration 2cm x 1cm, 3.) linear pink skin 2cm x 1cm, [client K was] seen gripping her shoulders, arms crossed over chest...T (Temperature) 99, Urine reported to be strong smelling but clear and yellow light (sic). wax noted to bil (bilateral) ear canals, no drainage...Guardian/Administrator notified." -On 9/25/2013 at 3:00pm, indicated "(Client K) sitting in chair in group room has purple, yellow discoloration under L (Left) eye, slightly raised." -On 9/25/2013 at 10:30am, indicated "Called to grp (group) #3 for assessment, client became agitated...Client also observed (with) .2cm x .3cm dk (dark) purple discoloration under L (Left) eye (with) 3cm x 1cm bluish yellow parameters slightly raised. [Doctor name] notified...Guardian/Administrator...notified." -On 9/24/2013 at 10:00pm, indicated "Areas to	W 157		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 137 clients' LFA (Left Facial Area) (without) discoloration. Skin Sheet complete." -On 9/20/2013 at 10:00pm, indicated "L side of face (without) discoloration noted. Skin sheet complete." -On 9/19/2013 at 10:00pm, indicated "L inner thigh 3 discoloration noted. Skin Sheet complete." No further information documented. -On 9/1/2013 at 12:00pm, indicated "Discoloration to LFA (Left Facial Area) 9 x 4 + 7 x 4 (sic) purple/red, [no] edema, Guardian/Administrator notified." -On 9/2/2013 at 10:30am, indicated "Observed the following discolorations: #1.) R (Right) thigh 1cm x 1cm, #2.) L (Left) thigh 4cm x 2cm, #3.) L inner thigh 2cm x 2cm...#4.) L inner thigh 2cm x 2cm purple, #5.) L inner knee 1cm x 1cm purple discoloration. Notified [name of doctor]...Notified Guardian/Administrator." -On 9/2/2013 at 6:30am, indicated "floor staff reported multiple discolorations to inner thighs while getting client up." The NN indicated "Writer told staff since client already OOB (Out of Bed) measurements would be taken later this AM (Morning)." -On 11/11/2012 at 10:00pm, indicated client K's lower gluteal fold discoloration resolved. -On 11/7/2012 at 2:15pm, indicated the nurse was "called to group room" and "noted (with) 1cm x 5cm purple discoloration to L (Left) lower gluteal fold...Guardian/Administrator notified." -On 10/29/2012 at 10:00pm, indicated area to client K's nose "flesh colored." -On 10/25/2012 at 7:00pm, indicated the nurse was "called to the group room" and "noted a purple discoloration to tip of nose" of 2cm (centimeters). The NN indicated "Guardian/Administrator" notified.	W 157		

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	15G580		C 11/06/2013

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W 157	Continued From page 138 On 10/23/13 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client K was non verbal, did not recognize danger, and could not advocate for herself. The QIDP stated "each" of client K's injuries in her Nurses Notes were from SIB (Self Injurious Behavior). Client K's 4/13/2012 BSP (Behavior Support Plan) was reviewed with the QIDP. The QIDP and client K's BSP both indicated client K's targeted behavior of "SIB" was defined as "Anti Social: Chewing her clothing, pulling her shirt up, and striping her shirt." Client K's 4/25/2013 "Behavior Assessment" indicated client K had identified behaviors of "Removing clothing/pulling shirt up...Chew on clothing." Client K's 4/25/13 "Behavior Assessment" did not indicate client K had currently and if client K had a history of self injurious behaviors which resulted in injuries (skin discolorations to face, shoulders, arms, inner thighs). The QIDP stated "No, [client K's] BSP and Behavior Assessment" did not include behaviors which "resulted in injuries." The QIDP stated "each" of client K's injuries were "self inflicted." The QIDP stated client K had a "history of putting her hands between her legs and squeezing her hands which resulted in bruises on [client K's] thighs." The QIDP indicated no documented evidence of client K's history of behaviors which included putting her hands between her legs and squeezing causing injuries (skin discolorations). The QIDP indicated "Accident/Incident Forms" for each incident were recorded. When asked if these were available for review, the QIDP stated "I can provide them." The QIDP indicated the facility did not take corrective action. On 10/23/13 at 2:45pm, an interview with the	W 157		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 139 QIDP was conducted. The QIDP indicated no reviews/revisions to client K's ISP or BSP were completed. The QIDP indicated at the time of each incident client K's injuries were not "suspicious." The QIDP indicated after discussing client K's injuries documented in her nurses notes "I can see where these would be suspicious in nature." The QIDP provided no documented Interdisciplinary Team discussions for review. The QIDP indicated no corrective measures were implemented. On 10/23/13 at 2:45pm, the QIDP provided the following "Accident/Incident Form(s)" for client K: -Incident 9/28/13, Time: 9:00am, indicated "Nursing description of injury: 1) L side (left inner thigh) 3cm x 1cm blue green discoloration. 2) 2cm x 1cm blue green discoloration L (left). Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/26/13, Time: 3:30pm, indicated "Nursing description of injury: Nurse note area to top of R shoulder...1) Linear line of pink skin, 3cm x .1cm, 2) pink/purple above circular discoloration 2 x 1cm (sic), 3) 2cm x .1cm pink linear line below circular discoloration. Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/25/13, Time: 10:30am, indicated "Nursing description of injury: Under R eye .2cm x .3cm DK purple discoloration (with) parameters 3cm x 1cm bluish yellow discoloration slightly	W 157		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 140 raised...Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -An undated investigation which indicated "After investigation, it was determined that the incidents documented for September 25, 26, and 28th (2013) should be combined following a noted trend for areas of discoloration. The area of discoloration located under [client K's] left eye - 25th, was the result of self inflicted injury by [client K]. Behavior data collected noted observation by attending staff that witnessed [client K] to strike herself under her left eye while sitting on her bed. The area of discoloration noted to the top of her left shoulder was also created by [client K] - 26th. The areas of discoloration reflect finger grasps that melded into a cluster of discolorations. [Client K] was observed to have her arms crossed over her chest and grasping the tops of both of her shoulders firmly with her fingers prior to medical assessment completed by the D.O.N. The areas of discoloration documented to [client K's] inner thighs occurred when [client K] placed her hands between her legs and pressing - 28th. Following review of [client K's] environment, the group and bedroom, possible changes in routine, potential changes to her diet, dental visit, weights, staff discussion, medications, labs, and medical assessment, few changes were documented. Review of nurse's notes determined that revisions to her bowel medications may be contributing to [client K's] recent behavior/actions. In an effort to determine whether the recent revisions to her bowel medications is a contributing factor for [client K] recent behavior (sic), nursing will assess	W 157		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 157	Continued From page 141 her current bowel sounds...[signed by D.O.N. and Administrator]." - Incident 9/15/13, Time: 11:30am, indicated "Nursing description of injury: 3cm x 2cm faint black yellow area to L side of face. Physician notified." Guardian/Administrator notified. "Investigative Findings: While engaged in a sensory stimulation activity [client K] accidentally struck the left side of her face with a tongue depressor." The report did not indicate any measures were taken regarding the behaviors and did not indicate witnesses interviewed. -Incident 9/2/13, Time: 6:30am, indicated "Nursing description of injury: 1) R thigh 1cm x 1cm light brown discoloration, 2) L thigh 4cm x 2cm blue purple, 3) L inner thigh 2cm x 2cm purple discoloration, 4) L inner thigh 2cm x 2cm purple discoloration, 5) L inner knee 1cm x 1cm purple discoloration. Physician notified." Guardian/Administrator notified. "Investigative Findings: Areas noted are consistent with pressure placed on [client K's] hands placed between her knees. [Client K] placed her bilateral hands together, palms together, between her thighs and knees. The pressure created areas of discoloration as noted in the description undue pressure occurred during increased activity within her group." The report did not indicate witness statements and did not indicate a review/revisions of client K's plans. -Incident 11/7/12, Time: 2:15pm, indicated "Nursing description of injury: Pt. (Patient) [client K] noted (with) 1cm x 5cm purple discoloration to L lower gluteal fold. Physician Notified." Guardian/Administrator notified. The report's "Investigative Findings: Upon investigation it was	W 157		

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W 157	Continued From page 142 reported by staff member [name] that [client K] had gone shopping earlier in the day and when she sat down on the seat of the van she accidentally sat on the seat belt clip. No injury was noted at the time." The report did not indicate witness statements and did not indicate a review by the facility leadership. -Incident 10/12/13, Time: 7:00pm, indicated "Nursing description of Injury: Tip of nose noted (with) purple discoloration, Pt. (Patient) uncooperative (with) measurements, area approximated (at) 2cm." The "Investigative Findings" indicated a staff was placing client K's hands on her walker to go to the dining room for supper, client K "pulled her hand back," and bumped herself in the nose. The report did not indicate witness statements and did not indicate corrective action. -Incident 10/8/12, Time: (not indicated) "Nursing description of Injury: L deltoid noted with 1cm blue discoloration with pinpoint site to L of center." The report did not indicate "Investigative finding, Current Behavior Program," or review of client K's ISP/BSP.	W 157		
W 158	3.1-28(e) 483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to meet the Condition of Participation: Facility Staffing: due to the lack	W 158		

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W 158	Continued From page 143 of sufficient staff and staff training that affected 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC and DDD). Findings include: 1. Please refer to W159 as the QIDP (Qualified Intellectual Disabilities Professional failed to: coordinate and monitor assessments, active treatment implementation, data documentation, plan revisions and reviews, and Human Rights Committee review, approval, and monitoring of restrictive techniques for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 24 additional clients, (K, M, T, V, Y, AA, DD, FF, HH, II, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, YY, XX, AAA, BBB and DDD). 2. Please refer to W164 as the facility failed to: To ensure a professional program services clinician (behavioral consultant) was available to work with 5 of 10 sampled clients (clients A, B, G, H and J) and 7 additional clients (clients V, Y, AA, II, UU, SS, and XX) with identified behavioral needs. 3. Please refer to W176 as the facility failed to: Employee an individual with a graduate degree in social work (BSW/MSW) as staff or as a consultant for 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and	W 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 158	Continued From page 144 DDD living at the facility. 4. Please refer to W186 as the facility failed to: Provide sufficient staff to supervise and meet the needs of 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 26 additional clients (clients K, L, M, T, V, Y, AA, CC, DD, FF, GG, HH, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, WW, XX, YY, AAA, and BBB. 5. Please refer to W189 as the facility failed to: Ensure the facility staff were trained to do a 3 person lift for 1 of 10 sampled clients (client E). 6. Please refer to W193 as the facility failed to: Ensure direct care staff were trained to consistently implement the behavioral interventions specified in the individual behavior support plans (BSP) for 2 of 3 sampled clients (A and G) and 4 additional clients (AA, HH, II and SS) who had BSPs.	W 158		
W 159	3.1-14 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) coordinated and monitored assessments, active treatment implementation, data documentation, plan revisions and reviews, and Human Rights	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 145 Committee review, approval, and monitoring of restrictive techniques for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 24 additional clients, (K, M, T, V, Y, AA, DD, FF, HH, II, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, YY, XX, AAA, BBB and DDD). Findings include: 1. Please refer to W196 as the facility failed to: Ensure a continuous active treatment program was implemented at all opportunities for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 24 additional clients, (K, M, T, V, Y, AA, DD, FF, HH, II, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, YY, XX, AAA, BBB and DDD). 2. Please refer to W209 as the facility failed to: Encourage participation in the development of the Individual Program Plan/Behavior Support (IPP/BSP) by the parent/guardian of 2 of 10 sampled clients (clients A and G). 3. Please refer to W210 as the facility failed to: Ensure needed assessments were completed for 6 of 10 sample clients (clients C, D, E, F, I, and J) and 9 additional clients (clients L, M, FF, GG, JJ, PP, YY, AAA, BBB) who required assessments. 4. Please refer to W225 as the facility failed to: Assess clients' vocational skills to include work interest skills and opportunities for 3 of 10 sampled clients (clients C, D, and E). 5. Please refer to W227 as the facility failed to: Ensure a Behavior Support Plan stated specific objectives to meet Self Injurious Behavioral (SIB) needs to prevent 1 additional client (client HH) from punching himself in the face with his fists.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 159	Continued From page 146 6. Please refer to W230 as the facility failed to: Ensure the clients' Individualized Habilitation Plan (IHP) objective completion dates were reviewed and updated for 8 of 10 sample clients (A, B, C, F, G, H, I, J). 7. Please refer to W240 as the facility failed to: Include specific relevant supports in their Individual Program Plan (IPP) for 3 of 10 sampled clients (A, G, I) and 1 additional client (BBB). 8. Please refer to W247 as the facility failed to: Provide opportunities for choice dining room times, and the choice of when to leave the program room for 8 of 10 sampled (clients A, B, C, D, F, G, H, and I) and 12 additional clients (clients M, V, FF, II, JJ, PP, QQ, UU, VV, YY, AAA, and BBB). 9. Please refer to W249 as the facility failed to: Ensure clients' objectives were implemented as written for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 26 additional clients, (M, S, T, V, W, Y, AA, CC, FF, HH, II, JJ, KK, LL, QQ, RR, SS, TT, UU, VV, WW, YY, XX, AAA, BBB and DDD). 10: Please refer to W252 as the facility failed to: Record data to reflect individual performance for 8 of 10 sampled clients (clients B, C, D, E, F, H, I, and J) and 2 additional clients (clients DD and UU). 11. Please refer to W253 as the facility failed to: Develop a recording system to document client changes which included behaviors, events, and/or episodes for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 4 additional	W 159		

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W 159	Continued From page 147 clients (clients AA, HH, UU, and DDD). 12. Please refer to W262 as the facility failed to: Ensure the Human Rights Committee (HRC) reviewed, approved and monitored restrictive techniques for 2 of 4 sampled clients (clients A and G).	W 159		
W 164	7-4(a) 483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview, and record review for 5 of 10 sampled clients (clients A, B, G, H and J) and 7 additional clients (clients V, Y, AA, II, UU, SS, and XX), the facility failed to ensure a professional program services clinician (behavioral consultant) was available to work with the clients' identified behavioral needs. Findings include: 1. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J rubbed his eye with his left middle finger. Client H threw a block on the floor. Staff #80 asked client H to "stop." Client DDD repeatedly took his shirt off and staff #80 put it back on. Client J put his helmet strap back in his mouth after his helmet was placed	W 164		

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W 164	Continued From page 148 back on his head. Staff #57 was interviewed on 10/21/13 at 5:32 PM. He indicated client J often chewed on his shirt in addition to his helmet strap and stated, "He got it from staff," and indicated one of the staff assigned to client J's program room also chewed on his shirt. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU grabbed food from client V, and was redirected away from the dining room by staff #35. Client UU then walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth. Client Y lay on the floor in the recreation room or rocked back and forth on his feet. Client H was redirected away from looking out the window by staff #58, but did not respond. Client II lay on the floor, staff #66 placed her arms around to raise him up from the floor. Client II attempted to hit staff #66. Staff #66 indicated client II was to use a communication book to use to communicate his needs. Staff #66 stated, "We're not smacking our head or hitting [staff #66]. I'm asking you to get in the wheelchair. What's your problem?" Client II stood, dropped to the floor again, grabbed at staff #66, then tried to bang his head on the floor. Staff #66 stated, "I said No. Listen to Me. If you get much more aggressive, you're not giving me a choice." Staff #66 then asked staff to call for client II's helmet. "I know you're not happy because you know it's coming." Staff #66 placed her arms around client II from behind as she was seated on the floor, and stated, "You know sign language. There's no excuse." Client II then got into the wheelchair and was wheeled by staff #66 to program room 6.	W 164		

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W 164	Continued From page 149 During observations on 10/22/13 from 11:28 AM until 11:35 AM, client J had the strap of his helmet in his mouth, client UU had his hand in his mouth, and client Y lay on the floor. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA hit himself in the head. Staff #80 asked client AA what was wrong, but no activity was offered. Client J crawled on the floor. Client UU walked around with this hand in his mouth without direction to activity. Client VV had holes in his shirt. When staff #38 asked him if he chewed on it, client VV nodded his head "yes." Client UU had his hands in his mouth. Client V asked to take a walk. Client V was directed away from the door, and staff stated, "you have to have someone with you." Client H attempted to leave the room and was directed back. Client UU put a block in his mouth, and staff #65 stated, "[Client UU]. Don't put that in your mouth." Client UU's hands dripped saliva and he put his hand back in his mouth. Staff #38 was interviewed on 10/22/13 at 2:10 PM. She indicated the nursing staff had informed staff it was too cold to go outside for the clients. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Staff #42 was alone in room 6 with 9 clients V, Y, J, AA, DD, H, UU, VV, XX and B at 10:35 AM. Clients B and H were asleep in a chair at 10:35 AM. Client DDD crawled on the floor from one chair to another chair. Client DDD crawled on the floor, was redirected from sitting in the path of the doorway, and sat in a recliner without activity. Clients II and J lay on the floor during the observation. Client H lay on the floor and staff #42 gave a ball to client H and client H dropped the ball over his head.	W 164		

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W 164	Continued From page 150 Client UU walked around with a woven ball fastened around his neck on a plastic wire. Client J chewed on the strap of his helmet during the observation. Client UU put his hand in his mouth and walked around the program room. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Client II banged his head on the floor 4 times without redirection. Client II banged his head again and staff #42 asked client II to say "Please. If you want something, you have to talk. Do you want to play with something?" Staff #42 got client II a ball, but client II did not engage in activity with the ball, and got on the floor. Client II had discoloration around his eyes. At 11:20 AM, client II banged his head on the floor 5 more times as staff #42 spoke with client XX. Staff #42 picked up client J to move him. Client V was reminded to ask clients politely to move from his recliner when he pushed client DDD after he sat in client V's recliner. At 11:45 AM. At 11:50 AM, client H was pulled back from the doorway by staff #42 putting his arms around client H. Client H bumped into the doorway as he was pulled back into the room. At 11:56 AM, client II banged his head again, and staff #42 indicated client II would not wear a helmet. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." Staff #42 was interviewed on 10/23/13 at 11:20 AM. When asked about client II's discoloration around his eyes, he stated, "This is due to SIB	W 164		

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W 164	Continued From page 151 (self injurious behavior)." Observations were completed on 10/25/13 at 11:31 AM in program room 6. Client H was physically escorted back to the room when he left the room and staff (unidentified) stated, "You have to wait." Staff #48 was interviewed on 10/25/13 at 11:31 AM and indicated program room 6 was referred to as the behavior area. He stated, "behaviors are not behaviors to me, but lack of communication between staff and and clients." Observations were completed on 10/28/13 from 11:40 AM until 11:58 AM. Client II hit his head against the recliner with no redirection. At 12:58 PM client DDD sat in a chair with both of his hands down his pants. Client DDD had a wound with a with a dark center that had scabbed over. Staff #93 stated, "He picks at it all the time and won't leave a band aide on. He takes it off as soon as we put it on." Staff #93 called the nurse to come put another band aide over client DDD's area on his lower arm. Observations were completed on 10/29/13 from 12:55 PM until 1:10 PM. Client AA hit his ear 15 times without redirection from staff #497. The surveyor pointed out client AA hitting his head and he redirected him from hitting his head. Client II hit his head on the floor and had tears on his face after he was redirected from holding client J's helmet. Staff #497 was interviewed on 10/29/13 at 12:55 PM. He indicated client AA was to be redirected from hitting his head.	W 164		

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W 164	Continued From page 152 Staff #498 was interviewed on 10/29/13 at 1:05 PM. She indicated client II usually wears one, but doesn't wear one now due to an increase in behaviors when he wore one. Staff #498 indicated nursing staff had been notified of client II's behavior. Client J's record was reviewed on 10/24/13 at 1:20 PM. Client J's BMP effective 2/1/08 and updated 6/25/12 included Anti-Social Behavior defined as "hands in his pants, playing with self, actual masturbation, chewing on objects. [Client J's] main behavior at this time, is chewing on objects." A section Antecedent indicated, client J's "behavior appears to be cyclic. However, there is no known antecedent except possibly seeking attention. Usually he finds humor in the behaviors he exhibits. The program description indicated client J should be reinforced with one on one staff attention for 1 minute if he does not engage in any of the targeted behaviors, and if client J exhibits the targeted behavior, staff "should attempt to verbally interrupt the behavior...If [client J] bites down on an object and won't release it, offer him a drink of water or bite of something to eat...Never place your fingers in his mouth to get the object free. This could result in getting yourself bit..." The plan included the use of Prozac (anti-depressive) 20 mg (milligrams) daily. There was no evidence in client J's record that the BMP was developed by a behavioral consultant or client J received services of a behavioral consultant. Client B's record was reviewed on 10/29/13 at 2:06 PM. The BMP effective 3/16/10 and revised 6/1/13 indicated target behaviors "Anti-social behavior: Typically consisting of hitting, pulling hair, kicking others, cussing and spitting.	W 164		

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W 164	Continued From page 153 Antecedent: Typically [client B] will be aggressive prior to seizure activity. He appears to know that something is not right with him and he can't verbally communicate what it is. Other times (sic)." The plan included the use of Intuniv (Attention Deficit Hyperactivity Disorder) 2 mg, and physical holds of a Bearhug, Baskethold, Half Mat, and Full Mat. The Full Mat hold indicated staff were to straddle client B's chest and leg area while he lies on his side. There was no evidence in client record that the BMP was developed by a behavioral consultant or client B received services of a behavioral consultant. Client DDD's record was reviewed on 10/24/13 at 1:35 PM. Client DDD's record indicated he had lost 33.8 pounds since his admission on 5/13/13. Client DDD's 10/2013 physician's orders indicated client DDD was taking Prozac (anti-depressive) 20 milligrams a day for sexual frustration, Klonopin (anti-anxiety) 1 milligram three times a day for behavior modification and Trazadone 150 milligrams at bedtime to help client DDD sleep. Client DDD's informed consent of 8/28/13 indicated side effects of Prozac to be nervousness, anxiety, insomnia, headache, drowsiness, tremors, dizziness, nausea, diarrhea, dry mouth and anorexia (weight loss). Client DDD's Behavior Support Plan (BSP) dated 8/10/13 indicated target behaviors of Sexual Acting Out and Physical Aggression. Antecedent and Function of Behavior indicated client DDD's sexual acting out was "likely" caused by reaching puberty, and physical aggression "more likely occurs in a loud/disruptive environment,and not getting his way." The plan included Prozac 20 mg BID and Klonopin 0.5 mg BID. The plan indicated client DDD was to be redirected from placing his hands in his pants and to encourage	W 164		

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W 164	Continued From page 154 handwashing. There was no evidence in client DDD's record that the BMP was developed by a behavioral consultant or client DDD received services of a behavioral consultant, or his BMP had been updated to indicate current medications. Client UU's record in program room 6 was reviewed on 10/24/13 at 12:55 PM. Client UU's BMP dated 3/20/13 indicated he took Remeron (depression) 7.5 mg at bedtime, Depo Provera (hormonal imbalance) 150 mg every 3 months, Ativan (anxiety) 2 mg TID (three times daily), Saphris (schizophrenia/bi-polar) 10 mg BID, and Clonidine (ADHD) 0.2 mg BID. Client UU's indicated target behaviors of anti-social behavior of "mouthing of hands, pinching, hitting staff and clients, biting hand and spitting." There was no evidence in client UU's record that the BMP was developed by a behavioral consultant or client UU received services of a behavioral consultant. Client AA's record in program room 6 was reviewed on 10/29/13 at 1:31 PM. Client AA's BSP dated 2/1/13 indicated a goal "will refrain from self abusive behavior as evidenced by no more than 100 incidents a month for 3 consecutive months. Target behavior included Self-Abuse; hitting his head/ears, biting his hand, punching his head, smack his head, throwing himself backwards against a chair. There was no evidence in client AA's record that the BMP was developed by a behavioral consultant or client AA received services of a behavioral consultant. Client II's record in program room 6 was reviewed on 10/29/13 at 1:32 PM. Client II's BMP effective 3/23/95 included the use of Depo-Provera 150 mg, Risperdal 3 mg BID (twice daily), Clonidine.	W 164		

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W 164	Continued From page 155 0.2 mg BID, Naltrexone (opiate antagonist) 50 mg HS (bedtime), Lithium (manic depression) ER (extended release) 450 mg BID and the target behaviors of "biting hand or wrist and banging his head on the floor or hitting his head on his hands while lying on the floor and running into the wall, dropping to floor, hitting and choking staff...Although no definite antecedent is determined, it is believed that [client II] may engage in this behavior as a response to staff request or when excited." Client II's plan included the use of a helmet to address his self injurious behavior. There was no evidence in client II's record that the BMP was developed by a behavioral consultant or client II received services of a behavioral consultant. Staff #66/Human Resource Trainer was interviewed on 10/28/13 at 4:06 PM. She indicated she did all the training on the BMP's for the clients, and the behavioral specialist did not train staff on client plans. The Program Director was interviewed on 10/29/13 at 12:45 PM. She indicated the behavior consultant notes were not kept as part of the client record. She indicated the consultant had reviewed and revised clients B, J, II, V, Y, AA, XX, DDD's plans, and was in the process of updating client UU's plan. She indicated the behavior consultant had not yet written clients H and VV's plans. She indicated there was no evidence of the behavior consultant having written the plans or of training staff on the clients plans. She indicated she had written client DDD's initial plan and the behavior consultant had revised it. She indicated client II was not to use a helmet as it increased his behaviors, and sign language was to be included in his behavior plan	W 164		

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W 164	Continued From page 156 to address his behaviors. When asked if staff were using the plan located in the program room, she stated, "More than likely, Yes." 2. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. client A and client G were in the room with (direct care staff) DCS #11. Client A attempted to leave the room DCS #11 redirected her to put her shoes and socks on first. The QIDPD (Qualified Intellectual Disabilities Professional Designee) took client A out of the room for a walk. At 2:00 P.M. client A returned to the room with a CD player. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was returned to the room by the QIDPD at 2:24 P.M. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a loud sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors) she did not immediately offer client G her baseball hat or helmet due to intervening with client A's continued running behaviors. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. Observations were conducted in program room 4	W 164		

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W 164	Continued From page 157 on 10/21/13 from 3:30 P.M. until 5:43 P.M. Client A returned to the room at 3:37 P.M. DCS #66 assisted client A to sit at the table and had her work on cards pointing to the object the staff named. At 3:40 P.M. recreational staff assisted client G back to the program room. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room .Client SS got a CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest.	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 164	Continued From page 158 DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. A review of the behavior data cards for program room 4 for 10/21/13 through 10/23/13 for clients A and client G was completed on 10/24/13 at 3:45 P.M. The behavior data cards indicated client G had hit herself 20 times on 10/21/13. Client A had left the program room 55 times and had hit staff and other clients 35 times on 10/21/13. There were no cards available for review for 10/22/13 or 10/23/13. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client G's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients noses, Stripping: Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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STREET ADDRESS, CITY, STATE, ZIP CODE
303 FRANKLIN
ARCADIA, IN 46030

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W 164	Continued From page 159	W 164		

without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to: photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs and her body. Straddle her back to hold her in position."

Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 164	Continued From page 160 with a revision date of 9/2013. Client G's BMP indicated she had the targeted behaviors of Anti-Social: Self-Abuse: repeatedly hitting herself in the head and chin with her hand or toy, kicking her ankles. Physical Aggression: pull hair, scratch, hit, kick. Staff are to verbally praise her for appropriate activity, give her one-on-one time out of room once per shift after she performs an act of compliance. If self-abuse occurred, staff were to verbally interrupt the behavior, offer an item for her to manipulate, and guide her hands down and release repeating until the behavior stops. Client SS's record was reviewed on 10/23/13 at 8:09 P.M. Client SS's record indicated she had a BSP dated 2/6/13 with a revision date of 9/2013. Client SS's BSP indicated she had the targeted behaviors of pouting (sitting quietly, looking unhappy), agitation (pulling a chair away from the wall and throwing herself into it to make a noise, then kicking off her shoes and covering her face with her hands, facing the wall, mean statements to peers), temper tantrums consisting of verbal abuse (screaming, crying, name calling, telling others to 'shut up'), physical aggression (hitting, head butting, scratching, biting, kicking) and self-abuse (biting her arm, hitting her head/leg/arm with a clenched fist, self-inflicted scratches, etc.). She will also throw herself to the floor and 'trash' her bedroom." Staff were to praise appropriate behavior and appearance. Provide activities or IPP objectives. Polish her fingernails. Have her dictate a letter to mom. Client SS was to be able to earn time each hour for out of room activities (she was to set timer for 15 minutes to know when she was to return to the room). Staff were to encourage her identify emotions. Staff were to ignore pouting behavior,	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 164	Continued From page 161 provide attention/fun activity to peers. For temper tantrums staff were to remind her she lost her time out of room activity, have her sit in hall outside room, ask her to go to her room-with staff standing outside her door to monitor her. If she began to 'trash' her room remind her she needs to stop or her items will be removed. if she continued staff were to remove her items to another area and return them the next day. Encourage her to apologize. An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/24/13 at 12:45 P.M. When asked about further documentation for the injuries indicated above, the PD/QIDP stated, "I gave you everything I had. I understand sometimes the nurses see something and note it, but I am not notified." An interview was conducted with the DON on 10/24/13 at 2:48 P.M. The DON indicated direct care staff were to notify the nurses of any SIB or aggressive behaviors between clients so the nursing staff could complete an assessment. The facility's Behavior Management Policy dated 4/3/2006 with a revision date of 8/20/13 was reviewed on 10/30/13 at 10:02 A.M. The policy indicated "...This facility will formulate the necessary behavioral guidelines to define the need for interventions. these (sic) guidelines shall be composed through documentation, review of documented events via committee, creation of needed intervention through behavioral programming or alternate means, implementation of the least restrictive methods for identified maladaptive behaviors, tracking of the effectiveness of the methods chosen and	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 164	Continued From page 162 continued review or adaptations as warranted by altered behavior... Interventions shall include review of programmatic needs to address areas of anti-social behavior, client-to-client interaction, emotional needs and other areas of need identified through committee review. Data will be collected through the use of behavior cards in which staff record episodes of observed maladaptive or inappropriate behavior. These cards shall reflect the staff member's name, the date, the client's name, the time of the observed behavior, the type of the observed behavior (self injurious, physical aggression, etc.) An additional intervention card will contain information specific to the intervention used to interrupt the behavior. This card will be used to ensure that the least restrictive techniques have been implemented and documented for review. This data will be collected by any staff who directly observes the inappropriate behavior, documented and given to the Program Director (QIDP) each day at the end of their shift. The Program Director will then track, document and distribute this data to the Behavior Management Committee. All behavior programs formulated form (sic) this collected and reviewed data will also be critiqued by the Human Rights Committee (HRC) prior to implementation of a designated intervention...." The PD/QIDP was interviewed again on 10/30/13 at 4:15 P.M. When asked about Behavior Consultant/Ph.D. involvement, the PD/QIDP stated, "He comes monthly, makes notes, talks with staff, observes the clients. He keeps his own notes. I type up the changes to the BSP's for him, because he has terrible spelling." When asked to see notes for clients A, G, or SS, the QIDP was able to locate one, it was for client SS dated 2/6/13.	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 164	Continued From page 163	W 164		
	3.1-23(a)			
W 176	483.430(b)(5)(vi) PROFESSIONAL PROGRAM SERVICES	W 176		
	To be designated as a social worker, an individual must hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.			
	This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to employ an individual with a graduate degree in social work (BSW/MSW) as staff or as a consultant for 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I and J) and 46 additional clients (clients K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD living at the facility.			
	Findings include:			
	Facility employee records were reviewed on 11/4/13 at 1:30 P.M. including the record for the Activity Director/Social Service Designee (AD/SSD). The AD/SSD's record indicated he had successfully completed an Activity Director's 90 hour Basic Course developed by the Indiana Health Care Association on 3/13/2008. The AD/SSD's record indicated he had completed a 48 hour course for Social Service Designee. The AD/SSD's record did not indicate he had a			

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	15G580		C 11/06/2013

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STREET ADDRESS, CITY, STATE, ZIP CODE
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ARCADIA, IN 46030

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W 176	Continued From page 164 graduate degree in social work. An interview was conducted with the Administrator on 11/4/13 at 3:22 P.M. The Administrator stated, "We do not have a current contract with a social worker." The Administrator indicated the facility had not had a social worker or consultant social worker since the beginning of 2012. The Administrator indicated she had already contacted someone to fill the social worker consultant position in the future. The Administrator further indicated the Activity Director/Social Service Designee worked with clients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, and DDD living at the facility.	W 176		
	3.1-34(d)(3)			
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide sufficient staff to supervise and meet the needs of 10 of 10 sampled clients (clients A, B, C, D, E, F, G, H, I, and J) and 26 additional clients (clients K, L, M, T, V, Y, AA, CC, DD, FF, GG, HH, JJ, KK, LL,	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 165 PP, QQ, RR, SS, UU, VV, WW, XX, YY, AAA, and BBB). Findings include: 1. Client GG was observed in program room 5 on 10/22/13 from 8:10 A.M. until 9:00 A.M.. During the observation, there were a total of eight clients in program room 5. Client GG sat in a arm chair periodically changing positions in the chair. Client GG was not wearing a helmet or any other device or adaptive apparatus which would protect her from injuries due to falls. Direct care staff #60 was the only staff working with the clients in program room 5 during the 10/22/13 8:10 A.M. to 9:00 A.M. observation period. Direct care staff #60 was interviewed on 10/22/13 at 9:01 A.M.. Direct care staff #60 stated she was the only staff assigned to group room 5 "right now, this morning." She further stated, "There is a supervisor and float staff that comes in periodically or I can page staff for assistance if I need it." When asked what she would do if client GG had a seizure or began to fall from her chair, direct care staff #60 stated, "I would page the nurse if she (client GG) started having a seizure and I would do my best to not let her (client GG) fall." When asked if she could manage client GG falling while having a seizure, direct care staff #60 stated, "I'm not sure, I can only do my best." Incident reports and nursing notes for client GG were reviewed on 10/24/13 at 10:05 A.M. The review indicated client GG suffered the following falls: -10/20/13 incident report: "On October 20th, at approximately 5:05pm, [Client GG] fell in program	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 166 room after returning from [hospital] one hour prior. Preliminary nursing assessment noted moderate size hematoma (blood/fluid filled bruise) to the right side of [client GG's] suture line at the top of her head. Large amount of blood noted with [client GG] uncooperative for complete assessment. New orders were received from [client GG's] PCP (primary care physician) to send to [hospital] for evaluation and possible treatment. Plan to Resolve: [Client GG] was transported to [hospital] via facility van and the assistance of two staff members. [Client GG] received IV (intravenous) Depakote (anti-seizure medication) during her stay at [hospital] and returned to this facility at approximately 9:10pm. No new medications were prescribed for [client GG] for seizure activity, but will complete an appointment with her neurologist sometime next week. [Client GG] was place on 15 minute checks for additional monitoring throughout the night. [Client GG] returned to her normal group of peers this AM (morning) and attended a community outing without difficulty." -10/19/13 incident report: "On October 19th, at approximately 10:00 A.M., [client GG] was independently ambulating in her program room walking toward the group room closet. One of her peers scooted their chair out into her (client GG's) path. [Client GG] caught the toe of her shoe on the inside corner of her peer's chair leg. [Client GG] fell forward, without any attempt to break her fall. Plan to Resolve: New orders were taken to send [client GG] to [hospital] for evaluation. [Client GG] returned with staples closing the laceration to the top of her head at approximately 1:00PM. A CT (diagnostic x-ray scan) was completed during her evaluation with no negative findings from the scan. [Client GG]	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 167 consumed 75% of her afternoon meal and returned to her group of peers. Nursing has started a 48 hour neurological monitoring sheet." -10/12/13 nursing note: "Slipped and fell in program room. 0 (no) injury." -9/25/13 nursing note: "Outside with peers and fell. 3cm (centimeter) x(by) 2cm abrasion." -9/1/13 incident report: "At approximately 5:00PM on September 1, [client GG] was being assisted with her evening routine of putting on her pajamas. [Client GG] experienced a seizure, falling forward as staff broke her forward motion. [Client GG] struck her head on the handrail located next to the toilet without redness, discoloration or other areas noted to her head. Plan to Resolve: Nursing personnel initiated neurological checks. [Client GG] continued her routine of assisting with putting on her pajamas for the evening without further incident." -8/10/13 nursing note: "[Client GG] fell from chair to floor in group room." -8/9/13 incident report: "On August 9, 2013 at about 8:00 pm [client GG] experienced a drop seizure landing on her tailbone. She now has an 8cm x 9 cm bruise at that sight. She is not showing any signs or symptoms of pain or discomfort. She was able to sleep her normal manner during the night hours. She has resumed her normal daily routine. The DON (Director of Nursing), Program Director, Physician, Guardian and Administrator were notified on 8-9-13. Plan to Resolve: Nursing will continue to monitor her seizure activity and report to Neuro physician. Nursing will also monitor her vital signs and watch	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 168 for any discomfort or signs of ain. A skin sheet had been itiated (sic) to monitor the bruise until healed." -6/26/13 nursing note: "[Client GG] fell in group room. No injury." -4/29/13 nursing note: "Seizure, [client GG] fell, hit head, 2cm laceration stapled." Client GG record was further reviewed on 10/24/13 at 1:12 P.M.. The review indicated the client had a diagnosis, which included but was not limited to, seizure disorder. Further review indicated the client had a risk plan for falls dated 6/27/13. The risk plan for falls indicated client GG's history of "impaired vision when she has her helmet on" and a "possible risk of falling due to unsteady gait." The Program Director was interviewed on 10/25/13 at 10:41 A.M.. When asked if there was enough direct care staff in program room 5 to prevent client GG from falling, Program Director stated, "There is always two staff in the room and a third staff can be called when needed. There needs to be at least two staff in program room 5 to manage the clients in there." 2(a) Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 3:30 PM, on 10/21/13 from 3:40 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42 AM, on 10/24/13 from 8:30 AM until 9:45 AM, and on 10/24/13 from 3:25 PM until 4:00 PM, with clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW. During the observation periods clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were not	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 169 given the choice of activity by the facility staff. During these observation periods clients C, K, and T chewed on clothing protectors tied around their necks without activity and without redirection. During these observation periods two staff were on duty inside the Program Group #1 with twelve clients. One staff was continuously inside the bathroom with one client at a time and the second staff was alone inside the training area with the eleven other clients in the room. During the observation periods clients were not observed to have goals/objectives/activity schedules implemented. On 10/21/13 from 11:20 AM until 12:40 PM, clients CC, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were inside Program Group #1 with facility staff (FS) #31 and FS #41. Clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW rotated with facility staff to and from the dining room for lunch. On 10/23/13 from 1:00 PM until 3:30 PM and from 3:40 PM until 5:50 PM, clients sat in recliners, wheelchairs, were transferred between the two chairs (each personal wheelchair and recliners) individually, and taken to into the bathroom by one staff to toilet each client, and two staff were present. From 1:00 PM until 5:50 PM, clients C, T, and K chewed on clothing protectors tied around their necks without redirection. Clients in the room slept without redirection, interaction, and/or activity. Client HH struck himself in his face without redirection and no activity was offered. Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW did not have activity or interaction. At 2:05 PM, FS #31 stated "It is all we can do to keep them (the clients) dry." At 2:05 PM, male staff FS #31 walked to client E who was reclined in a recliner with her fractured	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 170 leg positioned upward in the recliner, pulled down the front of her pants, exposed her incontinent brief in full view, pulled down client E's brief which exposed client E's pubic area, and indicated client E was wet and needed changed to FS #41 who was across the program room. From 3:02 PM until 5:50 PM, FS #31 and FS #41 walked to each client and handed/laid an object on each client's lap. FS #31 continued toileting clients individually. FS #41 walked to each client and asked them a question about the weather. From 1:00 PM until 3:30 PM, client D was not assisted to the bathroom. At 3:30 PM, FS #31 assisted client D to the bathroom and indicated client D was wet from incontinence of urine. On 10/22/13 at 8:02 AM, an interview was conducted with FS #17. When asked what the clients in Program Group #1 were to do during waking hours. FS #17 stated "We can't really do much (active treatment). We keep them (the clients) dry." FS #17 indicated the facility staff checks and changes each client in Program Group #1 every two hours. FS #17 stated "all" clients in group #1 were a two person assist to transfer and client E was a three person assist. When asked if all the clients in the room were two person assist to transfer from their wheelchairs into recliners (and recliners to wheelchairs), why then does one staff take the client into the bathroom alone without two staff, FS #17 indicated he did not know. On 10/24/13 from 3:25 PM until 4:00 PM, FS #31 was the single staff person in Program Group #1 with twelve clients, clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW. Confidential Interview (CI) #3 stated "It's just like	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 171 the staff, no one is in the program rooms and when you're here (the State Department of Health), the staff is inside the rooms." Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's undated "(Program) Group 1 Daily Activity Schedule" indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, Economics, sensory stim (stimulation). (Client D did not have Economics listed on her activity schedule). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity. 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure, communication, choice of activities, TV, parties if scheduled, movies, group activity, bathing, special events, outing if applicable, etc." An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW stayed in Program Group #1 all day from rising in the morning until	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 172 going to bed at night. The QIDP/PD indicated clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW went to the dining room for meals and out of the program room. The QIDP/PD indicated each client should have received teaching and training during formal and informal opportunities throughout their time in the program room by the direct care staff. The QIDP/PD indicated there should be two (2) facility staff in the program room at all times when clients were present. The QIDP/PD stated with two staff in the program room "it's (it is) all the staff can do to keep clients dry and toileted." The QIDP/PD stated "I knew staffing" was going to be "a problem." The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's goals and active treatment schedules should have been implemented and indicated staff should have been prompting each client every 15 minutes and given them a choice of activities. 2(b) On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
303 FRANKLIN
ARCADIA, IN 46030

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W 186	Continued From page 173 around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. Client HH was not offered or encouraged activity. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 174 during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), for which resulted in right and left black, swollen, and discolored eyes. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." Client HH's non reportable incident report did not indicate behavioral rates, injuries caused by self injurious behaviors, and client HH's right eye injury. The QIDP indicated there was no one on one staff available for when client HH was SIB for his plan. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm.	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 175 Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 3. Observations were conducted at the facility on	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 176 10/21/13 between 1:30 PM and 5 PM. Upon entering group #2 there was one staff (#57) and nine clients (clients F, I, M, FF, JJ, PP, YY, AAA, and BBB). The television was on but no one in the room was watching and/or paying attention to what was on the television. All clients were sitting in recliners except for client BBB. __At 1:45 PM staff #57 stated, "I'm gonna find something for [client F] to throw." Staff #36 brought client I a pudding snack, fed it to her and left the room. Clients AAA and M were receiving a continuous tube feeding. Clients M, PP and AAA were laying in recliners with their eyes closed. Client BBB sat in a saucer chair with metal tubing for legs. The chair sat low to the floor preventing client BBB from standing on her own. Client BBB sat with her legs crossed, falling asleep, her head bobbing and neck hyperextended backwards. Client BBB's chair provided no neck support and/or no option for client BBB to stretch her legs. __Client F sat slumped to the right in a recliner, his hands were a dark purplish red in color. __At 2 PM staff #57 went from client to client with a book in his hand and reading. __At 2:15 PM staff #57 went into the bathroom that was attached to the program room to put something away. __At 2:10 PM staff #57 stated to client PP, "Wake up, did you not sleep last night?" Staff #57 lay a small stuffed bear beside client PP. Staff then approached client BBB and stated, "Wake up, come on you need to wake up." Staff #57 stated, "She can't get up on her own. She broke her hand on her new chair and now she's using her old chair until the other chair gets fixed." Staff #57 indicated client BBB slept a lot while in the program room. __At 2:20 PM staff #57 placed a clothing protector on client M. Staff #57 stated, "She	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 177 drools a lot." Staff #57 handed client M a mirror and stated, "She likes to look at her self in a mirror." Client M lay in the recliner with her eyes closed. __At 2:23 PM staff #57 placed a plastic toy on client F's lap and gave client I some small objects to put in a plastic cup. Client JJ was mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __At 2:30 PM staff #57 stated to client YY, "Can you tell me what kind of dog this is?" At the same time client A (a young small female from group 4) ran in the room and rushed over to the window, bounced off the windows and ran through the program room into the bathroom. Staff #57 ran after her and prompted her out of the bathroom and back into the program room. Client A was dragging a long jump rope with her and swing it around. Client A began knocking over all the items, toys, books and etc. on the self in the room. Staff #11 from group four came into the room and escorted client A out of the room. __At 2:37 PM staff #57 asked client F, "What kind of dog would you like?" Staff #57 shoed client F the book. Client YY said, "Me too." And staff #57 stated, "Ok, you have to wait till it's your turn and I get back to you." __At 2:30 PM another staff came and took client YY out of the room. __At 2:47 PM staff #57 and another staff from another room lifted client AAA out of the recliner and placed him into his wheelchair. __At 2:55 PM staff #57 and another staff from another room lifted client M out of the recliner and put her in her wheelchair. __At 2:57 PM staff #57 stated, "Come on [client PP] wake up. You shouldn't be sleeping this much." Client JJ still mouthing/sucking on his	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 178 hands and fingers. __At 3 PM clients M and AAA were wheeled out of the program room. Staff #57 was not alone in group two with 6 clients. Staff #57 stated, "Now, where were we?" And picked an object up out of the box. __At 3:02 PM client JJ was incontinent of urine. Staff #57 escorted client JJ to the bathroom and closed the door. Clients I, F, FF, PP and BBB sat alone and unsupervised in group two while staff #57 changed client JJ. __At 3:07 PM staff #44 arrived and stood in the group room. Client F dropped the toys on his lap to the floor. Client I sat fingering the items in her plastic cup. __At 3:10 PM staff #57 came out of the bathroom with client JJ. Client A ran back into the group room again from group four. Client A now had a long strand of materials tied together, running and laughing and pushing past staff to get to the bathroom in group 2. Staff #57 attempted to prompt client A to go back to her group without success. Staff #11 came in the room, wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced. When asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. Sometimes it's the only way to control her." Staff #44 left group room two to help staff #11 with client A. __At 3:15 PM staff #57 called someone to ask for a break. Staff #64 came to relieve staff #57 for a break. Staff #57 offered no training and or leisure choices while with the clients in group two. __At 3:40 PM staff #57 returned from his break. Client JJ still mouthing/sucking on his hands and fingers. Staff #57 asked client I if she wanted shaving cream and client I screamed, "No! No!	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 179 No!" Staff #57 smiled and put a dab of shaving cream on client I's right forearm and nose. Client I screamed again and turned her head away from staff #57. Staff #57 then asked client BBB if she wanted some shaving cream and client BBB looked away from staff #57. Staff #57 put some on client BBB's face, client BBB immediately started rubbing her face and got some of the shaving cream in her eyes. __At 3:42 RN (Registered Nurse) #1 came into the room to look at client BBB's right thumb and stated, "I don't know how she can sit for long hours like that in that chair. I couldn't hold my head up either and her neck has got to be breaking." __At 3:43 PM staff #44 wheeled client YY back to group two activity room. Another staff wheeled client AAA back to group two also. Staff #57 and staff #44 took client YY into the bathroom to change her adult brief. __At 3:50 PM client F continues to drop the plastic toy on the floor, staff #44 picked it up and gave it back to him. __At 4:30 PM staff #44 and staff #57 lifted client FF from the recliner and placed him in a wheel chair. Staff #57 took him to the bathroom. Staff #57 and #44 lifted client FF out of the wheelchair and onto the changing table. Staff #44 came out of the bathroom and woke client BBB up. Client BBB held out her arms for staff #44 to help her. Staff #44 grabbed client BBB by both forearms and pulled her to a sanding position. Staff #44 escorted client BBB to the dining room. Staff #57 was still in the bathroom with client FF and clients F, I, M, JJ, PP, YY and AAA remained unsupervised in group room two. __At 4:45 PM staff #57 came out of the bathroom with client FF. Staff #44 returned to group two. Staff #57 walked with client I to the dining room,	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 180 his arms interlocked under client I's arms, his knees touching the back of her legs. Client I was walking on her tip toes and taking one step at a time with staff #57 verbally and physically prompting client I to continue walking toward the dining room. Client I's gait was unsteady and slow and dependent of staff #57 to take one step at a time. __At 5:20 PM client I was wheeled from group two to the dining room. Client JJ still sat mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __During this observation the staff did not offer clients F, I , M, FF, JJ, PP, YY, AAA and BBB training objectives and or a choices of activities. The clients sat for long periods of time with prompting to activity. The staff did not provide client F with something to keep his hands warm. The staff did not provide client BBB a way to elevate her legs. The staff did not follow client JJ's and YY's BSP (Behavior Support Plan) On 10/25/13 at 1:35 PM clients F, I, M, FF, JJ, PP, YY, AAA and BBB were sitting in group room two, the radio was playing loudly, the television was on and there were no staff in the room. None of the clients in the room was watching the television. After waiting for 10 minutes, staff #57 came out of the bathroom. Staff #57 indicated he was the only staff in the room at the time and the clients were involved in watching television. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's IHP (Individual Habilitation Plan) of 2/14/13 indicated client F had the following objectives: __To grasp his brief prior to assisted changing. __To pull his shirt down over his head after	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 181 placement to assist with dressing. __To accept lotion in the palm of his hand. __To take one coin from the instructor when the coin is named. __To interact with one peer and one staff for at least 2 minutes. __To appropriately manipulate a desired item for 5 seconds. __To propel his own wheelchair one time per shift in the hallway for 15 feet. __To remove three items from his lap. Client F's record indicated client F had a diagnosis of, but not limited to, Raynauds Disease (a condition that causes some areas of the body such as fingers, toes, the tip of the nose and ears, to feel numb and cool in response to cold temperatures or stress). Client F's physician's progress note of 5/21/13 indicated "both feet deep purple - black at toes, feet cold and unable to find pulses both lower extremities. Left hand fingers deep purple cold. HR (heart rate) apical faint, radial pulse faint, both slow." The note indicated client F had a medical history of mild tricuspid insufficiency and blood clots in his left leg. The physician's order of 8/30/12 indicated an order to "Keep his hands and feet warm." Client I's record was reviewed on 10/23/13 at 2 PM. Client I's IHP of 11/8/12 indicated client I had the following objectives: __To match 3 different colored cups one at a time. __To remove 8 items from a shallow container one at a time. __To select the correct shaped object from a triangle and a circle. __To select a coin when shown with one other item.	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 182 __To ambulate to the dining room with minimal assistance. __To maintain her attention to selected task for at least 5 minutes. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's IHP of 3/31/13 indicated client M had the following objectives: __To look toward her reflection in the mirror presented by staff. __To look at the staff by turning her head to the left or right. __To track a noise or light device twice by moving her head. __To make three rocking motions in her rocking chair. __To respond with a smile or frown to textures placed in her hand. Client FFs record was reviewed on 10/24/13 at 1:30 PM. Client FF's IHP of 1/15/13 indicated client FF had the following objectives: __To appropriately manipulate a selected activity for five seconds. __To tolerate a selected item in his hand for ten seconds after placement. __To follow one simple request given one verbal prompt. __To allow touch of staff's hand for fifteen seconds. __To manipulate a penny for two seconds. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's IHP 8/22/13 indicated client JJ had the following objectives: __To participate in a small group activity for at least five minutes. __To pull himself up from his chair using staff's hands for assistance.	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 183 __To accept a coin in his hand for five seconds. __To manipulate a selected item appropriately for twenty five seconds. __To follow simple instructions of hands up, hands down and hand me. Client JJ's revised BSP (Behavior Support Plan) of 4/2/13 indicated client JJ had a targeted behavior of, but not limited to, mouthing his hands. The BSP indicated "[Client JJ] should be afforded the opportunity to have access to the items that he likes. Once every 30 minutes, [client JJ] should be afforded the opportunity to have one-on-one staff attention. During this time, encourage him to manipulate items. Allow him to choose the item he wants to manipulate. Verbally praise him for doing so. If he independently chooses to manipulate an item, staff should reward him with excessive verbal praise. Should [client JJ] exhibit the target behaviors, the staff should verbally interrupt.... If he continues, staff should attempt to verbally interrupt the behavior again. Allow him 10 seconds to comply. If he continues, staff should guide his hands down and release. Repeat as needed." Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's IHP of 11/29/12 indicated client PP had the following objectives: __To look in the direction of staff for five seconds. __To look in the direction of staff when his name is called. __To grasp a quarter for ten seconds when presented by the staff. __To listen for one minute to a story while staff are reading from a book or magazine. __To allow staff to rub textured items on the palm of his hand __To interact appropriately for 30 seconds with staff one to one.	W 186		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 186	Continued From page 184 Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's IHP of 9/19/13 indicated client YY had the following objectives: __To respond appropriately to the question of do you need to be changed. __To verbally name a quarter and a penny. __To count to twenty with the staff. __To verbally identify a magazine and a book. __To state whether she wants her hair up or down. __To move her head to the right or left as far as she can with a verbal prompt. Client YY's BSP of 6/15/10 indicated client YY had targeted behaviors of biting, cussing and spitting. The BSP indicated "Once every 30 minutes, staff should verbally praise [client YY] for appropriate behavior, no Anti-Social Behavior. In addition, should [client YY] not exhibit the Anti-Social Behavior for two consecutive hours, staff should spend two minutes interacting with her. Praise her for her good behavior...." Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's IHP of 1/31/13 indicated client AAA had the following objectives: __To extend both of his arms forward three times per shift. __To select a desired leisure item from a group of two or more leisure activities by moving his arm toward desired choice. __To place his own socks in his dresser one time per shift. __To select the appropriate coin when shown 2 coins __To turn one page of a magazine. __To verbally answer five questions about TV or music.	W 186		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 185 Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's IHP of 5/2/13 indicated client BBB had the following objectives: __To match a dime when given a dime and a quarter to choose from. __To uncross her legs prior to standing up from her chair. __To participate in a table activity with at least one other peer for five minutes. __To place her soiled clothes in the laundry barrel when appropriate. __To choose her own picture when presented with 2 differing pictures. __To answer 5 yes/no questions of her daily routine. Client BBB's 8/1/13 physician's orders indicated every two hours client BBB was to elevate her legs and feet for 30 minutes due to poor circulation. During interview with staff #57 on 10/21/13 at 3 PM, staff #57 indicated whenever a staff was working alone, the staff would have to call for help a lot because of the lifts and the toileting. Staff #57 stated, "We try to make sure everybody gets toileted at least before going to lunch and I think they are toileted before they come to the group room in the mornings. When asked if he was aware of each client's active treatment schedule and the objectives that were to be offered, staff #57 stated, "We have a program book in every room and we can look at that." Staff #57 stated on days when there is only one staff in group two "it's difficult." Interview with staff #28 on 10/23/13 at 11:20 AM indicated one person in a group room with nine to twelve clients was difficult to do. Staff #28 indicated when she was in a room alone, she	W 186		

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	15G580		C 11/06/2013

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W 186	Continued From page 186 found she often had to call for help and then wait. Confidential interview #20 stated it was "impossible" for one staff to provide active treatment to nine to 12 clients with only one staff in the room, "especially in group six." CI #20 stated, "It happens all the time." CI #20 indicated the clients were to be toileted and repositioned every two hours. CI #20 indicated that doesn't happen either. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated the staff were to follow the clients' program plans as written and provide the clients continual active treatment. The QIDP indicated the staff were to offer training objectives and/or choices of leisure activity every fifteen minutes whenever the clients were sitting idle or not involved in an activity. The QIDP indicated it was facility practice for the clients that were non ambulatory to be taken to the bathroom and their position changed every 2 hours. When asked how was it possible to provide active treatment to nine to twelve clients with one staff and provide toileting every two hours providing it takes on an average of 10 minutes per client to assist or change each client, the QIDP indicated the staff would have to call for help. Interview with the Administrator of 10/25/13 at 3 PM indicated staff to client ratio was 2 staff for every 11 clients or 1 staff to every 5 1/2 clients. 4. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J rubbed his eye with his left middle finger. Client H threw a block on the floor. Staff #80 asked client H to "stop."	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 187 Client DDD repeatedly took his shirt off and staff #80 put it back on. Client J put his helmet strap back in his mouth after his helmet was placed back on his head. There was only one staff in program room 6 during the observation. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth the size of a quarter on the floor. The surveyor pointed out the saliva on the floor to staff and it was then cleaned with a mop bucket. Client UU then continued to walk around the room with saliva dripping from his hands and was not prompted to wash his hands. Client G knocked a basket of toys on the floor and books and a bean bag were on the floor. Client BB kicked the toys and books on the floor as she walked around. Client Y lay on the floor in the recreation room. The program materials were not sanitized and client Y was not prompted to wash his hands. There were 2 staff (staff #58 and #7) and 14 clients in the recreation room. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Staff #42 was alone in room 6 with 9 clients V, Y, J, AA, DDD, H, UU, VV, XX and B at 10:35 AM. Clients B and H were asleep in a chair at 10:35 AM. Client DDD crawled on the floor from one chair to another chair. Staff #42 talked to the clients in the room about a volcano they had made in earlier that morning. The structure had paint on the mound. Client UU had 5 red marks on his face 1/8 of an inch or less. Client DDD crawled on the floor, and was redirected from sitting in the path of the doorway, and sat in a recliner without activity. Clients II and J lay on the floor during the	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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303 FRANKLIN
ARCADIA, IN 46030

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W 186	Continued From page 188 observation. Client H lay on the floor and staff #42 gave a ball to client H and client H dropped the ball over his head. At 11:05 AM, staff #42 and #35 were in the room. Client H was offered a ball again and dropped it behind his head. Staff #42 stated, to client H, "You love that ball." Client UU walked around with a woven ball fastened around his neck on a plastic wire. Client AA chewed on the strap of his helmet during the observation. Client UU put his hand in his mouth and walked around the program room. In the dining room, client AA ate food that spilled onto a non-skid mat from his plate. Client J sat with his helmet strap in his mouth. Client UU, DDD, H, II and J were not prompted to wash their hands. Client II banged his head on the floor 4 times without redirection. Client II banged his head again and asked client II to say "Please. If you want something, you have to talk. Do you want to play with something?" Staff #42 got client II a ball, but client II did not engage in activity with the ball, and got on the floor. Client S sat in a chair tapping on a clothespin. At 11:20 AM, client II banged his head on the floor 5 more times as staff #42 spoke with client XX stating, staff #495 was "taking kids to the dining room." During the observation, staff #65 took pictures of a clock made using a potato and wires. The clock on a wall in the room was 2 hours slow. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Staff #42 was interviewed on 10/23/13 at 10:36 AM and indicated usually there were two staff in the room. Staff #42 was interviewed on 10/23/13 at 11:25 AM. He indicated he was unable to take clients to	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 186	Continued From page 189 the restroom and there needed to be 2 staff in each room in order for clients to be able to use the restroom. Observations were completed on 10/29/13 from 12:55 PM until 1:10 PM. Client AA hit his ear 15 times without redirection from staff #497. The surveyor pointed out client AA hitting his head and he redirected him from hitting his head. At 1:00 PM, client DDD had not yet been taken to the dining room. Client II hit his head on the floor and had tears on his face after he was redirected from holding client J's helmet. Clients Y, AA and J were on the floor without activity and clients UU and H were sitting in chairs without activity. Client DDD left to go to the dining room at 1:00 PM. Staff #42 was interviewed on 10/29/13 at 1:00 PM. When asked if client DDD normally ate at 1:00 PM, he indicated, "No. We are probably short." The Program Director was interviewed on 10/25/13 at 2:40 PM and indicated there should always be 2 staff in program room 6. 5. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. client A and client G were in the room with (direct care staff) DCS #11. Client A was not engaged in any activity. Client A ran out of the program room eight times during the observation period. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a sound.	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 186	Continued From page 190 Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors) she did not immediately offer client G her baseball hat or helmet due to intervening with client A's continued running behaviors. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room preparing to have a morning snack. Client G was wearing her helmet. Client A was asleep in a chair. When client A saw the snacks she woke up and ate	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 191 some snack crackers. DCS #36 assisted client A to the restroom to wash her face and hands. While DCS #36 and client A were in the restroom client G ate pieces of crackers off of the floor. Client SS got a CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G, who was alone in the room, threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. Client G's record was reviewed on 10/23/13 at 11:23 A.M. 8/24/13 at 12:45 P.M. Nursing Note: "Called for assessment. Per staff when coming out of bathroom with another client they observed client pulling (client G's) hair, pulling her to the floor. Causing her to bite her tongue and hitting her head. The two clients were separated." Client A's record was reviewed on 10/23/13 at 2:42 P.M. 8/24/13 at 12:45 P.M. Nursing Note: "Called for assessment. Per staff when coming out of bathroom with another client they observed client A pulling (client G's) hair, pulling her to the floor. Causing her to bite her tongue and hitting her head. The two clients were separated." An interview was conducted with DCS #48 on	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 186	Continued From page 192 10/25/13 at 12:51 P.M. DCS #48 stated, "Yeah, we work short a lot. We just can't seem to get enough staff to have two in here." An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/30/13 at 4:18 P.M. When asked how many staff were to be in each room, the PD/QIDP stated, "Two staff are to be in each of the program rooms at all times, even in program room four." 3.1-13(b) 3.1-37(a)	W 186		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the facility staff were trained to do a 3 person lift for 1 of 10 sampled clients (client E). Findings include: On 10/21/13 at 12:20pm, client E was observed sitting in her wheel chair in the main dining room. Client E was non verbal, her legs were extended outward from her wheel chair, and client E wore a fracture boot (appliance used to stabilize fracture as it healed) on her left leg. At 12:20pm, facility staff #64 stated client E fractured her fibula on her left leg "about" six (6) weeks ago. At 2:00pm,	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 189	Continued From page 193 facility staff #41 and RN (Registered Nurse) #5 both indicated client E was a three person lift to transfer from her wheel chair to another location because of her left leg fracture. At 2:00pm, facility staff #31 and RN #5 checked client E's left leg. RN #5 removed client E's left leg fracture boot, stated client E had a "1 1/2cm" red area on her left inner ankle where her fracture boot had rubbed against the skin. At 3:10pm, client E was assisted back to Program Room #1 with facility staff #30, #31, and #80 entered Program Room #1 and approached client E who sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #30 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #31 grasped client E's fracture boot on her left leg. Facility staff #80 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #80 stated "I pull the handles together" which he did and lifted client E with on hand holding both handles. When facility staff #80 held the sling handles together at her hips, client E's left leg moved to overlap her right leg and was squeezed in/by the sling. Client E's face wrinkled and her eyebrows connected to form a line on her forehead. Client E's face was red and watery. Client E made high a pitched vocalization when she was moved and the pitch went higher when her left leg was squeezed by the sling. On 10/24/13 at 8:30am, upon entering the facility at the front conference room, vocalizations were heard (crying and yelling out). At 8:30am, the surveyor followed sounds by walking down the front hallway and down the second hallway to Program Room/Group #1 located on the second hallway. The DON (Director of Nurses) was in the	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 189	Continued From page 194 doorway to the entrance of the room. Inside the room was client E, who was crying and yelling out. Client E sat in a wheelchair with her left leg elevated, wore a fracture boot on her left lower leg, and client E's left foot was turned sideways on top of a positioning pillow. At 8:30am, LPN (Licensed Practical Nurse) #7, facility staffs #28, and #37 stood around client E's wheelchair. The three staff offered client E different cause/effect items which client E refused and she continued to cry and yell. At 8:30am, the DON indicated client E had been crying and yelling "for about fifteen minutes" (or since 8:15 am). At 8:45am, the DON was overheard to instruct LPN #7 to administer client E's PRN (as needed) pain medication "now." From 8:30am until 8:45am, LPN #7 instructed the facility staff to transfer client E into a recliner and out of her wheelchair. At 8:45am, client E was approached by facility staff #17, #28, and #37 to transfer her into a recliner chair inside the program room. Client E sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #37 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #28 grasped client E's fracture boot on her left leg. Facility staff #17 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #17 stated "I pull the handles together" which he did and lifted client E with one hand holding both handles. When facility staff #17 held the sling handles together at her hips, client E's left leg moved together with client E's right leg, and client E's legs were squeezed together in/by the sling. Client E's face was red, wrinkled, her eyebrows leveled, and she continued to cry and yell. Client E made high pitched vocalizations when she was moved and the pitch went higher	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 189	Continued From page 195 when her left leg was squeezed by the sling. From 8:45am until 8:48 am, client E was calmer but continued to make vocalizations. At 8:50 am, client E was crying and yelling again while seated in the recliner. At 8:50 am, facility staff #28 stated "She (client E) seems like (she's) in pain" and facility staff #28 held client E's hand while client E continued to cry and yell. At 8:50am, facility staff #64 entered the program room and stated to the facility staff "if the med (medication) doesn't help, come and get me." At 8:55am, facility laundry/housekeeping staff #82 entered the program room, talked to client E, and tried to reassure client E to calm her. Client E continued to thrash her head back and forth, cried and yelled, and her face was red. At 9:00am, facility laundry/housekeeping staff #82 stated "I've never seen her like this before, She's either upset or in pain." Staff #82 indicated she had been employed at the facility over nineteen years (19 years) and had a rapport with client E. At 9:00am, the DON returned to the program room and asked staff to assist client E to her bed room and for client E to go back to bed. From 9:00 am until 9:10am, client E was wheeled in the recliner from the program room, down the hallways to client E's bedroom (room #36), and transferred from the recliner into her bed. At 9:10am, client E continued cry and yell and to have a red face. At 9:40am, client E was observed calm and in bed. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. An 8/16/13 BDDS (Bureau of Developmental Disabilities Services) report indicated "On August 15th at approximately 5:40 AM, staff entered [client E's] bedroom to prep and assist [client E] with getting for her daily routine (sic). Staff stated that they removed [client E's] covers and touched her foot.	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 189	Continued From page 196 Upon touching her foot, staff stated that [client E] cried out. Reporting staff further stated that they then removed her sock in an attempt to determine what caused [client E] to cry out. [Client E] then cried out in a louder tone. Staff then stated that they left [client E] in her bed and alerted nursing personnel of the situation for further assessment. The following nursing assessment is as follow: [Client E's] left foot was noted with full range of motion capabilities. Under normal conditions, [client E's] tone and overall range of motion capabilities are minimal. Additionally, slight edema was noted to [client E's] left foot and ankle area with less than 3 seconds for cap (capillary) refill. Plan to resolve: Nursing placed a splint/rigid boot on [client E's] left foot/ankle and contacted her PCP (Primary Care Physician) for instructions. New orders were obtained to send [client E] for x-rays of [client E's] left foot and ankle area...." Client E was taken for x-rays at a nearby facility at 8 AM and returned to the facility at 10:20 AM. At 12 PM, client E's PCP called the facility with new orders for client E to "immediately" see an orthopedic surgical doctor due to x-ray results "regarding left leg fractures." The report indicated the following x-ray results: __"Acute, minimally displaced spiral fracture of the distal tibia diaphysis." __"Acute, non-displaced distal fibular diaphyseal (pertaining to or affecting the shaft of a long bone) fracture." __"Diffuse bone demineralization." __"Ped planus (flat foot) deformity of the foot." The 8/16/13 BDDS report indicated client E was taken to a local hospital and another set of X-rays were completed at [name of hospital]. The findings of the x-rays were as follows: __"Non-displaced spiral fracture of the distal tibial	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 189	Continued From page 197 diaphysis (the main or midsection shaft of a long bone)." __"Non-displaced spiral Weber type C fracture of the adjacent fibula with no significant joint space widening." __"Extensive bony demineralization without convincing evidence for acute fracture." The report indicated "Immediate Action Taken: New orders from [name of hospital] were to apply ice for swelling, provide Tylenol 500 mg (milligrams) Q (every) 4 hours for pain and follow up with an orthopedic consult within 6 days. On August 16th, nursing personnel scheduled an appointment with [name of doctor] for August 21st at 10:15 AM.... [Client E] has also been scheduled for a bone density diagnostic on August 30th. The 8/16/13 BDDS report indicated the facility had implemented the following measures in response to the current x-ray findings: __"[Client E's] wheelchair foot box has been widened approximately 3 additional inches to facilitate additional protection when [client E] is up in her wheelchair." __"A three-man lifting protocol has been designed to ensure the protection of her [client E's] leg." __All appropriate staff have been in-serviced regarding "client E's" current condition and on the protocol for lifting." __"[Client E's] recliner has been modified, in height, to allow for smooth transitioning during three man-lifting." Review of client E's record on 10/22/13 at 2 PM indicated diagnoses of, but not limited to, Epilepsy, Cerebral Palsy with spastic quadriparesis (arms and legs) with associated hyperflexia (the over flexing/bending of a limb),	W 189		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 189	Continued From page 198 Congenital left hip dysplasia, Bilateral Pulmonary Emboli (blood clots), incontinence of bowel and bladder, risk of aspiration, Osteopenia (low bone mineral density), fractured left distal femur and Osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density that leads to an increased risk of fracture). Client E's record indicated client E was non verbal and non-ambulatory. Client E used an adaptive wheelchair for transportation. __Client E's Radiology report of 5/21/12 indicated "Evidence of fracture which appears acute over the distal femur at the level of the femoral condyles (round projection at the end of a long bone) anterior rotation or displacement of the distal femoral metaphysis (the wide part at the end of a long bone) in relation to the diaphysis is present. Diffuse bone osteopenia (reduced bone mass) with postoperative changes stable over the proximal left femur and changes of chronic hip dysplasia." __Client E's Radiology Report of 7/16/12 indicated "Severe osteoporosis, Distal femoral fracture appears healing, could be old injury...." __Client E's Adaptive Skills Assessment of 10/22/12 indicated client E was a non-ambulatory female "who uses a tilt in space wheelchair with custom molded inserts pelvic stabilizer and shoe holders. She can make eye contact and can turn her head. [Client E] has minimal active movement of the extremities with no attempts to roll. She can flex and rotate her head when in supine. [Client E] has decreased bilateral hip flexion in extension and rotation, ankle inversion, decreased bilateral shoulder flexion, abduction and rotation, wrist extension and forearm supination (a kind of rotation). [Client E] displays decreased muscle tone and strength in her neck and trunk. She displays decreased muscle tone in	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 189	Continued From page 199 all extremities with poor muscle strength. [Client E] requires total support in all positions. [Client E] presents with a forward flexed head tilted to the right, neuromuscular scoliosis." __Client E's Fall Fracture Risk Plan dated 10/20/12 indicated client E was at risk for falls and/or fractures. The plan indicated client E was non ambulatory and the staff were to use a "3 man lift" with transfer sling to transfer resident from bed to wheelchair to recliner. __Client E's Osteoporosis Risk Plan of 11/7/12 indicated client E was at "Risk of injury during self repositioning, transferring from bed to chair or vice versa.... Protect client using sling to transfer from bed to wheelchair, wheelchair to recliner.... Monitor for any discomfort/pain. Use sling for all transfers...." Review of the lifting protocol for client E dated 8/15/13 on 10/22/13 at 3 PM indicated when transferring client E from the wheelchair to the bed or from the bed to the wheelchair the staff were to: A) Ensure client E had the appropriate sling positioned under her. B) The first staff was to position themselves at client E's right side. "This should be completed as a measure to protect her feet. C) The second staff member was to be positioned on client E's left side, "firmly grasping each corner of the sling to assist with sliding [client E] into her bed." D) The third member at client E's head should control the count (1, 2, 3, lift); to ensure client E is lifted in unison. E) After client E was positioned in her bed, staff were to use the sling to move client E within her bed. F) The staff were to ensure client E's bedrails	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 189	Continued From page 200 were up securely and to ensure padding over both bedrails and positioned at the bottom portion of her bed. The protocol indicated to transfer client E from/to her wheelchair to her recliner: A) The staff were to repeat steps A through F. B) The staff were to be aware of the slight drop/lift when transferring her during this time. The protocol indicated until further notice as a measure to ensure client E's safety, client E was to be provided a bed bath. Review of the facility staff training records on 10/22/13 at 3 PM indicated 5 nursing staff and 11 direct care staff had not trained to do a 3 person lift. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated it was possible client E could have been injured when she was repositioned during the night and/or during the two person lift. The QIDP stated the facility did not use mechanical lifts. The QIDP stated client E had a history of breaks and "brittle bones" and after client E's injury the facility implemented a three person lift until client E's leg was healed. The QIDP indicated all nursing and direct care staff were to be trained to do a three person lift. The QIDP indicated she had trained the first group of staff and nursing was responsible for training the rest of the staff. The QIDP stated, "Apparently that didn't happen." The QIDP indicated client E was the only client requiring a three person lift. All other clients were a two man lift and/or a one man lift. 2-7-3(a) 3.1-13(b)(1) 3.1-13(b)(2)	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure direct care staff were trained to consistently implement the behavioral interventions specified in the individual behavior support plans (BSP) for 2 of 3 sampled clients (A and G) and 4 additional clients (AA, HH, II and SS). Findings include: 1(a). On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 193	Continued From page 202 had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. Client HH was not offered or encouraged activity. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 193	Continued From page 203 one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." No staff training or retraining was available for review. An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), for which resulted in right and left black, swollen, and discolored eyes. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's reports did not indicate staff training was completed. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 193	Continued From page 204 medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's 10/21/13 BSP was not available for the facility staff to use. No staff retraining for client HH's 10/21/13 BSP was available. Client HH's behavior data, injury information, and staff retraining were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data, injury records,and staff retraining records was given. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm, did not indicate if staff were retrained or monitored to ensure client HH's BSP was implemented and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 193	Continued From page 205 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 2. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client II lay on the floor, staff #66 placed her arms around to raise him up from the floor. Client II attempted to hit	W 193		

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W 193	Continued From page 206 staff #66. Staff #66 indicated client II was to use a communication book to use to communicate his needs. Staff #66 stated, "We're not smacking our head or hitting [staff #66]. I'm asking you to get in the wheelchair. What's your problem?" Client II stood, dropped to the floor again, grabbed at staff #66, then tried to bang his head on the floor. Staff #66 stated, "I said No. Listen to Me. If you get much more aggressive, you're not giving me a choice." Staff #66 then asked staff to call for client II's helmet. "I know you're not happy because you know it's coming." Staff #66 placed her arms around client II from behind as she was seated on the floor, and stated, "You know sign language. There's no excuse." Client II then got into the wheelchair and was wheeled by staff #66 to program room 6. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA hit himself in the head. Staff #80 asked client AA what was wrong, but no activity was offered. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Client II banged his head on the floor 4 times without redirection. Client II banged his head again and staff #42 asked client II to say "Please. If you want something, you have to talk. Do you want to play with something?" Staff #42 got client II a ball, but client II did not engage in activity with the ball, and got on the floor. Client II had discoloration around his eyes. At 11:20 AM, client II banged his head on the floor 5 more times as staff #42 spoke with client XX. At 11:56 AM, client II banged his head again, and staff #42 indicated client II would not wear a helmet. Staff #42 was interviewed on 10/23/13 at 11:20	W 193		

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	15G580		C 11/06/2013

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W 193	Continued From page 207 AM. When asked about client II's discoloration around his eyes, he stated, "This is due to SIB (self injurious behavior). Staff #48 was interviewed on 10/25/13 at 11:31 AM and indicated program room 6 was referred to as the behavior area. He stated, "behaviors are not behaviors to me, but lack of communication between staff and and clients." Observations were completed on 10/28/13 from 11:40 AM until 11:58 AM. Client II hit his head against the recliner with no redirection. Observations were completed on 10/29/13 from 12:55 PM until 1:10 PM. Client AA hit his ear 15 times without redirection from staff #497. The surveyor pointed out client AA hitting his head and he redirected him from hitting his head. Client II hit his head on the floor and had tears on his face after he was redirected from holding client J's helmet. Staff #497 was interviewed on 10/29/13 at 12:55 PM. He indicated client AA was to be redirected from hitting his head. Staff #498 was interviewed on 10/29/13 at 1:05 PM. She indicated client II usually wears a helmet, but doesn't wear one now due to an increase in behaviors when he wore one. Staff #498 indicated nursing staff had been notified of client II's behavior. Client AA's record in program room 6 was reviewed on 10/29/13 at 1:31 PM. Client AA's BSP dated 2/1/13 indicated a goal "will refrain from self abusive behavior as evidenced by no more than 100 incidents a month for 3	W 193		

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W 193	Continued From page 208 consecutive months. Target behavior included Self-Abuse; hitting his head/ears, biting his hand, punching his head, smack his head, throwing himself backwards against a chair." Client II's record in program room 6 was reviewed on 10/29/13 at 1:32 PM. Client II's BMP effective 3/23/95 included the use of Depo-Provera 150 mg, Risperdal 3 mg BID (twice daily), Clonidine. 0.2 mg BID, Naltrexone (opiate antagonist) 50 mg HS (bedtime), Lithium (manic depression) ER (extended release) 450 mg BID and the target behaviors of "biting hand or wrist and banging his head on the floor or hitting his head on his hands while lying on the floor and running into the wall, dropping to floor, hitting and choking staff...Although no definite antecedent is determined, it is believed that [client II] may engage in this behavior as a response to staff request or when exited." Client II's plan included the use of a helmet to address his self injurious behavior. Staff #66/Human Resource Trainer was interviewed on 10/28/13 at 4:06 PM. She indicated she did all the training on the BMP's for the clients, and the behavioral specialist did not train staff on client plans. The Program Director was interviewed on 10/29/13 at 12:45 PM. She indicated client II was not to use a helmet as it increased his behaviors, and sign language was to be included in his behavior plan to address his behaviors. When asked if staff were using the plan located in the program room, she stated, "More than likely, Yes." 3. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M.	W 193		

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	15G580		C 11/06/2013

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W 193	Continued From page 209 client A and client G were in the room with (direct care staff) DCS #11. Client A attempted to leave the room DCS #11 redirected her to put her shoes and socks on first. The QIDPD (Qualified Intellectual Disabilities Professional Designee) took client A out of the room for a walk. At 2:00 P.M. client A returned to the room with a CD player. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was returned to the room by the QIDPD at 2:24 P.M. Client A had a jump rope she was dragging around on the floor behind her. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors) she did not immediately offer client G her baseball hat or helmet. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no." After client A hit/flipped client G in the head/face DCS #66 assisted client A to a	W 193		

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W 193	Continued From page 210 chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room. Client G was wearing her helmet. Client A was asleep in a chair. When client A saw the snacks she woke up and ate some snack crackers. DCS #36 assisted client A to the restroom to wash her face and hands. While DCS #36 and client A were in the restroom client G ate pieces of crackers off of the floor. Client SS got a CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then	W 193		

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ARCADIA DEVELOPMENTAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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ARCADIA, IN 46030

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W 193	Continued From page 211 threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. At 10:15 A.M. the QIDP brought a MP3 player with headphones to the room for client A and assisted client A in putting them on. Client A smiled. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client G's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients noses, Stripping: Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to:	W 193		

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W 193	Continued From page 212 photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs and her body. Straddle her back to hold her in position. Client A's BSP was not implemented during any of the three observations. Staff did not utilize a fanny pack with a MP3 player, did not utilize reward cards and did not use edible reinforcement. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03 with a revision date of 9/2013. Client G's BMP indicated she had the targeted behaviors of Anti-Social: Self-Abuse: repeatedly hitting herself in the head and chin with her hand or toy, kicking her ankles. Physical Aggression: pull hair, scratch, hit, kick. Staff are to verbally praise her for appropriate activity, give her one-on-one time	W 193		

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W 193	Continued From page 213 out of room once per shift after she performs an act of compliance. If self-abuse occurred, staff were to verbally interrupt the behavior, offer an item for her to manipulate,and guide her hands down and release repeating until the behavior stops. Client G's BSP was not implemented during any of the three observations. Staff did not give verbal praise for appropriate behavior and did not give her one-on-one time out of the room. Client SS's record was reviewed on 10/23/13 at 8:09 P.M. Client SS's record indicated she had a BSP dated 2/6/13 with a revision date of 9/2013. Client SS's BSP indicated she had the targeted behaviors of pouting (sitting quietly, looking unhappy), agitation (pulling a chair away from the wall and throwing herself into it to make a noise, then kicking off her shoes and covering her face with her hands, facing the wall, mean statements to peers), temper tantrums consisting of verbal abuse (screaming, crying, name calling, telling others to 'shut up'), physical aggression (hitting, head butting, scratching, biting, kicking) and self-abuse (biting her arm, hitting her head/leg/arm with a clenched fist, self-inflicted scratches, etc.). She will also throw herself to the floor and 'trash' her bedroom." Staff were to praise appropriate behavior and appearance. Provide activities or IPP objectives. Polish her fingernails. Have her dictate a letter to mom. Client SS was to be able to earn time each hour for out of room activities (she was to set timer for 15 minutes to know when she was to return to the room). Staff were to encourage her identify emotions. Staff were to ignore pouting behavior, provide attention/fun activity to peers. For temper tantrums staff were to remind her she lost her time out of room activity, have her sit in hall outside room, ask her to go to her room-with staff	W 193		

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W 193	Continued From page 214 standing outside her door to monitor her. If she began to 'trash' her room remind her she needs to stop or her items will be removed. if she continued staff were to remove her items to another area and return them the next day. encourage her to apologize. Client SS's BSP was not implemented during any of the three observations. Staff did not encourage her to identify her emotions, did not work on her ISP goals, polish her nails, or use a timer to allow her time out of the room. An interview was conducted with the Human Resource/Trainer (HRT) on 10/30/13 at 3:20 P.M. The HRT stated, "Yes I train the staff on behavior interventions." An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/30/13 at 3:45 P.M. The PD/QIDP stated, "No there is no client specific training on behavior support plans. We do have orientation and they are trained on behavior interventions, but it is not person specific. I don't know if they do person specific training for medical issues, it would be completed by nursing."	W 193		
W 195	3.1-13(b)(2) 483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record	W 195		

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W 195	Continued From page 215 review for 10 of 10 sampled clients (A, B,C, D, E, F, G, H, I, J) and 31 additional clients (K, L, M, S, T, V, W, Y, AA, CC, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, AAA, BBB, and DDD), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure clients received a continuous and aggressive active treatment program which addressed the training needs of each client, failed encourage participation in the development of individual program plans, failed to ensure accurate assessments and/or re-assessments were completed as needed, failed to assess clients' vocational needs, failed to ensure specific objectives were included in Individual Program Plans, failed to ensure completion dates were accurate in individual program plans, failed to include relevant supports in Individual Program Plans, failed to ensure client opportunities for choice, failed to ensure facility staff implemented clients' program schedules, behavior and program plans, failed to ensure clients' recorded data reflected individual performance, failed to develop a recording system to document client behaviors and events, and failed to ensure the facility's Human Rights Committee reviewed, approved and monitored restrictive techniques. The facility failed to ensure the QMRP (Qualified Mental Retardation Professional) monitored and/or coordinated clients' programs as needed. Findings include: 1. Please refer to W196 as the facility failed to: Ensure a continuous active treatment program was implemented at all opportunities for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 24 additional clients, (K, M, T, V, Y, AA, DD,	W 195		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 195	Continued From page 216 FF, HH, II, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, YY, XX, AAA, BBB and DDD). 2. Please refer to W209 as the facility failed to: Encourage participation in the development of the Individual Program Plan/Behavior Support (IPP/BSP) by the parent/guardian of 2 of 10 sampled clients (clients A and G). 3. Please refer to W210 as the facility failed to: Ensure needed assessments were completed for 6 of 10 sample clients (clients C, D, E, F, I, and J) and 9 additional clients (clients L, M, FF, GG, JJ, PP, YY, AAA, BBB) who required assessments. 4. Please refer to W225 as the facility failed to: Assess clients' vocational skills to include work interest skills and opportunities for 3 of 10 sampled clients (clients C, D, and E). 5. Please refer to W227 as the facility failed to: Ensure a Behavior Support Plan stated specific objectives to meet Self Injurious Behavioral (SIB) needs to prevent 1 additional client (client HH) from punching himself in the face with his fists. 6. Please refer to W230 as the facility failed to: Ensure the clients' Individualized Habilitation Plan (IHP) objective completion dates were reviewed and updated for 8 of 10 sample clients (A, B, C, F, G, H, I, J). 7. Please refer to W240 as the facility failed to: Include specific relevant supports in their Individual Program Plan (IPP) for 3 of 10 sampled clients (A, G, I) and 1 additional client (BBB). 8. Please refer to W247 as the facility failed to: Provide opportunities for choice dining room	W 195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 195	Continued From page 217 times, and the choice of when to leave the program room for 8 of 10 sampled (clients A, B, C, D, F, G, H, and I) and 12 additional clients (clients M, V, FF, II, JJ, PP, QQ, UU, VV, YY, AAA, and BBB). 9. Please refer to W249 as the facility failed to: Ensure clients' objectives were implemented as written for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 26 additional clients, (M, S, T, V, W, Y, AA, CC, FF, HH, II, JJ, KK, LL, QQ, RR, SS, TT, UU, VV, WW, YY, XX, AAA, BBB and DDD). 10: Please refer to W252 as the facility failed to: Record data to reflect individual performance for 8 of 10 sampled clients (clients B, C, D, E, F, H, I, and J) and 2 additional clients (clients DD and UU). 11. Please refer to W253 as the facility failed to: Develop a recording system to document client changes which included behaviors, events, and/or episodes for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 4 additional clients (clients AA, HH, UU, and DDD). 12. Please refer to W262 as the facility failed to: Ensure the Human Rights Committee (HRC) reviewed, approved and monitored restrictive techniques for 2 of 4 sampled clients (clients A and G).	W 195		
W 196	3.1-35(a) 483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive,	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 196	Continued From page 218 consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed for for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 24 additional clients, (K, M, T, V, Y, AA, DD, FF, HH, II, JJ, KK, LL, PP, QQ, RR, SS, UU, VV, YY, XX, AAA, BBB and DDD) to ensure a continuous active treatment program was implemented at all opportunities. Findings include: 1. Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 3:30 PM, on 10/21/13 from 3:40 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42 AM, on 10/24/13 from 8:30 AM until 9:45 AM, and on 10/24/13 from 3:25 PM until 4:00 PM, with clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW. During the observation periods clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were not given the choice of activity by the facility staff. During these observation periods clients C, K, and T chewed on clothing protectors tied around their necks without activity and without redirection. During these observation periods two staff were on duty inside the Program Group #1	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 196	Continued From page 219 with twelve clients. One staff was continuously inside the bathroom with one client at a time and the second staff was alone inside the training area with the eleven other clients in the room. During the observation periods clients were not observed to have goals/objectives/activity schedules implemented. On 10/21/13 from 11:20 AM until 12:40 PM, clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were inside Program Group #1 with facility staff (FS) #31 and FS #41. Clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW rotated with facility staff to and from the dining room for lunch. FS #31 indicated clients C and D did not leave the program room because both clients received G tube feeding and the nurse administered the feeding inside the program room. On 10/23/13 from 1:00 PM until 3:30 PM and from 3:40 PM until 5:50 PM, clients sat in recliners, wheelchairs, were transferred between the two chairs (each personal wheelchair and recliners) individually, and taken to into the bathroom by one staff to toilet each client, and two staff were present. From 1:00 PM until 5:50 PM, clients C, T, and K chewed on clothing protectors tied around their necks without redirection. Clients in the room slept without redirection, interaction, and/or activity. Client HH struck himself in his face without redirection and no activity was offered. Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW did not have activity or interaction. At 2:05 PM, FS #31 stated "It is all we can do to keep them (the clients) dry." At 2:05 PM, male staff FS #31 walked to client E who was reclined in a recliner with her fractured leg positioned upward in the recliner, pulled down the front of her pants, exposed her incontinent	W 196		

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	15G580		C 11/06/2013

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W 196	Continued From page 220 brief in full view, pulled down client E's brief which exposed client E's pubic area, and indicated client E was wet and needed changed to FS #41 who was across the program room. From 3:02 PM until 5:50 PM, FS #31 and FS #41 walked to each client and handed/laid an object on each client's lap. FS #31 continued toileting clients individually. FS #41 walked to each client and asked them a question about the weather. From 1:00 PM until 3:30 PM, client D was not assisted to the bathroom. At 3:30 PM, FS #31 assisted client D to the bathroom and indicated client D was wet from incontinence of urine. On 10/22/13 at 8:02 AM, an interview was conducted with FS #17. When asked what the clients in Program Group #1 were to do during waking hours, FS #17 stated "We can't really do much (active treatment). We keep them (the clients) dry." FS #17 indicated the facility staff checks and changes each client in Program Group #1 every two hours. FS #17 stated "all" clients in group #1 were a two person assist to transfer and client E was a three person assist. When asked if all the clients in the room were two person assist to transfer from their wheelchairs into recliners (and recliners to wheelchairs), why then does one staff take the client into the bathroom alone without two staff, FS #17 indicated he did not know. Confidential Interview (CI) #3 stated "I've never seen this stuff (referring to the materials inside bags placed inside a broken blue Rubbermaid container labeled group #1 supplies)." CI #3 stated the state comes in "and this stuff is all of a sudden available." CI #3 stated "It's just like the staff, no one is in the program rooms and when you're here, the staff is inside the rooms."	W 196		

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	15G580		C 11/06/2013

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W 196	Continued From page 221 Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's undated "(Program) Group 1 Daily Activity Schedule" indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, Economics, sensory stim (stimulation).(Client D did not have Economics listed on her activity schedule). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity. 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure, communication, choice of activities, TV, parties if scheduled, movies, group activity, bathing, special events, outing if applicable, etc." Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated objectives/goals to release her brief to staff given one verbal request, grasp the bottom of her shirt to assist with pulling it down, to remove her toothette from her mouth after assisted swabbing, to identify her own nose by pointing given a request, to take a penny from staff when shown with another coin, to carry her	W 196		

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	15G580		C 11/06/2013

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303 FRANKLIN
ARCADIA, IN 46030

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W 196	Continued From page 222 hang up clothes to her closet, to turn two pages of a selected magazine on at a time, to raise her head up to look at staff to take a desired item, to make one washing motion to her chest given a prepared washcloth, to hold unopened split gauge during G tube cleaning, and to identify common objects from a field of 2 objects. Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 IHP indicated objectives/goals to follow 3 simple one step instructions, to encourage client D to look in the direction of speaker when spoken to, to maintain grasp of a leisure item for 15 seconds, to verbally state Y/N (Yes/No) to a question on a community outing, to verbally respond Y/N when asked if she needs to be changed, to extend both arms through her shirt sleeves, to spit out toothpaste after brushing, to maintain grasp of selected item for 5 seconds, to verbally identify a soft and solid item by stating Y/N when placed in her hand, to tolerate by allowing the touch of staff for 15 seconds, to appropriately state Y/N if she is happy or mad when asked, to maintain grasp of a prepared washcloth, to hold washcloth during medication administration, and to follow 3 simple one step instructions. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dis similar object, to select preferred DVD (movie), to respond to text item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses	W 196		

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W 196	Continued From page 223 as tolerated. An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW stayed in Program Group #1 all day from rising in the morning until going to bed at night. The QIDP/PD indicated clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW went to the dining room for meals and out of the program room. The QIDP/PD indicated each client should have received teaching and training during formal and informal opportunities throughout their time in the program room by the direct care staff. The QIDP/PD stated with two staff in the program room "it's all the staff can do to keep clients dry and toileted." The QIDP/PD stated "I knew staffing" was going to be "a problem." The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's goals and active treatment schedules should have been implemented and indicated staff should have been prompting each client every 15 minutes and given them a choice of activities. 2. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 5 PM. Upon entering group #2 there was one staff (#57) and nine clients (clients F, I, M, FF, JJ, PP, YY, AAA, and BBB). The television was on but no one in the room was watching and/or paying attention to what was on the television. All clients were sitting in recliners except for client BBB. __At 1:45 PM staff #57 stated, "I'm gonna find something for [client F] to throw." Staff #36 brought client I a pudding snack, fed it to her and left the room. Clients AAA and M were receiving a continuous tube feeding. Clients M, PP and AAA were laying in recliners with their eyes closed.	W 196		

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W 196	Continued From page 224 Client BBB sat in a saucer chair with metal tubing for legs. The chair sat low to the floor preventing client BBB from standing on her own. Client BBB sat with her legs crossed, falling asleep, her head bobbing and neck hyperextended backwards. Client BBB's chair provided no neck support and/or no option for client BBB to stretch her legs. __Client F sat slumped to the right in a recliner, his hands were a dark purplish red in color. __At 2 PM staff #57 went from client to client with a book in his hand and reading. __At 2:15 PM staff #57 went into the bathroom that was attached to the program room to put something away. __At 2:10 PM staff #57 stated to client PP, "Wake up, did you not sleep last night?" Staff #57 lay a small stuffed bear beside client PP. Staff then approached client BBB and stated, "Wake up, come on you need to wake up." Staff #57 stated, "She can't get up on her own. She broke her hand on her new chair and now she's using her old chair until the other chair gets fixed." Staff #57 indicated client BBB slept a lot while in the program room. __At 2:20 PM staff #57 placed a clothing protector on client M. Staff #57 stated, "She drools a lot." Staff #57 handed client M a mirror and stated, "She likes to look at her self in a mirror." Client M lay in the recliner with her eyes closed. __At 2:23 PM staff #57 placed a plastic toy on client F's lap and gave client I some small objects to put in a plastic cup. Client JJ was mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __At 2:30 PM staff #57 stated to client YY, "Can you tell me what kind of dog this is?" At the same time client A (a young small female from group 4)	W 196		

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	15G580		C 11/06/2013

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W 196	Continued From page 225 ran in the room and rushed over to the window, bounced off the windows and ran through the program room into the bathroom. Staff #57 ran after her and prompted her out of the bathroom and back into the program room. Client A was dragging a long jump rope with her and swing it around. Client A began knocking over all the items, toys, books and etc. on the self in the room. Staff #11 from group four came into the room and escorted client A out of the room. __At 2:37 PM staff #57 asked client F, "What kind of dog would you like?" Staff #57 shoed client F the book. Client YY said, "Me too." And staff #57 stated, "Ok, you have to wait till it's your turn and I get back to you." __At 2:30 PM another staff came and took client YY out of the room. __At 2:47 PM staff #57 and another staff from another room lifted client AAA out of the recliner and placed him into his wheelchair. __At 2:55 PM staff #57 and another staff from another room lifted client M out of the recliner and put her in her wheelchair. __At 2:57 PM staff #57 stated, "Come on [client PP] wake up. You shouldn't be sleeping this much." Client JJ still mouthing/sucking on his hands and fingers. __At 3 PM clients M and AAA were wheeled out of the program room. Staff #57 was not alone in group two with 6 clients. Staff #57 stated, "Now, where were we?" And picked an object up out of the box. __At 3:02 PM client JJ was incontinent of urine. Staff #57 escorted client JJ to the bathroom and closed the door. Clients I, F, FF, PP and BBB sat alone and unsupervised in group two while staff #57 changed client JJ. __At 3:07 PM staff #44 arrived and stood in the group room. Client F dropped the toys on his lap	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 196	Continued From page 226 to the floor. Client I sat fingering the items in her plastic cup. __At 3:10 PM staff #57 came out of the bathroom with client JJ. Client A ran back into the group room again from group four. Client A now had a long strand of materials tied together, running and laughing and pushing past staff to get to the bathroom in group 2. Staff #57 attempted to prompt client A to go back to her group without success. Staff #11 came in the room, wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced. When asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. Sometimes it's the only way to control her." Staff #44 left group room two to help staff #11 with client A. __At 3:15 PM staff #57 called someone to ask for a break. Staff #64 came to relieve staff #57 for a break. Staff #57 offered no training and or leisure choices while with the clients in group two. __At 3:40 PM staff #57 returned from his break. Client JJ still mouthing/sucking on his hands and fingers. Staff #57 asked client I if she wanted shaving cream and client I screamed, "No! No! No!" Staff #57 smiled and put a dab of shaving cream on client I's right forearm and nose. Client I screamed again and turned her head away from staff #57. Staff #57 then asked client BBB if she wanted some shaving cream and client BBB looked away from staff #57. Staff #57 put some on client BBB's face, client BBB immediately started rubbing her face and got some of the shaving cream in her eyes. __At 3:42 RN (Registered Nurse) #1 came into the room to look at client BBB's right thumb and stated, "I don't know how she can sit for long hours like that in that chair. I couldn't hold my	W 196		

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W 196	Continued From page 227 head up either and her neck has got to be breaking." __At 3:43 PM staff #44 wheeled client YY back to group two activity room. Another staff wheeled client AAA back to group two also. Staff #57 and staff #44 took client YY into the bathroom to change her adult brief. __At 3:50 PM client F continues to drop the plastic toy on the floor, staff #44 picked it up and gave it back to him. __At 4:30 PM staff #44 and staff #57 lifted client FF from the recliner and placed him in a wheel chair. Staff #57 took him to the bathroom. Staff #57 and #44 lifted client FF out of the wheelchair and onto the changing table. Staff #44 came out of the bathroom and woke client BBB up. Client BBB held out her arms for staff #44 to help her. Staff #44 grabbed client BBB by both forearms and pulled her to a sanding position. Staff #44 escorted client BBB to the dining room. Staff #57 was still in the bathroom with client FF and clients F, I, M, JJ, PP, YY and AAA remained unsupervised in group room two. __At 4:45 PM staff #57 came out of the bathroom with client FF. Staff #44 returned to group two. Staff #57 walked with client I to the dining room, his arms interlocked under client I's arms, his knees touching the back of her legs. Client I was walking on her tip toes and taking one step at a time with staff #57 verbally and physically prompting client I to continue walking toward the dining room. Client I's gait was unsteady and slow and dependent of staff #57 to take one step at a time. __At 5:20 PM client F was wheeled from group two to the dining room. Client JJ still sat mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity.	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 228 __During this observation the staff did not offer clients F, I , M, FF, JJ, PP, YY, AAA and BBB training objectives and or a choices of activities. The clients sat for long periods of time with prompting to activity. The staff did not provide client F with something to keep his hands warm. The staff did not provide client BBB a way to elevate her legs. The staff did not follow client JJ's and YY's BSP (Behavior Support Plan). On 10/25/13 at 1:35 PM clients F, I, M, FF, JJ, PP, YY, AAA and BBB were sitting in group room two, the radio was playing loudly, the television was on and there were no staff in the room. None of the clients in the room was watching the television. After waiting for 10 minutes, staff #57 came out of the bathroom. Staff #57 indicated he was the only staff in the room at the time and the clients were involved in watching television. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's IHP (Individual Habilitation Plan) of 2/14/13 indicated client F had the following objectives: __To grasp his brief prior to assisted changing. __To pull his shirt down over his head after placement to assist with dressing. __To accept lotion in the palm of his hand. __To take one coin from the instructor when the coin is named. __To interact with one peer and one staff for at least 2 minutes. __To appropriately manipulate a desired item for 5 seconds. __To propel his own wheelchair one time per shift in the hallway for 15 feet. __To remove three items from his lap. Client F's record indicated client F had a diagnosis of, but not limited to, Raynauds	W 196		

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W 196	Continued From page 229 Disease (a condition that causes some areas of the body such as fingers, toes, the tip of the nose and ears, to feel numb and cool in response to cold temperatures or stress). Client F's physician's progress note of 5/21/13 indicated "both feet deep purple - black at toes, feet cold and unable to find pulses both lower extremities. Left hand fingers deep purple cold. HR (heart rate) apical faint, radial pulse faint, both slow." The note indicated client F had a medical history of mild tricuspid insufficiency and blood clots in his left leg. The physician's order of 8/30/12 indicated an order to "Keep his hands and feet warm." Client I's record was reviewed on 10/23/13 at 2 PM. Client I's IHP of 11/8/12 indicated client I had the following objectives: __To match 3 different colored cups one at a time. __To remove 8 items from a shallow container one at a time. __To select the correct shaped object from a triangle and a circle. __To select a coin when shown with one other item. __To ambulate to the dining room with minimal assistance. __To maintain her attention to selected task for at least 5 minutes. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's IHP of 3/31/13 indicated client M had the following objectives: __To look toward her reflection in the mirror presented by staff. __To look at the staff by turning her head to the left or right. __To track a noise or light device twice by moving	W 196		

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W 196	Continued From page 230 her head. __To make three rocking motions in her rocking chair. __To respond with a smile or frown to textures placed in her hand. Client FFs record was reviewed on 10/24/13 at 1:30 PM. Client FF's IHP of 1/15/13 indicated client FF had the following objectives: __To appropriately manipulate a selected activity for five seconds. __To tolerate a selected item in his hand for ten seconds after placement. __To follow one simple request given one verbal prompt. __To allow touch of staff's hand for fifteen seconds. __To manipulate a penny for two seconds. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's IHP 8/22/13 indicated client JJ had the following objectives: __To participate in a small group activity for at least five minutes. __To pull himself up from his chair using staff's hands for assistance. __To accept a coin in his hand for five seconds. __To manipulate a selected item appropriately for twenty five seconds. __To follow simple instructions of hands up, hands down and hand me. Client JJ's revised BSP (Behavior Support Plan) of 4/2/13 indicated client JJ had a targeted behavior of, but not limited to, mouthing his hands. The BSP indicated "[Client JJ] should be afforded the opportunity to have access to the items that he likes. Once every 30 minutes, [client JJ] should be afforded the opportunity to have one-on-one staff attention. During this time,	W 196		

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W 196	Continued From page 231 encourage him to manipulate items. Allow him to choose the item he wants to manipulate. Verbally praise him for doing so. If he independently chooses to manipulate an item, staff should reward him with excessive verbal praise. Should [client JJ] exhibit the target behaviors, the staff should verbally interrupt.... If he continues, staff should attempt to verbally interrupt the behavior again. Allow him 10 seconds to comply. If he continues, staff should guide his hands down and release. Repeat as needed." Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's IHP of 11/29/12 indicated client PP had the following objectives: __To look in the direction of staff for five seconds. __To look in the direction of staff when his name is called. __To grasp a quarter for ten seconds when presented by the staff. __To listen for one minute to a story while staff are reading from a book or magazine. __To allow staff to rub textured items on the palm of his hand __To interact appropriately for 30 seconds with staff one to one. Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's IHP of 9/19/13 indicated client YY had the following objectives: __To respond appropriately to the question of do you need to be changed. __To verbally name a quarter and a penny. __To count to twenty with the staff. __To verbally identify a magazine and a book. __To state whether she wants her hair up or down. __To move her head to the right or left as far as she can with a verbal prompt.	W 196		

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	15G580		C 11/06/2013

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W 196	Continued From page 232 Client YY's BSP of 6/15/10 indicated client YY had targeted behaviors of biting, cussing and spitting. The BSP indicated "Once every 30 minutes, staff should verbally praise [client YY] for appropriate behavior, no Anti-Social Behavior. In addition, should [client YY] not exhibit the Anti-Social Behavior for two consecutive hours, staff should spend two minutes interacting with her. Praise her for her good behavior...." Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's IHP of 1/31/13 indicated client AAA had the following objectives: __To extend both of his arms forward three times per shift. __To select a desired leisure item from a group of two or more leisure activities by moving his arm toward desired choice. __To place his own socks in his dresser one time per shift. __To select the appropriate coin when shown 2 coins __To turn one page of a magazine. __To verbally answer five questions about TV or music. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's IHP of 5/2/13 indicated client BBB had the following objectives: __To match a dime when given a dime and a quarter to choose from. __To uncross her legs prior to standing up from her chair. __To participate in a table activity with at least one other peer for five minutes. __To place her soiled clothes in the laundry barrel when appropriate. __To choose her own picture when presented with 2 differing pictures.	W 196		

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W 196	Continued From page 233 __To answer 5 yes/no questions of her daily routine. Client BBB's 8/1/13 physician's orders indicated every two hours client BBB was to elevate her legs and feet for 30 minutes due to poor circulation. During interview with staff #57 on 10/21/13 at 3 PM, staff #57 indicated whenever a staff was working alone, the staff would have to call for help a lot because of the lifts and the toileting. Staff #57 stated, "We try to make sure everybody gets toileted at least before going to lunch and I think they are toileted before they come to the group room in the mornings. When asked if he was aware of each client's active treatment schedule and the objectives that were to be offered, staff #57 stated, "We have a program book in every room and we can look at that." Staff #57 stated on days when there is only one staff in group two "its difficult." Interview with staff #28 on 10/23/13 at 11:20 AM indicated one person in a group room with nine to twelve clients was difficult to do. Staff #28 indicated when she was in a room alone, she found she often had to call for help and then wait. Confidential interview #20 stated it was "impossible" for one staff to provide active treatment to nine to 12 clients with only one staff in the room, "especially in group six" CI #20 stated, "It happens all the time." CI #20 indicated the clients were to be toileted and repositioned every two hours. CI #20 indicated that doesn't happen either. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM	W 196		

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W 196	Continued From page 234 indicated the staff were to follow the client's program plans as written and provide the clients continual active treatment. The QIDP indicated the staff were to offer training objectives and/or choices of leisure activity every fifteen minutes whenever the clients were sitting idle or not involved in an activity. 3. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J rubbed his eye with his left middle finger. Client H threw a block on the floor. Staff #80 asked client H to "stop." Client DDD repeatedly took his shirt off and staff #80 put it back on. Client J put his helmet strap back in his mouth after his helmet was placed back on his head. No activity was offered during the observation. Staff #57 was interviewed on 10/21/13 at 5:32 PM. He indicated client J often chewed on his shirt in addition to his helmet strap and stated, "He got it from staff," and indicated one of the staff assigned to client J's program room also chewed on his shirt. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU grabbed food from client V, and was redirected away from the dining room by staff #35. Client UU then walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth. Client Y lay on the floor in the recreation room or rocked back and forth on his feet. Client H was redirected away from looking out the window by staff #58, but did not respond. Clients UU, Y, II were not were not prompted to engage in activity. Client II lay on the floor, staff #66 placed her arms around to raise him up from	W 196		

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W 196	Continued From page 235 the floor. Client II attempted to hit staff #66. Staff #66 indicated client II was to use a communication book to use to communicate his needs. No communication book was offered. Staff #66 stated, "We're not smacking our head or hitting [staff #66]. I'm asking you to get in the wheelchair. What's your problem?" Client II stood, dropped to the floor again, grabbed at staff #66, then tried to bang his head on the floor. Staff #66 stated, "I said No. Listen to Me. If you get much more aggressive, you're not giving me a choice." Staff #66 then asked staff to call for client II's helmet. "I know you're not happy because you know it's coming." Staff #66 placed her arms around client II from behind as she was seated on the floor, and stated, "You know sign language. There's no excuse." Client II then got into the wheelchair and was wheeled by staff #66 to program room 6. During observations on 10/22/13 from 11:28 AM until 11:35 AM, client J had the strap of his helmet in his mouth, client UU had his hand in his mouth, and client Y lay on the floor. The television was on and no other activity was offered. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA hit himself in the head. Staff #80 asked client AA what was wrong, but no activity was offered. Client J was without activity. Staff #80 asked client J "What are you doing?" Client H looked out the window without activity. Client J was offered a barrel of toy monkeys to hold. Client VV pointed outside the window. Staff #38 stated, "You have to wait. We have to check with the nurses." Client B indicated he wanted to go outside also. Client J crawled on the floor. Client UU walked around with this hand in his mouth without direction to activity. Client B had an	W 196		

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W 196	Continued From page 236 electronic device he played a game on, but put it up to wait for the nursing staff to call back about going outside. Nursing staff then called on the phone and staff #38 stated, "The nurse called and said we can't go out right now." Client VV had holes in his shirt. When staff #38 asked him if he chewed on it, client VV nodded his head "yes." Client UU had his hands in his mouth. There were smudges of opaque material on two windows in the room. Staff #80 cleaned the windows after the surveyor asked about the smudges, without involving clients in the activity. Staff #38 offered purple circles to hang up on the wall, but client J lay on the floor, client II sat in a chair without activity, client B played a game on his electronic device, and client V asked to take a walk. Client V was directed away from the door, and staff stated, "you have to have someone with you." Client H attempted to leave the room and was directed back. Client J was offered to draw a circle, but lay on the floor. Client UU put a block in his mouth, and staff #65 stated, "[Client UU]. Don't put that in your mouth." The block was not cleaned it after client UU took it out of his mouth. Client UU's hands dripped saliva and he put his hand back in his mouth. No hand washing was observed. Staff #68 was asked about the block client UU put in his mouth, and staff #68 stated, "Oh [client UU]. You're a mess," and washed the block. Client AA slept in a chair during the observation. Staff #38 was interviewed on 10/22/13 at 2:10 PM. She indicated the nursing staff had informed staff it was too cold to go outside for the clients. Staff #80 was interviewed on 10/22/13 at 2:45 PM. He indicated the smudges on the window were from client H putting his hands on the	W 196		

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W 196	Continued From page 237 window. When asked if client H could assist with washing windows, he stated client H was capable, "but stubborn." He indicated clients B, V, Y, UU, and XX were capable of assisting with housekeeping tasks. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Staff #42 was alone in room 6 with 9 clients V, Y, J, AA, DD, H, UU, VV, XX and B at 10:35 AM. Clients B and H were asleep in a chair at 10:35 AM. Client DDD crawled on the floor from one chair to another chair. Staff #42 talked to the clients in the room about a volcano they had made in earlier that morning. The structure had paint on the volcano mound. Client DDD crawled on the floor, was redirected from sitting in the path of the doorway, and sat in a recliner without activity. Clients II and J lay on the floor during the observation. Client H lay on the floor and staff #42 gave a ball to client H and client H dropped the ball over his head. At 11:05 AM, staff #42 and #35 were in the room. Client H was offered a ball again and dropped it behind his head. Staff #42 stated, to client H, "You love that ball." Client UU walked around with a woven ball fastened around his neck on a plastic wire. Client AA chewed on the strap of his helmet during the observation. Client UU put his hand in his mouth and walked around the program room. In the dining room, client AA ate food that spilled onto a non-skid mat from his plate. Client J sat with his helmet strap in his mouth. Client UU, DDD, H, II and J were not prompted to wash their hands after being on the floor, or having their hands in their mouth. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Client II	W 196		

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W 196	Continued From page 238 banged his head on the floor 4 times without redirection. Client II banged his head again and staff #42 asked client II to say "Please. If you want something, you have to talk. Do you want to play with something?" Staff #42 got client II a ball, but client II did not engage in activity with the ball, and got on the floor. Client II had discoloration around his eyes. Client S sat in a chair tapping on a clothespin. At 11:20 AM, client II banged his head on the floor 5 more times as staff #42 spoke with client XX stating, staff #495 was "taking kids to the dining room." During the observation, staff #65 took pictures of a clock made using a potato and wires. The clock on a wall in the room was 2 hours slow. Staff #42 picked up client J to move him. Client V was reminded to ask clients politely to move from his recliner when he pushed client DDD after he sat in client V's recliner. Client DDD crawled on the floor and client H held a ball. Client AA walked without activity at 11:45 AM. At 11:50 AM, client H was pulled back from the doorway by staff #42 putting his arms around client H. Client H bumped into the doorway as he was pulled back into the room. At 11:56 AM, client II banged his head again, and staff #42 indicated client II would not wear a helmet. Client DDD went to the dining room at 12:20 PM and staff #35 poured his water for him. Client DDD was brought his plate of hot dog with chili sauce and did not assist in preparing his food. Client DDD refused his food and left the dining room. Client AA's food was brought to him, on a tray and he was assisted to scoop his food. Client UU at his lunch at 12:40 PM, and clients AA and UU spilled food on the table while eating, and had food around their mouths. Clients AA and UU were not prompted to use a napkin. Staff #53 took client AA and UU's plates to the sink when they were done eating. Staff #495 wiped client	W 196		

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W 196	Continued From page 239 UU's hands without encouraging client UU to wash his hands. Staff #42 was interviewed on 10/23/13 at 10:46 AM. When asked what skill the volcano activity developed, he stated, "It teaches them the science of mixing baking soda and vinegar-what chemicals not to mix." When asked if the clients had access to chemicals, he stated, "No." When asked if the activity developed skills for daily activities, he stated, the skill developed "Painting." He stated the clients assisted in making food "a couple of times a week," and indicated different clients go to cooking class from each program room. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." Staff #42 was interviewed on 10/23/13 at 11:20 AM. When asked about client II's discoloration around his eyes, he stated, "This is due to SIB (self injurious behavior)." Staff #35 was interviewed on 10/23/13 at 11:45 AM. When asked what activity was to be taking place in program room 6, he stated, "This is structured activity. Free time if they want to chill." Observations were completed on 10/28/13 from 11:40 AM until 11:58 AM. Client II hit his head against the recliner with no redirection. Client J sat on a mat without activity, and client S sat in a recliner without activity. Observations were completed on 10/29/13 from	W 196		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 196	Continued From page 240 12:55 PM until 1:10 PM. Client AA hit his ear 15 times without redirection from staff #497. The surveyor pointed out client AA hitting his head and he redirected him from hitting his head. At 1:00 PM, client DDD had not yet been taken to the dining room. Client II hit his head on the floor and had tears on his face after he was redirected from holding client J's helmet. Clients Y, AA and J were on the floor without activity and clients UU and H were sitting in chairs without activity. Staff #497 was interviewed on 10/29/13 at 12:55 PM. He indicated client AA was to be redirected from hitting his head. Staff #42 was interviewed on 10/29/13 at 1:00 PM. When asked if client DDD normally ate at 1:00 PM, he indicated, "No. We are probably short." Staff #498 was interviewed on 10/29/13 at 1:05 PM. She indicated client II usually wears a helmet, but doesn't wear one now due to an increase in behaviors when he wore one. Staff #498 indicated nursing staff had been notified of client II's behavior. Client J's record was reviewed on 10/24/13 at 1:20 PM. Client J's Adaptive Skills Assessment dated 2/12/13 indicated client J "shows no concern for his privacy or for that of others. When dealing with others there are reports of invasion of space, biting and pulling hair pointing toward his tendency for anti-social behavior. The use of medication and the Behavior Management Program (BMP)are in place to try to reduce these behaviors such as putting his hands in his pants, playing with himself, actual masturbation, placing his thumb in his mouth, biting clients, pulling	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 196	Continued From page 241 others hair, chewing on objects, hitting himself, banging his head, kicking, scratching and biting himself. Keeping him occupied with a variety of stimuli appears to reduce the occurrence of behaviors. It has been noticed he has an attraction toward pain and sometimes requires one on one when he has a wound that must heal." Client J's BMP effective 2/1/08 and updated 6/25/12 included Anti-Social Behavior defined as "hands in his pants, playing with self, actual masturbation, chewing on objects. [Client J's] main behavior at this time, is chewing on objects." A section Antecedent indicated, client J's "behavior appears to be cyclic. However, there is no known antecedent except possibly seeking attention. Usually he finds humor in the behaviors he exhibits. The program description indicated client J should be reinforced with one on one staff attention for 1 minute if he does not engage in any of the targeted behaviors, and if client J exhibits the targeted behavior, staff "should attempt to verbally interrupt the behavior...If [client J] bites down on an object and won't release it, offer him a drink of water or bite of something to eat...Never place your fingers in his mouth to get the object free. This could result in getting yourself bit..." The plan included the use of Prozac (anti-depressive) 20 mg (milligrams) daily. An IHP (Individual Habilitation Plan) dated 2/12/13 included objectives to grasp waist of pants with one hand, place one arm into shirt, remove toothbrush from mouth after toothbrushing, rinse soap from hands, make 3 brushing motions to hair, hold his own cup twice during the meal, grasp a prepared washcloth, place 2 objects into an empty container, hand a quarter to staff, participate in a 1:1 activity with staff for 2 minutes, select a leisure item/object by grasping given 2 choices, grasp a preferred	W 196		

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W 196	Continued From page 242 leisure object for 1 minute, walk to and from the dining room in the gait trainer for meals, will wipe tables in his program room. Client H's record was reviewed on 10/28/13 at 4:00 PM. His IHP dated 2/4/13 included objectives to sit on the toilet, pull his shirt over his head, grasp his toothbrush, place his hands under running water, open deodorant before use, sort 6 items into 2 piles of any color, sort coins from dissimilar items, walk with staff to obtain clothing, maintain eye contact with staff for 10 seconds, bounce a ball with staff for 30 seconds, place a cup on its base after drinking to prevent spilling, rinse body when showering. There were no completion dates for the objectives in the IHP. Client B's record was reviewed on 10/29/13 at 2:06 PM. His IHP dated 4/4/13 included objectives to wipe thoroughly after a bowel movement, unbutton his pants, spray underarm deodorant of choice, brush front teeth, trace numerals from 1-10, hold a pencil with tripod grasp, hop consecutively 5 times, complete a 10 piece puzzle, fold 5 washcloths, participate in an informal leisure activity with 1 peer, place clean laundry items into his dresser/closet, use a napkin to wipe his mouth after meals. Client UU's record in program room 6 was reviewed on 10/24/13 at 12:55 PM. Client UU's October, 2013 data collection sheets indicated IHP objectives to walk to the bathroom upon staff request, place hand on waistband, allow staff to brush teeth for 45 seconds, will place brush under soap dispenser to accept soap for hand washing, will obtain paper towel from dispenser, grasp a textured item, accept 2 coins, look in staff's direction, will appropriately interact with staff for	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 196	Continued From page 243 45 seconds, will wipe tables/windows in his program room. Client DDD's records were reviewed on 10/24/13 at 1:35 PM. Client DDD's October data collection sheets indicated objectives for his IHP "transfer to toilet, pull up pants, remove his toothbrush from his mouth, propel gait trainer 50 feet at a time, place at least 4 items into a container, take a presented coin when displayed with a dissimilar item, participate in 10 minutes of group activity without interruption, greet peer/staff using hand shake, fist bump or high 5 1 time each shift, choose between a choice of leisure activities presented" was missing data for October 7, 11 on day shift, and missing data for October 9, 11, 14, 20, 21, for evening shift. Client DDD's Behavior Support Plan (BSP) dated 8/10/13 indicated target behaviors of Sexual Acting Out and Physical Aggression. Antecedent and Function of Behavior indicated client DDD's sexual acting out was "likely" caused by reaching puberty, and physical aggression "more likely occurs in a loud/disruptive environment,and not getting his way." The plan included Prozac 20 mg BID and Klonopin 0.5 mg BID. The plan indicated client DDD was to be redirected from placing his hands in his pants and to encourage handwashing. Client AA's record in program room 6 was reviewed on 10/29/13 at 1:31 PM. Client AA's BSP dated 2/1/13 indicated a goal "will refrain from self abusive behavior as evidenced by no more than 100 incidents a month for 3 consecutive months. Target behavior included Self-Abuse; hitting his head/ears, biting his hand, punching his head, smack his head, throwing himself backwards against a chair." The plan indicated client AA was to be given a small drink	W 196		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 196	Continued From page 244 of beverage every hours, and provided time to walk around the building or go to his bedroom for 30 minutes. Client AA was to wear a helmet if he engaged in hitting his head. Client II's record was reviewed on 10/29/13 at 1:32 PM. Client II's BMP effective 3/23/95 included the use of Depo-Provera 150 mg, Risperdal 3 mg BID (twice daily), Clonodine. 0.2 mg BID, Naltrexone 50 mg HS (bedtime), Lithium (manic depression) ER 450 mg BID and the target behaviors of "biting hand or wrist and banging his head on the floor or hitting his head on his hands while lying on the floor and running into the wall, dropping to floor, hitting and choking staff...Although no definite antecedent is determined, it is believed that [client II] may engage in this behavior as a response to staff request or when exited." The Program Description indicated, "Once every 30 minutes, during waking hours, [client II] will be reinforced for refraining from anti-social behavior with a drinkable paired with verbal praise. In addition, should [client II] refrain from anti-social behavior for the entire shift, staff should afford him the opportunity for 'reward time.' The reward time includes playing outside or having the opportunity to manipulate a mirror...." Behavior intervention included "If [client II] is observed to engage in SIB (self injurious behavior)," staff were to verbally redirect and if client II did not stop, "apply his helmet until the behavior stops. Remove the helmet once he stop banging his head...." Client II's plan did not include the use of placing arms around him, physically blocking him, or the use of sign language to address his behavior. Client B, H, J, S, V, Y, AA, II, UU, VV XX's and DDD's activity schedules were reviewed on	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 196	Continued From page 245 10/29/13 and indicated clients were to engage in the following activities: " 5:00 -7:30; toileting, shower/bath, dressing, structured leisure activity (sorting, coloring, sensory stim (stimulation) activity, playing ball, identify colors/shapes. Look at pictures in books/magazines, blocks, shape sorters, etc., medication goal, breakfast, eating goal. From 7:30 AM to 8:00 AM, toothbrushing, toileting, etc.. .From 8:00-9:00 AM, Money management, academics. From 9:00 AM -10:00 AM Communication, interaction. From 10:00 AM to 10:30 AM Choice of activity, (TV, puzzles, book, magazine, radio, leisure item, games, switch device:s, items for manipulation, etc.). 10:30 AM-11:00 AM toileting, group activity. From 11:00 AM to 12:30 PM, lunch, eating goal, structured leisure time, (sorting, coloring, sensory stim activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorters, etc.) 12:30 P M to 1:00 PM, recreation, group activity. From 1:00 PM to 1:30 PM toileting, group activity. From 1:30 PM to 2:30 PM, leisure manipulation. From 2:30 PM to 3:30 PM, communication, interaction. From 3:30 PM to 4:00 PM, toileting, group activity. From 4:00 PM to 5:30 PM, dinner, eating goal, structured recreation (sorting, coloring, sensory stim activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorters, etc. From 5:30 PM to 7:00 PM, Recreation, leisure, choice of activity, TV, parties if scheduled. From 7:00 PM to 8:00 PM, snack time, dressing for bed, toothbrushing, choice of recreation, toileting., etc." The Program Director was interviewed on 10/29/13 at 12:45 PM. She indicated the behavior consultant notes were not kept as part of the client record. She indicated the consultant had	W 196		

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	15G580		C 11/06/2013

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W 196	Continued From page 246 reviewed and revised clients B, J, II, V, Y, AA, XX, DDD's plans, and was in the process of updating client UU's plan. She indicated the behavior consultant had not yet written clients H and VV's plans. She indicated there was no evidence of the behavior consultant having written the plans or of training staff on the clients plans. She indicated she had written client DDD's initial plan and the behavior consultant had revised it. She indicated client II was not to use a helmet as it increased his behaviors, and sign language was to be included in his behavior plan to address his behaviors. When asked if staff were using the plan located in the program room, she stated, "More than likely, Yes." The Program Director was interviewed on 10/25/13 at 2:40 PM and indicated staff should prompt clients to engage in activity every 15 minutes. She indicated staff should offer client's activity as appropriate to their needs and should implement client plans as written. 4. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. client A and client G were in the room with (direct care staff) DCS #11. Client G had a box she put clothes pins in. Client G shook the box up by her ear, and then would dump the pins on the floor. There was a movie playing on the TV in the room. Client A was not engaged in any activity. Client A attempted to leave the room DCS #11 redirected her to put her shoes and socks on first. The QIDPD (Qualified Intellectual Disabilities Professional Designee) took client A out of the room for a walk. At 2:00 P.M. client A returned to the room with a CD player. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was	W 196		

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W 196	Continued From page 247 returned to the room by the QIDPD at 2:24 P.M. Client A had a jump rope she was dragging around on the floor behind her. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a loud sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors) she did not immediately offer client G her baseball hat or helmet due to intervening with client A's continued running behaviors. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:35 P.M. client A and client G were given yogurt and juice for snack. DCS #11 used a curved adaptive spoon to feed client G her yogurt. DCS #11 did not encourage client G to feed herself. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. At 2:46 P.M. client G was assisted to the recreation room to color Halloween pictures and a pumpkin. Client A was standing in the hallway with a staff (unknown) when client G went to the recreation area. Continuous, aggressive and consistent active treatment and implementation of goals at all formal and informal opportunities was not present during the observation. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. Client A was located in the hallway. The back of her	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 196	Continued From page 248 jeans were pulled down and her upper buttocks were visible. A male staff (unknown) asked her to pull up her jeans and she complied. Client SS was located in the program room watching a cartoon on the TV. Client A returned to the room at 3:37 P.M. DCS #66 assisted client A to sit at the table and had her work on cards pointing to the object the staff named. At 3:40 P.M. recreational staff assisted client G back to the program room. Client G's jeans were pulled down in the back and half of the back of her incontinence brief was visible. Client G sat down and began to shake her box of clothes pins. Client A began to walk around the room dragging a 12 foot long piece of fabric strips tied together. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. At 4:16 PM client SS left the room to go to the dining room. At 4:45 P. M client G entered the dining room. At 5:10 PM client A entered the dining	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 196	Continued From page 249 room. Dinner observations ended at 5:43 P.M. Continuous, aggressive and consistent active treatment and implementation of goals at all formal and informal opportunities were not present during the observation. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room preparing to have a morning snack. Client G was wearing her helmet. Client A was asleep in a chair. DCS #36 stated, "They upped her (client A's) med's (medication) yesterday. I am having trouble getting her awake. I've been wiping her face with this cool cloth trying to wake her up." When asked what medication had been changed, DCS #36 stated, "No, I don't know about her medications you would need to ask a nurse." When client A saw the snacks she woke up and ate some snack crackers. DCS #36 assisted client A to the restroom to wash her face and hands. While DCS #36 and client A were in the restroom client G ate pieces of crackers off of the floor. At 9:45 A.M. DCS #36 stated, "No, maybe twice I have seen the clients in this room become aggressive, I have been in here a month." At 10:03 A. M client SS asked to go get a CD player. Client SS got the CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 196	Continued From page 250 threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. Client G asked if she could go to another program area and was allowed to leave room 4. At 10:15 A.M. the QIDP brought a MP3 player with headphones to the room for client A and assisted client A in putting them on. Client A smiled. Continuous, aggressive and consistent active treatment and implementation of goals at all formal and informal opportunities were not present during the observation. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record included an IPP dated 11/29/12. Client A's IPP included the following goals: sit on toilet for 2 minutes 2 times per shift for at least 90 out of 120 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, place her shoes on her feet for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to brush her teeth for 1 minute for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 9/12, will place her hands under running water to rinse during hand washing for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 9/12, will brush her hair 1 time per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 1/13, will place her clothing protector into the correct bin after each meal for at least 70 out of 90 of the documented	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 196	Continued From page 251 data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will use the spray nozzle to wet and rinse her upper body for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, will sort 2 sets of 2 shapes into piles of matching shapes for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will sort coins into 2 piles (quarters and pennies) for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH (hand over hand) assistance for 3 consecutive months by 2/13, will participate in an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will tolerate wearing her shoes for at least 7 minutes for at least 45 out of 60 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will allow her seat belt to be fastened while on the school bus for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 9/12, will appropriately manipulate her chosen item for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will appropriately participate in an activity with 1 peer for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to rub lotion on her palms for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER
ARCADIA DEVELOPMENTAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
303 FRANKLIN
ARCADIA, IN 46030

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W 196	Continued From page 252 months by 1/13, will place clean laundry items in her dresser/closet for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 3/13. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included an IPP dated 12/6/12. Client G's IPP included the following goals: will sit on toilet for 1 minute 3 times per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 3/13, will pull her shirt over her head for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 12/12, will make brushing motions to her top teeth for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 3/13, will raise her arms 1 at a time for deodorant application for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 12/12, will brush her hair for 5 strokes for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 1/13, will use her spoon throughout her meal for at least 90 out of 90 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 12/12, will accept shampoo into her hand for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstrative prompts for 3 consecutive months by 12/12, will discriminate 'big' or 'little' by sorting them into 2 distinct piles for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 196	Continued From page 253 assistance for 3 consecutive months by 2/13, will identify, by pointing/reaching/grasping, groups having 'more' or 'less' for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 2/13, will sit beside staff and peer for 2 minutes for an activity for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 3/13, will share an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 2/13, will get linens out of the closet 2 times per week, will allow a soft item to be brushed across her palm for at least 23 out of 30 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 1/13, will assist with placing programming materials back into the group room closet for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 3/13. An interview was conducted with the PD/QIDP on 10/30/13 at 3:49 P.M. The PD/QIDP indicated goals she be worked on at all opportunities. The PD/QIDP indicated even if clients A and G are normally in school, their goals should be worked on during school breaks. 3.1-32.(a) 3.1-33(a) 3.1-37(a)	W 196		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the	W 209		

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W 209	Continued From page 254 client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to encourage participation in the development of the Individual Program Plan/Behavior Support (IPP/BSP) by the parent/guardian of 2 of 10 sampled clients (clients A and G). Findings include: Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was a minor and had a guardian. Client A's record included an IPP dated 11/29/12. There was no indication client A's guardian had participated in the IPP process. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had co-guardians. Client G's record included an IPP dated 12/6/12. There was no indication client G's guardians had participated in the IPP process. Client G's record indicated she had a BSP dated 9/2013. There was no indication client G's guardians had participated in the BSP process. An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/30/13 at 3:45 P.M. The PD/QIDP stated, "You would need to check with [name of social worker] about guardian participation and informed consent." An interview was conducted with the Social	W 209		

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W 209	Continued From page 255 Worker (SW) on 10/30/13 at 4:35 P.M. The SW stated, "I'm just not finding it. I know I talked with [client A's] mother, but she moves frequently. I am unable to locate the signature pages for [client G]."	W 209		
W 210	3.1-35(d)(2)(B) 483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure needed assessments were completed for 6 of 10 sample clients (clients C, D, E, F, I, and J) and 9 additional clients (clients L, M, FF, GG, JJ, PP, YY, AAA, BBB) who required assessments. Findings include: 1. Client GG was observed in program room 5 on 10/22/13 from 8:10 A.M. until 9:00 A.M.. During the observation, there were a total of eight clients in program room 5. Client GG sat in a arm chair periodically changing positions in the chair. Client GG was not wearing a helmet or any other device or adaptive apparatus which would protect her from injuries due to falls. Direct care staff #60 was the only staff working with the clients in program room 5 during the 10/22/13 8:10 A.M. to 9:00 A.M. observation period.	W 210		

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W 210	Continued From page 256 Incident reports and nursing notes for client GG were reviewed on 10/24/13 at 10:05 A.M. The review indicated client GG suffered the following falls: -10/20/13 incident report: "On October 20th, at approximately 5:05pm, [Client GG] fell in program room after returning from [hospital] one hour prior. Preliminary nursing assessment noted moderate size hematoma (blood/fluid filled bruise) to the right side of [client GG's] suture line at the top of her head. Large amount of blood noted with [client GG] uncooperative for complete assessment. New orders were received from [client GG's] PCP (primary care physician) to send to [hospital] for evaluation and possible treatment. Plan to Resolve: [Client GG] was transported to [hospital] via facility van and the assistance of two staff members. [Client GG] received IV (intravenous) Depakote (anti-seizure medication) during her stay at [hospital] and returned to this facility at approximately 9:10pm. No new medications were prescribed for [client GG] for seizure activity, but will complete an appointment with her neurologist sometime next week. [Client GG] was place on 15 minute checks for additional monitoring throughout the night. [Client GG] returned to her normal group of peers this AM (morning) and attended a community outing without difficulty." -10/19/13 incident report: "On October 19th, at approximately 10:00 A.M., [client GG] was independently ambulating in her program room walking toward the group room closet. One of her peers scooted their chair out into her (client GG's) path. [Client GG] caught the toe of her shoe on the inside corner of her peer's chair leg.	W 210		

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W 210	Continued From page 257 [Client GG] fell forward, without any attempt to break her fall. Plan to Resolve: New orders were taken to send [client GG] to [hospital] for evaluation. [Client GG] returned with staples closing the laceration to the top of her head at approximately 1:00PM. A CT (diagnostic x-ray scan) was completed during her evaluation with no negative findings from the scan. [Client GG] consumed 75% of her afternoon meal and returned to her group of peers. Nursing has started a 48 hour neurological monitoring sheet." -10/12/13 nursing note: "Slipped and fell in program room. 0 (no) injury." -9/25/13 nursing note: "Outside with peers and fell. 3cm (centimeter) x(by) 2cm abrasion." -9/1/13 incident report: "At approximately 5:00PM on September 1, [client GG] was being assisted with her evening routine of putting on her pajamas. [Client GG] experienced a seizure, falling forward as staff broke her forward motion. [Client GG] struck her head on the handrail located next to the toilet without redness, discoloration or other areas noted to her head. Plan to Resolve: Nursing personnel initiated neurological checks. [Client GG] continued her routine of assisting with putting on her pajamas for the evening without further incident." -8/10/13 nursing note: "[Client GG] fell from chair to floor in group room." -8/9/13 incident report: "On August 9, 2013 at about 8:00 pm [client GG] experienced a drop seizure landing on her tailbone. She now has an 8cm x 9 cm bruise at that sight. She is not showing any signs or symptoms of pain or	W 210		

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W 210	Continued From page 258 discomfort. She was able to sleep her normal manner during the night hours. She has resumed her normal daily routine. The DON (Director of Nursing), Program Director, Physician, Guardian and Administrator were notified on 8-9-13. Plan to Resolve: Nursing will continue to monitor her seizure activity and report to Neuro physician. Nursing will also monitor her vital signs and watch for any discomfort or signs of ain. A skin sheet had been itiated (sic) to monitor the bruise until healed." -6/26/13 nursing note: "[Client GG] fell in group room. No injury." -4/29/13 nursing note: "Seizure, [client GG] fell, hit head, 2cm laceration stapled." Client GG record was further reviewed on 10/24/13 at 1:12 P.M.. The review indicated the client had a diagnosis, which included but was not limited to, seizure disorder. Further review indicated the client had a risk plan for falls dated 6/27/13. The risk plan for falls indicated client GG 's history of "impaired vision when she has her helmet on" and a "possible risk of falling due to unsteady gait." Further review of the client GG's record failed to indicate the client had been assessed to address the client's continued falls. The Program Director was interviewed on 10/25/13 at 10:41 A.M.. When asked if the client had been assessed to address the client's continued falls, the Program Director stated, "No." 2. Observations were conducted at the facility on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 5:50 PM, and on 10/22/13 from 5:45am until 8:42 AM. During these observation periods:	W 210		

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W 210	Continued From page 259 -Client C sat in her recliner without reclining, sat in her wheelchair, and was picked up by the facility staff #17 in a one person lift to transfer her from the recliner to her wheelchair and back to her recliner chair. -Client D sat in her wheelchair, sat in recliner, and was picked up by the facility staff #31 and #17 two separate times in each in a one person lift, and placed in her wheelchair by the staff to go to the dining room for their evening meal and to go to the dining room for her breakfast meal. -Clients C and D could not get up from their recliners or wheelchairs without staff assistance. During these observation periods clients C and D were not observed to reposition themselves without staff assistance. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 8/30/13 quarterly physician's orders indicated client C had diagnoses of, but not limited to, Osteoporosis (brittle bones), Seizure Disorder, Kyphosis & Scoliosis (Curving of the Spine), Contractures, Pedal Edema (Swelling of the legs/feet), Major Scoliosis Predominately in the upper Lumbar Lower Thoracic Spine measuring 36 degrees with rotation, Conductive Hearing Loss, Aspiration Precautions/Reflux Precautions, Arthritis, and G Tube Placement (feeding into her stomach) on a pump (continuous). Client C's 3/28/13 ISP indicated client C used a wheelchair for ambulation and was dependent on a wheel chair for all transportation. Client C's record did not indicate client C's PT/OT (Physical Therapy/Occupational Therapy) evaluations. Client C's 3/28/13 "Annual Nursing Assessment" did not indicate client C's current PT/OT evaluations. Client C's record indicated a 3/28/13 "Adaptive Skills Assessment" completed by the	W 210		

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W 210	Continued From page 260 QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) which indicated "Ambulation Assistive Devices. [Client C] has a personal, adaptive, manual wheelchair. [Client C] does not gainfully propel her own wheelchair and requires maximum assistance from staff for movement. Her bilateral upper extremities are limited in should flexion and abduction...She is unable to sit unsupported and no longer possesses the ability to perform standing transfers." Client D's record was reviewed on 10/23/13 at 9:45 AM. Client D's 8/30/13 quarterly physician's orders indicated client D had diagnoses of, but not limited to, Osteoporosis, Cerebral Palsy, Club Feet, Visually Impaired due to Retinopathy of Prematurity (blind), spastic Quadriplegia, Neuromuscular Scoliosis, Lumbar Spinal Fusion, Incontinence of Bowel and Bladder, Aspiration Precautions, and G Tube Placement. Client D's 5/28/13 ISP indicated client D was non-ambulatory. Client D's 5/28/13 "Annual Nursing Assessment" indicated client D was non ambulatory, non weight bearing, and used an "Adaptive wheelchair for transport." Client D's record did not indicate a PT/OT assessment. Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on 10/22/13 at 4 PM indicated the facility "used to have a PT/OT person, but we haven't had for quite some time." The QIDP/PD indicated no PT/OT assessments for clients C and D. The QIDP/PD indicated client C and D did not have a current wheelchair assessment. The QIDP/PD indicated any client that used a wheel chair had an assessment conducted every 5 years or as needed by a company contracted out by the	W 210		

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W 210	Continued From page 261 facility. The QIDP/PD stated, "Any minor changes or fixes we do ourselves." 3. On 10/21/13 at 12:20pm, client E was observed sitting in her wheel chair in the main dining room, client E was non verbal, her legs were extended outward from her wheel chair, and client E wore a fracture boot (appliance used to stabilize fracture as it healed) on her left leg. At 12:20pm, facility staff #64 stated client E fractured her fibula on her left leg "about" six (6) weeks ago. At 2:00pm, facility staff #41 and RN (Registered Nurse) #5 both indicated client E was a three person lift to transfer from her wheel chair to another location because of her left leg fracture. At 2:00pm, facility staff #31 and RN #5 checked client E's left leg. RN #5 removed client E's left leg fracture boot, stated client E had a "1 1/2cm" red area on her left inner ankle where her fracture boot had rubbed against the skin. At 3:10pm, client E was assisted back to Program Room #1 with facility staff #30, #31, and #80 entered Program Room #1 and approached client E who sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #30 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #31 grasped client E's fracture boot on her left leg. Facility staff #80 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #80 stated "I pull the handles together" which he did and lifted client E with on hand holding both handles. When facility staff #80 held the sling handles together at her hips, client E's left leg moved to overlap her right leg and was squeezed in/by the sling. Client E's face wrinkled and her eyebrows connected to form a line on her	W 210		

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W 210	Continued From page 262 forehead. Client E's face was red and watery. Client E made high a pitched vocalization when she was moved and the pitch went higher when her left leg was squeezed by the sling. During observations at the facility on 10/22/13 at 2 PM, client E was sitting in her wheel chair in a semi reclining position with her upper body leaning to the right. Client E's feet were extended in front of her with both feet rotated in a fixed outward position. Client E's left foot was in a fracture boot and on a pillow. On 10/24/13 at 8:30am, upon entering the facility at the front conference room, vocalizations were heard (crying and yelling out). At 8:30am, the surveyor followed sounds by walking down the front hallway and down the second hallway to Program Room/Group #1 located on the second hallway. The DON (Director of Nurses) was in the doorway to the entrance of the room. Inside the room was client E, who was crying and yelling out. Client E sat in a wheelchair with her left leg elevated, wore a fracture boot on her left lower leg, and client E's left foot was turned sideways on top of a positioning pillow. At 8:30am, LPN (Licensed Practical Nurse) #7, facility staffs #28, and #37 stood around client E's wheelchair. The three staff offered client E different cause/effect items which client E refused and she continued to cry and yell. At 8:30am, the DON indicated client E had been crying and yelling "for about fifteen minutes" (or since 8:15 am). At 8:45am, the DON was overheard to instruct LPN #7 to administer client E's PRN (as needed) pain medication "now." From 8:30am until 8:45am, LPN #7 instructed the facility staff to transfer client E into a recliner and out of her wheelchair. At 8:45am, client E was approached by facility staff #17, #28,	W 210		

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W 210	Continued From page 263 and #37 to transfer her into a recliner chair inside the program room. Client E sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #37 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #28 grasped client E's fracture boot on her left leg. Facility staff #17 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #17 stated "I pull the handles together" which he did and lifted client E with one hand holding both handles. When facility staff #17 held the sling handles together at her hips, client E's left leg moved together with client E's right leg, and client E's legs were squeezed together in/by the sling. Client E's face was wrinkled, her eyebrows leveled, and she continued to cry and yell. Client E's face was red. Client E made high pitched vocalizations when she was moved and the pitch went higher when her left leg was squeezed by the sling. From 8:45am until 8:48am, client E was calmer but continued to make vocalizations. At 8:50am, client E was crying and yelling again while seated in the recliner. At 8:50am, facility staff #28 stated "She (client E) seems like (she's) in pain" and facility staff #28 held client E's hand while client E continued to cry and yell. At 8:50am, facility staff #64 entered the program room and stated to the facility staff "if the med (medication) doesn't help, come and get me." At 8:55am, facility laundry/housekeeping staff #82 entered the program room, talked to client E, and tried to reassure client E to calm her. Client E continued to thrash her head back and forth, cried and yelled, and her face was red. At 9:00am, facility laundry/housekeeping staff #82 stated "I've never seen her like this before, She's either upset or in	W 210		

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W 210	Continued From page 264 pain." Staff #82 indicated she had been employed at the facility over nineteen years (19 years) and had a rapport with client E. At 9:00am, the D.O.N. returned to the program room and asked staff to assist client E to her bed room and for client E to go back to bed. From 9:00am until 9:10am, client E was wheeled in the recliner from the program room, down the hallways to client E's bedroom (room #36), and transferred from the recliner into her bed. At 9:10am, client E continued cry and yell and to have a red face. At 9:40am, client E was observed calm and in bed. On 10/24/13 at 3:25pm, client E was observed inside Program Room/Group #1. Client E sat in her wheelchair, softly vocalized, and her face appeared to be red and she moved her head back and forth. At 3:35pm, facility staff #31 paged for assistance from the facility nurse for group #1. At 3:35pm, facility RN #5 entered the program room, approached client E, and walked to the phone inside the program room to call the medication nurse to inquire regarding client E's use of PRN pain medication. At 3:50pm, RN #5 indicated the medication nurse was checking for the availability of client E's medication. RN #5 indicated client E had been receiving her PRN pain medication today and he wanted to make sure it was time for another dose of PRN pain medication for her "breakthrough" pain. At 3:55pm, the unidentified medication nurse entered the Program Room and administered client E's PRN pain medication. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. An 8/16/13 BDDS (Bureau of Developmental Disabilities Services) report indicated "On August 15th at approximately 5:40 AM, staff entered [client E's]	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 210	Continued From page 265 bedroom to prep and assist [client E] with getting for her daily routine (sic). Staff stated that they removed [client E's] covers and touched her foot. Upon touching her foot, staff stated that [client E] cried out. Reporting staff further stated that they then removed her sock in an attempt to determine what caused [client E] to cry out. [Client E] then cried out in a louder tone. Staff then stated that they left [client E] in her bed and alerted nursing personnel of the situation for further assessment. The following nursing assessment is as follow: [Client E's] left foot was noted with full range of motion capabilities. Under normal conditions, [client E's] tone and overall range of motion capabilities are minimal. Additionally, slight edema was noted to [client E's] left foot and ankle area with less than 3 seconds for cap (capillary) refill. Plan to resolve: Nursing placed a splint/rigid boot on [client E's] left foot/ankle and contacted her PCP (Primary Care Physician) for instructions. New orders were obtained to send [client E] for x-rays of [client E's] left foot and ankle area...." Client E was taken for x-rays at a nearby facility at 8 AM and returned to the facility at 10:20 AM. At 12 PM, client E's PCP called the facility with new orders for client E to "immediately" see an orthopedic surgical doctor due to x-ray results "regarding left leg fractures." The report indicated the following x-ray results: __"Acute, minimally displaced spiral fracture of the distal tibia diaphysis." __"Acute, non-displaced distal fibular diaphyseal (pertaining to or affecting the shaft of a long bone) fracture." __"Diffuse bone demineralization." __"Ped planus (flat foot) deformity of the foot." The 8/16/13 BDDS report indicated client E was taken to a local hospital and another set of X-rays	W 210		

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W 210	Continued From page 266 were completed at [name of hospital]. The findings of the x-rays were as follows: __"Non-displaced spiral fracture of the distal tibial diaphysis (the main or midsection shaft of a long bone)." __"Non-displaced spiral Weber type C fracture of the adjacent fibula with no significant joint space widening." __"Extensive bony demineralization without convincing evidence for acute fracture." The report indicated "Immediate Action Taken: New orders from [name of hospital] were to apply ice for swelling, provide Tylenol 500 mg (milligrams) Q (every) 4 hours for pain and follow up with an orthopedic consult within 6 days. On August 16th, nursing personnel scheduled an appointment with [name of doctor] for August 21st at 10:15 AM.... [Client E] has also been scheduled for a bone density diagnostic on August 30th. The 8/16/13 BDDS report indicated the facility has implemented the following measures in response to the current x-ray findings: __"[Client E's] wheelchair foot box has been widened approximately 3 additional inches to facilitate additional protection when [client E] is up in her wheelchair." __"A three-man lifting protocol has been designed to ensure the protection of her [client E's] leg." __All appropriate staff have been in-serviced regarding "client E's" current condition and on the protocol for lifting." __"[Client E's] recliner has been modified, in height, to allow for smooth transitioning during three man-lifting." Review of client E's record on 10/22/13 at 2 PM indicated diagnoses of, but not limited to,	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 267 Epilepsy, Cerebral Palsy with spastic quadriparesis (arms and legs) with associated hyperflexia (the over flexing/bending of a limb), Congenital left hip dysplasia, Bilateral Pulmonary Emboli (blood clots), incontinence of bowel and bladder, risk of aspiration, Osteopenia (low bone mineral density), fractured left distal femur and Osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density that leads to an increased risk of fracture). Client E's record indicated client E was non verbal and non-ambulatory. Client E used an adaptive wheelchair for transportation. __Client E's August 2013 physician's orders indicated the following diagnosis history, but not limited to: 11/3/93 fracture of left femur above the pin, 1/30/05 blood clot removed from left breast incision, 10/4/10 left hip cellulitis (an infection of the skin), 12/5/11 acute renal failure secondary to hypotension volume depletion with history of hypokalemia (low blood potassium), 10/4/10 sepsis (a whole-body inflammation/infection) and 12/5/11 left hip cellulitis. __Client E's Radiology report of 5/21/12 indicated "Evidence of fracture which appears acute over the distal femur at the level of the femoral condyles (round projection at the end of a long bone) anterior rotation or displacement of the distal femoral metaphysis (the wide part at the end of a long bone) in relation to the diaphysis is present. Diffuse bone osteopenia (reduced bone mass) with postoperative changes stable over the proximal left femur and changes of chronic hip dysplasia." __Client E's Lower Venous Duplex scan of 5/21/12 indicated client E had an "Acute deep venous thrombosis (blood clots) noted in the left distal femoral vein. Acute deep venous thrombosis noted in the left popliteal vein (veins	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 268 in the leg)." __Client E's Radiology Report of 7/16/12 indicated "Severe osteoporosis, Distal femoral fracture appears healing, could be old injury..." __Client E's 8/2/13 physician's order indicated "Send [client E] out via ambulance for stat (immediate) x-ray of her left upper leg and hip at [name of facility]." __Client E's Emergency Room report of 8/7/12 indicated client E "presents to the Emergency Department with a caregiver from her living facility.... They (the facility staff) said that there was an ultrasound done of her left lower extremity venous Doppler as well as an x-ray shot on the 21st of last month. It has been 2 weeks. On the x-ray they said that there was a femur fracture and they just found out today so they bring her in here. She (client E) does not walk. She is non-verbal.... There has been no injury. She had an ultrasound because she has developed blood clots in the past." The report indicated client E's left femur shows chronic changes as well as a healing fracture of the distal left femur.... I (ER doctor) spoke with [name of doctor] on call for orthopedics. He looked at the x-ray. He talked about the patient's situation. This is not something he would surgically fix. The patient is bed ridden anyway with a long history of severe mental retardation. He also would not splint it at this point based on the patient's body habitus (the tendency to develop a certain disease). They (the staff) transfer her anyway. It may be more cumbersome and be of little to no benefit at this point...." __Client E's physician's progress note of 8/21/13 indicated client E was diagnosed with cellulitis to her upper left leg. The note indicated client E was placed on antibiotics. __Client E's Social Service Quarterly Summary of	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 269 5/13 through 7/13 indicated client E is non verbal but vocal. She will turn her head away when she does not like what is presented to her. She will fuss or cry when she is upset.... She needs total assistance with all her ADL (Adult Daily Living) care and feeding...." __Client E's physician's orders of 9/18/13 indicated client E was to "Remain in boot for left leg at all times, except may remove for skin care, etc prn (as needed)." __Client E's Adaptive Skills Assessment of 10/22/12 indicated client E was a non-ambulatory female "who uses a tilt in space wheelchair with custom molded inserts pelvic stabilizer and shoe holders. She can make eye contact and can turn her head. [Client E] has minimal active movement of the extremities with no attempts to roll. She can flex and rotate her head when in supine. [Client E] has decreased bilateral hip flexion in extension and rotation, ankle inversion, decreased bilateral shoulder flexion, abduction and rotation, wrist extension and forearm supination (a kind of rotation). [Client E] displays decreased muscle tone and strength in her neck and trunk. She displays decreased muscle tone in all extremities with poor muscle strength. [Client E] requires total support in all positions. [Client E] presents with a forward flexed head tilted to the right, neuromuscular scoliosis." __Client E's Fall Fracture Risk Plan dated 10/20/12 indicated client E was at risk for falls and/or fractures. The plan indicated client E was non ambulatory and the staff were to use a "3 man lift" with transfer sling to transfer resident from bed to wheelchair to recliner. The plan indicated "Check every 2 hours." The plan indicated the staff were to monitor for client E "repositioning herself or attempting to transfer herself." The plan indicated the staff were to	W 210		

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W 210	Continued From page 270 "Notify the nurse immediately if [client E] falls or a fracture is suspected." __Client E's Osteoporosis Risk Plan of 11/7/12 indicated client E was at "Risk of injury during self repositioning, transferring from bed to chair or vice versa.... Protect client using sling to transfer from bed to wheelchair, wheelchair to recliner.... Monitor for any discomfort/pain. Use sling for all transfers...." Client E's record indicated no PT (physical therapy) assessment in regard to the supports and equipment needed to position client E to prevent further injuries due to client E's history of fractures and diagnosis of Osteoporosis and to provide client E stability and support while in her wheelchair, recliner and/or bed. Client E's record indicated no wheelchair assessment. Client E's record indicated no positioning schedule and/or nursing care plans in regard to skin integrity and/or toileting plan. Client E's record did not indicate how and when the staff were to monitor client E in regard to pain and/or regular assessments of client E's pain. Review of the lifting protocol for client E dated 8/15/13 on 10/22/13 at 3 PM indicated when transferring client E from the wheelchair to the bed or from the bed to the wheelchair the staff were to: A) Ensure client E had the appropriate sling positioned under her. B) The first staff was to position themselves at client E's right side. "This should be completed as a measure to protect her feet. C) The second staff member was to be positioned on client E's left side, "firmly grasping each corner of the sling to assist with sliding [client E] into her bed."	W 210		

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W 210	Continued From page 271 D) The third member at client E's head should control the count (1, 2, 3, lift); to ensure client E is lifted in unison. E) After client E was positioned in her bed, staff were to use the sling to move client E within her bed. F) The staff were to ensure client E's bedrails were up securely and to ensure padding over both bedrails and positioned at the bottom portion of her bed. The protocol indicated to transfer client E from/to her wheelchair to her recliner: A) The staff were to repeat steps A through F. B) The staff were to be aware of the slight drop/lift when transferring her during this time. The protocol indicated until further notice as a measure to ensure client E's safety, client E was to be provided a bed bath. Review of the undated Nursing Policy and Procedures "Transfer Activities" on 10/22/13 at 1 PM indicated "All evaluations shall be mindful of current guidelines recognizing that any client weighing over 99 pounds to be considered a two person transfer candidate. Those clients who have been identified through assessment or through physician's orders to require use of a sling for assisted transfers will be identified on their physician's orders and reflected on the DST (Developmental Skills Technician) treatment sheets. Professional Therapy recommendations in concurrence with staff evaluation may further determine that an individual resident may be best served as a single person transfer.... All clients will be assessed upon admission, annually and quarterly by Occupational and Physical Therapy Professionals to determine the most effective method to safely and efficiently transfer clients. The assessments shall be submitted to the	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 272 Interdisciplinary Team to be further integrated into each resident's Individual Program Plan. These recommendations shall indicate the methods in which a resident is to be transferred, the number of staff that may be required to perform the desired transfers and any additional instructions that may apply to an individual client." Review of the facility staff training records on 10/22/13 at 3 PM indicated 5 nursing staff and 11 direct care staff that were not trained to do a 3 person lift. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated it was possible client E could have been injured when she was repositioned during the night and/or during the 2 person lift. The QIDP stated client E had a history of breaks and "brittle bones." The QIDP stated the facility did not use any mechanical lifts "The staff do the lifts." The QIDP indicated after client E's injury the facility implemented a 3 person lift until client E's leg was healed. The QIDP indicated after client E's injury the staff were to put a pillow under client E's foot. The QIDP indicated client E had not had a wheelchair assessment since fracturing her leg. The QIDP indicated client E's foot rest was widened by the facility maintenance personnel. The QIDP indicated client E had not been assessed by PT/OT for the specific positioning supports/equipment needed to maintain client E's body, to provide optimal support to ensure client E's safety due to potential of pain or further injury with healing fractures and to assist client E with her basic needs. Interview with the DON (Director of Nurses) on 10/22/13 at 5:30 PM indicated she had been with	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 273 the facility as the DON for 3 months. The DON indicated she did not know what happened to client E, "I think she got her foot caught or something." The DON stated, "I think the staff do repositioning every 2 hours." The DON indicated the facility did not have a mechanical lift and the staff did the lifting. The DON indicated client E was a 3 person lift. Interview with Administrator (ADM) #1 on 10/23/13 at 2 PM indicated the facility did not have a mechanical lift. ADM #1 stated, "I think you can do more damage with a mechanical lift than the way we do it." Adm. #1 indicated the facility did not utilize a mechanical lift because a lift would not go under the tubs (bathtubs) and or the clients' chairs. 4. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. A 10/4/13 BDDS (Bureau of Developmental Disabilities Services) report indicated client BBB was noted with discoloration to her right and left thumbs surrounding area. Client BBB was sent to [name of hospital] for evaluation. The report indicated client BBB had a "non-displaced fracture at the base of the proximal phalanx of the right thumb with diffuse surrounding soft tissue swelling." The investigative record indicated client BBB had injured her hand while getting up from her newly purchased chair which was low to the ground, circular and had a 4 inch opening around the outside edge of woven elastic bands. The record indicated client BBB had gotten her hand caught in the webbing while getting up. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 6 PM. During this observation:	W 210		

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W 210	Continued From page 274 __Clients M, YY and AAA sat in wheelchairs. __Clients F, FF and PP sat in recliners and were picked up and placed in wheelchairs by the staff to go to the dining room for their evening meal. __Staff #57 walked with client I to the dining room, his arms interlocked under client I's arms, his knees touching the back of her legs. Client I was walking on her tip toes and taking one step at a time with staff #57 verbally and physically prompting client I to continue walking toward the dining room. Client I's gait was unsteady and slow and required staff assistance from staff #57 to take one step at a time. __Client JJ could get up on his own but was unsteady on his feet and walked into the other clients' chairs, the staff in the room and the walls. Client JJ was escorted by staff to the dining room. __Client BBB sat in a small circular saucer chair with metal tubes for legs. The chair sat close to the floor. Client BBB had to be pulled up from the chair and assisted to the dining room by the staff. Client BBB walked with an unsteady gait. __During this observationclients F, I, M, FF, PP, YY, AAA and BBB were not observed to reposition themselves without staff assistance. __During this observation client I was observed eating her evening meal. Prior to the meal, the staff placed a clothing protector on the client and then proceeded to feed client I. Client I had no food spillage. At 5:30 PM staff #36 indicated the clothing protector was used to keep client I's clothes from getting soiled. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's 8/30/13 quarterly physician's orders indicated client F had diagnoses of, but not limited to, Osteoporosis (brittle bones), Valgus feet bilaterally (outward formation of both feet) and Levoscoliosis (a side to side curvature of the	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 210	Continued From page 275 spine). Client F's ISP of 2/14/13 indicated client F would "occasionally" get on the floor and crawl but for the most part used a wheel chair for all transportation. Client F's record indicated client F's most recent wheelchair assessment was conducted in May of 2011. Client F's record indicated no PT/OT assessment. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's 8/30/13 quarterly physician's orders indicated client F had diagnoses of, but not limited to, Osteoporosis, CP, Dwarfism and Pedal Edema (swelling of the feet). Client I's ISP of 11/8/12 indicated client I was ambulatory. Client I's August 2013 nursing summary indicated client I walked with a "shuffling" gait and used a wheelchair when needed. Client I's record indicated no PT/OT assessment. Client I's record indicated no assessment for the need for the clothing protector. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's 8/30/13 quarterly physician's orders indicated client M had diagnoses of, but not limited to, CP (Cerebral Palsy), severe spastic quadriparesis (not able to walk), Osteoarthritis, Osteoporosis and Arthritis. Client M's record indicated no PT/OT assessment. Client AA's record was reviewed on 10/25/13 at 11 AM. Client AA's 8/30/13 quarterly physician's orders indicated client AA had diagnoses of, but not limited to, Scoliosis (curvature of the spine) and chronic back pain with spasms. Client AAA's record indicated no PT/OT assessment. Client FF's record was reviewed on 10/24/13 at 1:30 PM. Client FF's 8/30/13 quarterly physician's orders indicated client FF had diagnoses of, but	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 210	Continued From page 276 not limited to, CP, Scoliosis, Spasticity and contractures of bilateral lower extremities and right upper extremity with a right dislocated hip. Client FF's record indicated no PT/OT assessment. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's 8/30/13 quarterly physician's orders indicated client JJ had diagnoses of, but not limited to, Osteoporosis, Kyphosis (hunchback) and Spastic quadriplegic (spasticity of the limbs). Client JJ's record indicated no PT/OT assessment. Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's 8/30/13 quarterly physician's orders indicated client PP had diagnoses of, but not limited to, CP, Hypotonia (low muscle tone), Chronic right hip dislocation and Left hip lateral subluxation (a partial dislocation). Client PP's record indicated no PT/OT assessment. Client UU's record was reviewed on 10/25/13 at 12 PM. Client UU's 8/30/13 quarterly physician's orders indicated client UU had diagnoses of, but not limited to, CP, Scoliosis, Levoscoliosis (a side-to-side curvature of the spine) and Hypertrophic (enlarged) knuckles. Client UU's record indicated no PT/OT assessment. Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's 8/30/13 quarterly physician's orders indicated client YY had diagnoses of, but not limited to, CP, Scoliosis, Degenerative Osteoarthritis and Spastic Quardriparesis (inability to walk). Client YY's record indicated no PT/OT assessment. Client AAA's record was reviewed on 10/24/13 at	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 210	Continued From page 277 4 PM. Client AAA's 8/30/13 quarterly physician's orders indicated client AAA had diagnoses of, but not limited to, Louis Bar Syndrome (a rare, neurodegenerative disease that causes severe disability), severe spastic quadriparesis, Scoliosis and Osteoporosis (brittle bones). Client AAA's record indicated no PT/OT assessment. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's quarterly physician's orders indicated client BBB could use a low bed and a wheel chair for transportation due to "unsteady gait." Client BBB's record indicated client BBB was ambulatory. Client BBB's record indicated client BBB had a fractured right hand/thumb. Client BBB's record indicated no PT/OT assessment. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated the facility "used to have a PT/OT person, but we haven't had for quite some time." The QIDP indicated no PT/OT assessments for clients F, I, M, AA, FF, JJ, PP, YY, UU, AAA and BBB. The QIDP indicated client F's most current wheelchair assessment was May 2011. The QIDP indicated any client that used a wheel chair had an assessment conducted every 5 years or as needed by a company contracted out by the facility. The QIDP stated, "Any minor changes or fixes we do ourselves." The QIDP indicated no assessment for client I for food spillage in regard to the use of a clothing protector. Review of the undated Nursing Policy and Procedures "Transfer Activities" on 10/22/13 at 1 PM indicated "All clients will be assessed upon admission, annually and quarterly by Occupational and Physical Therapy Professionals	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 278 to determine the most effective method to safely and efficiently transfer clients. The assessments shall be submitted to the Interdisciplinary Team to be further integrated into each resident's Individual Program Plan. These recommendations shall indicate the methods in which a resident is to be transferred, the number of staff that may be required to perform the desired transfers and any additional instructions that may apply to an individual client." 4. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J was strapped into a chair with cushions on either side of the back during his evening meal. Staff #87 was interviewed on 10/21/13 at 6:00 PM. When asked about the purpose of the chair, he stated, "It's to keep him from pushing himself from the chair." Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client J was strapped into the dining room chair with a seat belt and the chair had cushions on either side of the back during breakfast. Client J's record was reviewed on 10/24/13 at 1:20 PM. Client J's 2/12/13 nursing assessment, Individual Habilitation Program assessment recommendations dated 2/12/13, Quarterly Nutritional Assessment dated 8/27/13, and an Adaptive Skills Assessment dated 2/12/13 did not include the use of the dining chair with a seat belt and cushions. The record indicated client J was to use a gait trainer. There was no evidence of a physical therapy or occupational therapy assessment in client J's record regarding his needs for an adapted dining chair or for his mobility needs.	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 279 The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/29/13 at 4:40 PM. and indicated there should be an assessment as part of the ISP (Individual Support Plan) regarding the use of client J ' s gait trainer and chair. 5. Client L's record was reviewed on 10/29/13 at 1:40 PM. A physician's progress note dated 10/20/13 indicated client L was found on the floor with a laceration over his right eye. A nurses note dated 10/29/13 at 7:00 AM indicated an area to client L's right outer elbow was red and abraised. The area was treated with antibiotic ointment and a bandaid. There was no evidence in the record of a physical therapy assessment. During observations in program room 3 on 10/29/13 from 12:45 PM until 12:55 PM, client L sat in the room with a lap top on his wheelchair and a bandaid on his right elbow. Staff #45 was interviewed on 10/29/13 at 12:55 PM. She indicated it was now Doctor's orders client L use a wheelchair after he fell from his wheelchair and required stitches. The QIDP (Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/29/13 at 4:45 PM. She indicated client L's wheelchair had a lap tray as recommended by his initial wheelchair assessment. The QIDP/Program Director was interviewed again on 10/29/13 at 5:51 PM and indicated there was no evidence of a wheelchair evaluation for client L.	W 210		

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	15G580		C 11/06/2013

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W 210	Continued From page 280	W 210		
W 225	3.1-31(a) 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review, and interview, for 3 of 10 sampled clients (clients C, D, and E), the facility failed to assess each client's vocational skill to include work interest skills and opportunities. Findings include: Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 CFA (Comprehensive Functional Assessment) and 3/28/13 IHP (Individual Habilitation Plan) did not include an assessment of specific vocational skills or work interests and opportunities. Client C's 3/28/13 "Adaptive Skills Assessment" indicated "Vocational History: [Client C] has no previous, documented history of gainful employment. Further, she has had no formal training or experience with outside vocation placement. Current vocational stimulation training involves increased focus on fine motor skills, selection of desired objects." Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 CFA and 5/28/13 IHP did not include an assessment of specific vocational skills or work interests and opportunities. Client D's 5/28/13 "Adaptive Skills Assessment" indicated "Vocational History: [Client	W 225		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 225	Continued From page 281 D] has no previous, documented history of gainful employment. Further, she has had no formal training or experience with outside vocation placement. Current vocational stimulation training involves increasing her willingness to participate, selection of desired items, and increasing fine motor skills." Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 CFA and 11/8/12 IHP did not include an assessment of specific vocational skills or work interests and opportunities. Client E's 11/8/12 "Adaptive Skills Assessment" indicated "Vocational History: [Client E] has no previous, documented history of gainful employment. Further, she has had no formal training or experience with outside vocation placement. Current vocational stimulation training...." Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on 10/24/13 at 1:25 PM, was conducted. The QIDP/PD indicated there were no additional assessments for clients C, D, and E available for review.	W 225		
W 227	3.1-31(c)(10) 483.440(c)(4) 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. This STANDARD is not met as evidenced by:	W 227		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 227	Continued From page 282 Based on observation, record review, and interview, for 1 additional client (client HH), the facility failed to ensure client HH's BSP (Behavior Support Plan) stated specific objectives to meet his Self Injurious Behavioral (SIB) needs to prevent client HH from punching himself in the face with his fists. Findings include: On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without	W 227		

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	15G580		C 11/06/2013

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W 227	Continued From page 283 redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. Client HH was not offered or encouraged activity. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual	W 227		

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	15G580		C 11/06/2013

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W 227	Continued From page 284 Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors) which resulted in right and left black, swollen, and discolored eyes. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's non reportable incident report did not indicate a program revision to include behavioral rates, objectives to prevent the SIB, injuries caused by self injurious behaviors, and client HH's right eye injury. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into	W 227		

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	15G580		C 11/06/2013

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W 227	Continued From page 285 others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's 10/21/13 BSP was not available for the facility staff to use. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with	W 227		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 227	Continued From page 286 pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission.	W 227		
W 230	3.1-35(a) 483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be assigned projected completion dates. This STANDARD is not met as evidenced by: Based on record review and interview for 8 of 10 sample clients (A, B, C, F, G, H, I, H), the facility	W 230		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 230	Continued From page 287 failed to ensure the clients' Individualized Habilitation Plan (IHP) objective completion dates were reviewed and updated. Findings include: 1. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) did not include completion dates for each objective. Client C's IHP indicated objectives/goals to release her brief to staff given one verbal request, grasp the bottom of her shirt to assist with pulling it down, to remove her toothette from her mouth after assisted swabbing, to identify her own nose by pointing given a request, to take a penny from staff when shown with another coin, to carry her hang up clothes to her closet, to turn two pages of a selected magazine on at a time, to raise her head up to look at staff to take a desired item, to make one washing motion to her chest given a prepared washcloth, to hold unopened split gauge during G tube cleaning, and to identify common objects from a field of 2 objects. Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 IHP did not include completion dates for each objective/goal. Client D's IHP indicated objectives/goals to follow 3 simple one step instructions, to encourage client D to look in the direction of speaker when spoken to, to maintain grasp of a leisure item for 15 seconds, to verbally state Y/N (Yes/No) to a question on a community outing, to verbally respond Y/N when asked if she needs to be changed, to extend both arms through her shirt sleeves, to spit out toothpaste after brushing, to maintain grasp of selected item for 5 seconds, to verbally identify a soft and solid item by stating	W 230		

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	15G580		C 11/06/2013

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W 230	Continued From page 288 Y/N when placed in her hand, to tolerate by allowing the touch of staff for 15 seconds, to appropriately state Y/N if she is happy or mad when asked, to maintain grasp of a prepared washcloth, to hold washcloth during medication administration, and to follow 3 simple one step instructions. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP did not include completion dates for each objective/goal. Client E's IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dis similar object, to select preferred DVD (movie), to respond to textured item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses as tolerated. Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on 10/24/13 at 1:25 PM, was conducted. The QIDP/PD indicated clients C, D, and E's objectives/goals had their annual IHP dates and no additional information was available for review. 2. Client F's record was reviewed on 10/23/13 at 1 PM. The client's IHP of 2/14/13 indicated client F had objectives: __To grasp his brief prior to being changed to assist the staff. __To pull his shirt down over his head after placement to assist with dressing. __To throw his soiled toothette into the trash after using. __To accept lotion in the palm of his hand.	W 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 230	Continued From page 289 __To take one coin from his instructor when the coin was presented. __To interact with one peer and one staff for at least 2 minutes. __To appropriately manipulate a desired item for 30 seconds. __To propel his own wheelchair one time per shift in the hallway for 15 feet. __To remove three items from his lap. Client F's IHP indicated July 2011 as completion dates for client F's goals. Client F's record indicated client F's goals had not been reassigned projected completion dates since July 2011. Client I's record was reviewed on 10/23/13 at 2 PM. The client's IHP of 11/8/12 indicated client I had objectives: __To pull up her underwear after assisted to the toilet. __To select her own shirt to match her selected pants. __To swab her mouth with a toothette and to assist with brushing her mouth. __To match three different colored cups one at a time. __To remove eight items from a shallow container one at a time. __To select the correct shaped object from a triangle and a circle. __To select a coin when presented with one other item. __To ambulate to the dining room with minimal assistance. __To maintain her attention to selected task for at least five minutes. Client I's IHP "Formal Goal" sheet indicated May 2013 as completion dates for client I's goals. Client I's record indicated client I's goals had not	W 230		

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W 230	Continued From page 290 been reassigned projected completion dates since May 2013. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/25/13 at 5 PM indicated the current completion dates for clients I and F were on the clients' IHP on the last page that indicated "Formal Goal." The QIDP stated the clients objectives were reviewed monthly and dates and goals were to be updated "as needed." 3. Client J's record was reviewed on 10/24/13 at 1:20 PM. An IHP (Individual Habilitation Plan) dated 2/12/13 included objectives to grasp waist of pants with one hand, place one arm into shirt, remove toothbrush from mouth after toothbrushing, rinse soap from hands, make 3 brushing motions to hair, hold his own cup twice during the meal, grasp a prepared washcloth, place 2 objects into an empty container, hand a quarter to staff, participate in a 1:1 activity with staff for 2 minutes, select a leisure item/object by grasping given 2 choices, grasp a preferred leisure object for 1 minute, walk to and from the dining room in the gait trainer for meals, will wipe tables in his program room. There were no completion dates for the objectives in the IHP. Client H's record was reviewed on 10/28/13 at 4:00 PM. Client H's IHP dated 2/4/13 included objectives to sit on the toilet, pull his shirt over his head, grasp his toothbrush, place his hands under running water, open deodorant before use, sort 6 items into 2 piles of any color, sort coins from dissimilar items, walk with staff to obtain clothing, maintain eye contact with staff for 10 seconds, bounce a ball with staff for 30 seconds, place a cup on it's base after drinking to prevent spilling, rinse body when showering. There were no completion dates for the objectives in the IHP.	W 230		

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W 230	Continued From page 291 Client B's record was reviewed on 10/29/13 at 2:06 PM. His IHP dated 4/4/13 included objectives to wipe thoroughly after a bowel movement, unbutton his pants, spray underarm deodorant of choice, brush front teeth, trace numerals from 1-10, hold a pencil with tripod grasp, hop consecutively 5 times, complete a 10 piece puzzle, fold 5 washcloths, participate in an informal leisure activity with 1 peer, place clean laundry items into his dresser/closet, use a napkin to wipe his mouth after meals. There were no completion dates for the objectives in the IHP. 4. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record included an IPP dated 11/29/12. Client A's IPP included the following goals: sit on toilet for 2 minutes 2 times per shift for at least 90 out of 120 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, place her shoes on her feet for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to brush her teeth for 1 minute for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 9/12, will place her hands under running water to rinse during hand washing for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 9/12, will brush her hair 1 time per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 1/13, will place her clothing protector into the correct bin after each meal for at least 70 out of 90 of the documented	W 230		

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W 230	Continued From page 292 data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will use the spray nozzle to wet and rinse her upper body for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, will sort 2 sets of 2 shapes into piles of matching shapes for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will sort coins into 2 piles (quarters and pennies) for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH (hand over hand) assistance for 3 consecutive months by 2/13, will participate in an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will tolerate wearing her shoes for at least 7 minutes for at least 45 out of 60 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will allow her seat belt to be fastened while on the school bus for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 9/12, will appropriately manipulate her chosen item for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will appropriately participate in an activity with 1 peer for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to rub lotion on her palms for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive	W 230		

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W 230	Continued From page 293 months by 1/13, will place clean laundry items in her dresser/closet for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 3/13. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included an IPP dated 12/6/12. Client G's IPP included the following goals: will sit on toilet for 1 minute 3 times per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 3/13, will pull her shirt over her head for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 12/12, will make brushing motions to her top teeth for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 3/13, will raise her arms 1 at a time for deodorant application for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 12/12, will brush her hair for 5 strokes for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 1/13, will use her spoon throughout her meal for at least 90 out of 90 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 12/12, will accept shampoo into her hand for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstrative prompts for 3 consecutive months by 12/12, will discriminate 'big' or 'little' by sorting them into 2 distinct piles for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH	W 230		

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W 230	Continued From page 294 assistance for 3 consecutive months by 2/13, will identify, by pointing/reaching/grasping, groups having 'more' or 'less' for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 2/13, will sit beside staff and peer for 2 minutes for an activity for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 3/13, will share an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 2/13, will get linens out of the closet 2 times per week, will allow a soft item to be brushed across her palm for at least 23 out of 30 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 1/13, will assist with placing programming materials back into the group room closet for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 3/13. An interview was conducted with PD/QIDP on 10/30/13 at 3:45 P.M. The PD/QIDP stated, " Yes all goals should have completion dates. "	W 230		
W 240	3.1-35(a) 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by:	W 240		

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W 240	Continued From page 295 Based on record review and interview, the facility failed for 3 of 10 sampled clients (A, G, I) and 1 additional client (BBB) to include specific relevant supports in their Individual Program Plan (IPP). Findings include: 1. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 6 PM. During this observation: __Staff #57 walked with client I to the dining room, his arms interlocked under client I's arms, his knees touching the back of her legs, taking one step at a time and staff #57 verbally and physically prompted client I to continue toward the dining room. Client I walked with an unsteady slow gait. __Client BBB sat in a small circular saucer chair with metal tubes for legs. The chair sat close to the floor. Client BBB had to be pulled up from the chair and assisted to the dining room by the staff. Client BBB walked with a slow unsteady gait. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's 8/30/13 quarterly physician's orders indicated client F had diagnoses of, but not limited to, Osteoporosis, CP (cerebral palsy), Dwarfism and Pedal Edema (swelling of the feet). Client I's ISP of 11/8/12 indicated client I was ambulatory. Client I's August 2013 nursing summary indicated client I walked with a "shuffling" gait and used a wheelchair when needed. Client I's IHP (Individual Habilitaion Program) of 11/8/12 failed to indicate how the staff were to assist and monitor client I while ambulating. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's quarterly physician's orders	W 240		

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W 240	Continued From page 296 indicated client BBB could use a low bed and a wheel chair for transportation due to "unsteady gait." The physician's orders indicated client BBB was to elevate her legs for 30 minutes every 2 hours. Client BBB's record indicated client BBB had a fractured right hand/thumb and wore a hand splint. Client BBB's IHP of 5/2/13 failed to indicate how the staff were to assist and monitor client I while ambulating, when client I was to use her saucer chair and how the staff were to ensure client I elevated her legs for 30 minutes every 2 hours. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/25/13 at 4 PM indicated client I's and client BBB's IHPs did not include how the staff were to assist and monitor clients I and BBB in regard to their ambulation. The QIDP indicated client BBB should sit in the recliner to elevate her legs. The QIDP indicated client BBB's IHP did not specify how the staff were to monitor and assist client BBB with elevating her legs. 2. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had an IPP dated 11/29/12. Client A's Physician's Orders signed and dated by her Primary Care Physician (PCP) on 8/30/13 indicated "Swaddle with blanket TID (three times daily) to brush teeth and gums thoroughly after meals using Peridex (oral rinse) on brush for gums after removing soft debris." A 6/2013 monthly nursing summary indicated "6/14/13 Swaddle with blanket while brushing teeth." A 6/4/13 dental form indicated "Swaddle with blanket while brushing teeth." Client A's plan did not include guidance or a specific description of how staff were to swaddle client A with a blanket.	W 240		

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W 240	Continued From page 297 Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had an IPP dated 12/6/12. Client G's PO signed and dated by her PCP on 8/30/13 indicated "Wear helmet during waking hours R/T SIB (for self-injurious behaviors) PRN (as needed). Client G's plan did not include the use of a helmet and did not include specific criteria indicating when she was to wear a helmet.	W 240		
W 247	3.1-38(a)(1) 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed for 8 of 10 sampled (clients A, B, C, D, F, G, H, and I) and 12 additional clients (clients M, V, FF, II, JJ, PP, QQ, UU, VV, YY, AAA, and BBB to provide opportunities for choice of dining room times, and the choice of when to leave the program room. Findings include: 1. Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 3:30 PM, on 10/21/13 from 3:40 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42 AM, on 10/24/13 from 8:30 AM until 9:45 AM, and on 10/24/13 from 3:25 PM until 4:00 PM. During that time, clients C and D did not leave the program room for activity and/or social interaction. On	W 247		

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W 247	Continued From page 298 10/21/13 at 3:30 PM, FS (Facility Staff) #31 indicated clients C and D did not leave the program room because both clients received G tube feeding and the nurse administered the feeding inside the program room. On 10/22/13 at 8:02 AM, an interview was conducted with FS #17. When asked what the clients in Program Group #1 were to do during waking hours. FS #17 stated "We can't really do much (active treatment). We keep them (the clients) dry." FS #17 stated "all" clients in group #1 were a two person assist to transfer and client E was a three person assist. Clients C and D's undated "(Program) Group 1 Daily Activity Schedule" indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, Economics, sensory stim (stimulation).(Client D did not have Economics listed on her activity schedule). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity. 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure,	W 247		

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W 247	Continued From page 299 communication, choice of activities, TV, parties if scheduled, movies, group activity, bathing, special events, outing if applicable, etc." Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated objectives/goals to release her brief to staff given one verbal request, grasp the bottom of her shirt to assist with pulling it down, to remove her toothette from her mouth after assisted swabbing, to identify her own nose by pointing given a request, to take a penny from staff when shown with another coin, to carry her hang up clothes to her closet, to turn two pages of a selected magazine on at a time, to raise her head up to look at staff to take a desired item, to make one washing motion to her chest given a prepared washcloth, to hold unopened split gauge during G tube cleaning, and to identify common objects from a field of 2 objects. Client C's record did not indicate if she was to be given a choice of activity in or out of the program room. Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 IHP indicated objectives/goals to follow 3 simple one step instructions, to encourage client D to look in the direction of speaker when spoken to, to maintain grasp of a leisure item for 15 seconds, to verbally state Y/N (Yes/No) to a question on a community outing, to verbally respond Y/N when asked if she needs to be changed, to extend both arms through her shirt sleeves, to spit out toothpaste after brushing, to maintain grasp of selected item for 5 seconds, to verbally identify a soft and solid item by stating Y/N when placed in her hand, to tolerate by allowing the touch of staff for 15 seconds, to appropriately state Y/N if she is happy or mad when asked, to maintain grasp of a	W 247		

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W 247	Continued From page 300 prepared washcloth, to hold washcloth during medication administration, and to follow 3 simple one step instructions. Client D's record did not indicate if she was to be given the choice of activity in or out of the program room. An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C and D stayed in Program Group #1 all day from rising in the morning until going to bed at night. The QIDP/PD indicated clients should be offered choice during time in program areas. 2. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 5 PM. Upon entering group two there was one staff (#57) and nine clients (clients F, I, M, FF, JJ, PP, YY, AAA, and BBB). The television was on but no one in the room was watching and/or paying attention to what was on the television. All clients were sitting in recliners except for client BBB. __At 1:45 PM staff #57 stated, "I'm gonna find something for [client F] to throw." Staff #36 brought client I a pudding snack, fed it to her and left the room. Client I was not asked if she wanted the pudding snack and/or a choice of flavors. Clients AAA and M were receiving a continuous tube feeding. Clients M, PP and AAA were laying in recliners with their eyes closed. Client BBB sat in a saucer chair supported by metal tubing. The chair sat low to the floor preventing client BBB from standing on her own. Client BBB sat with her legs crossed, falling asleep, her head bobbing and neck hyperextended backwards. Client BBB's chair provided no neck support and/or no opportunity for client BBB to stretch her legs. __Client F sat slumped to the right in a recliner, his hands were a dark purplish red in color.	W 247		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 301 __At 2 PM staff #57 went from client to client with a book in his hand and reading. __At 2:10 PM staff #57 went into the bathroom that was attached to the program room to put something away and came out and stated to client PP, "Wake up, didn't you sleep last night?" Staff #57 lay a small stuffed bear beside client PP. Staff then approached client BBB and stated, "Wake up, come on you need to wake up." Staff #57 stated, "She can't get up on her own. She broke her hand on her new chair and now she's using her old chair until the other chair gets fixed." Staff #57 indicated client BBB slept a lot while in the program room. __At 2:20 PM staff #57 placed a clothing protector on client M. Staff #57 stated, "She drools a lot." Staff #57 handed client M a mirror and stated, "She likes to look at her self in a mirror." Client M lay in the recliner with her eyes closed. __At 2:23 PM staff #57 placed a plastic toy on client F's lap and gave client I some small objects to put in a plastic cup. Client JJ was mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __At 2:30 PM staff #57 stated to client YY, "Can you tell me what kind of dog this is?" At the same time client A (a small young female from group 4) ran in the room and rushed over to the window, bounced off the window and ran through the program room into the bathroom. Staff #57 ran after her and prompted her out of the bathroom and back into the program room. Client A was dragging a long jump rope behind her and swinging it around. Client A began knocking over the items on a self near client FF. Staff #11 from group four came into the room and escorted client A out of the room.	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 302 __At 2:35 PM staff #57 asked client F, "What kind of dog would you like?" Staff #57 showed client F the book. Client YY said, "Me too." And staff #57 stated, "Ok, you have to wait till it's your turn and I get back to you." __At 2:37 PM another staff came and took client YY out of the room. __At 2:47 PM staff #57 and another staff from another room lifted client AAA out of the recliner and placed him into his wheelchair. __At 2:52 PM staff #57 and another staff from another room lifted client M out of the recliner and put her in her wheelchair. __At 2:57 PM staff #57 stated, "Come on [client PP] wake up. You shouldn't be sleeping this much." Client JJ still mouthing/sucking on his hands and fingers. __At 3 PM clients M and AAA were wheeled out of the program room. Staff #57 was now alone in group two with 6 clients. Staff #57 stated, "Now, where were we?" And picked an object up out of the box. __At 3:02 PM client JJ got up from his recliner, the front of his pants was wet where he had urinated on himself. Staff #57 escorted client JJ to the bathroom and closed the door. Clients I, F, FF, PP and BBB sat alone and unsupervised in group two while staff #57 changed client JJ. __At 3:10 PM staff #44 arrived and stood in the group room. Client F dropped the toys on his lap to the floor. Client I sat fingering the items in her plastic cup. __At 3:12 PM staff #57 came out of the bathroom with client JJ. Client A ran back into the group room again from group four. Client A now had a long strand of materials tied together, running and laughing and pushing past staff to get to the bathroom in group two. Staff #57 attempted to prompt client A to go back to her group without	W 247		

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	15G580		C 11/06/2013

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303 FRANKLIN
ARCADIA, IN 46030

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W 247	Continued From page 303	W 247		

success. Staff #11 came in the room, wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced. When asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. Sometimes it's the only way to control her." Staff #44 left group room two to help staff #11 with client A. Staff #11 stated client A "needs to have" one on one staffing "when she is like this."

__At 3:15 PM staff #57 called someone to ask for a break. Staff #64 came to relieve staff #57. Staff #64 offered no training and or leisure choices while with the clients in group two.

__At 3:40 PM staff #57 returned from his break. Client JJ still mouthing/sucking on his hands and fingers. Staff #57 asked client I if she wanted some shaving cream in her hand and client I screamed, "No! No! No!" Staff #57 smiled and put a dab of shaving cream on client I's right forearm and nose. Client I screamed again and turned her head away from staff #57. Staff #57 then asked client BBB if she wanted some shaving cream and client BBB looked away from staff #57. Staff #57 put some on client BBB's face, client BBB immediately started rubbing her face and got some of the shaving cream in her eyes.

__At 3:42 RN (Registered Nurse) #1 came into the room to look at client BBB's right thumb and stated, "I don't know how she can sit for long hours like that in that chair. I couldn't hold my head up either and her neck has got to be breaking."

__At 3:43 PM staff #44 wheeled client YY back to group two activity room. Another staff wheeled client AAA back to group two also. Staff #57 and staff #44 took client YY into the bathroom to change her adult brief.

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 304 __At 3:50 PM client F dropped the plastic toy on the floor, staff #44 picked it up and gave it back to him. __At 4:30 PM staff #44 and staff #57 lifted client FF from the recliner and placed him in a wheel chair. Staff #57 took him to the bathroom. Staff #57 and #44 lifted client FF out of the wheelchair and onto the changing table. Staff #44 came out of the bathroom and woke client BBB. Client BBB held out her arms for staff #44 to help her. Staff #44 grabbed client BBB by both forearms and pulled her to a sanding position. Staff #44 escorted client BBB to the dining room. Staff #57 was still in the bathroom with client FF and clients F, I, M, JJ, PP, YY and AAA remained unsupervised in group room two. __At 4:45 PM staff #57 walked behind client I with his arms interlocked under client I's arms, his knees touching the back of her legs and step by step, staff #57 verbally and physically prompted client I to take a step and to continue toward the dining room. Client I was prompted to the sink inside the dining room to wash her hands and then escorted to a table with 2 chairs. Staff #57 pulled out one of the chairs and assisted client I to sit down. Staff #36 brought a high sided divided plate and youth silverware to the table and sat them down in front of client I. Staff #36 then placed a clothing protector on client I. Client I then sat and waited. Staff #36 stated, "I'm waiting on [client Q] to get here before I get their food. We do family style dining and the two of them eat together." At 5 PM client Q arrived and sat down at the table with client I. Staff #36 went up to returned the dining room serving counter and brought back client I's food and pre-filled 6 ounce drinking glasses with thickened liquids. Staff #36 served client I pureed chicken and then, with hand over hand assistance client I placed a	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER
ARCADIA DEVELOPMENTAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
303 FRANKLIN
ARCADIA, IN 46030

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W 247	Continued From page 305 serving of mixed vegetables on her plate. Staff #36 then picked up client I's youth silverware and began feeding client I her evening meal. Staff #36 prompted client I to pick up her spoon twice during the meal and once provided hand over hand assistance for client I to feed herself. At 5:30 PM staff #36 stated the staff were to prompt client I to feed herself, "But she doesn't want to and we just end up feeding her." __At 5:24 PM staff #57 pushed client F to the dining room via a wheel chair. Staff #57 positioned client F at one of the dining room tables and left the room to escort another client to the dining room. Client F sat without interaction from staff until 5:33 PM when staff 57 cleansed client F's hands with a hand sanitizer. Staff #57 placed a clothing protector on client F and then brought client F's high sided divided plate and silverware to the table and placed them in front of client F. At 5:35 PM staff #44 brought client F's food to the table and served client F pureed chicken, vegetables and chocolate cake. Staff #44 placed prefilled 6 ounce drinking glasses with thickened liquid on the table in front of client F. As soon as the food was in client F's plate, client F began feeding himself, taking large bites, eating at a fast pace with lots of food spillage onto his face, chest and lap. Staff #44 got a napkin and wiped client F's face. At 5:45 PM client F dropped his spoon on the floor. Staff #36 stated, "That's a sign that he's done eating." Client F's plate and tableware was removed from the table and taken to the dining room serving counter. Client F was then cleaned up and escorted out of the dining room. The staff did not prompt client F to slow his pace of eating or to take smaller bites. __During this observation the staff did not offer clients F, I , M, FF, JJ, PP, YY, AAA and BBB choices of activities.	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 306 On 10/25/13 at 1:35 PM clients F, I, M, FF, JJ, PP, YY, AAA and BBB were sitting in group room two, the radio was playing loudly, the television was on and no staff in the room. None of the clients in the room was watching or paying attention to the television. After waiting for 10 minutes, staff #57 came out of the bathroom. Staff #57 indicated he was the only staff in the room at the time and the clients were involved in watching television. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's IHP (Individual Habilitation Plan) of 2/14/13 indicated client F had the following objectives: __To grasp his brief prior to assisted changing. __To pull his shirt down over his head after placement to assist with dressing. __To accept lotion in the palm of his hand. __To take one coin from the instructor when the coin is named. __To interact with one peer and one staff for at least 2 minutes. __To appropriately manipulate a desired item for 5 seconds. __To propel his own wheelchair one time per shift in the hallway for 15 feet. __To remove three items from his lap. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's IHP of 11/8/12 indicated client I had the following objectives: __To match 3 different colored cups one at a time. __To remove 8 items from a shallow container one at a time. __To select the correct shaped object from a triangle and a circle.	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 307 __To select a coin when shown with one other item. __To ambulate to the dining room with minimal assistance. __To maintain her attention to selected task for at least 5 minutes. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's IHP of 3/31/13 indicated client M had the following objectives: __To look toward her reflection in the mirror presented by staff. __To look at the staff by turning her head to the left or right. __To track a noise or light device twice by moving her head. __To make three rocking motions in her rocking chair. __To respond with a smile or frown to textures placed in her hand. Client FFs record was reviewed on 10/24/13 at 1:30 PM. Client FF's IHP of 1/15/13 indicated client FF had the following objectives: __To appropriately manipulate a selected activity for five seconds. __To tolerate a selected item in his hand for ten seconds after placement. __To follow one simple request given one verbal prompt. __To allow touch of staff's hand for fifteen seconds. __To manipulate a penny for two seconds. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's IHP of 8/22/13 indicated client JJ had the following objectives: __To participate in a small group activity for at least five minutes.	W 247		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 308 __To pull himself up from his chair using staff's hands for assistance. __To accept a coin in his hand for five seconds. __To manipulate a selected item appropriately for twenty five seconds. __To follow simple instructions of hands up, hands down and hand me. Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's IHP of 11/29/12 indicated client PP had the following objectives: __To look in the direction of staff for five seconds. __To look in the direction of staff when his name is called. __To grasp a quarter for ten seconds when presented by the staff. __To listen for one minute to a story while staff are reading from a book or magazine. __To allow staff to rub textured items on the palm of his hand __To interact appropriately for 30 seconds with staff one to one. Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's IHP of 9/19/13 indicated client YY had the following objectives: __To respond appropriately to the question of do you need to be changed. __To verbally name a quarter and a penny. __To count to twenty with the staff. __To verbally identify a magazine and a book. __To state whether she wants her hair up or down. __To move her head to the right or left as far as she can with a verbal prompt. Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's IHP of 1/31/13 indicated client AAA had the following objectives:	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 309 __To extend both of his arms forward three times per shift. __To select a desired leisure item from a group of two or more leisure activities by moving his arm toward desired choice. __To place his own socks in his dresser one time per shift. __To select the appropriate coin when shown 2 coins __To turn one page of a magazine. __To verbally answer five questions about TV or music. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's IHP of 5/2/13 indicated client BBB had the following objectives: __To match a dime when given a dime and a quarter to choose from. __To uncross her legs prior to standing up from her chair. __To participate in a table activity with at least one other peer for five minutes. __To place her soiled clothes in the laundry barrel when appropriate. __To choose her own picture when presented with 2 differing pictures. __To answer 5 yes/no questions of her daily routine. Client BBB's 8/1/13 physician's orders indicated every two hours client BBB was to elevate her legs and feet for 30 minutes due to poor circulation. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated the staff were to follow the clients' program plans as written and provide the clients continual active treatment. The QIDP indicated the staff were to offer training objectives and/or	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 247	Continued From page 310 choices of leisure activity every fifteen minutes whenever the clients were sitting idle or not involved in an activity. 3. During observations on 10/22/13 from 1:40 PM until 3:05 PM, Client VV pointed outside the window. Staff #38 stated, "You have to wait. We have to check with the nurses." Client B indicated he wanted to go outside also. Client UU walked around with this hand in his mouth without direction to activity. Client B had an electronic device he played a game on, but put it up to wait for the nursing staff to call back about going outside. Nursing staff then called on the phone and staff #38 stated, "The nurse called and said we can't go out right now." Client V asked to take a walk. Client V was directed away from the door, and staff stated, "you have to have someone with you." Client H attempted to leave the room and was directed back. Staff #38 was interviewed on 10/22/13 at 2:10 PM. She indicated the nursing staff had informed staff it was too cold to go outside for the clients. She indicated clients B and VV had coats, but some of the clients in room 6 had medical issues and could not go outside. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." The QIDP (Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/25/13 at 2:40 PM. She indicated clients should be offered choice and arrangements could be made for clients to go outside for walks.	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 247	Continued From page 311	W 247		
W 249	3.1-3(u)(3) 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based upon record review, interview and observation for 10 of 10 clients (clients A, B, C, D, E, F, G, H, I and J), and for 26 additional clients, (M, S, T, V, W, Y, AA, CC, FF, HH, II, JJ, KK, LL, QQ, RR, SS, TT, UU, VV, WW, YY, XX, AAA, BBB and DDD), the facility failed to ensure clients' objectives were implemented as written. Findings include: 1. Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 3:30 PM, on 10/21/13 from 3:40 PM until 5:50 PM, on 10/22/13 from 5:45 AM until 8:42 AM, on 10/24/13 from 8:30 AM until 9:45 AM, and on 10/24/13 from 3:25 PM until 4:00 PM, with clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW. During the observation periods clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were not given the choice of activity by the facility staff.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 312 During these observation periods clients C, K, and T chewed on clothing protectors tied around their necks without activity and without redirection. During these observation periods two staff were on duty inside the Program Group #1 with twelve clients. One staff was continuously inside the bathroom with one client at a time and the second staff was alone inside the training area with the eleven other clients in the room. During the observation periods clients were not observed to have goals/objectives/activity schedules implemented. On 10/21/13 from 11:20 AM until 12:40 PM, clients CC, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW were inside Program Group #1 with facility staff (FS) #31 and FS #41. Clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW rotated with facility staff to and from the dining room for lunch. FS #31 indicated clients C and D did not leave the program room because both clients received G tube feeding and the nurse administered the feeding inside the program room. On 10/23/13 from 1:00 PM until 3:30 PM and from 3:40 PM until 5:50 PM, clients sat in recliners, wheelchairs, were transferred between the two chairs (each personal wheelchair and recliners) individually, and taken to into the bathroom by one staff to toilet each client, and two staff were present. From 1:00 PM until 5:50 PM, clients C, T, and K chewed on clothing protectors tied around their necks without redirection. Clients in the room slept without redirection, interaction, and/or activity. Client HH struck himself in his face without redirection and no activity was offered. Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW did not have activity or interaction. At 2:05 PM, FS #31 stated	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 249	Continued From page 313 "It is all we can do to keep them (the clients) dry." At 2:05 PM, male staff FS #31 walked to client E who was reclined in a recliner with her fractured leg positioned upward in the recliner, pulled down the front of her pants, exposed her incontinent brief in full view, pulled down client E's brief which exposed client E's pubic area, and indicated client E was wet and needed changed to FS #41 who was across the program room. From 3:02 PM until 5:50 PM, FS #31 and FS #41 walked to each client and handed/laid an object on each client's lap. FS #31 continued toileting clients individually. FS #41 walked to each client and asked them a question about the weather. From 1:00 PM until 3:30 PM, client D was not assisted to the bathroom. At 3:30 PM, FS #31 assisted client D to the bathroom and indicated client D was wet from incontinence of urine. On 10/22/13 at 8:02 AM, an interview was conducted with FS #17. When asked what the clients in Program Group #1 were to do during waking hours, FS #17 stated "We can't really do much (active treatment). We keep them (the clients) dry." FS #17 indicated the facility staff checks and changes each client in Program Group #1 every two hours. FS #17 stated "all" clients in group #1 were a two person assist to transfer and client E was a three person assist. When asked if all the clients in the room were two person assist to transfer from their wheelchairs into recliners (and recliners to wheelchairs), why then does one staff take the client into the bathroom alone without two staff, FS #17 indicated he did not know. Confidential Interview (CI) #3 stated "I've never seen this stuff (referring to the materials inside bags placed inside a broken blue Rubbermaid	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 249	Continued From page 314 container labeled group #1 supplies)." CI #3 stated the state comes in "and this stuff is all of a sudden available." CI #3 stated "It's just like the staff, no one is in the program rooms and when you're here, the staff is inside the rooms." Clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's undated "(Program) Group 1 Daily Activity Schedule" indicated the following: "5:00-7:30AM, Get up Toileting, Dressing for the day, Independent Leisure activity, medication goal, breakfast, eating goal. 7:30-8:00AM, toothbrushing, toileting, dressing etc. 8:00-9:00AM, Economics, sensory stim (stimulation).(Client D did not have Economics listed on her activity schedule). 9:00-10:00AM, Communication, Reality. 10:00-10:30AM, Choice of Activity trucks, TV, puzzles, magazines, radio, leisure item, games, table activities, socializing, etc. 10:30-11:00AM, Toileting, large group activity. 11:00-12:30PM, Lunch, eating goals, structured leisure. 12:30-1:30PM, Recreation, group activities. 1:30-3:30PM, Leisure, communication. 3:30-4:00PM, Toileting, handwashing, choice of activity, socializing. 4:00-5:00PM, Dinner, eating goals, structured recreation. 5:00-7:00PM, Recreation, Leisure, communication, choice of activities, TV, parties if scheduled, movies, group activity, bathing, special events, outing if applicable, etc." Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated objectives/goals to release her brief to staff given one verbal request,	W 249		

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W 249	Continued From page 315 grasp the bottom of her shirt to assist with pulling it down, to remove her toothette from her mouth after assisted swabbing, to identify her own nose by pointing given a request, to take a penny from staff when shown with another coin, to carry her hang up clothes to her closet, to turn two pages of a selected magazine on at a time, to raise her head up to look at staff to take a desired item, to make one washing motion to her chest given a prepared washcloth, to hold unopened split gauge during G tube cleaning, and to identify common objects from a field of 2 objects. Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 IHP indicated objectives/goals to follow 3 simple one step instructions, to encourage client D to look in the direction of speaker when spoken to, to maintain grasp of a leisure item for 15 seconds, to verbally state Y/N (Yes/No) to a question on a community outing, to verbally respond Y/N when asked if she needs to be changed, to extend both arms through her shirt sleeves, to spit out toothpaste after brushing, to maintain grasp of selected item for 5 seconds, to verbally identify a soft and solid item by stating Y/N when placed in her hand, to tolerate by allowing the touch of staff for 15 seconds, to appropriately state Y/N if she is happy or mad when asked, to maintain grasp of a prepared washcloth, to hold washcloth during medication administration, and to follow 3 simple one step instructions. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dis similar	W 249		

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W 249	Continued From page 316 object, to select preferred DVD (movie), to respond to textured item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses as tolerated. An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW stayed in Program Group #1 all day from rising in the morning until going to bed at night. The QIDP/PD indicated clients E, K, T, CC, HH, KK, LL, QQ, RR, and WW went to the dining room for meals and out of the program room. The QIDP/PD indicated each client should have received teaching and training during formal and informal opportunities throughout their time in the program room by the direct care staff. The QIDP/PD stated with two staff in the program room "it's (it is) all the staff can do to keep clients dry and toileted." The QIDP/PD stated "I knew staffing" was going to be "a problem." The QIDP/PD indicated clients C, D, E, K, T, CC, HH, KK, LL, QQ, RR, and WW's goals and active treatment schedules should have been implemented and indicated staff should have been prompting each client every 15 minutes and given them a choice of activities. 2. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 5 PM. Upon entering group two there was one staff (#57) and nine clients (clients F, I, M, FF, JJ, PP, YY, AAA, and BBB). The television was on but no one in the room was watching and/or paying attention to what was on the television. All clients were sitting in recliners except for client BBB. __At 1:45 PM staff #57 stated, "I'm gonna find	W 249		

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	15G580		C 11/06/2013

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W 249	Continued From page 317 something for [client F] to throw." Staff #36 brought client I a pudding snack, fed it to her and left the room. Client I was not asked if she wanted the pudding snack and/or a choice of flavors. Clients AAA and M were receiving a continuous tube feeding. Clients M, PP and AAA were laying in recliners with their eyes closed. Client BBB sat in a saucer chair supported by metal tubing. The chair sat low to the floor preventing client BBB from standing on her own. Client BBB sat with her legs crossed, falling asleep, her head bobbing and neck hyperextended backwards. Client BBB's chair provided no neck support and/or no opportunity for client BBB to stretch her legs. __Client F sat slumped to the right in a recliner, his hands were a dark purplish red in color. __At 2 PM staff #57 went from client to client with a book in his hand and reading. __At 2:10 PM staff #57 went into the bathroom that was attached to the program room to put something away and came out and stated to client PP, "Wake up, didn't you sleep last night?" Staff #57 lay a small stuffed bear beside client PP. Staff then approached client BBB and stated, "Wake up, come on you need to wake up." Staff #57 stated, "She can't get up on her own. She broke her hand on her new chair and now she's using her old chair until the other chair gets fixed." Staff #57 indicated client BBB slept a lot while in the program room. __At 2:20 PM staff #57 placed a clothing protector on client M. Staff #57 stated, "She drools a lot." Staff #57 handed client M a mirror and stated, "She likes to look at her self in a mirror." Client M lay in the recliner with her eyes closed. __At 2:23 PM staff #57 placed a plastic toy on client F's lap and gave client I some small objects to put in a plastic cup. Client JJ was	W 249		

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W 249	Continued From page 318 mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __At 2:30 PM staff #57 stated to client YY, "Can you tell me what kind of dog this is?" At the same time client A (a small young female from group 4) ran in the room and rushed over to the window, bounced off the window and ran through the program room into the bathroom. Staff #57 ran after her and prompted her out of the bathroom and back into the program room. Client A was dragging a long jump rope behind her and swinging it around. Client A began knocking over the items on a self near client FF. Staff #11 from group four came into the room and escorted client A out of the room. __At 2:35 PM staff #57 asked client F, "What kind of dog would you like?" Staff #57 showed client F the book. Client YY said, "Me too." And staff #57 stated, "Ok, you have to wait till it's your turn and I get back to you." __At 2:37 PM another staff came and took client YY out of the room. __At 2:47 PM staff #57 and another staff from another room lifted client AAA out of the recliner and placed him into his wheelchair. __At 2:52 PM staff #57 and another staff from another room lifted client M out of the recliner and put her in her wheelchair. __At 2:57 PM staff #57 stated, "Come on [client PP] wake up. You shouldn't be sleeping this much." Client JJ still mouthing/sucking on his hands and fingers. __At 3 PM clients M and AAA were wheeled out of the program room. Staff #57 was now alone in group two with 6 clients. Staff #57 stated, "Now, where were we?" And picked an object up out of the box. __At 3:02 PM client JJ got up from his recliner,	W 249		

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W 249	Continued From page 319 the front of his pants was wet where he had urinated on himself. Staff #57 escorted client JJ to the bathroom and closed the door. Clients I, F, FF, PP and BBB sat alone and unsupervised in group two while staff #57 changed client JJ. __At 3:10 PM staff #44 arrived and stood in the group room. Client F dropped the toys on his lap to the floor. Client I sat fingering the items in her plastic cup. __At 3:12 PM staff #57 came out of the bathroom with client JJ. Client A ran back into the group room again from group four. Client A now had a long strand of materials tied together, running and laughing and pushing past staff to get to the bathroom in group two. Staff #57 attempted to prompt client A to go back to her group without success. Staff #11 came in the room, wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced. When asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. Sometimes it's the only way to control her." Staff #44 left group room two to help staff #11 with client A. Staff #11 stated client A "needs to have" one on one staffing "when she is like this." __At 3:15 PM staff #57 called someone to ask for a break. Staff #64 came to relieve staff #57. Staff #64 offered no training and or leisure choices while with the clients in group two. __At 3:40 PM staff #57 returned from his break. Client JJ still mouthing/sucking on his hands and fingers. Staff #57 asked client I if she wanted some shaving cream in her hand and client I screamed, "No! No! No!" Staff #57 smiled and put a dab of shaving cream on client I's right forearm and nose. Client I screamed again and turned her head away from staff #57. Staff #57 then asked	W 249		

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W 249	Continued From page 320 client BBB if she wanted some shaving cream and client BBB looked away from staff #57. Staff #57 put some on client BBB's face, client BBB immediately started rubbing her face and got some of the shaving cream in her eyes. __At 3:42 RN (Registered Nurse) #1 came into the room to look at client BBB's right thumb and stated, "I don't know how she can sit for long hours like that in that chair. I couldn't hold my head up either and her neck has got to be breaking." __At 3:43 PM staff #44 wheeled client YY back to group two activity room. Another staff wheeled client AAA back to group two also. Staff #57 and staff #44 took client YY into the bathroom to change her adult brief. __At 3:50 PM client F dropped the plastic toy on the floor, staff #44 picked it up and gave it back to him. __At 4:30 PM staff #44 and staff #57 lifted client FF from the recliner and placed him in a wheel chair. Staff #57 took him to the bathroom. Staff #57 and #44 lifted client FF out of the wheelchair and onto the changing table. Staff #44 came out of the bathroom and woke client BBB. Client BBB held out her arms for staff #44 to help her. Staff #44 grabbed client BBB by both forearms and pulled her to a sanding position. Staff #44 escorted client BBB to the dining room. Staff #57 was still in the bathroom with client FF and clients F, I, M, JJ, PP, YY and AAA remained unsupervised in group room two. __At 4:45 PM staff #57 came out of the bathroom with client FF. Staff #44 returned to group two. Staff #57 walked with client I to the dining room, his arms interlocked under client I's arms, his knees touching the back of her legs. Client I was walking on her tip toes and taking one step at a time with staff #57 verbally and physically	W 249		

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W 249	Continued From page 321 prompting client I to continue walking toward the dining room. Client I's gait was unsteady and slow and dependent on staff #57 to take one step at a time. __At 5:20 PM client F was wheeled from group two to the dining room. Client JJ still sat mouthing/sucking on his hands and fingers. The staff did not redirect client JJ and/or offer JJ an activity. __During this observation the staff did not offer clients F, I , M, FF, JJ, PP, YY, AAA and BBB training objectives and or a choices of activities. The clients sat for long periods of time without prompting to activity. The staff did not provide client F with something to keep his hands warm. The staff did not provide client BBB a way to elevate her legs. The staff did not follow client JJ's and YY's BSP (Behavior Support Plans) On 10/25/13 at 1:35 PM clients F, I, M, FF, JJ, PP, YY, AAA and BBB were sitting in group room two, the radio was playing loudly, the television was on and no staff in the room. None of the clients in the room was watching or paying attention to the television. After waiting for 10 minutes, staff #57 came out of the bathroom. Staff #57 indicated he was the only staff in the room at the time and the clients were involved in watching television. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's IHP (Individual Habilitation Plan) of 2/14/13 indicated client F had the following objectives: __To grasp his brief prior to assisted changing. __To pull his shirt down over his head after placement to assist with dressing. __To accept lotion in the palm of his hand. __To take one coin from the instructor when the	W 249		

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W 249	Continued From page 322 coin is named. __To interact with one peer and one staff for at least 2 minutes. __To appropriately manipulate a desired item for 5 seconds. __To propel his own wheelchair one time per shift in the hallway for 15 feet. __To remove three items from his lap. Client F's record indicated client F had a diagnosis of, but not limited to, Raynauds Disease (a condition that causes some areas of the body such as fingers, toes, the tip of the nose and ears, to feel numb and cool in response to cold temperatures or stress). Client F's physician's progress note of 5/21/13 indicated "both feet deep purple - black at toes, feet cold and unable to find pulses both lower extremities. Left hand fingers deep purple cold. HR (heart rate) apical faint, radial pulse faint, both slow." The note indicated client F had a medical history of mild tricuspid insufficiency and blood clots in his left leg. The physician's order of 8/30/12 indicated an order to "Keep his hands and feet warm." Client I's record was reviewed on 10/23/13 at 2 PM. Client I's IHP of 11/8/12 indicated client I had the following objectives: __To match 3 different colored cups one at a time. __To remove 8 items from a shallow container one at a time. __To select the correct shaped object from a triangle and a circle. __To select a coin when shown with one other item. __To ambulate to the dining room with minimal assistance. __To maintain her attention to selected task for at	W 249		

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W 249	Continued From page 323 least 5 minutes. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's IHP of 3/31/13 indicated client M had the following objectives: __To look toward her reflection in the mirror presented by staff. __To look at the staff by turning her head to the left or right. __To track a noise or light device twice by moving her head. __To make three rocking motions in her rocking chair. __To respond with a smile or frown to textures placed in her hand. Client FFs record was reviewed on 10/24/13 at 1:30 PM. Client FF's IHP of 1/15/13 indicated client FF had the following objectives: __To appropriately manipulate a selected activity for five seconds. __To tolerate a selected item in his hand for ten seconds after placement. __To follow one simple request given one verbal prompt. __To allow touch of staff's hand for fifteen seconds. __To manipulate a penny for two seconds. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's IHP of 8/22/13 indicated client JJ had the following objectives: __To participate in a small group activity for at least five minutes. __To pull himself up from his chair using staff's hands for assistance. __To accept a coin in his hand for five seconds. __To manipulate a selected item appropriately for twenty five seconds.	W 249		

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W 249	Continued From page 324 __To follow simple instructions of hands up, hands down and hand me. Client JJ's revised BSP (Behavior Support Plan) of 4/2/13 indicated client JJ had a targeted behavior of, but not limited to, mouthing his hands. The BSP indicated "[Client JJ] should be afforded the opportunity to have access to the items that he likes. Once every 30 minutes, [client JJ] should be afforded the opportunity to have one-on-one staff attention. During this time, encourage him to manipulate items. Allow him to choose the item he wants to manipulate. Verbally praise him for doing so. If he independently chooses to manipulate an item, staff should reward him with excessive verbal praise. Should [client JJ] exhibit the target behaviors, the staff should verbally interrupt.... If he continues, staff should attempt to verbally interrupt the behavior again. Allow him 10 seconds to comply. If he continues, staff should guide his hands down and release. Repeat as needed." Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's IHP of 11/29/12 indicated client PP had the following objectives: __To look in the direction of staff for five seconds. __To look in the direction of staff when his name is called. __To grasp a quarter for ten seconds when presented by the staff. __To listen for one minute to a story while staff are reading from a book or magazine. __To allow staff to rub textured items on the palm of his hand __To interact appropriately for 30 seconds with staff one to one. Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's IHP of 9/19/13 indicated	W 249		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 249	Continued From page 325 client YY had the following objectives: __To respond appropriately to the question of do you need to be changed. __To verbally name a quarter and a penny. __To count to twenty with the staff. __To verbally identify a magazine and a book. __To state whether she wants her hair up or down. __To move her head to the right or left as far as she can with a verbal prompt. Client YY's BSP of 6/15/10 indicated client YY had targeted behaviors of biting, cussing and spitting. The BSP indicated "Once every 30 minutes, staff should verbally praise [client YY] for appropriate behavior, no Anti-Social Behavior. In addition, should [client YY] not exhibit the Anti-Social Behavior for two consecutive hours, staff should spend two minutes interacting with her. Praise her for her good behavior...." Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's IHP of 1/31/13 indicated client AAA had the following objectives: __To extend both of his arms forward three times per shift. __To select a desired leisure item from a group of two or more leisure activities by moving his arm toward desired choice. __To place his own socks in his dresser one time per shift. __To select the appropriate coin when shown 2 coins __To turn one page of a magazine. __To verbally answer five questions about TV or music. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's IHP of 5/2/13 indicated client BBB had the following objectives:	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 249	Continued From page 326 __To match a dime when given a dime and a quarter to choose from. __To uncross her legs prior to standing up from her chair. __To participate in a table activity with at least one other peer for five minutes. __To place her soiled clothes in the laundry barrel when appropriate. __To choose her own picture when presented with 2 differing pictures. __To answer 5 yes/no questions of her daily routine. Client BBB's 8/1/13 physician's orders indicated every two hours client BBB was to elevate her legs and feet for 30 minutes due to poor circulation. During interview with staff #57 on 10/21/13 at 3 PM, staff #57 indicated whenever a staff was working alone, the staff would have to call for help a lot because of the lifts and the toileting. Staff #57 stated, "We try to make sure everybody gets toileted at least before going to lunch and I think they are toileted before they come to the group room in the mornings. When asked if he was aware of each client's active treatment schedule and the objectives that were to be offered, staff #57 stated, "We have a program book in every room and we can look at that." Staff #57 stated on days when there is only one staff in group two "its difficult." Interview with staff #28 on 10/23/13 at 11:20 AM indicated one person in a group room with nine to twelve clients was difficult to do. Staff #28 indicated when she was in a room alone, she found she often had to call for help and then wait. Confidential interview #20 stated it was	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 249	Continued From page 327 "impossible" for one staff to provide active treatment to nine to 12 clients with only one staff in the room, "especially in group six" CI #20 stated, "It happens all the time." CI #20 indicated the clients were to be toileted and repositioned every two hours. CI #20 indicated that doesn't happen either. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated the staff were to follow the clients' program plans as written and provide the clients continual active treatment. The QIDP indicated the staff were to offer training objectives and/or choices of leisure activity every fifteen minutes whenever the clients were sitting idle or not involved in an activity. 3. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J rubbed his eye with his left middle finger. Client H threw a block on the floor. Staff #80 asked client H to "stop." Client DDD repeatedly took his shirt off and staff #80 put it back on. Client J put his helmet strap back in his mouth after his helmet was placed back on his head. No activity was offered during the observation. Staff #57 was interviewed on 10/21/13 at 5:32 PM. He indicated client J often chewed on his shirt in addition to his helmet strap and stated, "He got it from staff," and indicated one of the staff assigned to client J's program room also chewed on his shirt. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU grabbed food from client V, and was redirected away from the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 249	Continued From page 328 dining room by staff #35. Client UU then walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth. Client Y lay on the floor in the recreation room or rocked back and forth on his feet. Client H was redirected away from looking out the window by staff #58, but did not respond. Clients UU, Y, II were not were not prompted to engage in activity. Client II lay on the floor, staff #66 placed her arms around to raise him up from the floor. Client II attempted to hit staff #66. Staff #66 indicated client II was to use a communication book to use to communicate his needs. No communication book was offered. Staff #66 stated, "We're not smacking our head or hitting [staff #66]. I'm asking you to get in the wheelchair. What's your problem?" Client II stood, dropped to the floor again, grabbed at staff #66, then tried to bang his head on the floor. Staff #66 stated, "I said No. Listen to Me. If you get much more aggressive, you're not giving me a choice." Staff #66 then asked staff to call for client II's helmet. "I know you're not happy because you know it's coming." Staff #66 placed her arms around client II from behind as she was seated on the floor, and stated, "You know sign language. There's no excuse." Client II then got into the wheelchair and was wheeled by staff #66 to program room 6. During observations on 10/22/13 from 11:28 AM until 11:35 AM, client J had the strap of his helmet in his mouth, client UU had his hand in his mouth, and client Y lay on the floor. The television was on and no other activity was offered. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA hit himself in the head. Staff #80 asked client AA what was wrong, but no	W 249		

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ARCADIA, IN 46030

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W 249	Continued From page 329 activity was offered. Client J was without activity. Staff #80 asked client J "What are you doing?" Client H looked out the window without activity. Client J was offered a barrel of toy monkeys to hold. Client VV pointed outside the window. Staff #38 stated, "You have to wait. We have to check with the nurses." Client B indicated he wanted to go outside also. Client J crawled on the floor. Client UU walked around with this hand in his mouth without direction to activity. Client B had an electronic device he played a game on, but put it up to wait for the nursing staff to call back about going outside. Nursing staff then called on the phone and staff #38 stated, "The nurse called and said we can't go out right now." Client VV had holes in his shirt. When staff #38 asked him if he chewed on it, client VV nodded his head "yes." Client UU had his hands in his mouth. There were smudges of opaque material on two windows in the room. Staff #80 cleaned the windows after the surveyor asked about the smudges,without involving clients in the activity. Staff #38 offered purple circles to hang up on the wall, but client J lay on the floor, client II sat in a chair without activity, client B played a game on his electronic device, and client V asked to take a walk. Client V was directed away from the door, and staff stated, "you have to have someone with you." Client H attempted to leave the room and was directed back. Client J was offered to draw a circle, but lay on the floor. Client UU put a block in his mouth, and staff #65 stated, "[Client UU]. Don't put that in your mouth." The block was not cleaned it after client UU took it out of his mouth. Client UU's hands dripped saliva and he put his hand back in his mouth. No hand washing was observed. Staff #68 was asked about the block client UU put in his mouth, and staff #68 stated, "Oh [client UU]. You're a mess," and washed the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 249	Continued From page 330 block. Client AA slept in a chair during the observation. Staff #38 was interviewed on 10/22/13 at 2:10 PM. She indicated the nursing staff had informed staff it was too cold to go outside for the clients. Staff #80 was interviewed on 10/22/13 at 2:45 PM. He indicated the smudges on the window were from client H putting his hands on the window. When asked if client H could assist with washing windows, he stated client H was capable, "but stubborn." He indicated clients B, V, Y, UU, and XX were capable of assisting with housekeeping tasks. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Staff #42 was alone in room 6 with 9 clients V, Y, J, AA, DD, H, UU, VV, XX and B at 10:35 AM. Clients B and H were asleep in a chair at 10:35 AM. Client DDD crawled on the floor from one chair to another chair. Staff #42 talked to the clients in the room about a volcano they had made in earlier that morning. The structure had paint on the volcano mound. Client DDD crawled on the floor, was redirected from sitting in the path of the doorway, and sat in a recliner without activity. Clients II and J lay on the floor during the observation. Client H lay on the floor and staff #42 gave a ball to client H and client H dropped the ball over his head. At 11:05 AM, staff #42 and #35 were in the room. Client H was offered a ball again and dropped it behind his head. Staff #42 stated, to client H, "You love that ball." Client UU walked around with a woven ball fastened around his neck on a plastic wire. Client AA chewed on the strap of his helmet during the observation. Client UU put his hand in his mouth and walked around the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 331 program room. In the dining room, client AA ate food that spilled onto a non-skid mat from his plate. Client J sat with his helmet strap in his mouth. Client UU, DDD, H, II and J were not prompted to wash their hands after being on the floor, or having their hands in their mouth. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to thedining room)." Client II banged his head on the floor 4 times without redirection. Client II banged his head again and staff #42 asked client II to say "Please. If you want something, you have to talk. Do you want to play with something?" Staff #42 got client II a ball, but client II did not engage in activity with the ball, and got on the floor. Client II had discoloration around his eyes. Client S sat in a chair tapping on a clothespin. At 11:20 AM, client II banged his head on the floor 5 more times as staff #42 spoke with client XX stating, staff #495 was "taking kids to the dining room." During the observation, staff #65 took pictures of a clock made using a potato and wires. The clock on a wall in the room was 2 hours slow. Staff #42 picked up client J to move him. Client V was reminded to ask clients politely to move from his recliner when he pushed client DDD after he sat in client V's recliner. Client DDD crawled on the floor and client H held a ball. AA walked without activity at 11:45 AM. At 11:50 AM, client H was pulled back from the doorway by staff #42 putting his arms around client H. Client H bumped into the doorway as he was pulled back into the room. At 11:56 AM, client II banged his head again, and staff #42 indicated client II would not wear a helmet. Client DDD went to the dining room at 12:20 PM and staff #35 poured his water for him. Client DDD was brought his plate of hot dog with chili sauce and did not assist in	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 332 preparing his food. Client DDD refused his food and left the dining room. Client AA's food was brought to him, on a tray and he was assisted to scoop his food. Client UU at his lunch at 12:40 PM, and clients AA and UU spilled food on the table while eating,and had food around their mouths. Clients AA and UU were not prompted to use a napkin. Staff #53 took client AA and UU's plates to the sink when they were done eating. Staff #495 wiped client UU's hands without encouraging client UU to wash his hands. Staff #42 was interviewed on 10/23/13 at 10:46 AM. When asked what skill the volcano activity developed, he stated, "It teaches them the science of mixing baking soda and vinegar-what chemicals not to mix." When asked if the clients had access to chemicals, he stated, "No." When asked if the activity developed skills for daily activities, he stated, the skill developed "Painting." He stated the clients assisted in making food "a couple of times a week," and indicated different clients go to cooking class from each program room. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." Staff #42 was interviewed on 10/23/13 at 11:20 AM. When asked about client II's discoloration around his eyes, he stated, "This is due to SIB (self injurious behavior). Staff #35 was interviewed on 10/23/13 at 11:45 AM. When asked what activity was to be taking place in program room 6, he stated, "This is	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 333 structured activity. Free time if they want to chill." Observations were completed on 10/28/13 from 11:40 AM until 11:58 AM. Client II hit his head against the recliner with no redirection. Client J sat on a mat without activity, client S sat in a recliner without activity. Observations were completed on 10/29/13 from 12:55 PM until 1:10 PM. Client AA hit his ear 15 times without redirection from staff #497. The surveyor pointed out client AA hitting his head and he redirected him from hitting his head. At 1:00 PM, client DDD had not yet been taken to the dining room. Client II hit his head on the floor and had tears on his face after he was redirected from holding client J's helmet. Clients Y, AA and J were on the floor without activity and clients UU and H were sitting in chairs without activity. Staff #497 was interviewed on 10/29/13 at 12:55 PM. He indicated client AA was to be redirected from hitting his head. Staff #42 was interviewed on 10/29/13 at 1:00 PM. When asked if client DDD normally ate at 1:00 PM, he indicated, "No. We are probably short." Staff #498 was interviewed on 10/29/13 at 1:05 PM. She indicated client II usually wore a helmet, but doesn't wear one now due to an increase in behaviors when he wore one. Staff #498 indicated nursing staff had been notified of client II's behavior. Client J's record was reviewed on 10/24/13 at 1:20 PM. Client J's Adaptive Skills Assessment dated 2/12/13 indicated client J "shows no	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 334 concern for his privacy or for that of others. When dealing with others there are reports of invasion of space, biting and pulling hair pointing toward his tendency for anti-social behavior. The use of medication and the Behavior Management Program (BMP)are in place to try to reduce these behaviors such as putting his hands in his pants, playing with himself, actual masturbation, placing his thumb in his mouth, biting clients, pulling others hair, chewing on objects, hitting himself, banging his head, kicking, scratching and biting himself. Keeping him occupied with a variety of stimuli appears to reduce the occurrence of behaviors. It has been noticed he has an attraction toward pain and sometimes requires one on one when he has a wound that must heal." Client J's BMP effective 2/1/08 and updated 6/25/12 included Anti-Social Behavior defined as "hands in his pants, playing with self, actual masturbation, chewing on objects. [Client J's] main behavior at this time, is chewing on objects." A section Antecedent indicated, client J's "behavior appears to be cyclic. However, there is no known antecedent except possibly seeking attention. Usually he finds humor in the behaviors he exhibits. The program description indicated client J should be reinforced with one on one staff attention for 1 minute if he does not engage in any of the targeted behaviors, and if client J exhibits the targeted behavior, staff "should attempt to verbally interrupt the behavior...If [client J] bites down on an object and won't release it, offer him a drink of water or bite of something to eat...Never place your fingers in his mouth to get the object free. This could result in getting yourself bit..." The plan included the use of Prozac (anti-depressive) 20 mg (milligrams) daily. An IHP (Individual Habilitation Plan) dated 2/12/13 included objectives to grasp waist of	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 335 pants with one hand, place one arm into shirt, remove toothbrush from mouth after toothbrushing, rinse soap from hands, make 3 brushing motions to hair, hold his own cup twice during the meal, grasp a prepared washcloth, place 2 objects into an empty container, hand a quarter to staff, participate in a 1:1 activity with staff for 2 minutes, select a leisure item/object by grasping given 2 choices, grasp a preferred leisure object for 1 minute, walk to and from the dining room in the gait trainer for meals, will wipe tables in his program room. Client H's record was reviewed on 10/28/13 at 4:00 PM. His IHP dated 2/4/13 included objectives to sit on the toilet, pull his shirt over his head, grasp his toothbrush, place his hands under running water, open deodorant before use, sort 6 items into 2 piles of any color, sort coins from dissimilar items, walk with staff to obtain clothing, maintain eye contact with staff for 10 seconds, bounce a ball with staff for 30 seconds, place a cup on it's base after drinking to prevent spilling, rinse body when showering. There were no completion dates for the objectives in the IHP. Client B's record was reviewed on 10/29/13 at 2:06 PM. His IHP dated 4/4/13 included objectives to wipe thoroughly after a bowel movement, unbutton his pants, spray underarm deodorant of choice, brush front teeth, trace numerals from 1-10, hold a pencil with tripod grasp, hop consecutively 5 times, complete a 10 piece puzzle, fold 5 washcloths, participate in an informal leisure activity with 1 peer, place clean laundry items into his dresser/closet, use a napkin to wipe his mouth after meals. Client UU's record in program room 6 was	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 336 reviewed on 10/24/13 at 12:55 PM. Client UU's October, 2013 data collection sheets indicated IHP objectives to walk to the bathroom upon staff request, place hand on waistband, allow staff to brush teeth for 45 seconds, will place brush under soap dispenser to accept soap for hand washing, will obtain paper towel from dispenser, grasp a textured item, accept 2 coins, look in staff's direction, will appropriately interact with staff for 45 seconds, will wipe tables/windows in his program room. Client DDD's records were reviewed on 10/24/13 at 1:35 PM. Client DDD's October data collection sheets indicated objectives for his IHP "transfer to toilet, pull up pants, remove his toothbrush from his mouth, propel gait trainer 50 feet at a time, place at least 4 items into a container, take a presented coin when displayed with a dissimilar item, participate in 10 minutes of group activity without interruption, greet peer/staff using hand shake, fist bump or high 5 1 time each shift, choose between a choice of leisure activities presented" was missing data for October 7, 11 on day shift, and missing data for October 9, 11, 14, 20, 21, for evening shift. Client DDD's Behavior Support Plan (BSP) dated 8/10/13 indicated target behaviors of Sexual Acting Out and Physical Aggression. Antecedent and Function of Behavior indicated client DDD's sexual acting out was "likely" caused by reaching puberty, and physical aggression "more likely occurs in a loud/disruptive environment,and not getting his way." The plan included Prozac 20 mg BID and Klonopin 0.5 mg BID. The plan indicated client DDD was to be redirected from placing his hands in his pants and to encourage handwashing. Client AA's record in program room 6 was	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 249	Continued From page 337 reviewed on 10/29/13 at 1:31 PM. Client AA's BSP dated 2/1/13 indicated a goal "will refrain from self abusive behavior as evidenced by no more than 100 incidents a month for 3 consecutive months. Target behavior included Self-Abuse; hitting his head/ears, biting his hand, punching his head, smack his head, throwing himself backwards against a chair. The plan indicated client AA was to be given a small drink of beverage every hours, and provided time to walk around the building or go to his bedroom for 30 minutes. Client AA was to wear a helmet if he engaged in hitting his head. Client II's record was reviewed on 10/29/13 at 1:32 PM. Client II's BMP effective 3/23/95 included the use of Depo-Provera 150 mg, Risperdal 3 mg BID (twice daily), Clonidine. 0.2 mg BID, Naltrexone 50 mg HS (bedtime), Lithium (manic depression) ER 450 mg BID and the target behaviors of "biting hand or wrist and banging his head on the floor or hitting his head on his hands while lying on the floor and running into the wall, dropping to floor, hitting and choking staff...Although no definite antecedent is determined, it is believed that [client II] may engage in this behavior as a response to staff request or when exited." The Program Description indicated, "Once every 30 minutes, during waking hours, [client II] will be reinforced for refraining from anti-social behavior with a drinkable paired with verbal praise. In addition, should [client II] refrain from anti-social behavior for the entire shift, staff should afford him the opportunity for 'reward time.' The reward time includes playing outside or having the opportunity to manipulate a mirror...." Behavior intervention included "If [client II] is observed to engage in SIB (self injurious behavior)," staff were to verbally	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 338 redirect and if client II did not stop, "apply his helmet until the behavior stops. Remove the helmet once he stop banging his head...." Client II's plan did not include the use of placing arms around him, physically blocking him, or the use of sign language to address his behavior. Client B, H, J, S, V, Y, AA, II, UU, VV XX's and DDD's activity schedules were reviewed on 10/29/13 and indicated clients were to engage in the following activities: "5:00 -7:30; toileting, shower/bath, dressing, structured leisure activity (sorting, coloring, sensory stim (stimulation) activity, playing ball, identify colors/shapes. Look at pictures in books/magazines, blocks, shape sorters, etc., medication goal, breakfast, eating goal. From 7:30 AM to 8:00 AM, toothbrushing, toileting, etc.. .From 8:00-9:00 AM, Money management, academics. From 9:00 AM -10:00 AM Communication, interaction. From 10:00 AM to 10:30 AM Choice of activity, (TV, puzzles, book, magazine, radio, leisure item, games, switch device:s, items for manipulation, etc.). 10:30 AM-11:00 AM toileting, group activity. From 11:00 AM to 12:30 PM, lunch, eating goal, structured leisure time, (sorting, coloring, sensory stim activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorters, etc.) 12:30 P M to 1:00 PM, recreation, group activity. From 1:00 PM to 1:30 PM toileting, group activity. From 1:30 PM to 2:30 PM, leisure manipulation. From 2:30 PM to 3:30 PM, communication, interaction. From 3:30 PM to 4:00 PM, toileting, group activity. From 4:00 PM to 5:30 PM, dinner, eating goal, structured recreation (sorting, coloring, sensory stim activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorters, etc. From 5:30 PM to 7:00 PM,	W 249		

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W 249	Continued From page 339 Recreation, leisure, choice of activity, TV, parties if scheduled. From 7:00 PM to 8:00 PM, snack time, dressing for bed, toothbrushing, choice of recreation, toileting., etc." The Program Director was interviewed on 10/29/13 at 12:45 PM. She indicated client II was not to use a helmet as it increased his behaviors, and sign language was to be included in his behavior plan to address his behaviors. When asked if staff were using the plan located in the program room, she stated, "More than likely, Yes." The Program Director was interviewed on 10/25/13 at 2:40 PM and indicated staff should prompt clients to engage in activity every 15 minutes. She indicated staff should offer client's activity as appropriate to their needs and should implement client plans as written. 4. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. client A and client G were in the room with (direct care staff) DCS #11. Client G had a box she put clothes pins in. Client G shook the box up by her ear, and then would dump the pins on the floor. There was a movie playing on the TV in the room. Client A was not engaged in any activity. Client A attempted to leave the room DCS #11 redirected her to put her shoes and socks on first. The QIDPD (Qualified Intellectual Disabilities Professional Designee) took client A out of the room for a walk. At 2:00 P.M. client A returned to the room with a CD player. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was returned to the room by the QIDPD at 2:24 P.M. Client A had a jump rope she was dragging	W 249		

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ARCADIA, IN 46030

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W 249	Continued From page 340 around on the floor behind her. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a loud sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. DCS #11 did not provide immediate intervention for client G's SIB (self-injurious behaviors) she did not immediately offer client G her baseball hat or helmet due to intervening with client A's continued running behaviors. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:35 P.M. client A and client G were given yogurt and juice for snack. DCS #11 used a curved adaptive spoon to feed client G her yogurt. DCS #11 did not encourage client G to feed herself. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. At 2:46 P.M. client G was assisted to the recreation room to color Halloween pictures and a pumpkin. Client A was standing in the hallway with a staff (unknown) when client G went to the recreation area. Continuous, aggressive and consistent active treatment and implementation of goals at all formal and informal opportunities was not present during the observation. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. Client A was located in the hallway. The back of her jeans were pulled down and her upper buttocks were visible. A male staff (unknown) asked her to	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 341 pull up her jeans and she complied. Client SS was located in the program room watching a cartoon on the TV. Client A returned to the room at 3:37 P.M. DCS #66 assisted client A to sit at the table and had her work on cards pointing to the object the staff named. At 3:40 P.M. recreational staff assisted client G back to the program room. Client G's jeans were pulled down in the back and half of the back of her incontinence brief was visible. Client G sat down and began to shake her box of clothes pins. Client A began to walk around the room dragging a 12 foot long piece of fabric strips tied together. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. At 4:16 PM client SS left the room to go to the dining room. At 4:45 P. M client G entered the dining room. At 5:10 PM client A entered the dining room. Dinner observations ended at 5:43 P.M. Continuous, aggressive and consistent active	W 249		

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W 249	Continued From page 342 treatment and implementation of goals at all formal and informal opportunities was not present during the observation. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Clients A, G and SS were in the room preparing to have a morning snack. Client G was wearing her helmet. Client A was asleep in a chair. DCS #36 stated, "They upped her (client A's) med's (medication) yesterday. I am having trouble getting her awake. I've been wiping her face with this cool cloth trying to wake her up." When asked what medication had been changed, DCS #36 stated, "No, I don't know about her medications you would need to ask a nurse." When client A saw the snacks she woke up and ate some snack crackers. DCS #36 assisted client A to the restroom to wash her face and hands. While DCS #36 and client A were in the restroom client G ate pieces of crackers off of the floor. At 9:45 A.M. DCS #36 stated, "No, maybe twice I have seen the clients in this room become aggressive, I have been in here a month." At 10:03 A. M client SS asked to go get a CD player. Client SS got the CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 343 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. Client G asked if she could go to another program area and was allowed to leave room 4. At 10:15 A.M. the QIDP brought a MP3 player with headphones to the room for client A and assisted client A in putting them on. Client A smiled. Continuous, aggressive and consistent active treatment and implementation of goals at all formal and informal opportunities was not present during the observation. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record included an IPP dated 11/29/12. Client A's IPP included the following goals: sit on toilet for 2 minutes 2 times per shift for at least 90 out of 120 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, place her shoes on her feet for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to brush her teeth for 1 minute for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 9/12, will place her hands under running water to rinse during hand washing for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 9/12, will brush her hair 1 time per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 1/13, will place her clothing protector into the correct bin after each meal for at least 70 out of 90 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by	W 249		

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W 249	Continued From page 344 10/12, will use the spray nozzle to wet and rinse her upper body for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 10/12, will sort 2 sets of 2 shapes into piles of matching shapes for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will sort coins into 2 piles (quarters and pennies) for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH (hand over hand) assistance for 3 consecutive months by 2/13, will participate in an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will tolerate wearing her shoes for at least 7 minutes for at least 45 out of 60 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will allow her seat belt to be fastened while on the school bus for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 9/12, will appropriately manipulate her chosen item for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 10/12, will appropriately participate in an activity with 1 peer for 1 minute for at least 23 out of 30 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 10/12, will allow staff to rub lotion on her palms for at least 23 out of 30 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 1/13, will place clean laundry items in her dresser/closet for at least 23 out of 30 of the	W 249		

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W 249	Continued From page 345 documented data opportunities for 3 consecutive months by 3/13. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included an IPP dated 12/6/12. Client G's IPP included the following goals: will sit on toilet for 1 minute 3 times per shift for at least 45 out of 60 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 3/13, will pull her shirt over her head for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 12/12, will make brushing motions to her top teeth for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 3/13, will raise her arms 1 at a time for deodorant application for at least 45 out of 60 of the documented data opportunities with a monthly average of physical prompts for 3 consecutive months by 12/12, will brush her hair for 5 strokes for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 1/13, will use her spoon throughout her meal for at least 90 out of 90 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 12/12, will accept shampoo into her hand for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstrative prompts for 3 consecutive months by 12/12, will discriminate 'big' or 'little' by sorting them into 2 distinct piles for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 2/13, will identify, by pointing/reaching/grasping, groups	W 249		

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	15G580		C 11/06/2013

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W 249	Continued From page 346 having 'more' or 'less' for at least 45 out of 60 of the documented data opportunities with a monthly average of HOH assistance for 3 consecutive months by 2/13, will sit beside staff and peer for 2 minutes for an activity for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 3/13, will share an activity with 1 peer for 30 seconds for at least 23 out of 30 of the documented data opportunities with a monthly average of demonstration prompts for 3 consecutive months by 2/13, will get linens out of the closet 2 times per week, will allow a soft item to be brushed across her palm for at least 23 out of 30 of the documented data opportunities with a monthly average of independence for 3 consecutive months by 1/13, will assist with placing programming materials back into the group room closet for at least 23 out of 30 of the documented data opportunities for 3 consecutive months by 3/13. An interview was conducted with the PD/QIDP on 10/30/13 at 3:49 P.M. The PD/QIDP indicated goals she be worked on at all opportunities. The PD/QIDP indicated even if clients A and G are normally in school, their goals should be worked on during school breaks. 3.1-23(a) 3.1-32(a) 3.1-33(a) 3.1-37(a)	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 347 terms. This STANDARD is not met as evidenced by: Based on record review and interview, for 8 of 10 sampled clients (clients B, C, D, E, F, H, I, and J) and 2 additional clients (clients UU and DD), the facility failed to record data to reflect individual performance. Findings include: 1. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated objectives/goals to release her brief to staff given one verbal request, grasp the bottom of her shirt to assist with pulling it down, to remove her toothette from her mouth after assisted swabbing, to identify her own nose by pointing given a request, to take a penny from staff when shown with another coin, to carry her hang up clothes to her closet, to turn two pages of a selected magazine on at a time, to raise her head up to look at staff to take a desired item, to make one washing motion to her chest given a prepared washcloth, to hold unopened split gauge during G tube cleaning, and to identify common objects from a field of 2 objects. Client C's 10/2013 data record for objectives: Afternoon "Flow Sheet" for client location a recliner, a wheelchair, or in bed were not documented on 10/8/13, 10/11/13, and 10/18/13. Client C's data record for oral hygiene was not recorded on 10/9/13 and 10/12/13. Client C's data record for range of motion exercises was not recorded on 10/9/13 and 10/12/13. Client D's record was reviewed on 10/23/13 at	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 348 9:15 AM. Client D's 5/28/13 IHP indicated objectives/goals to follow 3 simple one step instructions, to encourage client D to look in the direction of speaker when spoken to, to maintain grasp of a leisure item for 15 seconds, to verbally state Y/N (Yes/No) to a question on a community outing, to verbally respond Y/N when asked if she needs to be changed, to extend both arms through her shirt sleeves, to spit out toothpaste after brushing, to maintain grasp of selected item for 5 seconds, to verbally identify a soft and solid item by stating Y/N when placed in her hand, to tolerate by allowing the touch of staff for 15 seconds, to appropriately state Y/N if she is happy or mad when asked, to maintain grasp of a prepared washcloth, to hold washcloth during medication administration, and to follow 3 simple one step instructions. Client D's 10/2013 data record for "Flow Sheet" for client D's location a recliner, a wheel chair, or in bed were not documented on 10/3/13, 10/8/13, 10/9/13, 10/11/13, 10/12/13, 10/18/13 and 10/21/13. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dis similar object, to select preferred DVD (movie), to respond to textured item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses as tolerated. Client E's 10/2013 "Flow Sheet" for client E's location a recliner, a wheel chair, or in bed were not documented on 10/9/13, 10/11/13, 10/12/13, 10/13/13, 10/17/13, 10/18/13, and 10/19/13. Client E's 10/2013 data record for	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 349 select own color brief, was not recorded on 10/3/13 and 10/19/13. Client E's data record for use eye gaze to select desired shirt, to select a desired flavor of toothpaste, to visually identify a coin, to select preferred DVD, to respond to textured item rubbed to skin was not documented on 10/17/13, 10/18/13, and 10/19/13. Interview was conducted on 10/25/13 at 1:35 PM, with the QIDP/PD. The QIDP/PD indicated the facility staff should have recorded results from implementing objectives/goals for each opportunity. The QIDP/PD stated " Yes " when asked if client C, D, and E ' s data sheets in the program rooms had incomplete records. 2. Client F and I's Flow Sheets for October were reviewed on 10/29/13 at 5PM. Client F's October 2013 flow sheet indicated: __No documentation and/or incomplete documentation for the AM shift for October 1, 2, 6, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27 and 28. __No documentation and/or incomplete documentation for the PM shift for October 3, 9, 11, 17, 20, 21, 22, 23, 24 and 29. Client I's October 2013 flow sheet indicated: __No documentation and/or incomplete documentation for the AM shift for October 1, 2, 6, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27 and 28. __No documentation and/or incomplete documentation for the PM shift for October 9, 11, 12, 17, 21, 22, 23 and 24. __The July Day flow sheet had written in big bold letters "DO NOT fill out flow sheet days Ahead!" Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/29/13 at 4 PM indicated the staff were to document the clients'	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 252	Continued From page 350 positioning, toileting, supports worn and etc. on the daily flow sheets by using the key at the top of the form. The QIDP indicated the flow sheets were then collected at the end of the month and reviewed. The QIDP indicated these forms were to be completed daily. 3. Client J's record was reviewed on 10/24/13 at 1:20 PM. An IHP (Individual Habilitation Plan) dated 2/12/13 included objectives to grasp waist of pants with one hand, place one arm into shirt, remove toothbrush from mouth after toothbrushing, rinse soap from hands, make 3 brushing motions to hair, hold his own cup twice during the meal, grasp a prepared washcloth, place 2 objects into an empty container, hand a quarter to staff, participate in a 1:1 activity with staff for 2 minutes, select a leisure item/object by grasping given 2 choices, grasp a preferred leisure object for 1 minute, walk to and from the dining room in the gait trainer for meals, will wipe tables in his program room. Client J's October, 2013 data recording sheets for IHP objectives was missing on October 10, 20, 26. and on day shift, on October 8, 17, 18, 21, 22, and 30 for evening shift, and on October, 1, 2, 11, 17, 18, 21, 22, for objectives to reach for or grasp blocks, ball, and noise making object for AM and PM. Client H's record was reviewed on 10/28/13 at 4:00 PM. His IHP dated 2/4/13 included objectives to sit on the toilet, pull his shirt over his head, grasp his toothbrush, place his hands under running water, open deodorant before use, sort 6 items into 2 piles of any color, sort coins from dissimilar items, walk with staff to obtain clothing, maintain eye contact with staff for 10 seconds, bounce a ball with staff for 30 seconds, place a cup on it's base after drinking to prevent spilling, rinse body when showering. There were	W 252		

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W 252	Continued From page 351 no completion dates for the objectives in the IHP. Client H's data collection sheets for October, 2013 was missing data for his IHP objectives on October 4, 13, 14,18, 19, 21, 22, 23, 24 on the evening shift. Client B's record was reviewed on 10/29/13 at 2:06 PM. His IHP dated 4/4/13 included objectives to wipe thoroughly after a bowel movement, unbutton his pants, spray underarm deodorant of choice, brush front teeth, trace numerals from 1-10, hold a pencil with tripod grasp, hop consecutively 5 times, complete a 10 piece puzzle, fold 5 washcloths, participate in an informal leisure activity with 1 peer, place clean laundry items into his dresser/closet, use a napkin to wipe his mouth after meals. Client B's October, 2013 data collections sheets for his IHP objectives was missing dated for October 5,6, 10, 15, 18, 19, 23 on the day shift, on October 4, and 13 on the evening shift. Client UU's record in program room 6 was reviewed on 10/24/13 at 12:55 PM. Client UU's October, 2013 data collection sheets for his IHP objectives to walk to the bathroom upon staff request, place hand on waistband, allow staff to brush teeth for 45 seconds, will place brush under soap dispenser to accept soap for hand washing, will obtain paper towel from dispenser, grasp a textured item, accept 2 coins, look in staff's direction, will appropriately interact with staff for 45 seconds, will wipe tables/windows in his program room was missing data on October 5, 6, 15, 23 on the day shift. Client DDD's records were reviewed on 10/24/13 at 1:35 PM. Client DDD's October data collection objectives for his IHP dated 6/12/13 "transfer to	W 252		

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W 252	Continued From page 352 toilet, pull up pants, remove his toothbrush from his mouth, propel gait trainer 50 feet at a time, place at least 4 items into a container, take a presented coin when displayed with a dissimilar item, participate in 10 minutes of group activity without interruption, greet peer/staff using hand shake, fist bump or high 5 1 time each shift, choose between a choice of leisure activities presented" was missing data for October 7, 11 on day shift, and missing data for October 9, 11, 14, 20, 21, on the evening shift.	W 252		
W 253	3.1-35(d)(2)(B) 483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop a recording system to document client changes which included behaviors, events, and/or episodes for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 4 additional clients (clients AA, HH, UU, and DDD). Findings include: 1. On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around	W 253		

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W 253	Continued From page 353 his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. Client HH was not offered or encouraged activity. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located	W 253		

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W 253	Continued From page 354 in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors), which resulted in right and left black, swollen, and discolored eyes. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his) left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to	W 253		

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W 253	Continued From page 355 recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's reports did not indicate staff training was completed. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's 10/21/13 BSP was not available for the facility staff to use. Client HH's behavior data and injury information were requested from the Program Director on 10/21/13 at 5:50pm, on 10/22/13 at 8:10am, and on 10/22/13 at 4:35pm. No evidence of behavior data and injury records was given.	W 253		

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W 253	Continued From page 356 Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm, did not indicate if staff were retrained on client HH's BSP and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with	W 253		

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W 253	Continued From page 357 darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. 2. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's record indicated client F was non ambulatory, used a wheelchair and was nonverbal and required complete staff assistance from staff to ensure all his needs were met. Client F's record indicated a flow sheet for the staff to follow a key to document things like W for wet, D for dry, BR for bed rest, RC for recliner and etc. Client F's record indicated no daily written notes/documentation from the direct care staff indicating care provided through out the day, the client's reaction to the care as well as client observations: skin condition, client complaints, unusual body language, elimination, activities, reactions to the day to day stimuli and/or staff assessments of the client and etc. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's record indicated client I was ambulatory and nonverbal and required assistance from staff to ensure all her needs were met. Client I's record indicated a flow sheet for the staff to follow a key to document things like W for wet, D for dry, BR for bed rest, RC for recliner and etc. Client I's record indicated no daily notes/documentation from the direct care staff indicating care provided through out the day, the clients reaction to the care as well as client observations; skin condition, client complaints, unusual body language, elimination, activities, reactions to the day to day stimuli and/or staff assessments of the client and etc.	W 253		

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W 253	Continued From page 358 Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 4:45 PM indicated clients F and I spent the majority of their time in group rooms from morning until evening directly supervised by the DSTs (Developmental Skills Technicians) and the CNA (Clinical Nursing Assistants). The QIDP indicated the facility did not require the DSTs and CNAs to complete daily written documentation even though the DSTs and CNAs spent the majority of time with the clients. The QIDP indicated the DSTs and CNAs document on the clients' daily flow sheets by using the key provided. 3. Client J's record was reviewed on 10/24/13 at 1:20 PM. An IHP (Individual Habilitation Plan) dated 2/12/13 included objectives to grasp waist of pants with one hand, place one arm into shirt, remove toothbrush from mouth after toothbrushing, rinse soap from hands, make 3 brushing motions to hair, hold his own cup twice during the meal, grasp a prepared washcloth, place 2 objects into an empty container, hand a quarter to staff, participate in a 1:1 activity with staff for 2 minutes, select a leisure item/object by grasping given 2 choices, grasp a preferred leisure object for 1 minute, walk to and from the dining room in the gait trainer for meals, will wipe tables in his program room. Client J's October, 2013 data recording sheets for IHP objectives was missing on October 10, 20, 26 on day shift, on October 8, 17, 18, 21, 22, for evening shift, and on October, 1, 2, 11, 17, 18, 21, 22, for objectives to reach for or grasp blocks, ball, and noise making object for AM and PM. Client H's record was reviewed on 10/28/13 at 4:00 PM. His IHP dated 2/4/13 included objectives to sit on the toilet, pull his shirt over his head, grasp his toothbrush, place his hands	W 253		

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W 253	Continued From page 359 under running water, open deodorant before use, sort 6 items into 2 piles of any color, sort coins from dissimilar items, walk with staff to obtain clothing, maintain eye contact with staff for 10 seconds, bounce a ball with staff for 30 seconds, place a cup on it's base after drinking to prevent spilling, rinse body when showering. There were no completion dates for the objectives in the IHP. Client H's data collection sheets for October, 2013 was missing data for his IHP objectives on October 4, 13, 14,18, 19, 21, 22, 23, 24 on the evening shift. Client B's record was reviewed on 10/29/13 at 2:06 PM. His IHP dated 4/4/13 included objectives to wipe thoroughly after a bowel movement, unbutton his pants, spray underarm deodorant of choice, brush front teeth, trace numerals from 1-10, hold a pencil with tripod grasp, hop consecutively 5 times, complete a 10 piece puzzle, fold 5 washcloths, participate in an informal leisure activity with 1 peer, place clean laundry items into his dresser/closet, use a napkin to wipe his mouth after meals. Client B's October, 2013 data collections sheets for his IHP objectives was missing dated for October 5,6, 10, 15, 18, 19, 23 on the day shift, on October 4, and 13 on the evening shift. Client UU's record in program room 6 was reviewed on 10/24/13 at 12:55 PM. Client UU's October, 2013 data collection sheets for his IHP objectives to walk to the bathroom upon staff request, place hand on waistband, allow staff to brush teeth for 45 seconds, will place brush under soap dispenser to accept soap for hand washing, will obtain paper towel from dispenser, grasp a textured item, accept 2 coins, look in staff's direction, will appropriately interact with staff for	W 253		

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W 253	Continued From page 360 45 seconds, will wipe tables/windows in his program room was missing data on October 5, 6, 15, 23 on the day shift. Client DDD's records were reviewed on 10/24/13 at 1:35 PM. Client DDD's October data collection objectives for his IHP dated 6/12/13 "transfer to toilet, pull up pants, remove his toothbrush from his mouth, propel gait trainer 50 feet at a time, place at least 4 items into a container, take a presented coin when displayed with a dissimilar item, participate in 10 minutes of group activity without interruption, greet peer/staff using hand shake, fist bump or high 5 1 time each shift, choose between a choice of leisure activities presented" was missing data for October 7, 11 on day shift, and missing data for October 9, 11, 14, 20, 21, on the evening shift. Client AA's record in program room 6 was reviewed on 10/29/13 at 1:31 PM. Client AA's BSP dated 2/1/13 indicated a goal "will refrain from self abusive behavior as evidenced by no more than 100 incidents a month for 3 consecutive months. Target behavior included Self-Abuse; hitting his head/ears, biting his hand, punching his head, smack his head, throwing himself backwards against a chair. There was no evidence in client J's record that the BMP was developed by a behavioral consultant or client J received services of a behavioral consultant. There was no evidence of daily progress notes in the clients' records. 4. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had an IPP dated 11/29/12. Client A's record did not include any direct care staff (DCS) documentation (case notes/progress notes) or IDT	W 253		

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W 253	Continued From page 361 (interdisciplinary team) meeting notes. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had an IPP dated 12/6/12. Client G's record did not include any DCS documentation (case notes/progress notes) or IDT meeting notes. There was no evidence of daily progress notes in the clients' records. The QIDP (Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/24/13 at 4:40 PM. The QIDP/Program Director indicated it was not a practice at the facility for Direct Support Trainers (DST), to write progress notes other than to record data relative to objectives.	W 253		
W 262	3.1-35(d)(2)(B) 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Human Rights Committee (HRC) reviewed, approved and monitored restrictive techniques for 2 of 4 sampled clients (clients A and G).	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 262	Continued From page 362 Findings include: Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had an IPP dated 11/29/12. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders signed and dated by her Primary Care Physician (PCP) on 8/30/13 indicated "Swaddle with blanket TID (three times daily) to brush teeth and gums thoroughly after meals using Peridex (oral rinse) on brush for gums after removing soft debris." A 6/2013 monthly nursing summary indicated "6/14/13 Swaddle with blanket while brushing teeth." A 6/4/13 dental form indicated "Swaddle with blanket while brushing teeth." Client A's plan did not include guidance or a specific description of how staff were to swaddle client A with a blanket. Client A's PO indicated she had a G-Tube. Client G's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients noses, Stripping: Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are	W 262		

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W 262	Continued From page 363 placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to: photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs and her body. Straddle her back to hold her in position. Client A's PO indicated she was prescribed Lorazepam (anti-anxiety), Saphris (anti-anxiety), Strattera (attention deficit hyper-activity) and Trazadone (anti-depressant/insomnia). Client A's record did not indicate the HRC had reviewed her BSP, Medications or use of swaddling to brush her teeth. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had an	W 262		

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W 262	Continued From page 364 IPP dated 12/6/12. Client G's PO signed and dated by her PCP on 8/30/13 indicated "Wear helmet during waking hours R/T SIB (for self-injurious behaviors) PRN (as needed). Client G's plan did not include the use of a helmet and did not include specific criteria indicating when she was to wear a helmet. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03 with a revision date of 9/2013. Client G's BMP indicated she had the targeted behaviors of Anti-Social: Self-Abuse: repeatedly hitting herself in the head and chin with her hand or toy, kicking her ankles. Physical Aggression: pull hair, scratch, hit, kick. Staff are to verbally praise her for appropriate activity, give her one-on-one time out of room once per shift after she performs an act of compliance. If self-abuse occurred, staff were to verbally interrupt the behavior, offer an item for her to manipulate,and guide her hands down and release repeating until the behavior stops. Client G's PO indicated she was prescribed Clonidine (anti-anxiety), Divalproex (mood stabilizer), Fluvoxamine (anti-depressant), Cogentin (side effects), Concerta (attention deficit), Saphris (anti-psychotic) and Trazadone (anti-depressant/insomnia). Client G's record did not indicate the HRC had reviewed her BSP, Medications or the use of helmet/hat for SIB. An interview was conducted with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) on 10/30/13 at 3:45 P.M. The PD/QIDP stated, "You would need to check with [name of social worker] about guardian participation, informed consent and HRC approval." An interview was conducted with the Social	W 262		

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W 262	Continued From page 365 Worker (SW) on 10/30/13 at 4:35 P.M. The SW stated, "I am unable to locate the signature pages for [client G]." The SW indicated he was unable to locate HRC consents for client A's and G's restrictive interventions.	W 262		
W 266	3.1-35(d)(2)(A) 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the Condition of Participation: Client Behavior and Facility Practices, is not met for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 27 additional clients (clients L, M, O, Q, S, V, W, Y, Z, AA, BB, DD, EE, FF, II, JJ, NN, OO, PP, UU, VV, XX, YY, ZZ, AAA, BBB, and DDD) as the facility failed to: Promote growth and dignity, ensure safeguards were in place for restraints, ensure restrictions were not used for the convenience of staff, justify the use of prone restraints, maintain a record of restraints, and monitor the side effects of psychotropic medications. Findings include: 1. Please refer to W268 as the facility failed to: Promote growth and dignity for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 16 additional clients (clients M, S, V, Y, AA, FF, II,	W 266		

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W 266	Continued From page 366 JJ, PP, UU, VV, XX, YY, AAA, BBB, and DDD) who lived at the facility. 2. Please refer to W285 as the facility failed to: Ensure sufficient individual safeguards were provided for the protection of 1 of 10 sampled clients (client A) who had a G-Tube, during the development of her Behavior Support Plan (BSP) which included the use of a full mat (prone restraint) and other restraints; and ensured monitoring by the IDT (interdisciplinary team), Human Rights Committee (HRC) and Behavior Consultant was occurring. 3. Please refer to W287 as the facility failed to: Ensure techniques used to restrict the clients were not used for the convenience of staff for 3 of 10 sample clients (A, G, and H) and 2 additional clients (VV and BBB). 4. Please refer to W290 as the facility failed to: Justify the behavior intervention of a prone restraint for 1 of 3 sampled clients (client A) who had the use of restraints in their plans. 5. Please refer to W303 as the facility failed to: Maintain a record of the usage of restraints for 3 of 3 sampled clients (clients A, G and H), and 2 additional clients (clients J and II) who had the use of restraints in their plans. 6. Please refer to W312 as the facility failed to: Have direct care staff #17, #35, and #60 monitor the client response to psychotropic medications, and the medications' potential side effects for 11 of 29 clients receiving psychotropic medications (clients L, O, Q, W, Z, BB, DD, EE, NN, OO, and ZZ).	W 266		

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	15G580		C 11/06/2013

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W 266	Continued From page 367 7. Please refer to W315 as the facility failed to: Have direct care staff #17, #35, and #60 monitor the client response to psychotropic medications, and the medications potential side effects for 11 of 29 clients receiving psychotropic medications (clients L, O, Q, W, Z, BB, DD, EE, NN, OO, and ZZ).	W 266		
W 268	3.1-26(a) 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to promote growth and dignity for 7 of 10 sampled clients (clients A, B, F, G, H, I, and J) and 16 additional clients (clients M, S, V, Y, AA, FF, II, JJ, PP, UU, VV, XX, YY, AAA, BBB, and DDD) who lived at the facility. Findings include: 1. During observations at the facility on 10/21/13 between 1:30 PM and 6 PM, the staff were overheard talking to the clients and referring to the clients as "the kids." Interview with staff #57 on 10/21/13 at 2 PM indicated clients F, I , M, FF, JJ, PP, YY, AAA, BBB were referred to as the "kids." Staff #57 stated, "We call them all the kids. I'm not sure why though. We just always have." On 10/21/13 at 2:10 PM staff #44 walked into the	W 268		

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W 268	Continued From page 368 room and stated, "I'm here to help out with the 'kids.'" Staff #44 stated, "That's what we call them (the clients.)" Interview with staff #28 on 10/23/13 at 11:20 AM indicated all the staff referred to and called the clients "the kids." Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated the staff refer to the clients as the kids. The QIDP indicated the staff use it as endearment and think of the clients as family. The QIDP indicated the staff should refer to the clients by their name. Interview with the Adm (Administrator) on 10/21/13 at 12:30 PM indicated the ages of the clients in the facility range from 16 years old to 55 years old. The Adm stated, "We call them our kids. We are just one big family." 2. During observation on 10/22/13 from 1:40 PM to 2:10 PM, staff #38 referred to clients B, H, J, S, V, Y, AA, II, UU, VV, XX, and DDD as "kids" during the observation. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM in program room 6. At 11:10 AM, client H was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Staff #42 referred to clients B, H, J, S, V, Y, AA, II, UU, VV, XX, and DDD as "kids" during the observation. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him	W 268		

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303 FRANKLIN
ARCADIA, IN 46030

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W 268	Continued From page 369 physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." When asked if any of the clients in program room were children, he stated, "No, I shouldn't (call them kids)." During interview with the ADON (Assistant Director of Nurses) on 10/23/13 at 2:20 PM, she referred to the clients as "kids." She indicated she refers to all of the clients as "kids." The DON (Director of Nurses) was interviewed on 10/22/13 at 3:10 PM. During the interview, she referred to the clients of the facility as "kids." 3. Observations were conducted on 10/21/13 from 3:30 P.M. until 5:43 P.M. At 3:30 P.M. Client A was located in the hallway. The back of her jeans was pulled down and her upper buttocks were visible. At 3:40 P.M. recreational staff assisted client G back to the program room. Client G's jeans were pulled down in the back and half of the back of her incontinence brief was visible. At 4:27 P.M. staff #87 walked with client G towards the dining room. Staff #87 stated, "I've got the runner (client G)." At 5:10 PM client A entered the dining room. Her jeans were down in the back revealing the top half of her buttocks. Client A leaned forward bending towards the table revealing more of her buttocks. At 5:28 P.M. supervisor #36 asked a QIDPD to assist client A with pulling up her jeans. At 5:30 P.M. Supervisor #36 stated, "Yes, she should have her jeans pulled up, and she should be wearing underwear." An interview was conducted with the Program Director/Qualified Mental Retardation Professional (PD/QIDP) on 10/30/13 at 3:52 P.M. when asked if the clients' briefs or buttocks	W 268		

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	15G580		C 11/06/2013

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W 268	Continued From page 370 should be visible in public areas, the PD/QIDP stated, "No, of course not in public." When asked if a client should be referred to as "the runner," the PD/QIDP shook her head no. When asked if the adolescents and adults who lived in the facility should be referred to as "the kids," the PD/QIDP stated, "No, it is derogatory, we don't mean it that way. I think client and resident sounds so hospital like, and many of the individuals here were young when they moved here."	W 268		
W 285	3.1-26(g) 483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) who had physical intervention in their plans to ensure sufficient individual safeguards were provided for the protection of client A who had a G-Tube, during the development of her Behavior Support Plan (BSP) which included the use of a full mat (prone restraint) and other restraints; and ensured monitoring by the IDT (interdisciplinary team), Human Rights Committee (HRC) and Behavior Consultant was occurring. Findings include:	W 285		

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W 285	Continued From page 371 The facility's Behavior Management Policy dated 4/3/2006 with a revision date of 8/20/13 was reviewed on 10/30/13 at 10:02 A.M. The policy indicated "It is the position of Arcadia Developmental Center in con-junction with State and Federal regulations, to establish a progression of techniques, implementation of these techniques and functionally appropriate approaches to manage inappropriate client behavior. These techniques and approaches shall be designed to include positive approaches. Programs will be designed to establish techniques that progress from least restrictive to the most restrictive measures necessary. This facility will formulate the necessary behavioral guidelines to define the need for interventions. these (sic) guidelines shall be composed through documentation, review of documented events via committee, creation of needed intervention through behavioral programming or alternate means, implementation of the least restrictive methods for identified maladaptive behaviors, tracking of the effectiveness of the methods chosen and continued review or adaptations as warranted by altered behavior. These guidelines shall be implemented as a means of attempting to prevent injury prior to and/or during behavioral episodes through the application of intervention designed for individual clients. Interventions shall include review of programmatic needs to address areas of anti-social behavior, client-to-client interaction, emotional needs and other areas of need identified through committee review." The policy included the following physical intervention techniques (restraints). BEARHUG: placing your arms around the client and immobilizing their arms at their sides. This is secured by grasping one of your wrists with your other hand above their elbows. Attempt to hold	W 285		

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W 285	Continued From page 372 them until calm, up to 15 minutes in duration. However, if necessary, move to the basket hold immediately if the targeted behaviors continue. BASKETHOLD: moving from bear hug by grasping the individual's wrists and crossing them over their chest; hold this position until they are calm. This position may be employed for up to 15 minutes in duration. However, if necessary, move to the half-mat procedure immediately if needed. HALF MAT: moving from a basket hold, by pushing forward and then stepping back with one foot and placing the client slightly off balance. Place the client on the floor in a sitting position while remaining in a basket hold position. Tuck your head behind their shoulder to prevent injury from the client's head and lean them forward with your own body. hold (sic) this position until they are calm for up to 15 minutes. FULL MAT: moving from a half-mat position by rolling the individual to the side into a prone position face down. Staff should then straddle the client by placing their knees at the client's hips and over their elbows. Their hands should be placed palms down to prevent injury and scratching. Secure their head if needed to further prevent head banging or other injury to their head. Hold the client until they are calm, but for no longer than 15 minutes. This procedure will be implemented in response to emergent behavior and intervention to prevent injury from displayed behaviors. Client's Individualized behavior programs may contain revised physical interventions as guided by medical, physical or other unusual circumstances/characteristics. Review of individual programs will reveal designated techniques to those identified individuals. "In addition, measures to maintain each client's physical, mental and psychosocial well being	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 285	Continued From page 373 shall be ensured through emergency intervention procedures as outlined and determined by the facility's governing body. This facility will formulate the necessary behavioral guidelines to define the need for interventions. these (sic) guidelines shall be composed through documentation, review of documented events via committee, creation of needed intervention through behavioral programming or alternate means, implementation of the least restrictive methods for identified maladaptive behaviors, tracking of the effectiveness of the methods chosen and continued review or adaptations as warranted by altered behavior... Interventions shall include review of programmatic needs to address areas of anti-social behavior, client-to-client interaction, emotional needs and other areas of need identified through committee review. Data will be collected through the use of behavior cards in which staff record episodes of observed maladaptive or inappropriate behavior. These cards shall reflect the staff member's name, the date, the client's name, the time of the observed behavior, the type of the observed behavior (self injurious, physical aggression, etc.) An additional intervention card will contain information specific to the intervention used to interrupt the behavior. This card will be used to ensure that the least restrictive techniques have been implemented and documented for review. This data will be collected by any staff who directly observes the inappropriate behavior, documented and given to the Program Director (QIDP) each day at the end of their shift. The Program Director will then track, document and distribute this data to the Behavior Management Committee. All behavior programs formulated form (sic) this collected and reviewed data will also be critiqued by the Human Rights Committee	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 285	Continued From page 374 (HRC) prior to implementation of a designated intervention...." Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client A's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP included the use of the following physical interventions (restraints) Bearhug, Basket hold, Half Mat and Full Mat. The PD/QIDP was interviewed again on 10/30/13 at 4:15 P.M. When asked about Behavior Consultant/Ph.D. involvement, the PD/QIDP stated, "He comes monthly, makes notes, talks with staff, observes the clients. He keeps his own notes. I type up the changes to the BSP's for him, because he has terrible spelling." When asked to see notes for client A was unable to locate any behavior notes. An interview was conducted with the PD/QIDP again on 10/30/13 at 3:45 P.M. The PD/QIDP stated, "You would need to check with [name of social worker] about guardian participation, informed consent and HRC approval." An interview was conducted with the Social Worker (SW) on 10/30/13 at 4:35 P.M. The SW indicated he was unable to locate HRC consents for client A's restrictive interventions.	W 285		
W 287	3.1-3(w) 483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 287	Continued From page 375 Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observation, record review and interview for 3 of 10 sample clients (A, G, and H) and 2 additional clients (VV and BBB), the facility failed to ensure techniques used to restrict the clients were not used for the convenience of staff. Findings include: 1. During observations at the facility on 10/21/13 between 1:30 PM and 6 PM and on 10/22/13 between 3 PM and 4: 30 PM client BBB sat in a small circular saucer chair with metal tubes for legs. The chair sat close to the floor. Several times client BBB tried to pull herself up out of the chair, but tired quickly and would fall asleep with her head hyperextended behind her. Client BBB was drowsy and her head kept falling backwards. The chair provided no neck or leg support for client BBB. Client BBB had to be pulled up from the chair and assisted to ambulate due to an unsteady gait. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB's record indicated client BBB was at risk for falling. Client BBB's IHP (Individual Habilitation Plan) of 5/2/13 indicated client BBB required her legs and feet to be elevated every 2 hours for 30 minutes at a time due to poor circulation in her legs. The IHP indicated client BBB required assistance to stand and ambulate. Client BBB's IHP and BSP (Behavior Support Plan) of 3/29/13 indicated no use of a saucer	W 287		

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W 287	Continued From page 376 chair to prevent client BBB of getting up on her own. Interview with staff #57 on 10/21/13 at 3 PM indicated client BBB would get up on her own and fall. Staff #57 indicated client BBB sat in the saucer chair to keep her from getting up and falling. Interview with staff #43 on 10/22/13 at 4 PM stated client BBB sat in the saucer chair because client BBB had a history of falls and "If she gets up by herself, she'll fall. This way, we know she won't get up on her own. We think that is what she did to break her hand." Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated client BBB likes sitting in the saucer chair. The QIDP indicated the staff were to get client BBB up every 2 hours and let her stretch her legs and to sit in the recliner. The QIDP indicated client BBB should not be sitting in the saucer chair for long periods at a time. On 10/21/13 at 3:10 PM client A ran into group room two trailing a long strand of materials tied together behind her, running, laughing and pushing past staff #57 to get to the bathroom in group 2. Staff #57 attempted to prompt client A to go back to her group without success. Staff #11 came into group two and wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced. When asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. Sometimes it's the only way to control her [client A]."	W 287		

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W 287	Continued From page 377 2. During observations on 10/22/13 from 1:40 PM until 3:05 PM, Client VV pointed outside the window. Staff #38 stated, "You have to wait. We have to check with the nurses." Client B indicated he wanted to go outside also. Client UU walked around with this hand in his mouth without direction to activity. Client B had an electronic device he played a game on, but put it up to wait for the nursing staff to call back about going outside. Nursing staff then called on the phone and staff #38 stated, "The nurse called and said we can't go out right now." Client V asked to take a walk. Client V was directed away from the door, and staff stated, "you have to have someone with you." Client H attempted to leave the room and was directed back. Staff #38 was interviewed on 10/22/13 at 2:10 PM. She indicated the nursing staff had informed staff it was too cold to go outside for the clients. She indicated clients B and VV had coats, but some of the clients in room 6 had medical issues and could not go outside. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM in program room 6. At 11:10 AM, client H walked out the door and was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Staff #42 picked up client J to move him. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." When asked if client H was in danger if he left the	W 287		

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W 287	Continued From page 378 room, he stated, "No, he isn't in danger. There are alarms on the doors." The QIDP (Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/25/13 at 2:40 PM. She indicated clients should be offered choice and arrangements could be made for clients to go outside for walks. 3. Observations were conducted in program room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. Client A attempted to leave the room; DCS #11 redirected her to put her shoes and socks on first. At 2:11 P.M. client A attempted to leave the room, but was redirected by DCS #11. At 2:15 P.M. client A ran out the program room door down the hall. Client A was returned to the room by the QIDPD at 2:24 P.M. At 2:28 P.M. Client A began to run from the door of the program room to the restroom (adjacent to the room) repeatedly with DCS #11 running after her. While DCS #11 was intervening with client A's running behaviors client G began to hit herself in the side of her head. Client G then banged her head backwards against the wall twice. Each time she hit her head on the wall it made a sound. Client G blinked her eyes when her head hit the wall. Client A continued to run out of the room three more times with DCS #11 chasing her into the hall. At 2:32 P.M. client A ran out of the program room down to program room #2. At 2:37 P.M. DCS #11 followed client A as she ran out of the room. Client G left the room while DCS #11 was with client A. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. At 3:48 P.M. client A began to hit/flip staff and client G in the face with her fingers. DCS #66 verbally prompted her "no" each time. After client A	W 287		

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W 287	Continued From page 379 hit/flipped client G in the head/face DCS #66 assisted client A to a chair, then DCS #66 used the phone to call for assistance. DCS #49 came to the program room and removed client A from the room. When client G was hit by client A, client G threw her box of clothes pins into the air. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." At 3:58 P.M. the QIDPD brought a baseball hat for client G to put on. Client G smiled and put on the hat. At 4:06 P.M. DCS #49 returned client A to the room. Client A hit DCS #66 and ran out the program room door to the nursing station. Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms. Client A's record was reviewed on 10/23/13 at	W 287		

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W 287	Continued From page 380 2:42 P.M. Client A's record indicated she had an IPP dated 11/29/12. Client G's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients noses, Stripping: Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to: photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving	W 287		

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W 287	Continued From page 381 from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs and her body. Straddle her back to hold her in position.	W 287		
W 290	3.1-3(w) 483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to justify the behavior intervention of a prone restraint for 1 of 3 sampled clients (client A) who had the use of restraints in their plans. Findings include: Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had an IPP (Individual Program Plan) dated 11/29/12. Client G's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated she had the following targeted behaviors, Physical Aggression: hitting, hair pulling, kicking, pinching, biting, (clients and staff), eye poking and sticking fingers up clients noses, Stripping:	W 290		

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W 290	Continued From page 382 Taking clothes off at inappropriate times. Most often pulling off her shirt or top. Taking off her shoes and socks is not considered stripping for the purpose of this program. Out of Bounds: Leaving the program room without permission or supervision. Absent without Leave (AWOL): Leaving the building without permission. Pulling on Staff: Pulling on staff's arm or hand. Staff are to have her wear a fanny pack when her behavior has been appropriate. The pack should contain an MP3 player, reward cards. Approximately every 15 minutes one or two small edible rewards are placed in the pack. Other rewards may be added. Staff were to provide verbal reinforcement for appropriate behavior. If she exhibits any of the identified target behaviors the pack is removed. Reward cards (photos) include, but not limited to: photo of favorite staff or peer, group 5 room, walk in hall, an interactive cat, the play yard. Twice each shift staff were to review the photos with [client G] and ask her what she would like to do. For reactive interventions staff were to tell her "no," remove her fanny pack, place her in non-exclusionary time out (bean bag) away from peers for 5 minutes. If she continues to be physically aggressive and can not be directed back to the bean bag staff start with the least restrictive physical intervention first. Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs	W 290		

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W 290	Continued From page 383 and her body. Straddle her back to hold her in position. The PD/QIDP was interviewed again on 10/30/13 at 4:19 P.M. When asked about documentation on restraint usage, the PD/QIDP indicated there had been no restraints utilized at the facility in the past year. The PD/QIDP indicated the Behavior Consultant was reviewing client A's BSP at this time. The PD/QIDP indicated she did not know client A's BSP contained the use of a prone restraint. An interview was conducted with the Social Worker (SW) on 10/30/13 at 4:35 P.M. The SW indicated he was unaware of any restraints being used on any of the clients, and did not know of any documented use of restraints or reported use of restraints to the Bureau of Developmental Disabilities Services (BDDS).	W 290		
W 303	3.1-26(b) 483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a record of the usage of restraints for 3 of 3 sampled clients (clients A, G and H), and 2 additional clients (clients J and II) who had the use of restraints in their plans. Findings include: 1. On 10/21/13 at 3:10 PM client A ran into group	W 303		

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W 303	Continued From page 384 room two trailing a long strand of materials tied together behind her, running, laughing and pushing past staff #57 to get to the bathroom in group two. Staff #57 tried to prompt client A to go back to her group without success. Staff #11 came into group two and wrapped her arms around client A, mummy style, and physically picked client A up and carried her back to her program room. Staff #11 was out of breath and red faced by the time she got client A back to group four. Staff #11 was asked if that was an approved hold and/or restraint for client A, staff #11 stated, "I do it all the time. sometimes it's the only way to control her [client A]." 2. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU grabbed food from client V, and was redirected away from the dining room by staff #35. Client UU then walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth. Client Y lay on the floor in the recreation room or rocked back and forth on his feet. Client H was redirected away from looking out the window by staff #58, but did not respond. Client II lay on the floor, staff #66 placed her arms around to raise him up from the floor. Client II attempted to hit staff #66. Staff #66 indicated client II was to use a communication book to use to communicate his needs. Staff #66 stated, "We're not smacking our head or hitting [staff #66]. I'm asking you to get in the wheelchair. What's your problem?" Client II stood, dropped to the floor again, grabbed at staff #66, then tried to bang his head on the floor. Staff #66 stated, "I said No. Listen to Me. If you get much more aggressive, you're not giving me a choice." Staff #66 then asked staff to call for client II's helmet. "I know you're not happy because you know it's coming." Staff #66 placed her arms	W 303		

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W 303	Continued From page 385 around client II from behind as she was seated on the floor, and stated, "You know sign language. There's no excuse." Client II then got into the wheelchair and was wheeled by staff #66 to program room 6. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM in program room 6. At 11:10 AM, client H walked out the door and was pulled back into the room by client #42 by placing his arms under client H's arm pits, and stated,"You have to wait. It's not your turn (to go to the dining room)." Staff #42 picked up client J to move him. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if physically moving client H was in his plan, he stated, "To move him physically?...With [client H] and all of these kids, if they don't obey, you can put holds on all of them." When asked if client H was in danger if he left the room, he stated, "No, he isn't in danger. There are alarms on the doors. 3. Observations were conducted in program room 4 on 10/21/13 from 3:30 P.M. until 5:43 P.M. At 3:50 P.M. client G hit herself in the head twice, then hit her head against the wall twice, then client G began to hit herself in the head using both of her fists. DCS #66 prompted her to "stop." Client G continued to hit herself in the head. DCS #66 touched client G's hands, bringing them down to client G's lap and prompted "stop." Observations were conducted in program room 4 on 10/23/13 from 9:25 A.M. until 10:55 A.M. Client SS got a CD player with headphones. Client A, who had been sleeping, jumped up out of her chair and began grabbing at client SS and	W 303		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 303	Continued From page 386 the headphones. Client SS pushed her away. Client A continued to forcefully try to get the headphones. DCS #36 prompted client SS "Don't smack her." Client A repeatedly grabbed at client SS and the headphones/CD player on her (client SS's) chest. DCS #36 again prompted client SS to "not hit her," when client SS retaliated. Client SS ran out of the room and client A ran after her with DCS #36 following them both. Client G then threw a plastic toy teapot across the room. Client G remained alone in the room until DCS #36 brought client A back to the program room. DCS #36 had her arms wrapped around client A's upper body and arms (bear hug). The facility's Behavior Management Policy dated 4/3/2006 with a revision date of 8/20/13 was reviewed on 10/30/13 at 10:02 A.M. The policy included the following physical intervention techniques (restraints). BEARHUG: placing your arms around the client and immobilizing their arms at their sides. This is secured by grasping one of your wrists with your other hand above their elbows. Attempt to hold them until calm, up to 15 minutes in duration. However, if necessary, move to the basket hold immediately if the targeted behaviors continue. BASKETHOLD: moving from bear hug by grasping the individual's wrists and crossing them over their chest; hold this position until they are calm. This position may be employed for up to 15 minutes in duration. However, if necessary, move to the half-mat procedure immediately if needed. HALF MAT: moving from a basket hold, by pushing forward and then stepping back with one foot and placing the client slightly off balance. Place the client on the floor in a sitting position while remaining in a basket hold position. Tuck your head behind their shoulder to prevent injury	W 303		

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	15G580		C 11/06/2013

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W 303	Continued From page 387 from the client's head and lean them forward with your own body. hold (sic) this position until they are calm for up to 15 minutes. FULL MAT: moving from a half-mat position by rolling the individual to the side into a prone position face down. Staff should then straddle the client by placing their knees at the client's hips and over their elbows. Their hands should be placed palms down to prevent injury and scratching. Secure their head if needed to further prevent head banging or other injury to their head. Hold the client until they are calm, but for no longer than 15 minutes. This procedure will be implemented in response to emergent behavior and intervention to prevent injury from displayed behaviors. Client's Individualized behavior programs may contain revised physical interventions as guided by medical, physical or other unusual circumstances/characteristics. Review of individual programs will reveal designated techniques to those identified individuals. "In addition, measures to maintain each client's physical, mental and psychosocial well being shall be ensured through emergency intervention procedures as outlined and determined by the facility's governing body...." The policy did not indicate how the use of restraints would be recorded monitored or reported to the Bureau of Developmental Disabilities Services (BDDS). Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP included the following types of restraints: Bearhug: placing arms around client and immobilizing the client's arms at their sides. Basket hold: Moving from Bearhug by grabbing the client's wrists and	W 303		

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	15G580		C 11/06/2013

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W 303	Continued From page 388 crossing them over the client's chest. Half Mat: Move backwards from a standing position, easing her to the floor in a sitting position. Continue by sitting behind her with your legs on either side of her, lean forward, moving her forward with you. Full Mat: From sitting position, roll her over onto her stomach. Place your legs on either side of her body with her hands face down between your legs and her body. Straddle her back to hold her in position. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03 with a revision date of 9/2013. Client G's BMP indicated for self-abusive behaviors staff were to verbally interrupt the behavior, offer an item for her to manipulate,and guide her hands down and release repeating until the behavior stops. The PD/QIDP was interviewed on 10/30/13 at 4:19 P.M. When asked about documentation on restraint usage, the PD/QIDP indicated there had been no restraints utilized at the facility in the past year. An interview was conducted with the Social Worker (SW) on 10/30/13 at 4:35 P.M. The SW indicated he was unaware of any restraints being used on any of the clients, and did not know of any documented use of restraints or reported use of restraints to BDDS.	W 303		
W 312	3.1-26(f) 483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed	W 312		

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	15G580		C 11/06/2013

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W 312	Continued From page 389 specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to include specific criteria as part of a plan of reduction for each class of medication used for the management or elimination of behaviors and/or symptoms of diagnoses as indicated in 2 of 6 sampled clients (clients A and G) who were prescribed medications for management of their behaviors. Findings include: Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she had a Behavior Support Plan (BSP) dated 12/14/12 with a revision date of 9/2013. Client A's BSP indicated "A medication reduction attempt will be made when criteria is reached or at least annually." With an objective of "Each of the four target behaviors will decline by 10% from baseline for three consecutive months." Client A's Physician's Orders (PO) dated 8/30/13 indicated she was prescribed Lorazepam (anti-anxiety), Saphris (anti-psychotic), Strattera (attention deficit hyper-activity) and Trazadone (anti-depressant/insomnia). Client A's BSP did not indicate what specific behaviors Lorazepam, Saphris, Strattera or Trazadone were prescribed to address. Client A's BSP did not indicate a specific medication and/or class of medications to be considered for a possible reduction. Client A's BSP did not indicate what specific criteria needed to be achieved for Lorazepam, Saphris, Strattera or Trazadone to be considered for a possible	W 312		

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	15G580		C 11/06/2013

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W 312	Continued From page 390 reductions. Client A's BSP did not indicate how each of the medications effectiveness could be determined. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record indicated she had a Behavior Management Plan (BMP) dated 12/1/03 with a revision date of 9/2013. Client G's BSP indicated "A medication reduction will be attempted when the criteria of the Behavior Program is met or at least annually." With an objective of "...increase appropriate use of hands and increase appropriate use of leisure time activities and refrain from self-abusive behaviors and physical aggressive behavior as evidenced by no more than 50 incidents a month for 4 consecutive months." Client G's PO dated 8/30/13 indicated she was prescribed Clonidine (anti-anxiety), Divalproex (mood stabilizer), Fluvoxamine (anti-depressant), Cogentin (side effects), Concerta (attention deficit), Saphris (anti-psychotic) and Trazadone (anti-depressant/insomnia). Client G's BSP did not indicate what specific behaviors Clonidine, Divalproex, Fluvoxamine, Cogentin, Concerta, Saphris and Trazadone were prescribed to address. Client G's BSP did not indicate a specific medication and/or class of medications to be considered for a possible reduction. Client G's BSP did not indicate what specific criteria needed to be achieved for Clonidine, Divalproex, Fluvoxamine, Cogentin, Concerta, Saphris and Trazadone to be considered for a possible reductions. Client G's BSP did not indicate how each of the medications effectiveness could be determined. The PD/QIDP was interviewed on 10/30/13 at 4:29 P.M. When asked about medication plans of	W 312		

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W 312	Continued From page 391 reduction being part of client A's and G's BSPs, the PD/QIDP indicated they attempted to reduce medications annually. The PD/QIDP indicated she was unaware a specific medication was to be named in the BSP as part of the plan of reduction. The PD/QIDP indicated it made sense to have plan of reduction for each therapeutic class of medications. 3.1-26(k) 3.1-26(l) 3.1-26(m)	W 312		
W 315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have direct care staff #17, #35, and #60 monitor the client response to psychotropic medications, and the medications' potential side effects for 11 of 29 clients receiving psychotropic medications (clients L, O, Q, W, Z, BB, DD, EE, NN, OO, and ZZ). Findings include: Clients L, Q, W, and BB were observed in program room 3 on 10/28/13 from 9:00 A.M. until 9:16 A.M.. Clients L and Q were sleeping in stuffed chairs. Client W was watching television and client BB was bouncing her leg and staring at the wall.	W 315		

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W 315	Continued From page 392 Direct care staff #17 and #35 were interviewed on 10/28/13 at 9:17 A.M.. When asked if clients L, Q, W, and BB received any medications for psychiatric diagnoses or for behaviors, direct care staff #17 and #35 both indicated they did not know or did not recall if clients L, Q, W, and BB took any medications for behaviors or for psychiatric or psychological reasons. When asked if they could find information on the clients' medications, direct care staff #17 and #35 stated they "didn't know" and suggested the surveyor ask the facility nursing staff. When asked if they monitor the clients for side effects of medications, direct care staff #17 and #35 stated, "No." Clients O, Z, DD, EE, NN, OO, and ZZ were observed in program room 5 on 10/28/13 from 9:21 A.M. until 9:37 A.M.. Clients O, Z, DD, EE, NN, OO, and ZZ were sitting in arm chairs scattered about the room. Direct care staff #60 was reading a story book and showing the pictures to the clients. Direct care staff #60 was interviewed on 10/28/13 at 9:38 A.M.. When asked if clients O, Z, DD, EE, NN, OO, and ZZ received any medications for psychiatric diagnoses or for behaviors, direct care staff #60 indicated she did not know or did not recall if clients O, Z, DD, EE, NN, OO, and ZZ took any medications for behaviors or for psychiatric or psychological reasons. When asked if they could find information on the clients' medications, direct care staff #60 took a binder off of the table and began paging through it. Direct care staff #60 stated to the surveyor while paging through the binder, "It's in here somewhere." After paging through the binder, direct care staff #60 stated, "You'll have to ask the nurse, I don't have any information like that. The	W 315		

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	15G580		C 11/06/2013

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W 315	Continued From page 393 nurse would know." When asked if she monitors the clients for side effects of medications, direct care staff #60 stated, "No, nursing does that." Client L's record was reviewed on 10/28/13 at 11:17 A.M.. Review of the client's 6/30/13 Physician Orders indicated the client received Geodon (anti-psychosis medication), Klonopin (anti-anxiety medication), and Lexapro (mood stabilizing medication) for anxiety. Client Q's record was reviewed on 10/28/13 at 11:33 A.M.. Review of the client's 8/31/13 Physician Orders indicated the client received Luvox (medication for Obsessive-Compulsive disorder). Client W's record was reviewed on 10/28/13 at 11:58 A.M.. Review of the client's 6/30/13 Physician Orders indicated the client received Celexa (anti-depressive medication). Client BB's record was reviewed on 10/28/13 at 12:23 P.M.. Review of the client's 8/31/13 Physician Orders indicated the client received Zoloft (anti -depressive medication) for anxiety and depression. Client O's record was reviewed on 10/28/13 at 12:58 P.M.. Review of the client's 8/31/13 Physician Orders indicated the client received Luvox (medication for Obsessive-Compulsive disorder). Client Z's record was reviewed on 10/28/13 at 1:41 P.M.. Review of the client's 6/30/13 Physician Orders indicated the client received Lorazepam (anti-anxiety medication) for "behaviors."	W 315		

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	15G580		C 11/06/2013

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W 315	Continued From page 394 Client DD's record was reviewed on 10/28/13 at 2:14 P.M.. Review of the client's 6/30/13 Physician Orders indicated the client received Saphris (anti-psychosis medication), Clonidine (anti-anxiety medication), Adderall (medication for attention deficit hyperactivity disorder) for anxiety and attention deficit hyperactivity disorder. Client EE's record was reviewed on 10/28/13 at 2:26 P.M.. Review of the client's 8/30/13 Physician Orders indicated the client received Geodon (anti-psychosis medication) for "aggression." Client NN's record was reviewed on 10/28/13 at 2:53 P.M.. Review of the client's 8/31/13 Physician Orders indicated the client received Xanax (anti-anxiety medication), Buspar (anti-anxiety medication), and Paxil (anti-depressive medication) for anxiety and depression. Client OO's record was reviewed on 10/28/13 at 3:23 P.M.. Review of the client's 7/25/13 Physician Orders indicated the client received Remeron (anti-depressive medication) and Risperdone (anti-psychosis medication) for affective (mood) disorder. Client ZZ's record was reviewed on 10/28/13 at 3:38 P.M.. Review of the client's 8/30/13 Physician Orders indicated the client received Zyprexa (anti-psychosis medication) for psychosis. The Program Director was interviewed on 10/28/13 at 5:17 P.M.. The Program Director stated direct care staff "have a binder in the	W 315		

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W 315	Continued From page 395 program room where they can look up what medications clients take." When asked if direct care staff monitor clients on psychotropic medications for desired effects or adverse reactions, the Program Director stated, "They (direct care staff) are supposed to let nursing know." Nurse #7 was interviewed on 10/28/13 at 5:58 P.M.. Nurse #7 stated, "They (direct care staff) don't really know what kind of medications the kids (clients) take. That's not really their job."	W 315		
W 318	3.1-48(b) 483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to ensure timely, effective, and appropriate nursing care and services were provided to 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no longer at the facility). Findings include: 1. Please refer to W331 as the facility failed to:	W 318		

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W 318	Continued From page 396 Ensure timely, effective and appropriate nursing services for 7 of 10 sample clients (A, C, D, E, F, H and I,) and 14 additional clients (K, M, Y, AA, HH, FF, JJ, NN, PP, UU, YY, AAA, BBB and DDD). 2. Please refer to W336 as the facility failed to: Conduct quarterly nursing assessments of clients' health status and medical needs and to ensure an RN (Registered Nurse) monitored the clients that were assessed by the LPN (Licensed Practical Nurse) for 9 of 10 sampled clients (A, B, C, D, E, F, G, I, and J) and 10 additional clients (F, I, M, AA, GG, JJ, PP, YY, AAA and BBB). 3. Please refer to W340 as the facility failed to: Ensure staff implemented training to follow Universal Precautions and promote hand washing to prevent the spread of infection for 4 of 10 sampled clients (B, C, D and J), and 19 additional clients (K, L, T, S, V, Y, AA, CC, HH, II, KK, LL, QQ, RR, UU, YY, VV, WW, and DDD). 4. Please refer to W351 as the facility failed to: Complete dental exam within one month of admission to the facility for 1 of 3 clients admitted to the facility (client CCC). 5. Please refer to W371 as the facility failed to: Develop a training objective/goal to teach clients about their medications for 3 of 10 sampled clients (clients C, D, and E). 6. Please refer to W390 as the facility failed to: Ensure all medications not properly labeled with expiration dates and all expired medications were removed from the facility for 20 of 20 medications found without labels and/or incomplete labels with no expiration dates for 10 of 10 sample clients (A,	W 318		

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W 318	Continued From page 397 B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no longer at the facility). 7. Please refer to W391 at the facility failed to: Ensure all medications in the facility were properly packaged and/or in the original containers with the label and/or were labeled by the facility pharmacy and included exploration dates for 20 of 20 medications found without labels and/or incomplete labels with no expiration dates for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no longer at the facility).	W 318		
W 331	3-1-17 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview for 7 of 10 sample clients (A, C, D, E, F, H and I,) and 14 additional clients (K, M, Y, AA, HH, FF, JJ, NN, PP, UU, YY, AAA, BBB and DDD), the facility failed to ensure timely, effective and appropriate nursing services. Findings include:	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 398 1. On 10/21/13 at 1:30pm, client HH was observed to sit in program room #1 without activity and without interaction by the facility staff. Client HH was observed to have a brown/gray colored skin area around his right eye. Client HH was observed to have swollen, puffy skin, and brown/black/purple/red colored skin area around his left eye. At 1:30pm, client HH took his right and left fists and struck himself in each eye with a fisted right and left hand eight times before facility staff #31 and #41, who were supervising in program room #1, asked client HH to stop. Client HH was not offered activity and client HH's eyes were not assessed by the facility nurse. At 1:50pm, client HH struck himself with his fisted hands into each of his right and left eyes four additional times each without redirection from facility staff #31 and #41. Client HH's skin area around his right and left eyes was red, brown, purple, and the skin was swollen around both eyes. At 2:00pm, facility Registered Nurse (RN) #5 entered the program room, stated client HH had right and left "swollen and blackened" eyes from self injurious behavior of "punching himself in the eyes with his (client HH's) fists." At 2:05pm, client HH struck himself repeatedly in his face with his right and left fists without redirection. At 2:15pm, client HH struck himself in each eye, with his fisted hands, eight times without redirection from staff #31 and #41. At 2:40pm, facility staff #31 and #41 both indicated the staff follow client HH's 6/14/2011 BSP (Behavior Support Plan) in his program book. Both staff indicated staff were to "watch" client HH when in the program room. From 1:30pm until 3:30pm, an activity was not offered or encouraged to client HH. At 4:50pm, client HH was brought into program room #1 in his wheelchair by an	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 399 unidentified facility staff. At 4:50pm, Facility staff #31 indicated client HH's left eye was swollen, red, black, brown, and purple. Client HH sat in his wheelchair and coughed. On 10/21/13 at 4:50pm, a review of client HH's 6/14/2011 BSP (Behavior Support Plan) located in Program Room #1's reference information, available for staff use, was conducted. Client HH's 6/14/2011 BSP indicated "Target Behaviors: Self stimulatory: Sticking his finger in the corner of his eye." Client HH's plan did not indicate self injurious behaviors of using his fists to strike himself in his eyes causing injuries of swollen and blackened right and left eyes. Client HH's 6/14/11 BSP indicated client HH should be redirected verbally each time he engages in Self stimulatory behavior. The plan indicated "Once each hour during all waking hours [client HH] should be offered 2 leisure time activity materials. Encourage him to touch and handle both...he should be given an opportunity to have one on one staff attention...." The plan indicated client HH should be verbally interrupted, if behavior continued, offered an activity or item to manipulate, if client HH continued staff were to "guide his hands to his lap and release." An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 10/22/13 at 4:35pm. The QIDP indicated client HH's SIB (Self Injurious Behaviors) which resulted in right and left black, swollen, and discolored eyes. The QIDP stated client HH's injuries "did not meet the size" requirement for reporting. The QIDP provided a 10/20/13 at 8:45am, non reportable "Accident/Incident Form" which indicated client HH had a "4 x 2 cm (four by two centimeters) brown discoloration under (his)	W 331		

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W 331	Continued From page 400 left eye." The report indicated "investigative findings: On October 20 (2013), nursing was called to assess an area of discoloration under [client HH's] left eye. Investigation notes increasing self abusive behavior of striking self. Review of behavior data notes increasing episodes of striking self." The QIDP indicated client HH's guardian and physician were notified and "discussion was to recommend the implementation of Ativan (behavior medication) for fourteen (14) days, scheduled an appointment with client HH's psychiatrist on 11/12/13, and appointment with neurologist on 10/22/13." Client HH's non reportable incident report did not indicate injuries caused by self injurious behaviors and client HH's right eye injury. The QIDP indicated client HH had no medical health care plan developed to monitor him for injuries once the injuries were healed. An interview with the QIDP was conducted on 10/22/13 at 4:35pm. The QIDP provided client HH's "10/21/13 (Revised) BSP which indicated "Ativan 1mg (milligram) BID (twice daily) x14 (times fourteen) days start 10/21/13...Goal: [Client HH's] self abusive behavior will decrease...Target Behaviors: Self stimulatory: sticking his finger in the corner of his eye. Self abuse: Slapping self, striking head/face on hard surfaces, Physical Aggression: Smacking others, attempting to bite others, running wheelchair into others." Client HH's 10/21/13 BSP indicated the following: "on 4/14/11 [client HH's] behavior medications were discontinued. on 8/9/13 [client HH] experienced increasing episodes of self abusive behaviors and agitation...This resurrection of behavioral episodes correlate to illness UTI (Urinary Tract Infection) and Ear infection. On 8/19/13 [client HH] Ativan 1mg	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 401 continued...On 9/10/13 a new order [from attending Physician] to titrate [client HH's] prescribed Ativan...On 10/21/13 [client HH] was prescribed Ativan 1mg BID x 14 days for increasing SIB beginning on 10/15/13...." Client HH's plan did not indicate his self injurious behavior of hitting himself in his right and left eyes with his fists causing injuries and did not include behavior data to track behaviors and injuries sustained by client HH. Client HH's Nurses Notes from 08/01/2013 through 10/22/13 were reviewed on 10/22/13 at 4:45pm and included the following: -On 10/20/13 at 8:45am, the nurse was called to Program Room (PR) #1 "client on changing table brown discoloration under left eye 4 1/2 cm. Recent medication changes to include Ativan for behaviors." -On 9/30/13 at 8:00pm, on 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/30/13 at 6:00am, right eye socket without drainage "under eye with 1cm pink abraised area." -On 9/28/13 at 4:00pm, antibiotic treatment continued for right eye. Resident was not touching eyes, no drainage. -On 9/26/13 at 8:00am, Right eye socket with pink irritation no drainage under right eye, "Dark Pink" discoloration with 1/2cm scratch and client reported with SIB this morning. -On 9/25/13 at 10:00pm, treatment to Right eye socket without adverse effects noted, area below eye dark pink irritation. -On 9/25/13 at 3:00pm, Drainage apparent Right eye, light brown, continue small red area under Right eye unchanged. -On 9/25/13 at 6:00am, right eye drainage	W 331		

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W 331	Continued From page 402 (socket), antibiotic administered, brownish drainage with irritation to each eye 1cm x .5cm red area. -On 9/24/13 at 8:45am, "called to give assessment, client with large amount of yellowish/brown drainage from left eye. Also under eye pinkish red area possible (sic) caused by drainage/client aggression, this writer observed client poking self in right eye." -On 9/5/13 at 3:00pm, "client color pale with darker discolorations under both eyes." -On 9/4/13 2:30pm, returned to facility from hospital. -On 8/26/13 at 2:05am, client had a grand mal seizure. Client was sent out EMS (Emergency Medical Services) to the hospital for admission. On 10/24/13 at 1:25 PM, an interview was conducted with the D.O.N. (Director of Nursing). The D.O.N. indicated client HH did not have an individual medical care plan which included each of client HH's identified medical needs. 2. On 10/23/13 at 11:00am, client K's record was reviewed. Client K's record did not indicate a reportable incident from 10/2012 through 10/23/13. Client K's 4/25/13 ISP (Individual Support Plan) indicated client K was non verbal and the facility's Administrator was also client K's Guardian. Client K's 4/25/13 ISP and 4/25/13 CFA (Comprehensive Functional Assessment) both indicated client K did not recognize danger and could not advocate for herself. Client K's "Nurses Notes (NN)" from 10/2012 through 10/23/2013 were reviewed and included the following incidents: -On 10/2/2013 at 11:00pm, indicated "area to R (right) shoulder resolved skin sheet complete."	W 331		

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W 331	Continued From page 403 -On 10/1/2013 at 11:00am, indicated "New Order per Dr. [Doctor Name] KUB (Diagnostic medical imaging technique of the abdomen, Kidney Ureter Bladder) Poss Abd (abdominal) Disc (discomfort) leading to agitation + (and) upset." -On 9/28/2013 at 9:00am, indicated the nurse was "called for assessment, observed client (with) 3cm x 1cm blue discoloration to L (Left) side 2 cm x 1cm blue to R inner thigh" and the doctor and Guardian/Administrator were notified. -On 9/26/2013 at 3:00pm, indicated "Sm (Small) areas noted to top of R (Right) Shoulder 1.) 3cm x 1cm pink linear skin above 2.) pink/purple circular discoloration 2cm x 1cm, 3.) linear pink skin 2cm x 1cm, [client K was] seen gripping her shoulders, arms crossed over chest...T (Temperature) 99, Urine reported to be strong smelling but clear and yellow light (sic). wax noted to bil (bilateral) ear canals, no drainage...Guardian/Administrator notified." -On 9/25/2013 at 3:00pm, indicated "(Client K) sitting in chair in group room has purple, yellow discoloration under L (Left) eye, slightly raised." -On 9/25/2013 at 10:30am, indicated "Called to grp (group) #3 for assessment, client became agitated...Client also observed (with) .2cm x .3cm dk (dark) purple discoloration under L (Left) eye (with) 3cm x 1cm bluish yellow parameters slightly raised. [Doctor name] notified...Guardian/Administrator...notified." -On 9/24/2013 at 10:00pm, indicated "Areas to clients' LFA (Left Facial Area) (without) discoloration. Skin Sheet complete." -On 9/20/2013 at 10:00pm, indicated "L side of face (without) discoloration noted. Skin sheet complete." -On 9/19/2013 at 10:00pm, indicated "L inner thigh 3 discoloration noted. Skin Sheet complete." No further information documented.	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 404 -On 9/1/2013 at 12:00pm, indicated "Discoloration to LFA (Left Facial Area) 9 x 4 + 7 x 4 (sic) purple/red, [no] edema, Guardian/Administrator notified." -On 9/2/2013 at 10:30am, indicated "Observed the following discolorations: #1.) R (Right) thigh 1cm x 1cm, #2.) L (Left) thigh 4cm x 2cm, #3.) L inner thigh 2cm x 2cm...#4.) L inner thigh 2cm x 2cm purple, #5.) L inner knee 1cm x 1cm purple discoloration. Notified [name of doctor]...Notified Guardian/Administrator." -On 9/2/2013 at 6:30am, indicated "floor staff reported multiple discolorations to inner thighs while getting client up." The NN indicated "Writer told staff since client already OOB (Out of Bed) measurements would be taken later this AM (Morning)." -On 11/11/2012 at 10:00pm, indicated client K's lower gluteal fold discoloration resolved. -On 11/7/2012 at 2:15pm, indicated the nurse was "called to group room" and "noted (with) 1cm x 5cm purple discoloration to L (Left) lower gluteal fold...Guardian/Administrator notified." -On 10/29/2012 at 10:00pm, indicated area to client K's nose "flesh colored." -On 10/25/2012 at 7:00pm, indicated the nurse was "called to the group room" and "noted a purple discoloration to tip of nose" of 2cm (centimeters). The NN indicated "Guardian/Administrator" notified. On 10/23/13 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client K was non verbal, did not recognize danger, and could not advocate for herself. The QIDP stated "each" of client K's injuries in her Nurses Notes were from SIB (Self Injurious Behavior). Client K's 4/13/2012 BSP	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 405 (Behavior Support Plan) was reviewed with the QIDP. The QIDP and client K's BSP both indicated client K's targeted behavior of "SIB" was defined as "Anti Social: Chewing her clothing, pulling her shirt up, and striping her shirt." Client K's 4/25/2013 "Behavior Assessment" indicated client K had identified behaviors of "Removing clothing/pulling shirt up...Chew on clothing." Client K's 4/25/13 "Behavior Assessment" did not indicate client K had currently and if client K had a history of self injurious behaviors which resulted in injuries (skin discolorations to face, shoulders, arms, inner thighs). The QIDP stated "No, [client K's] BSP and Behavior Assessment" did not include behaviors which "resulted in injuries." The QIDP stated "each" of client K's injuries were "self inflicted." The QIDP stated client K had a "history of putting her hands between her legs and squeezing her hands which resulted in bruises on [client K's] thighs." The QIDP indicated no documented evidence of client K's history of behaviors which included putting her hands between her legs and squeezing causing injuries (skin discolorations). The QIDP indicated "Accident/Incident Forms" for each incident were recorded. When asked if these were available for review, the QIDP stated "I can provide them." On 10/23/13 at 2:45pm, an interview with the QIDP was conducted. The QIDP indicated at the time of each incident client K's injuries were not "suspicious." The QIDP indicated after discussing client K's injuries documented in her nurses notes "I can see where these would be suspicious in nature." The QIDP indicated client K did not have a nursing health care plan developed. The QIDP provided no documented Interdisciplinary Team discussions for review. The QIDP indicated the nursing department	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 406 tracked client K's injuries through skin sheets and monitoring of the skin sheets. No health care plan for client K's skin was developed. On 10/23/13 at 2:45pm, the QIDP provided the following "Accident/Incident Form(s)" for client K: -Incident 9/28/13, Time: 9:00am, indicated "Nursing description of injury: 1) L side (left inner thigh) 3cm x 1cm blue green discoloration. 2) 2cm x 1cm blue green discoloration L (left). Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/26/13, Time: 3:30pm, indicated "Nursing description of injury: Nurse note area to top of R shoulder...1) Linear line of pink skin, 3cm x .1cm, 2) pink/purple above circular discoloration 2 x 1cm (sic), 3) 2cm x .1cm pink linear line below circular discoloration. Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -Incident 9/25/13, Time: 10:30am, indicated "Nursing description of injury: Under R eye .2cm x .3cm DK purple discoloration (with) parameters 3cm x 1cm bluish yellow discoloration slightly raised...Physician notified." Guardian/Administrator notified. The report did not indicate "Investigative finding, Current Behavior Program," or if the incident was reviewed by facility leadership. -An undated investigation which indicated "After investigation, it was determined that the incidents	W 331		

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W 331	Continued From page 407 documented for September 25, 26, and 28th (2013) should be combined following a noted trend for areas of discoloration. The area of discoloration located under [client K's] left eye - 25th, was the result of self inflicted injury by [client K]. Behavior data collected noted observation by attending staff that witnessed [client K] to strike herself under her left eye while sitting on her bed. The area of discoloration noted to the top of her left shoulder was also created by [client K] - 26th. The areas of discoloration reflect finger grasps that melded into a cluster of discolorations. [Client K] was observed to have her arms crossed over her chest and grasping the tops of both of her shoulders firmly with her fingers prior to medical assessment completed by the D.O.N. The areas of discoloration documented to [client K's] inner thighs occurred when [client K] placed her hands between her legs and pressing - 28th. Following review of [client K's] environment, the group and bedroom, possible changes in routine, potential changes to her diet, dental visit, weights, staff discussion, medications, labs, and medical assessment, few changes were documented. Review of nurse's notes determined that revisions to her bowel medications may be contributing to [client K's] recent behavior/actions. In an effort to determine whether the recent revisions to her bowel medications is a contributing factor for [client K] recent behavior (sic), nursing will assess her current bowel sounds...[signed by D.O.N. and Administrator]." - Incident 9/15/13, Time: 11:30am, indicated "Nursing description of injury: 3cm x 2cm faint black yellow area to L side of face. Physician notified." Guardian/Administrator notified. "Investigative Findings: While engaged in a	W 331		

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W 331	Continued From page 408 sensory stimulation activity [client K] accidentally struck the left side of her face with a tongue depressor." The report did not indicate any measures were taken regarding the behaviors and did not indicate witnesses interviewed. -Incident 9/2/13, Time: 6:30am, indicated "Nursing description of injury: 1) R thigh 1cm x 1cm light brown discoloration, 2) L thigh 4cm x 2cm blue purple, 3) L inner thigh 2cm x 2cm purple discoloration, 4) L inner thigh 2cm x 2cm purple discoloration, 5) L inner knee 1cm x 1cm purple discoloration. Physician notified." Guardian/Administrator notified. "Investigative Findings: Areas noted are consistent with pressure placed on [client K's] hands placed between her knees. [Client K] placed her bilateral hands together, palms together, between her thighs and knees. The pressure created areas of discoloration as noted in the description undue pressure occurred during increased activity within her group." The report did not indicate witness statements and did not indicate a review/revisions of client K's plans. -Incident 11/7/12, Time: 2:15pm, indicated "Nursing description of injury: Pt. (Patient) [client K] noted (with) 1cm x 5cm purple discoloration to L lower gluteal fold. Physician Notified." Guardian/Administrator notified. The report's "Investigative Findings: Upon investigation it was reported by staff member [name] that [client K] had gone shopping earlier in the day and when she sat down on the seat of the van she accidentally sat on the seat belt clip. No injury was noted at the time." The report did not indicate witness statements and did not indicate a review by the facility leadership.	W 331		

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W 331	Continued From page 409 -Incident 10/12/13, Time: 7:00pm, indicated "Nursing description of Injury: Tip of nose noted (with) purple discoloration, Pt. (Patient) uncooperative (with) measurements, area approximated (at) 2cm." The "Investigative Findings" indicated a staff was placing client K's hands on her walker to go to the dining room for supper, client K "pulled her hand back," and bumped herself in the nose. The report did not indicate witness statements and did not indicate corrective action. -Incident 10/8/12, Time: (not indicated) "Nursing description of Injury: L deltoid noted with 1cm blue discoloration with pinpoint site to L of center." The report did not indicate "Investigative finding, Current Behavior Program," or review of client K's ISP/BSP. Interview on 10/25/13 at 10:15 AM was conducted with the D.O.N. (Director of Nursing). The D.O.N. indicated no pictures of client K's injuries were recorded. The D.O.N. stated "all" of client K's laboratory testing, urinanalysis, and "all other medical" testing were within client K's "normal ranges." The D.O.N. indicated she was discouraged from requesting a gynecological examination for client K after the injuries were identified. The D.O.N. stated client K "displayed a guarded" body position after the injuries and "displayed a guarded" body position when she (the D.O.N.) attempted to complete a body check and to obtain a urine sample for testing. When asked in what way client K was guarded, the D.O.N. stated client K "cried" when disrobed and laid down on her bed. The D.O.N. stated "she (client K) was clearly upset, turned away, pushed away, tried to cover herself, and pulled her legs up in a fetal position." The D.O.N. indicated client	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 410 K did not have a health care plan developed to monitor her further once the injuries were healed. Confidential Interview #2 (CI #2) was conducted. CI #2 stated the Administrator and the QIDP/PD both "discouraged" a gynecological examination recommendation for client K at the time of client K's suspicious injuries. Interview on 10/28/13 at 2:10pm, with the facility's Administrator was conducted. The Administrator indicated the investigation completed for client K's injuries was done by the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director). The Administrator stated client K had "SIB" behaviors. When asked if client K's SIB behaviors were "Chewing on her clothing," the Administrator stated "Yes." The Administrator indicated client K had an undocumented history of SIB squeezing her hands between her legs. The Administrator indicated no documented witness statements, no documented formal investigation, no documented medical interventions, no BDDS reporting, and no gynecological exam was completed. On 10/24/13 at 1:25 PM, an interview was conducted with the D.O.N. (Director of Nursing). The D.O.N. indicated client K did not have an individual medical care plan which included each of client K's identified medical needs. 3. (b) Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's record did not include a Health Care Plan for client C's current identified medical needs. Client C's 8/30/13 quarterly physician's orders indicated client C had diagnoses of, but not limited to, Osteoporosis (brittle bones), Seizure Disorder, Kyphosis &	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 411 Scoliosis (Curving of the Spine), Contractures, Pedal Edema (Swelling of the legs/feet), Major Scoliosis Predominately in the upper Lumbar Lower Thoracic Spine measuring 36 degrees with rotation, Constipation, G Tube placement, and Arthritis. Client C's 8/30/13 "Physician's Orders" indicated the use of the following medications: Docusate Sodium and Polyeth Glycol for constipation, Furosemide for Congestive Heart Failure and Pedal Edema, Levetiracetam Solution for Seizure Disorder, Meloxicam for Arthritis Pain, Montelukast for Bronchospasms, Potassium Chloride Solution for Potassium Replacement, Ranitidine Syrup for Reflux, Oxygen by nasal cannula at 2 liters, and Nutren Pulmonary at 58cc per hour for 12 hours per G Tube pump. Client C's 3/28/13 ISP indicated client C used a wheelchair for ambulation. Client C's 3/28/13 "Annual Nursing Assessment" did not indicate client C's current PT/OT evaluations and indicated client C was incontinent of bowel and bladder. Client C's record indicated a 3/28/13 "Adaptive Skills Assessment" completed by the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) which indicated "Ambulation Assistive Devices. [Client C] has a personal, adaptive, manual wheelchair. [Client C] does not gainfully propel her own wheelchair and requires maximum assistance from staff for movement. Her bilateral upper extremities are limited in should flexion and abduction...She is unable to sit unsupported and no longer possesses the ability to perform standing transfers." Client C's record did not indicate she was a two person transfer. Client C's record did not indicate a plan for her identified medical needs. Client D's record was reviewed on 10/23/13 at	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 412 9:45 AM. Client D's record did not include a Health Care Plan for client D's current identified medical needs. Client D's 8/30/13 quarterly physician's orders indicated client D had diagnoses of, but not limited to, Osteoporosis, Cerebral Palsy, Club Feet, Visually Impaired due to Retinopathy of Prematurity (blind), spastic Quadriplegia, Neuromuscular Scoliosis, Lumbar Spinal Fusion, Incontinence of Bowel and Bladder, Aspiration Precautions, Constipation, Seizure Disorder, Gastric Upset, and G Tube Placement. Client D's 8/30/13 "Physician's Orders" indicated client D was given the following routine medications of: Baclofen for Spasticity, Cymbalta for behaviors, Loratadine for Environmental Allergies, Meloxicam for Pain, Polyeth Glycol for Constipation, Ranitidine Syrup for Gastric Acid, Risperidone for Agitation, Topiramate for Seizure Disorder, Vimpat for Seizure Disorder, Diastat for Seizures lasting longer than 5 minutes, and Nutren 2.0 by G Tube at 55cc per hour for 12 hours. Client D's 5/28/13 ISP indicated client D was non-ambulatory. Client D's 5/28/13 "Annual Nursing Assessment" indicated client D was non ambulatory, non weight bearing, incontinent of bowel and bladder, and used an "Adaptive wheelchair for transport." Client D's record did not indicate she was a two person transfer. Client D's record did not indicate a plan for her identified medical needs. On 10/24/13 at 1:25 PM, an interview was conducted with the D.O.N. (Director of Nursing). The D.O.N. indicated clients C and D did not have an individual medical care plan which included each of client C and D's identified medical needs. 4. On 10/21/13 at 12:20pm, client E was observed sitting in her wheel chair in the main	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 413 dining room, client E was non verbal, her legs were extended outward from her wheel chair, and client E wore a fracture boot (appliance used to stabilize fracture as it healed) on her left leg. At 12:20pm, facility staff #64 stated client E fractured her fibula on her left leg "about" six (6) weeks ago. At 2:00pm, facility staff #41 and RN (Registered Nurse) #5 both indicated client E was a three person lift to transfer from her wheel chair to another location because of her left leg fracture. At 2:00pm, facility staff #31 and RN #5 checked client E's left leg. RN #5 removed client E's left leg fracture boot, stated client E had a "1 1/2cm" red area on her left inner ankle where her fracture boot had rubbed against the skin. At 3:10pm, client E was assisted back to Program Room #1 with facility staff #30, #31, and #80 entered Program Room #1 and approached client E who sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #30 grasped the two top handles with his left and right hands to lift client E's shoulders. Facility staff #31 grasped client E's fracture boot on her left leg. Facility staff #80 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #80 stated "I pull the handles together" which he did and lifted client E with on hand holding both handles. When facility staff #80 held the sling handles together at her hips, client E's left leg moved to overlap her right leg and was squeezed in/by the sling. Client E's face wrinkled and her eyebrows connected to form a line on her forehead. Client E's face was red and watery. Client E made high a pitched vocalization when she was moved and the pitch went higher when her left leg was squeezed by the sling.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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ARCADIA, IN 46030

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W 331	Continued From page 414	W 331		

During observations at the facility on 10/22/13 at 2 PM, client E was sitting in her wheel chair in a semi reclining position with her upper body leaning to the right. Client E's feet were extended in front of her with both feet rotated in a fixed outward position. Client E's left foot was in a fracture boot and on a pillow.

On 10/24/13 at 8:30am, upon entering the facility at the front conference room, vocalizations were heard (crying and yelling out). At 8:30am, the surveyor followed sounds by walking down the front hallway and down the second hallway to Program Room/Group #1 located on the second hallway. The DON (Director of Nurses) was in the doorway to the entrance of the room. Inside the room was client E, who was crying and yelling out. Client E sat in a wheelchair with her left leg elevated, wore a fracture boot on her left lower leg, and client E's left foot was turned sideways on top of a positioning pillow. At 8:30am, LPN (Licensed Practical Nurse) #7, facility staffs #28, and #37 stood around client E's wheelchair. The three staff offered client E different cause/effect items which client E refused and she continued to cry and yell. At 8:30am, the DON indicated client E had been crying and yelling "for about fifteen minutes" (or since 8:15 am). At 8:45am, the DON was overheard to instruct LPN #7 to administer client E's PRN (as needed) pain medication "now." From 8:30am until 8:45am, LPN #7 instructed the facility staff to transfer client E into a recliner and out of her wheelchair. At 8:45am, client E was approached by facility staff #17, #28, and #37 to transfer her into a recliner chair inside the program room. Client E sat in her wheel chair on a black sling with four handles (one handle on each corner of the sling). Facility staff #37 grasped the two top handles with his left and right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 415 hands to lift client E's shoulders. Facility staff #28 grasped client E's fracture boot on her left leg. Facility staff #17 grasped client E's two sling handles at her hip level and pulled the two handles together for a tight fit around client E's hips. Facility staff #17 stated "I pull the handles together" which he did and lifted client E with one hand holding both handles. When facility staff #17 held the sling handles together at her hips, client E's left leg moved together with client E's right leg, and client E's legs were squeezed together in/by the sling. Client E's face was wrinkled, her eyebrows leveled, and she continued to cry and yell. Client E's face was red. Client E made high pitched vocalizations when she was moved and the pitch went higher when her left leg was squeezed by the sling. From 8:45am until 8:48am, client E was calmer but continued to make vocalizations. At 8:50am, client E was crying and yelling again while seated in the recliner. At 8:50am, facility staff #28 stated "She (client E) seems like (she's) in pain" and facility staff #28 held client E's hand while client E continued to cry and yell. At 8:50am, facility staff #64 entered the program room and stated to the facility staff "if the med (medication) doesn't help, come and get me." At 8:55am, facility laundry/housekeeping staff #82 entered the program room, talked to client E, and tried to reassure client E to calm her. Client E continued to thrash her head back and forth, cried and yelled, and her face was red. At 9:00am, facility laundry/housekeeping staff #82 stated "I've never seen her like this before, She's either upset or in pain." Staff #82 indicated she had been employed at the facility over nineteen years (19 years) and had a rapport with client E. At 9:00am, the D.O.N. returned to the program room and asked staff to assist client E to her bed room and for client E to	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 416 go back to bed. From 9:00am until 9:10am, client E was wheeled in the recliner from the program room, down the hallways to client E's bedroom (room #36), and transferred from the recliner into her bed. At 9:10am, client E continued cry and yell and to have a red face. At 9:40am, client E was observed calm and in bed. On 10/24/13 at 3:25pm, client E was observed inside Program Room/Group #1. Client E sat in her wheelchair, softly vocalized, and her face appeared to be red and she moved her head back and forth. At 3:35pm, facility staff #31 paged for assistance from the facility nurse for group #1. At 3:35pm, facility RN #5 entered the program room, approached client E, and walked to the phone inside the program room to call the medication nurse to inquire regarding client E's use of PRN pain medication. At 3:50pm, RN #5 indicated the medication nurse was checking for the availability of client E's medication. RN #5 indicated client E had been receiving her PRN pain medication today and he wanted to make sure it was time for another dose of PRN pain medication for her "breakthrough" pain. At 3:55pm, the unidentified medication nurse entered the Program Room and administered client E's PRN pain medication. The facility's reportable and investigative records were reviewed on 10/21/13 at 2 PM. An 8/16/13 BDDS (Bureau of Developmental Disabilities Services) report indicated "On August 15th at approximately 5:40 AM, staff entered [client E's] bedroom to prep and assist [client E] with getting for her daily routine (sic). Staff stated that they removed [client E's] covers and touched her foot. Upon touching her foot, staff stated that [client E] cried out. Reporting staff further stated that they	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 417 then removed her sock in an attempt to determine what caused [client E] to cry out. [Client E] then cried out in a louder tone. Staff then stated that they left [client E] in her bed and alerted nursing personnel of the situation for further assessment. The following nursing assessment is as follow: [Client E's] left foot was noted with full range of motion capabilities. Under normal conditions, [client E's] tone and overall range of motion capabilities are minimal. Additionally, slight edema was noted to [client E's] left foot and ankle area with less than 3 seconds for cap (capillary) refill. Plan to resolve: Nursing placed a splint/rigid boot on [client E's] left foot/ankle and contacted her PCP (Primary Care Physician) for instructions. New orders were obtained to send [client E] for x-rays of [client E's] left foot and ankle area...." Client E was taken for x-rays at a nearby facility at 8 AM and returned to the facility at 10:20 AM. At 12 PM, client E's PCP called the facility with new orders for client E to "immediately" see an orthopedic surgical doctor due to x-ray results "regarding left leg fractures." The report indicated the following x-ray results: __"Acute, minimally displaced spiral fracture of the distal tibia diaphysis." __"Acute, non-displaced distal fibular diaphyseal (pertaining to or affecting the shaft of a long bone) fracture." __"Diffuse bone demineralization." __"Ped planus (flat foot) deformity of the foot." The 8/16/13 BDDS report indicated client E was taken to a local hospital and another set of X-rays were completed at [name of hospital]. The findings of the x-rays were as follows: __"Non-displaced spiral fracture of the distal tibial diaphysis (the main or midsection shaft of a long bone)."	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 418 __"Non-displaced spiral Weber type C fracture of the adjacent fibula with no significant joint space widening." __"Extensive bony demineralization without convincing evidence for acute fracture." The report indicated "Immediate Action Taken: New orders from [name of hospital] were to apply ice for swelling, provide Tylenol 500 mg (milligrams) Q (every) 4 hours for pain and follow up with an orthopedic consult within 6 days. On August 16th, nursing personnel scheduled an appointment with [name of doctor] for August 21st at 10:15 AM.... [Client E] has also been scheduled for a bone density diagnostic on August 30th." The 8/16/13 BDDS report indicated the facility has implemented the following measures in response to the current x-ray findings: __"[Client E's] wheelchair foot box has been widened approximately 3 additional inches to facilitate additional protection when [client E] is up in her wheelchair." __"A three-man lifting protocol has been designed to ensure the protection of her [client E's] leg." __All appropriate staff have been in-serviced regarding "client E's" current condition and on the protocol for lifting." __"[Client E's] recliner has been modified, in height, to allow for smooth transitioning during three man-lifting." Review of client E's record on 10/22/13 at 2 PM indicated diagnoses of, but not limited to, Epilepsy, Cerebral Palsy with spastic quadriparesis (arms and legs) with associated hyperflexia (the over flexing/bending of a limb), Congenital left hip dysplasia, Bilateral Pulmonary Emboli (blood clots), incontinence of bowel and	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 419 bladder, risk of aspiration, Osteopenia (low bone mineral density), fractured left distal femur and Osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density that leads to an increased risk of fracture). Client E's record indicated client E was non verbal and non-ambulatory. Client E used an adaptive wheelchair for transportation. __Client E's August 2013 physician's orders indicated the following diagnosis history, but not limited to: 11/3/93 fracture of left femur above the pin, 1/30/05 blood clot removed from left breast incision, 10/4/10 left hip cellulitis (an infection of the skin), 12/5/11 acute renal failure secondary to hypotension volume depletion with history of hypokalemia (low blood potassium), 10/4/10 sepsis (a whole-body inflammation/infection) and 12/5/11 left hip cellulitis. __Client E's Radiology report of 5/21/12 indicated "Evidence of fracture which appears acute over the distal femur at the level of the femoral condyles (round projection at the end of a long bone) anterior rotation or displacement of the distal femoral metaphysis (the wide part at the end of a long bone) in relation to the diaphysis is present. Diffuse bone osteopenia (reduced bone mass) with postoperative changes stable over the proximal left femur and changes of chronic hip dysplasia." __Client E's Lower Venous Duplex scan of 5/21/12 indicated client E had an "Acute deep venous thrombosis (blood clots) noted in the left distal femoral vein. Acute deep venous thrombosis noted in the left popliteal vein (veins in the leg)." __Client E's Radiology Report of 7/16/12 indicated "Severe osteoporosis, Distal femoral fracture appears healing, could be old injury..." __Client E's 8/2/13 physician's order indicated	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 420 "Send [client E] out via ambulance for stat (immediate) x-ray of her left upper leg and hip at [name of facility]." The Radiology report dated 8/2/13 indicated __Client E's Emergency Room report of 8/7/12 indicated client E "presents to the Emergency Department with a caregiver from her living facility.... They (the facility staff) said that there was an ultrasound done of her left lower extremity venous Doppler as well as an x-ray shot on the 21st of last month. It has been 2 weeks. On the x-ray they said that there was a femur fracture and they just found out today so they bring her in here. She (client E) does not walk. She is non-verbal.... There has been no injury. She had an ultrasound because she has developed blood clots in the past." The report indicated client E's left femur shows chronic changes as well as a healing fracture of the distal left femur.... I (ER doctor) spoke with [name of doctor] on call for orthopedics. He looked at the x-ray. He talked about the patient's situation. This is not something he would surgically fix. The patient is bed ridden anyway with a long history of severe mental retardation. He also would not splint it at this point based on the patient's body habitus (the tendency to develop a certain disease). They (the staff) transfer her anyway. It may be more cumbersome and be of little to no benefit at this point...." __Client E's physician's progress note of 8/21/13 indicated client E was diagnosed with cellulitis to her upper left leg. The note indicated client E was placed on antibiotics. __Client E's Social Service Quarterly Summary of 5/13 through 7/13 indicated client E is non verbal but vocal. She will turn her head away when she does not like what is presented to her. She will fuss or cry when she is upset.... She needs total	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 421 assistance with all her ADL (Adult Daily Living) care and feeding...." __Client E's physician's orders of 9/18/13 indicated client E was to "Remain in boot for left leg at all times, except may remove for skin care, etc prn (as needed)." __Client E's Adaptive Skills Assessment of 10/22/12 indicated client E was a non-ambulatory female "who uses a tilt in space wheelchair with custom molded inserts pelvic stabilizer and shoe holders. She can make eye contact and can turn her head. [Client E] has minimal active movement of the extremities with no attempts to roll. She can flex and rotate her head when in supine. [Client E] has decreased bilateral hip flexion in extension and rotation, ankle inversion, decreased bilateral shoulder flexion, abduction and rotation, wrist extension and forearm supination (a kind of rotation). [Client E] displays decreased muscle tone and strength in her neck and trunk. She displays decreased muscle tone in all extremities with poor muscle strength. [Client E] requires total support in all positions. [Client E] presents with a forward flexed head tilted to the right, neuromuscular scoliosis." __Client E's Fall Fracture Risk Plan dated 10/20/12 indicated client E was at risk for falls and/or fractures. The plan indicated client E was non ambulatory and the staff were to use a "3 man lift" with transfer sling to transfer resident from bed to wheelchair to recliner. The plan indicated "Check every 2 hours." The plan indicated the staff were to monitor for client E "repositioning herself or attempting to transfer herself." The plan indicated the staff were to "Notify the nurse immediately if [client E] falls or a fracture is suspected." __Client E's Osteoporosis Risk Plan of 11/7/12 indicated client E was at "Risk of injury during self	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 422 repositioning, transferring from bed to chair or vice versa.... Protect client using sling to transfer from bed to wheelchair, wheelchair to recliner.... Monitor for any discomfort/pain. Use sling for all transfers...." Client E's record indicated no PT (physical therapy) assessment in regard to the supports and equipment needed to position client E to prevent further injuries due to client E's history of fractures and diagnosis of Osteoporosis and to provide client E stability and support while in her wheelchair, recliner and/or bed. Client E's record indicated no wheelchair assessment. Client E's record indicated no protocols or risk plans in regard to client E's positioning needs, skin integrity, toileting plan. Client E's record did not indicate how and when the staff were to monitor client E in regard to pain and/or regular assessments of client E's pain. Review of the lifting protocol for client E dated 8/15/13 on 10/22/13 at 3 PM indicated when transferring client E from the wheelchair to the bed or from the bed to the wheelchair the staff were to: A) Ensure client E had the appropriate sling positioned under her. B) The first staff was to position themselves at client E's right side. "This should be completed as a measure to protect her feet. C) The second staff member was to be positioned on client E's left side, "firmly grasping each corner of the sling to assist with sliding [client E] into her bed." D) The third member at client E's head should control the count (1, 2, 3, lift); to ensure client E is lifted in unison. E) After client E was positioned in her bed, staff	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 423 were to use the sling to move client E within her bed. F) The staff were to ensure client E's bedrails were up securely and to ensure padding over both bedrails and positioned at the bottom portion of her bed. The protocol indicated to transfer client E from/to her wheelchair to her recliner: A) The staff were to repeat steps A through F. B) The staff were to be aware of the slight drop/lift when transferring her during this time. The protocol indicated until further notice as a measure to ensure client E's safety, client E was to be provided a bed bath. Review of the facility staff training records on 10/22/13 at 3 PM indicated 5 nursing staff and 11 direct care staff that assisted client E had not been trained to do a 3 person lift. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated through investigation the exact cause of client E's injury had not been determined but was thought to be due to another client pulling at her sock on her foot. The QIDP indicated it was possible client E could have been injured when she was repositioned during the night and/or during the 2 person lift. The QIDP stated client E had a history of breaks and "brittle bones." The QIDP stated the facility did not use any mechanical lifts "The staff do the lifts." The QIDP indicated after client E's injury the facility implemented a 3 person lift until client E's leg was healed. The QIDP indicated all nursing and direct care staff were to be trained to do a 3 person lift. The QIDP indicated she had trained the first group of staff and nursing was responsible for training the rest of the staff. The QIDP stated,	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 424 "Apparently that didn't happen." The QIDP indicated no positioning plan in place for client E. The QIDP indicated all clients "as a rule," are to be turned or repositioned every 2 hours. The QIDP indicated after client E's injury the staff were to put a pillow under client E's foot. The QIDP indicated client E had not been assessed by physical therapy for the specific positioning supports/equipment needed to maintain client E's body and provide optimal support to ensure client E's safety due to potential of pain or further injury with healing fractures. Interview with the DON (Director of Nurses) on 10/22/13 at 5:30 PM indicated she had been with the facility as the DON for 3 months. The DON indicated she did not know what happened to client E, "I think she got her foot caught or something." When asked for nursing care plans, the DON indicated the facility was not a nursing facility and did not have to do nursing care plans. The DON indicated no positioning schedule, no skin integrity plan and/or toileting plan in place for client E. The DON stated, "I think the staff do repositioning every 2 hours." The DON indicated the facility did not have a mechanical lift and the staff did the lifting. The DON indicated client E was a 3 person lift. Interview with Administrator (ADM) #1 on 10/23/13 at 2 PM indicated the facility did not have a mechanical lift. ADM #1 stated, "I think you can do more damage with a mechanical lift than the way we do it." Adm. #1 indicated the facility did not utilize a mechanical lift because a lift would not go under the tubs (bathtubs) and or the clients' chairs. 5. Observations were conducted at the facility	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 425 dining room on 10/21/13 between 4 PM and 7 PM. During this time client DDD was escorted to the dining room. Client DDD did not eat or drink anything while in the dining room. The staff in the dining room did not offer client DDD a snack or a substitution for food not eaten. During observations on 10/23/13 from 10:35 AM until 12:50 AM, client DDD was taken to be weighed before going to dining room at 12:00 PM. Client DDD weighed 113.8 lbs. (pounds). Client DDD went to the dining room, but refused his mechanical soft chili dogs, potatoes and pears. He was then offered pureed food and also refused the pureed food. On 10/25/13 at 6 PM, client DDD was observed sitting in a chair in group 6 activity room. Client DDD had a small red raised swollen area with a dark center on the outer aspect of his lower right arm above his wrist. No seeping was noted and area was not covered. The facility nurse was called to come to the room to look at client DDD's arm. RN #1 placed a Band-Aid over the area. RN #1 stated, "He won't keep it covered. We try, but he just pulls it off again. The area looks like it's ready to pop." On 10/28/13 at 12:55 PM client DDD was observed sitting in a chair in group 6 activity room. Client DDD was observed putting both of his hands down his pants. Client DDD's was wearing a long sleeve shirt. Staff #93 was asked to roll up client DDD's sleeve on his right arm. The area noted on client DDD's lower arm on 10/25/13 had burst. The area was now red and swollen with a dark center that had scabbed over. Staff #93 stated, "He picks at it all the time and won't leave a band aid on. He takes it off as soon	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 426 as we put it on." Staff #93 called the nurse to come put another band aid over client DDD's area on his lower arm. On 10/29/13 at 6:45 PM client DDD was escorted to the dining room for his evening meal. Client DDD was the last client to be served that evening. Client DDD was offered regular lasagna, green beans and upside down pineapple cake along with white, strawberry and chocolate milk. Client DDD took 2 sips of milk and refused the rest of his meal. The Dietician Manager offered client DDD some cooked cereal that was also refused. Client DDD got onto the floor and began crawling out of the dining room when the staff assisted client DDD back to activity room #6. Client DDD's record was reviewed on 10/24/13 at 1 PM. Client DDD's record indicated client DDD was a 13 year old male who was an emergency admission to the facility on 5/13/13 due to behaviors and family problems. Client DDD had diagnoses which included, but were not limited to, Cerebral Palsy and Hydrocephalus (water on the brain) and did not take any behavior modification medications upon admission to the facility. The record indicated upon admission client DDD weighed 147.6 pounds and was 60 inches tall. Client DDD's monthly weight record indicated the following weights for 2013: May 147.6 pounds (admission weight). June 140.6 pounds. July 135.2 pounds. August 133 pounds. September 131.2 pounds. October 118.2 pounds. Client DDD's monthly weight records indicated client DDD had lost 29.4 pounds since his admission to the facility. The	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 427 weight record indicated the DON (Director of Nursing) and the physician were notified. Client DDD's nutrition assessment of 6/6/13 indicated client DDD was to receive a mechanical soft diet. The assessment indicated client DDD's intake was "fair" and client DDD had no difficulty chewing and/or swallowing. The assessment indicated the dietician will monitor as client DDD was acclimated to the facility. Client DDD's 10/8/13 Nutrition Quarterly Assessment indicated "No new diet orders, but will offer puree diet if refuses mechanical soft due to dental problems...." The report indicated client DDD had 12.6% weight loss in 90 days. Client DDD "continues to have dental problems at this time. Spoke with dietary staff about his weight loss, and the need to get any food items he may want to him." __Client DDD's Oral Food and Fluid Intake Record for August, September and October indicated client DDD refused 4 meals out of 93 in August, 39 meals out of 90 in September and 35 meals out of 68 in October. There was no evidence of supplements or food substitutes being offered. __Client DDD's dental assessment of 6/4/13 indicated no dental issues. __Client DDD's 10/2013 physician's orders indicated client DDD was now taking Prozac 20 milligrams a day for sexual frustration, Klonopin 1 milligram three times a day for behavior modification and Trazadone 150 milligrams at bedtime to help client DDD sleep. __Client DDD's informed consent of 8/28/13 indicated side effects of Prozac to be nervousness, anxiety, insomnia, headache, drowsiness, tremors, dizziness, nausea, diarrhea, dry mouth and anorexia (weight loss).	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 428 __Client DDD's nursing notes indicated on 5/14/13 at 6 AM "Staff report client ate well having second helping of French toast." Client DDD's nursing notes indicated no further documentation in the nursing notes in regard to client DDD's lack of eating and/or refusal to eat his meals. Client DDD's nursing notes indicated nursing services did not monitor client DDD's weight loss and or refusals to eat. __Client DDD's physician's order dated 10/16/13 indicated client DDD was to start Megace 4 (for appetite and added calories) milligrams twice a day to assist in gaining weight. __Client DDD's Physician's visit record indicated client DDD saw a doctor on 8/23/13 due to "skin lesions-moles/warts and cellulitis." The record indicated "The patient (client DDD) is a 13 year, 9 month old male who presents with skin lesions. Note for 'Skin lesions': PT (patient) in office for possible boils. PT has raised yellow area on R (right) knee, 2 on L (left) knee. PT also has a pink raised area on L forearm. Knee lesions have popped, left arm red bump still persist." __Client DDD's record indicated no protocols and/or plan of care in regard to client DDD's refusals to eat, weight loss and cellulitis. Confidential Interview #5 stated sometimes staff did not take client DDD to the dining room for the meal because "he doesn't eat anyway." Staff #94 was interviewed and when asked if client DDD had lost weight, stated, "Yeah. He just fell off eating lately." Staff #53 and #495 were interviewed on 10/23/13 at 12:30 PM and stated client DDD had "dental problems" and nursing services was working with the dentist to resolve the problem.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 429 Interview with facility nurse #5 on 10/24/13 at 3:30 PM indicated client DDD's weight was at the "low end of his weight range." The DON and ADON (Assistant DON) were interviewed on 10/23/13 at 2:00 PM. The ADON indicated the dentist had cleared client DDD of dental issues. The ADON stated, "He probably has depression," and indicated the psychiatrist prescribed Megace (appetite stimulant). The ADON indicated client DDD had previously lived in a car and stated, "He prefers junk food. When he doesn't eat at lunch, we give him a snack at 2:00 PM." The ADON indicated nursing staff did not review client DDD's snack intake. When asked if client DDD's weight was lower this week than last week, the DON indicated client DDD's weight was lower and when asked if the interventions to address client DDD's weight had been effective stated, "No." Staff #48 was interviewed on 10/24/13 at 12:50 PM. He stated client DDD "stopped eating after he started receiving Klonopin." Interview with the DON (Director of Nurses) on 10/24/13 at 3:35 PM indicated nursing had not addressed and/or monitored client DDD's weight loss. The DON indicated no protocols or nursing care plan and/or risk plan was developed to address client DDD's continued weight loss and/or refusals to eat. The DON indicated the staff were to offer client DDD snacks three times a day. The DON stated if client DDD continued to refuse his meals, client DDD's physician would "more than likely" want to insert a feeding tube. The DON indicated client DDD did not have a plan in place in regard to the cellulitis. The DON	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 430 stated the staff "try to keep it covered but he won't leave anything on it." The DON stated client DDD was in the same activity group room as another client that currently had "ring worm" and another client that had skin issues. The DON stated, "This same room of clients recently had issues with MRSA (Methicillin-resistant Staphylococcus aureus) and we also tested those clients recently for scabies, but their tests came back negative." Interview with the ADON (Assistant Director of Nursing) on 10/24/13 at 4:15 PM stated client DDD had lived in a car with his family prior to admission, "so they started to offer more convenience food items" as that was probably what he was used to eating prior to admission. The ADON indicated client DDD's response to the snacks was not reviewed and/or monitored by nursing. The ADON indicated client DDD did not have dental issues. Interview with the QIDP (Qualified Intellectual Disabilities Professional), the Administrator, the DON and the ADON on 10/24/13 at 4:45 PM indicated no IDT (Interdisciplinary Team) meetings and/or notes to address client DDD's 29.4 pound weight loss over a 5 month period. The QIDP indicated client DDD's physician, client DDD's family and/or the IDT team had not convened to develop and/or implement a plan to address client DDD's refusals to eat. The QIDP indicated client DDD's physician would be notified. 6. Observations were conducted at the facility in group two on 10/21/13 from 1:30 PM through 5 PM. During this time client F sat in a recliner from 1:30 PM until 4:30 PM. Client F's hands were deep reddish purple in color. Client F did not have	W 331		

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W 331	Continued From page 431 a blanket or covering over his hands. At 4:30 PM staff #57 and staff #44 picked client F up and placed him in a wheelchair and took client F to the bathroom to change his adult brief. After changing client F, staff #57 picked client F up and placed client F in his wheel chair. Staff #57 then took client F to the dining room for his evening meal. During this observation, client F's position was not changed from 1:30 PM until 4:30 and client F was not offered a blanket or covering for his hands/feet. Client F's record was reviewed on 10/23/13 at 1 PM. __Client F's 8/30/13 quarterly physician's orders indicated client F had diagnoses of, but not limited to, Osteoporosis (brittle bones), Constipation, Valgus Feet Bilaterally (club feet), Levoscoliosis of the Thoracolumbar Spine (curvature of the spine), GERD (Gastroesophageal Reflux Disease), Incontinence of bowel and bladder, Paraparesis (partial paralysis of the lower limbs), Geographic tongue (an inflammatory condition of the mucous membrane of the tongue), Edentulous (no teeth), DJD (Degenerative Joint Disease) of the left hand, Benign Lipomas of the right foot/ankle, Reflux requiring aspiration precautions, Moderate to severe oral pharyngeal dysphasia with aspiration of thin liquids, HTN (hypertension), Raynauds Disease (a rare condition that causes some areas of the body, such as fingers, toes, the tip of the nose and ears, to feel numb and cool in response to cold temperatures or stress). Client F's record indicated client F had a history of pneumonia and hypotension (low blood pressure) requiring hospitalization. __Client F's physician's progress note of 5/21/13 indicated "both feet deep purple - black at toes,	W 331		

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W 331	Continued From page 432 feet cold and unable to find pulses both lower extremities. Left hand fingers deep purple cold. HR (heart rate) apical faint, radial pulse faint, both slow." The note indicated client F had a medical history of mild tricuspid insufficiency and blood clots in his left leg. Client F's physician's order of 8/30/12 indicated an order to "Keep his hands and feet warm." __Client F's record indicated client F was non ambulatory and non weight bearing and required "maximum assistance to complete most transfers" and used a wheelchair for ambulation. Client F's record indicated a Falls Risk Plan and a Seizure Risk Plan both dated 3/8/13. __Client F had a VNS (Vagus Nerve Stimulator - used to control seizures) implanted on 7/25/13. Client F's Risk Plan for Seizures indicated the plan was not updated to include the use of the VNS, who was to use the VNS, how it was to be used, when it was to be used and where the VNS would be stored. Client F's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 2, 6, 17, 18, 22, 24, 25, 26, 27 and 28. __No documentation for the PM shift for October 3, 9, 11, 17, 20, 21, 22, 23, 24 and 29. Client F's flow sheets indicated client F was not being repositioned and or toileted every 2 hours. The October Day flow sheet indicated on October 4, 5, 10, 11, 12, 13, 14, 15, 16 client F sat in a recliner from 6 AM or 7 AM until 1 PM. The October PM flow sheet indicated on October 2, 4, 5, 6, 7, 8, 12, 13, 15, 16, 18, 19, 25, 26, 27, 28 and 30 client F sat in a recliner from 1 PM until 7 PM every day and was taken to bed at 8 PM.	W 331		

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W 331	Continued From page 433 Client F's record indicated no protocols, risk plans or plans of care in regard to client F's positioning schedules, skin integrity, toileting plans, constipation, bowel and bladder incontinence, circulatory needs/Raynauds disease and/or dysphasia/GERD. Client F's record indicated monthly nursing summaries for October, November, December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client F's record indicated no oversight or assessments by an RN in regard to client F's monthly/quarterly health assessments and needs. 7. Observations were conducted at the facility on 10/21/13 between 1:30 PM and 5 PM. Client I sat in a recliner in group two from 1:30 PM until 4:45 PM at which time client I was escorted to the dining room. Staff #57 walked with client I to the dining room, his arms interlocked under client I's arms, his knees touching the back of her legs. Client I was walking on her tip toes and taking one step at a time with staff #57 verbally and physically prompting client I to continue walking toward the dining room. Client I's gait was unsteady and slow and required staff #57 to take one step at a time. Once in the dining room, the staff brought client I's food to the table for her and fed client I. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's 8/30/13 quarterly physician's orders indicated client I had diagnoses of, but not limited to, CP (Cerebral Palsy), Constipation, Diabetes Mellitus Type 1, Menorrhagia (an abnormally heavy and prolonged menstrual period) Renal Insufficiency (poorly functioning kidneys), Osteoporosis, Seizure Disorder, Rhinitis	W 331		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 434 (allergies), Hyperlipidemia (a high concentration of fat in the blood), Pedal (foot) Edema, Hypothryroidism and Mild Gastritis. Client I's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 6, 17, 22, 24, 25, 26, 27, 28, 30 and 31. __No documentation and/or incomplete documentation for the PM shift for October 9, 11, 21, 22, 23, 24 and 31. Client I's flow sheets indicated client I was not being repositioned and or toileted every 2 hours. The October Day flow sheet indicated on October 4, 5, 10, 11, 12, 13, 14, 15, 16 client I sat in a recliner from 6 AM or 7 AM until 12 PM. The October PM flow sheet indicated on October 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 16, 18, 19 and 20 client I sat in a recliner from 1 PM until 7 PM every day and was taken to bed at 8 PM. The July Day flow sheet had written in big bold letters "DO NOT fill out flow sheet days Ahead!" Client I's record indicated a 1/25/12 risk plan for diabetes. The Diabetic plan indicated no updates for 2013. The 3/25/13 risk plan for falls did not include how the staff were to monitor and assist client I while ambulating. Client I's record indicated no protocols or risk plans in regard to client I's seizures, positioning needs, skin integrity, toileting, heavy menstruation, constipation and dining needs. Client I's record indicated monthly nursing summaries for October, November, December 2012, January, February, March, April, May, June, July and August 2013 were conducted and signed by an LPN. Client I's record indicated no	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 435 oversight or assessments by an RN in regard to client I's monthly/quarterly health assessments and needs. 8. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's 8/30/13 quarterly physician's orders indicated client M had diagnoses of, but not limited to, Constipation, Seizure Disorder, CP, Severe Spastic Quadriparesis (not able to walk), Dysphagia (difficulty swallowing), history of chronic UTIs (urinary tract infections), Osteoarthritis, Osteoporosis, Incontinence of bowel and bladder, Renal Stones, GERD, Arthritis, Diabetes Mellitus, Right Upper Lung Lobe Atelectasis (collapsed portion of the lung), Mild Gastritis, a G-tube (gastrostomy tube). Client M's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 2, 6, 19, 22, 23, 24, 25, 26, 27, 30 and 31. __No documentation for the PM shift for October 3, 9, 19, 21, 22, 23, 24, 28 and 31. Client M's flow sheets indicated client M was not being repositioned and or toileted every 2 hours. Client M's record indicated a Falls Risk Plan of 2/8/13 and a G-tube Plan of 1/8/13. Client M's record indicated no protocols, risk plans or plans of care in regard to client M's Diabetes, Seizures, positioning needs, skin integrity, toileting, constipation and respiratory needs. Client M's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client M's health since June 2013. Client M's Monthly Nursing Summaries for December 2012, January, February, March, April, May and June 2013 were	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 436 conducted and signed by an LPN. Client M's record indicated no oversight by an RN in regard to client M's monthly/quarterly health assessments and needs. 9. Client AA's record was reviewed on 10/25/13 at 11 AM. Client AA's record indicated the client was not in need of a medical care plan from a physician. Client AA's 8/30/13 quarterly physician's orders indicated client AA had diagnoses of, but not limited to, Profound MR, Autism, CP, Microcephaly, Incontinence of bowel and bladder, Seizure Disorder, Scoliosis (curvature of the spine), Risk of Aspiration, Low Lung Volume, Constipation, Reflux, Chronic Back Pain with Spasms. Client AA's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client AA's health since February 2013. Client AA's Monthly Nursing Summaries for October, November, December 2012, January and February 2013 were conducted and signed by an LPN. Client AA's record indicated no oversight by an RN in regard to client AA's monthly/quarterly health assessments and needs. 10. Client FF's record was reviewed on 10/24/13 at 1:30 PM. Client FF's 8/30/13 quarterly physician's orders indicated client FF had diagnoses of, but not limited to, Seizure Disorder, CP with Choreoathetosis (a movement disorder with rapid, irregular, unpredictable contractions of the muscles), Anemia (a decrease in red blood cells), Chronic Otitis (ear infections), Scoliosis, Legally Blind, Two V/P (Ventriculoperitioneal) shunts (used to relieve pressure from the brain caused by fluid accumulation), Large Hiatal	W 331		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 437 Hernia, Incontinence of bowel and bladder, GT (gastrostomy tube - a tube inserted through the abdomen that allows nutrition to be directly entered into the stomach), Constipation, Kyphoscoliosis, Spasticity, Contractures of Bilateral Lower Extremities and Right Upper Extremity Right Dislocated Hip. Client FF's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 6, 17, 18, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31. __No documentation for the PM shift for October 3, 9, 10, 11, 21, 22, 23, 24, 29 and 31. Client FF's flow sheets indicated client FF was not being repositioned and or toileted every 2 hours. Client FF's record indicated a Falls Risk Plan of 2/8/13 and a G-tube Plan of 1/8/13. Client FF's record indicated no protocols, risk plans and/or plan of care in regard to client FF's needs in regard to Seizures, positioning, skin integrity, toileting, constipation and V/P shunts. 11. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's 8/30/13 quarterly physician's orders indicated client JJ had diagnoses of, but not limited to, Profound MR, CP, Hypothryroidism (abnormally low activity of the thyroid gland), Autism, ADHD (Attention Deficit Hyperactivity Disorder), Myopia, Reflux with Erosive Esophagitis, Constipation, Osteoporosis, Kyphosis (hunchback), Generalized Brain Atrophy (getting smaller), Spastic Quadriplegic (spasticity of the limbs) Encephalopathy, Seizure Disorder, Rumination, excessive drooling, anxiety and Acne.	W 331		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 438 Client JJ's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client JJ's health since June 2013. Client JJ's Monthly Nursing Summaries for December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client JJ's record indicated no oversight by an RN in regard to client JJ's monthly/quarterly health assessments and needs. 12. Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's 8/30/13 quarterly physician's orders indicated client PP had diagnoses of, but not limited to, Failure to thrive, Seizure Disorder, Delayed Gastric Emptying, Reflux Disease, Constipation, CP, Aphasia (unable to speak), Hypotonia (low muscle tone), Chronic right hip dislocation and left hip lateral subluxation (a partial dislocation), Anxiety and a Sliding Hiatal Hernia. Client PP's record indicated client PP was non ambulatory and dependent upon a wheel chair for ambulation. Client PP's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 6, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31. __No documentation for the PM shift for October 10, 11, 17, 19, 20, 21, 22, 23, 24 and 29. Client PP's flow sheets indicated client PP was not repositioned and or toileted every 2 hours. Client PP's record indicated no protocols, risk plans and/or plan of care in regard to client PP's Seizures, positioning, skin integrity, toileting, constipation and V/P shunts.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 439 Client PP's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client PP's health since December 2012. Client PP's Monthly Nursing Summaries for October, November and December 2012 were conducted and signed by an LPN. Client PP's record indicated no oversight by an RN in regard to client PP's monthly/quarterly health assessments and needs. 13. Client YY's record was reviewed on 10/24/13 at 3:30 PM. Client YY's 8/30/13 quarterly physician's orders indicated client YY had diagnoses of, but not limited to, Constipation, Seizure Disorder, CP, Ventriculoperitioneal Shunt (to treat excess cerebrospinal fluid in the brain), Cardiomegaly (an abnormal enlargement of the heart), Severe Obstructive Sleep Apnea, Microcephaly, Erosive Esophagitis (inflammation of the esophagus), Scoliosis, Incontinence of bowel and bladder, Hypoxemia (a deficiency in the concentration of dissolved oxygen in arterial blood), Degenerative Osteoarthritis, History of aspirations, Spastic Quardriparesis (inability to walk), Bilateral renal calculi (stones) with stints in bilateral ureters, Gall Stones and G-Tube. Client YY's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 5, 6, 9, 12, 13, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31. __No documentation for the PM shift for October 10, 11, 17, 19, 20, 21, 22, 23, 24 and 29. Client YY's flow sheets indicated client YY was not repositioned and or toileted every 2 hours. Client YY's record indicated no protocols, risk plans and/or plan of care in regard to client YY's	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 440 Seizures, positioning, skin integrity, toileting, constipation, sleep apnea and V/P shunts. Client YY's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client YY's health since December 2012. Client YY's Monthly Nursing Summary for December 2012 was conducted and signed by an LPN. Client YY's record indicated no oversight by an RN in regard to client YY's monthly/quarterly health assessments and needs. 14. Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's 8/30/13 quarterly physician's orders indicated client AAA had diagnoses of, but not limited to, Constipation, Seizure Disorder, Louis Bar Syndrome (a rare, neurodegenerative disease that causes severe disability), Severe Spastic Quadriparesis, Peg G-tube, Mild COPD (Chronic Obstructive Pulmonary Disease causing severe breathing problems), Scoliosis, Mild Erosive Esophagitis, Incontinence of the bowel and bladder, Gastroparesis (a delayed gastric emptying), Kidney Stones, Excessive Drooling, Depression, GERD and Osteoporosis. Client AAA's October 2013 flow sheets were reviewed. The flow sheets indicated: __No documentation for the AM shift for October 1, 5, 6, 7, 8, 9, 12, 13, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31. __No documentation for the PM shift for October 3, 9, 11, 21, 22, 23, 24 and 29. Client AAA's flow sheets indicated client AAA was not repositioned and or toileted every 2 hours. Client AAA's record indicated a 2/8/13 Falls Risk	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 441 Plan and a 1/4/13 G-Tube Risk Plan. Client AAA's record indicated client AAA was non ambulatory and dependent upon staff for ambulation and toileting. Client AAA's record indicated no protocols, risk plan and or plan of care in regard to client AAA's positioning needs, skin integrity, toileting, seizures and respiratory needs. Client AAA's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client AAA's health since June 2012. Client AAA's Monthly Nursing Summary for October 2012 was not signed by the person that conducted the assessment nor reviewed by an RN. Client AAA's Monthly Nursing Summaries for November, December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client PP's record indicated no oversight by an RN in regard to client PP's monthly/quarterly health assessments and needs. 15. Client BBB's record was reviewed on 10/22/13 at 3 PM. Client BBB was admitted to the facility on 4/2/13. Client BBB's record indicated a diagnosis of, but not limited to, Seizure Disorder, Chronic Right Otitis Media, Anemia, Tourette syndrome , Amenorrhea, GERD, Stereotyped movements, Sclerotic Mastoid Cells, Hearing loss, Anxiety Disorder, Intramedullary Rod in right humerus with stabilizing screw within the rod proximally. Client BBB ' s 8/30/13 physician ' s orders indicated client BBB was to elevate both legs and feet for 30 minutes every two hours due to poor circulation. Client BBBs' record indicated no monthly/quarterly nursing summaries since client BBB's admission to the facility in 4/2/13. Client BBB's October 2013 flow sheets were	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 442 reviewed. The flow sheets indicated: __No documentation for the AM shift for October 6, 16, 22, 24, 25, 26, 27, 28, 30 and 31. __No documentation for the PM shift for October 9, 11, 21, 22, 23 and 24. Client BBB's flow sheets indicated client BBB was not repositioned and or toileted every 2 hours. Client BBB's record indicated a 2/8/13 Falls Risk Plan and a 1/4/13 G-Tube Risk Plan. Client BBB's record indicated client BBB has a fractured right arm. Client BBB's record indicated no protocols, risk plan and or plan of care in regard to client BBB's toileting, seizures, respiratory needs, circulatory issues and fractured arm. Interview with staff #57 on 10/21/13 at 4 PM indicated he was not aware of all of client I ' s, F ' s, M ' s, FF ' s, JJ ' s, PP ' s, YY ' s, AAA ' s and BBB ' s medical needs and depended on the program book for information. Staff #57 stated, " We call the nurse if we think there is something wrong with one of them. " Staff #57 indicated some of the clients did have risk plans in their books, but not many. Interview with staff #35 on 10/24/13 at 10:10 AM indicated she had been at the facility for 2 months and was still learning all of the clients ' needs. Staff #35 stated program books are kept in every room and a few of them had health/risk plans, " But not many. " Staff #35 indicated she called the nurse or asked one of the other direct care staff if she thought one of the clients were not acting like them self. Staff #35 stated the clients were toileted in the morning, the afternoon, the evening and " I think before they go to bed. " Staff #35 stated the clients ' positioning was to be documented on the flow sheets, " But it doesn ' t	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 443 always get done or it gets filled in at the end of the day. " Interview with LPN (Licensed Practical Nurse) #2 on 10/24/13 at 1 PM indicated only the nurses used the VNS. If a client were to need it, the staff were to page nursing over the intercom and say the initials of the client and seizure. LPN #2 indicated there was a VNS in the medication carts and in the nursing office. Interview with the DON on 10/24/13 at 3:35 PM indicated client F did not have a plan of care and/or protocols in place in regard to decreased circulation and Raynauds disease, aspiration, skin integrity, positioning and/or toileting. The DON indicated the use of the VNS should have been added to client F's risk plan for seizures. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated the staff documented the client ' s position and if the clients were wet or dry on flow sheets. The QIDP indicated all clients should be toileted every two hours during the day and for those clients that were non ambulatory; their position was to be changed every 2 hours. The QIDP indicated no specific positioning plans and/or toileting schedules for clients I, F, M, FF, PP, YY, AAA and BBB. Interview with the DON (Director of Nursing) on 10/25/13 at 11 AM stated she had been with the facility for 4 months and "I'm trying to catch the nursing assessments up." The DON indicated it was facility practice for the clients to be assessed by a nurse once a month. The DON stated the previous DON had quit and the ADON (Assistant Director of Nursing, an LPN - Licensed Practical	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 444 Nurse) had done some, but many of the clients had not had nursing assessments conducted "for months." The DON indicated nursing services had not implemented nursing protocols and plans of care. The DON indicated some of the clients had "a few" risk plans in place. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/29/13 at 4 PM indicated the staff were to document the clients' positioning and toileting on the daily flow sheets by using the key at the top of the form. The QIDP indicated the flow sheets were then collected at the end of the month and reviewed. The QIDP indicated these forms were to be completed by the direct care staff during the shift. 16. During observations on 10/21/13 from 4:40 PM until 6:05 PM, client AA had 5 one quarter inch scabbed areas on his left elbow, a bump below his left elbow 1 and 1/2 inches in diameter, and 1/8 inch scabs on the top of his right index finger knuckle and knuckle of his right little finger. Client AA's record was reviewed on 10/22/13 at 12:15 PM. There was no evidence in the nursing notes of a scabbed area on client AA's right finger. A nursing note dated 10/8/13 indicated "client has band aid on L (left) index finger knuckle. Under band aid is 1.5 cm (centimeter) superficial opening in skin. Left open to air and cleaning with soap and water." There was no indication of the cause of client AA's skin opening. A Medical Treatment Follow-Up Form dated 10/7/13 indicated at 12 noon client #7 had fallen while ambulating to the dining room and no injuries were noted. The same form dated 10/7/13 in a section below the area where no injuries were noted indicated there was a 1.5 cm laceration to client AA's left index knuckle. There	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 331	Continued From page 445 was no indication on the form as to time of day when the laceration was noted or its cause. Additional entries on the form dated 10/8/13 and 10/9/13 indicated there were no areas of concern noted. There was no additional documentation on the form to indicate the status or cause of client AA's injury to his left index finger. A Medical Treatment Follow-Up Form dated 10/19/13 indicated a flesh colored edematous (swollen) area of his left elbow. The form indicated client AA's doctor had been notified on 10/16/13 and a note dated 10/21/13 indicated the swollen area on client AA's left elbow had been "resolved." There was no evidence in client AA's record to indicate the cause of client AA's swollen elbow or of the scabbed areas on his right and left index fingers, and on his elbow. The DON (Director of Nursing) was interviewed on 10/22/13 at 4:45 PM. She indicated nursing staff should be documenting and monitoring open skin areas. She indicated she had witnessed client AA have a behavioral incident on 10/21/13 at lunchtime with self injurious behavior and client AA had injured his left ear. She indicated the nurse on duty should have documented the injuries. She indicated client AA often has self injurious behavior of biting his hands, but nursing staff should be documenting and monitoring skin breaks. She indicated client AA's physician had been contacted about client AA's bump on his elbow, but the physician did not express concern and it was unknown as to cause. The Program Director (PD) was interviewed on 10/22/13 at 5:26 PM. She stated staff should document self injurious behavior on "behavior cards." The PD reviewed behavior cards for the month of September 2013 and October 2013, but	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 446 did not find any documentation of self injurious behavior for client AA. She indicated she was unaware of any injuries to client AA. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Client AA had a red open abrasion 1.5 cm by 2 cm along the top of his left elbow. Staff #42 was interviewed on 10/23/13 at 10:35 AM. He is uncertain of the origin of client AA's abrasion. 17. Client UU's records were reviewed on 10/24/13 at 4:00 PM. The note indicated at 8:00 AM. A nursing note for 10/16/13 indicated a 1 cm (centimeter) to 1/1/2 cm areas. Red. Slightly raised to outer margins. Dry flaky skin to the center (above L (left) knee. Low inner Rt (right) calf, Rt. calf. N.O (new orders) per [Dr.] clotrimazole (anti-fungal) cream apply topically to affected area BID (twice daily) x (for) 2 weeks." Another nursing note dated 10/16/13 at 11:50 AM indicated client UU was diagnosed with tinea corporis (ringworm) and continue treatment with prescribed lotrimine (anti-fungal). There was no evidence of a nursing protocol to instruct staff what to do to address client UU's ringworm. The ADON (Assistant Director of Nurses) was interviewed on on 10/23/13 at 2:20 PM and indicated there should be an ongoing skin assessment to document client UU's ringworm. The ADON indicated client UU's ringworm was no longer contagious, and when asked if it should be documented as to response to treatment, she stated, "Yes." 18. The facility's reports to the Bureau of Developmental Disabilities Services from 5/13-6/13 were reviewed on 10/21/13 at 2:20 PM	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 331	Continued From page 447 and included the following: -A BDDS report dated 6/3/13 indicated client NN had been taken to the hospital and diagnosed with renal failure after exhibiting altered mental status. -A BDDS report dated 6/6/13 indicated client Y had been taken to the hospital and admitted for bowel obstruction and appendectomy. -A BDDS report dated 6/12/13 indicated client XX was taken to the hospital for sodium imbalance. -A BDDS report dated 6/17/13 indicated client WW had fallen during a seizure which resulted in a "knot" to the back of the head. -A BDDS report dated 6/20/13 indicated client NN had been taken to the hospital and placed on a G (gastric)-tube due to meal refusals. Client NN was diagnosed with MRSA (Methicillin-resistant Staphylococcus aureus) colonized nares while in the hospital. -A BDDS report dated 5/2/13 indicated client NN had been taken to the hospital for low oxygen levels. Client NN was diagnosed with aspiration pneumonia. -A BDDS report dated 5/27/13 indicated client WW had fallen during a seizure causing a bump to her left temple. The DON (Director of Nurses) was interviewed on 10/22/13 at 3:10 PM and indicated there were no client specific protocols to instruct staff what to do to address their health care needs. The DON stated, "It's informal," and indicated staff are	W 331		

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W 331	Continued From page 448 trained every 2 months on general signs/symptoms of illness. 19. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record indicated she was 17 years old. She was 55 1/4 inches tall and currently weighed 84.2 pounds. Client A's Physician's Orders (PO) dated 8/30/13 indicated she had a G-Tube. Client A's record indicated she had a history of failure to thrive. A review of client A's Nutrition Assessments indicated "5/9/13 current weight (5/8/13) 82.5 (14 pound loss in past 6 months). D/C (discontinue) < 50% order (less then 50 % eaten at meals). Start bolus 1 can Nutren 2.0 (dietary supplement/via G-tube) post L/D (lunch and dinner) meals regardless of intakes. 6/20/13 weight 81.4. Client continues with < 50% L/D bolus. Past 7 days need of bolus was 10 times. Received 7 times in past week. Due to ongoing progressive wt (weight) loss Re-Rec (re-recommend) D/C < 50% bolus start bolus regardless of intake at all meals. 7/24/13 weight 75.4 Rec (recommend) again to D/C < 50% bolus (post) meals regardless of intakes. 8/8/13 Wt. has declined in past year but has stabilized in past 90 days. Continue boluses 4 A.M. and HS (hour of sleep) for nite (sic) support. Wt. stable x 30 days with 4 A.M. and HS boluses. Bolused 80 times in past 88 possible meals...." Client A's PO dated 8/30/13 indicated "11/05/2009 Nutren 2.0 Bolus 1 can per G-Tube at 4 A.M. for nutritional support. 11/06/2008 Nutren 2.0 1 can Bolus if eats less than 50% at lunch and dinner for nutritional support." There was no documentation indicating the repeated recommendations of the Registered Dietician had been followed, addressed by the nursing staff or brought to the attention of client A's Primary Care Physician until client A had lost 21 pounds in 9-10 months (more then 20% of her total body weight).	W 331		

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	15G580		C 11/06/2013

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W 331	Continued From page 449 There was no documentation available for review indicating client A's weight loss had been addressed by her physician. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's PO dated 8/30/13 indicated she had a diagnosis of aspiration and required aspiration precautions. Client A's record did not include individualized client specific aspiration precautions. An interview was conducted with the Registered Dietician (RD) and the Assistant Administrator (AA)/LPN on 10/30/13 at 4:50 P.M. The AA/LPN stated, "The doctor stated he did not want to start a bolus post every meal, because she (client A) was adjusting to medication changes and she (client A) likes to get a bolus and didn't want to encourage her behavior of wanting a bolus." The RD indicated she can make recommendations, but the doctor chooses if they are to be followed.	W 331		
W 336	3.1-17(a) 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interview, for 9 of 10 sampled clients (A, B, C, D, E, F, G, I, and J) and 10 additional clients (M, F, I, AA, GG, JJ, PP, YY, AAA and BBB), the facility's nursing services failed to conduct quarterly nursing assessments	W 336		

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W 336	Continued From page 450 of clients' health status and medical needs and to ensure an RN (Registered Nurse) monitored the clients that were assessed by the LPN (Licensed Practical Nurse). Findings include: 1. Client GG's record was reviewed on 10/24/13 at 10:05 A.M. The review failed to indicate client GG's health status had been reviewed quarterly during the 10/24/13 to 10/24/12 review period. Nurse #7 was interviewed on 10/29/13 at 10:10 A.M.. Nurse #7 indicated client GG did not have any quarterly nursing assessments available for review. 2. Client C's record was reviewed on 10/24/13 at 9:50am. Client C's record indicated "Nursing Quarterly" and "Nursing Monthly" assessments completed on 10/1/13, 3/28/13, 12/31/12, and 11/30/12. No nursing assessments were completed for the period from 3/28/13 until 10/1/13. Client C's 3/28/13 was the single document which was signed by the Registered Nurse (RN). Client D's record was reviewed on 10/23/13 at 9:15am. Client D's record indicated "Nursing Quarterly" and "Nursing Monthly" assessments completed on 10/1/13, 5/28/13, 12/31/12, and 11/13/12 signed by the Licensed Practical Nurse (LPN). No nursing assessments were signed by the RN and none were completed for the period from 12/31/12 until 5/28/13. Client E's record was reviewed on 10/24/13 at 11:35am. Client E's record indicated "Nursing Quarterly" and "Nursing Monthly" assessments	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 451 completed on 1/10/13, 12/17/12, and 11/15/12 signed by the LPN. No nursing assessments were signed by the RN and none were completed for the period from 1/10/12 through present 10/24/13. On 10/29/13 at 12:00 noon, an interview with the ADON (Assistant Director of Nursing) was conducted. The ADON indicated no additional nursing quarterly or nursing monthly assessments for clients C, D, and E were available for review. The ADON stated clients C, D, and E's monthly and quarterly nursing assessments were behind and the assessments "we were never caught up." 3. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's record indicated the client was not in need of a medical care plan from a physician. Client F's 8/30/13 quarterly physician's orders indicated client F had diagnoses of, but not limited to, Profound MR (Mental Retardation), Down's Syndrome, Seizure Disorder, Osteoporosis (brittle bones), Constipation, Valgus Feet Bilaterally (club feet), Levoscoliosis of the Thoracolumbar Spine (curvature of the spine), Hyperopia (vision problems), GERD (Gastroesophageal Reflux Disease), Incontinence of bowel and bladder, Paraparesis (partial paralysis of the lower limbs), Geographic tongue (an inflammatory condition of the mucous membrane of the tongue), Edentulous (no teeth), SIB (Self Injurious Behaviors), DJD (Degenerative Joint Disease) of the left hand, Benign Lipomas of the right foot/ankle, Reflux requiring aspiration precautions, Moderate to severe oral pharyngeal dysphasia with aspiration of thin liquids, HTN (hypertension), Raynauds Disease (a rare disorder of the blood vessels, usually in the fingers and toes causing the blood vessels to narrow and the extremities to get cold)	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 452 and Non-verbal. Client F's record indicated monthly nursing summaries for October, November, December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client F's record indicated no oversight or assessments by an RN in regard to client F's monthly/quarterly health assessments and needs. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's record indicated the client was not in need of a medical care plan from a physician. Client I's 8/30/13 quarterly physician's orders indicated client I had diagnoses of, but not limited to, Profound MR, CP (Cerebral Palsy), Constipation, non-verbal, Dwarfism (small stature), Microcephaly (abnormally small head), Diabetes Mellitus Type 1, Menorrhagia (an abnormally heavy and prolonged menstrual period) Renal Insufficiency (poorly functioning kidneys), Myopia (near sighted), Hypercholesterolemia (high cholesterol levels in the blood), Edentulous, Osteoporosis, Mild diffuse encephalopathy (disorder of the brain), Seizure Disorder, Rhinitis (allergies), Hyperlipidemia (a high concentration of fat in the blood), Pedal (foot) Edema, Hypothryroidism and Mild Gastritis. Client I's record indicated monthly nursing summaries for October, November, December 2012, January, February, March, April, May, June, July and August 2013 were conducted and signed by an LPN. Client I's record indicated no oversight or assessments by an RN in regard to client I's monthly/quarterly health assessments and needs. Client M's record was reviewed on 10/24/13 at 1 PM. Client M's record indicated the client was not in need of a medical care plan from a physician.	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 453 Client M's 8/30/13 quarterly physician's orders indicated client M had diagnoses of, but not limited to, Profound MR, Constipation, Seizure Disorder, CP, Severe Spastic Quadriparesis (not able to walk), Dysphagia (difficulty swallowing), Myopia, history of chronic UTIs (urinary tract infections), Osteoarthritis, Osteoporosis, Incontinence of bowel and bladder, Renal Stones, GERD, Arthritis, Diabetes Mellitus, Right Upper Lung Lobe Atelectasis (collapsed portion of the lung), Mild Gastritis, Hyperlipidemia, a G-tube (gastrostomy tube) and Abdominal Hernia. Client M's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client M's health since June 2013. Client M's Monthly Nursing Summaries for December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client M's record indicated no oversight by an RN in regard to client M's monthly/quarterly health assessments and needs. Client AA's record was reviewed on 10/25/13 at 11 AM. Client AA's record indicated the client was not in need of a medical care plan from a physician. Client AA's 8/30/13 quarterly physician's orders indicated client AA had diagnoses of, but not limited to, Profound MR, Autism, CP, Microcephaly, Incontinence of bowel and bladder, Seizure Disorder, Scoliosis (curvature of the spine), Risk of Aspiration, Low Lung Volume, Constipation, Reflux, Chronic Back Pain with Spasms. Client AA's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client AA's health since February 2013. Client AA's Monthly Nursing Summaries for October, November, December 2012, January and February 2013 were conducted and signed by an LPN. Client	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 454 AA's record indicated no oversight by an RN in regard to client AA's monthly/quarterly health assessments and needs. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's record indicated the client was not in need of a medical care plan from a physician. Client JJ's 8/30/13 quarterly physician's orders indicated client JJ had diagnoses of, but not limited to, Profound MR, CP, Hypothryroidism (abnormally low activity of the thyroid gland), Autism, ADHD (Attention Deficit Hyperactivity Disorder), Myopia, Reflux with Erosive Esophagitis, Constipation, Osteoporosis, Kyphosis (hunchback), Generalized Brain Atrophy (getting smaller), Spastic Quadriplegic (spasticity of the limbs) Encephalopathy, Seizure Disorder, Rumination (similar to a record that is stuck and keeps repeating), excessive drooling, anxiety and Acne. Client JJ's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client JJ's health since June 2013. Client JJ's Monthly Nursing Summaries for December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client JJ's record indicated no oversight by an RN in regard to client JJ's monthly/quarterly health assessments and needs. Client PP's record was reviewed on 10/24/13 at 3 PM. Client PP's record indicated the client was not in need of a medical care plan from a physician. Client PP's 8/30/13 quarterly physician's orders indicated client PP had diagnoses of, but not limited to, Profound MR, Failure to thrive, Microcephaly, Seizure Disorder, Delayed Gastric Emptying, Reflux Disease, Constipation, CP, Autism, Encephalpathy (a	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 455 disorder of the brain), Aphasia (unable to speak), Hypotonia (low muscle tone), Chronic right hip dislocation and left hip lateral subluxation (a partial dislocation), Anxiety and a Sliding Hiatal Hernia. Client PP's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client PP's health since December 2012. Client PP's Monthly Nursing Summaries for October, November and December 2012 were conducted and signed by an LPN. Client PP's record indicated no oversight by an RN in regard to client PP's monthly/quarterly health assessments and needs. Client YYs record was reviewed on 10/24/13 at 3:30 PM. Client YY's record indicated the client was not in need of a medical care plan from a physician. Client YY's 8/30/13 quarterly physician's orders indicated client YY had diagnoses of, but not limited to, Profound MR, Constipation, Seizure Disorder, CP, Ventriculoperitioneal Shunt (to treat excess cerebrospinal fluid in the brain), Cardiomegaly (an abnormal enlargement of the heart), Myopia, Severe Obstructive Sleep Apnea, Microcephaly, Erosive Esophagitis (inflammation of the esophagus), Scoliosis, Folate Deficiency Anemia, Incontinence of bowel and bladder, Hypoxemia (a deficiency in the concentration of dissolved oxygen in arterial blood), Slight hearing loss, Degenerative Osteoarthritis, History of aspirations, Spastic Quardriparesis (inability to walk), Bilateral renal calculi (stones) with stints in bilateral ureters, Enlarged right ovary with a 4 centimeter cyst, Gall Stones and G-Tube. Client YY's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client YY's health since December 2012. Client YY's Monthly Nursing	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 456 Summary for December 2012 was conducted and signed by an LPN. Client YY's record indicated no oversight by an RN in regard to client YY's monthly/quarterly health assessments and needs. Client AAA's record was reviewed on 10/24/13 at 4 PM. Client AAA's record indicated the client was not in need of a medical care plan from a physician. Client AAA's 8/30/13 quarterly physician's orders indicated client AAA had diagnoses of, but not limited to, Severe MR, Constipation, Seizure Disorder, Louis Bar Syndrome (a rare, neurodegenerative disease that causes severe disability), Severe Spastic Quadriparesis, Peg G-tube, Mild COPD (Chronic Obstructive Pulmonary Disease causing severe breathing problems), Scoliosis, Mild Erosive Esophagitis, Incontinence of the bowel and bladder, hyperprolactinemia Gynecomastia (excess prolactin in the blood causing benign enlargement of breast tissue in males), Gastroparesis (a delayed gastric emptying), Exotropia (the eyes turn outward), Kidney Stones, Excessive Drooling, Depression, GERD and Osteoporosis. Client AAA's record indicated no nursing quarterlies and/or monthly assessments had been completed in regard to client AAA's health since June 2012. Client AAA's Monthly Nursing Summary for October 2012 was not signed by the person that conducted the assessment nor reviewed by an RN. Client AAA's Monthly Nursing Summaries for November, December 2012, January, February, March, April, May and June 2013 were conducted and signed by an LPN. Client PP's record indicated no oversight by an RN in regard to client PP's monthly/quarterly health assessments and needs. Client BBB's record was reviewed on 10/22/13 at	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 457 3 PM. Client BBB was admitted to the facility on 4/2/13. Client BBB's record indicated a diagnosis of, but not limited to, Profound MR, Speech Disturbance, Seizure Disorder, Psychosis, Rumination Disorder, OCD, Chronic Right Otitis Media, Anemia, Tourette's, Amenorrhea, GERD, Hiruitism, Sterotyped movements, Scleretic Mastoid Cells, Hearing loss, Anxiety Disorder, Intramedullary Rod in right humerus with stabilizing screw within the rod proximally. Client BBB's record indicated no monthly/quarterly nursing summaries since client BBB's admission to the facility in 4/2/13. Interview with the DON (Director of Nursing) on 10/25/13 at 11 AM stated she had been with the facility for 4 months and "I'm trying to catch the nursing assessments up." The DON indicated it was facility practice for the clients to be assessed by a nurse once a month. The DON stated the previous DON had quit and the ADON (Assistant Director of Nursing, an LPN - Licensed Practical Nurse) had done some, but many of the clients had not had nursing assessments conducted "for months. 4. Client A's record was reviewed on 10/23/13 at 2:42 P.M. Client A's record included the following monthly nursing assessments: 7/1/2013-7/31/13 completed by LPN #5, 6/1/2013-6/30/13 completed by LPN #5, 5/1/2013- 5/31/13 completed by LPN #5, 4/1/2013-4/30/13 completed by LPN #5, 3/1/2013-3/31/13 completed by LPN #5, 2/1/2013-2/28/13 completed by LPN #5, and 1/1/2013-1/31/13 completed by LPN #5. Client A's record indicated an RN had not completed or reviewed her nursing assessments since 12/2012. Client B's record was reviewed on 10/29/13 at	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 458 2:06 P.M. Client B's record included the following monthly nursing assessments: 7/1/2013-7/31/13 completed by LPN #5, 6/1/2013-6/30/13 completed by LPN #5, 5/1/2013- 5/31/13 completed by LPN #5, 4/1/2013-4/30/13 completed by LPN #5, 3/1/2013-3/30/13 (sic) completed by LPN #5, 2/1/2013-2/28/13 completed by LPN #5, and 1/1/2013-1/31/13 completed by LPN #5. Client B's record indicated an RN had not completed or reviewed his nursing assessments since 12/2012. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included the following monthly nursing assessments: 7/1/2013-7/31/13 completed by LPN #6 Client H's record was reviewed on 10/28/13 at 4:00 P.M. Client H's record included the following monthly nursing assessments: 7/1/2013-7/31/13 completed by LPN #6, 6/1/2013-6/30/13 completed by LPN #5, 5/1/2013- 5/31/13 completed by LPN #5, 4/1/2013-4/30/13 completed by LPN #5, 3/1/2013-3/31/13 completed by LPN #5, 2/1/2013-2/28/13 completed by LPN #5, 1/1/2013-1/31/13 completed by LPN #5, and 10/1/2012-10/31/12 completed by LPN #6. Client H's record indicated an RN had completed an assessment for client H the month of 11/1/30/2012. There were no other monthly nursing assessments completed or reviewed for client H by an RN during the past year. Client J's record was reviewed on 10/24/13 at 1:20 P.M. Client J's record included the following monthly nursing assessments: 6/1/2013-6/30/13 completed by LPN #5, 5/1/2013- 5/31/13 completed by LPN #5, 4/1/2013-4/30/13	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 336	Continued From page 459 completed by LPN #5, 3/1/2013-3/31/13 completed by LPN #5 and 10/1/2012-10/31/12 completed by LPN #7. Client J's record indicated an RN had completed an assessment for client H the months of 11/1/2012-11/30/2012, 12/1/2012-12/31/2012, 1/1/2013-1/31/2013 and 2/1/2013-2/28/2013. 3.1-31(d)(3) 3.1-31(d)(3)(h)	W 336		
W 340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, record review, and interview for 4 of 10 sampled clients (B, C, D and J), and 19 additional clients (K, L, T, S, V, Y, AA, CC, HH, II, KK, LL, QQ, RR, UU, YY, VV, WW, and DDD), the facility nursing services failed to ensure staff implemented training to follow Universal Precautions and promote hand washing to prevent the spread of infection and failed to provide training on transfers. Findings include: 1. Observations were conducted at the facility in program group #1 for clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW on 10/21/13 from 1:00 PM until 5:50 PM, and on 10/22/13 from 5:45am until 8:42 AM. During these observation periods:	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 340	Continued From page 460 -Client C sat in her recliner without reclining, sat in her wheelchair, and was picked up by the facility staff #17 in a one person lift to transfer her from the recliner to her wheelchair and back to her recliner chair. -Client D sat in her wheelchair, sat in recliner, and was picked up by the facility staff #31 and #17 two separate times in each in a one person lift, and placed in her wheelchair by the staff to go to the dining room for their evening meal and to go to the dining room for her breakfast meal. -Clients C and D could not get up from their recliners or wheelchairs without staff assistance. During these observation periods clients C and D were not observed to reposition themselves without staff assistance. Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 8/30/13 quarterly physician's orders indicated client C had diagnoses of, but not limited to, Osteoporosis (brittle bones), Seizure Disorder, Kyphosis & Scoliosis (Curving of the Spine), Contractures, Pedal Edema (Swelling of the legs/feet), Major Scoliosis Predominately in the upper Lumbar Lower Thoracic Spine measuring 36 degrees with rotation, and Arthritis. Client C's 3/28/13 ISP indicated client C used a wheelchair for ambulation and was dependent on a wheel chair for all transportation. Client C's 3/28/13 "Annual Nursing Assessment" did not indicate client C's current PT/OT evaluations. Client C's record indicated a 3/28/13 "Adaptive Skills Assessment" completed by the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) which indicated "Ambulation Assistive Devices. [Client C] has a personal, adaptive, manual wheelchair. [Client C] does not gainfully propel her own wheelchair and requires maximum assistance	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 340	Continued From page 461 from staff for movement. Her bilateral upper extremities are limited in should flexion and abduction...She is unable to sit unsupported and no longer possesses the ability to perform standing transfers." Client C's record indicated she was a two person transfer. Client D's record was reviewed on 10/23/13 at 9:45 AM. Client D's 8/30/13 quarterly physician's orders indicated client D had diagnoses of, but not limited to, Osteoporosis, Cerebral Palsy, Club Feet, Visually Impaired due to Retinopathy of Prematurity (blind), spastic Quadriplegia, Neuromuscular Scoliosis, Lumbar Spinal Fusion, Incontinence of Bowel and Bladder, Aspiration Precautions, and G Tube Placement. Client D's 5/28/13 ISP indicated client D was ambulatory. Client D's 5/28/13 "Annual Nursing Assessment" indicated client D was non ambulatory, non weight bearing, and used an "Adaptive wheelchair for transport." Client D's record did not indicate she was a two person transfer. On 10/23/13 at 2:40pm, a review of clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW's Program Group #1 information book did not indicate how staff were to assist to transfer clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW. Interview with the D.O.N. (Director of Nursing) conducted on 10/25/13 at 10:15am, indicated the facility staff were to have a minimum of two (2) facility staff to transfer clients C, D, K, T, CC, HH, KK, LL, QQ, RR, and WW from their recliners to their wheel chairs and from their wheelchairs back to their recliners. Interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) on	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 340	Continued From page 462 10/25/13 at 2:40 PM was conducted. The QIDP/PD stated the facility staff were to use a two (2) person transfer for "all clients" and a three person lift to transfer client E. The QIDP/PD stated "no" client in the facility should be a one person lift to transfer the client safely. 2. During observations at the facility on 10/21/13 at 4:30 PM staff #44 and staff #57 lifted client FF from the recliner and placed him in a wheel chair. Staff #57 took client FF to the bathroom. Staff #57 and #44 lifted client FF out of the wheelchair and put him on the changing table. Staff #57 changed client FF and then lifted client FF by himself and put client FF back into his wheelchair. At 10/22/10 at 4:35 PM at the facility in activity room group two, staff #35 performed a one person lift and picked client FF up from his recliner and placed client FF in the wheelchair. Staff #35 indicated client FF was not a one person lift and there was no one else to help him at the time. Staff #35 indicated he had lifted client FF by himself several times. Staff #35 indicated the staff that were comfortable doing one person lifts would do them. Staff #35 stated, "I think if they weigh 90 pounds or less we can lift them." When asked if client FF was 90 pounds or less, staff #35 stated, "No, I don't know." Client FF's record was reviewed on 10/24/13 at 1:30 PM. Client FF's IHP (Individual Habilitation Plan) of 1/15/13 indicated client FF was a 2 person lift. Review of the undated Nursing Policy and Procedures "Transfer Activities" on 10/22/13 at 1 PM indicated "All evaluations shall be mindful of current guidelines recognizing that any client weighing over 99 pounds to be considered a two	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 340	Continued From page 463 person transfer candidate. Those clients who have been identified through assessment or through physician's orders to require use of a sling for assisted transfers will be identified on their physician's orders and reflected on the DST (Developmental Skills Technician) treatment sheets. Professional Therapy recommendations in concurrence with staff evaluation may further determine that an individual resident may be best served as a single person transfer.... All clients will be assessed upon admission, annually and quarterly by Occupational and Physical Therapy Professionals to determine the most effective method to safely and efficiently transfer clients. The assessments shall be submitted to the Interdisciplinary Team to be further integrated into each resident's Individual Program Plan. These recommendations shall indicate the methods in which a resident is to be transferred, the number of staff that may be required to perform the desired transfers and any additional instructions that may apply to an individual client." Interview with staff #28 on 10/23/13 at 11:20 AM indicated she did one person lifts on client PP because he was little. Staff #28 indicated everyone else was or should be a 2 person lift. Interview with the DON (Director of Nurses) on 10/22/13 at 5:30 PM stated she did not approve of the one man lifts being done and "I would not do a one man lift myself and I sure wouldn't ask the staff to do it either but I'm told that is the way it's done here." The DON indicated if staff were conducting 1 person lifts on clients that were not assessed to be a 1 person lift, then the staff would need to be retrained on the facility policy in regard to one, two and three person lifts.	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 340	Continued From page 464 Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/22/13 at 4 PM indicated client X's, PP's and RR's IHPs (Individual Habilitation Plans) included the use of one man lifts. 3. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J's helmet strap was not sanitized after the helmet was removed from his head in the dining room. Client J rubbed his eye with his left middle finger which was reddened around the nail bed. Client J put his helmet strap back in his mouth after his helmet was placed back on his head, and left the dining room without washing his hands. Staff #57 was interviewed on 10/21/13 at 5:32 PM. He indicated client J often chewed on his shirt in addition to his helmet strap and stated, "He got it from staff," and indicated one of the staff assigned to client J's program room also chewed on his shirt. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth the size of a quarter on the floor. The surveyor pointed out the saliva on the floor to staff and it was then cleaned with a mop bucket. Client UU then continued to walk around the room with saliva dripping from his hands and was not prompted to wash his hands. Client Client G knocked a basket of toys on the floor and books and a bean bag were on the floor. Client BB kicked the toys and books on the floor as she walked around. Client Y lay on the floor in the recreation room. The program materials were not	W 340		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 340	Continued From page 465 sanitized and client Y was not prompted to wash his hands. During observations on 10/22/13 from 11:28 AM until 11:35 AM, client J had the strap of his helmet in his mouth, client UU had his hand in his mouth, and client Y lay on the floor. Client J's helmet strap was not cleaned, and clients UU and Y were not asked to wash their hands. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA had a scab at the L top of his knuckle on his index finger, and was lying on the bare tiled floor. Client J had 2 parallel red marks under his left arm 1 inch in length and crawled on the floor. Client VV had holes in his shirt. When staff #38 asked him if he chewed on it, client VV nodded his head "yes." Client UU had his hands in his mouth. There were smudges of opaque material on two windows in the room. Staff #80 cleaned the windows after the surveyor asked about the smudges. Client UU put a block in his mouth, and staff #65 stated, "[Client UU]. Don't put that in your mouth." The block was not cleaned it after client UU took it out of his mouth. Client UU's hands dripped saliva and he put his hand back in his mouth. No hand washing was observed. Staff #68 was asked about the block client UU put in his mouth, and staff #68 stated, "Oh [client UU]. You're a mess," and washed the block. Staff #80 was interviewed on 10/22/13 at 2:45 PM. He indicated the smudges on the window were from client H putting his hands on the window. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Client AA had a red	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 340	Continued From page 466 open abrasion 1.5 by 2 cm (centimeter) along the bottom of his elbow. Client DDD crawled on the floor from one chair to another chair. Client UU had 5 red marks on his face 1/8 of an inch or less. Client UU had a red mark on his right arm 1 inch in diameter. Client DDD crawled on the floor, and was redirected from sitting in the path of the doorway. Clients H, II and J lay on the floor during the observation. Client AA had a scabbed abrasions on his L index finger 1/8 inch and on his left thumb. Client AA put his hand in his mouth. In the dining room, client AA ate food that spilled onto a non-skid mat from his plate. Client J sat with his helmet strap in his mouth. Client UU, DD, H, II and J were not prompted to wash their hands. Staff #80 was interviewed on 10/23/13 at 10:50 AM and indicated client UU's marks were "acne." When asked if client UU had any other skin issues, he indicated client UU had ringworm and it was being treated by the nursing staff. During the observation, client UU walked around the room with his hands in his mouth. Staff #35 was interviewed on 10/23/13 at 11:05 AM. He indicated client UU had ringworm and when asked if he knew the location of his ringworm, stated, "Yeah-on his head I think." He indicated prevention of ringworm included hand washing. Staff #494 was interviewed on 10/23/13 at 10:52 AM. When asked if client UU's ringworm was contagious, she stated, "Yes," and indicated the ringworm was located on client UU's lower legs. Interview with the DON (Director of Nurses) on 10/24/13 at 3:35 PM. The DON indicated client	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 340	Continued From page 467 DDD did not have a plan in place in regard to the cellulitis. The DON stated the staff "try to keep it covered but he won't leave anything on it." The DON stated client DDD was in the same activity group room as another client that currently had "ring worm" and another client that had skin issues. The DON stated, "This same room of clients recently had issues with MRSA (Methicillin-resistant Staphylococcus aureus) and we also tested those clients recently for scabies, but their tests came back negative." The ADON (Assistant Director of Nurses) was interviewed on 10/25/213 at 11:35 AM. She indicated client DDD's cellulitis had been treated with antibiotics and it was not cultured as to type of infection. She indicated client DDD's doctor had not indicated he was to keep the wound bandaged, but stated, "We did it anyway." She indicated client DDD had removed his bandage. On 10/25/13 at 6 PM, client DDD was observed sitting in a chair in group 6 activity room. Client DDD had a small red raised swollen area with a dark center on the outer aspect of his lower right arm above his wrist. No seeping was noted and area was not covered. The facility nurse was called to come to the room to look at client DDD's arm. RN #1 placed a Band-Aid over the area. RN #1 stated, "He won't keep it covered. We try, but he just pulls it off again. The area looks like it's ready to pop." During observations on 10/28/13 from 11:40 AM until 11:58 AM, client DDD had a raised area of skin with a small open area uncovered by a dressing. While in the dining room, client DDD had a urination accident. The chair client DDD was sitting in was pushed away from the table,	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 340	Continued From page 468 after he left the dining room but was not sanitized at 11:45 AM. The chair had cracks in the vinyl, exposing the padding underneath. Staff #495 was interviewed on 10/28/13 at 11:42 AM and stated, client DDD "keep ripping it off" when asked about bandaging client DDD's open area, and "I didn't realize he had it off." Staff #62 was interviewed on 10/28/13 at 11:55 AM, about the chair client DDD was sitting in sitting to one side of the dining room. She indicated the chair was available for use for any clients to sit in. The Dietary Manager was interviewed on 10/28/13 at 11:58 AM. She indicated staff should have notified her of the soiled chair and it would be sanitized and cracks repaired. On 10/28/13 at 12:55 PM client DDD was observed sitting in a chair in group 6 activity room. Client DDD was observed putting both of his hands down his pants. Client DDD's was wearing a long sleeve shirt. Staff #93 was asked to roll up client DDD's sleeve on his right arm. The area noted on client DDD's lower arm on 10/25/13 had burst. The area was now red and swollen with a dark center that had scabbed over. Staff #93 stated, "He picks at it all the time and won't leave a band aid on. He takes it off as soon as we put it on." Staff #93 called the nurse to come put another band aid over client DDD's area on his lower arm. 4. During observations in program room 5 on 10/29/13 from 12:45 PM to 12:55 PM, client L placed his hand down his pants, then placed the same hand in his mouth. Staff #45 prompted	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 340	Continued From page 469 client L to take his hands out his pants and his mouth, but did not prompt or assist client L to wash or sanitize his hands. There was a 6 inch in diameter pool of liquid on the floor in front of client L's chair. When the surveyor pointed out the spot on the floor, staff #45 called to have housekeeping clean the liquid up with a mop and bucket. Staff #45 was interviewed on 10/29/13 at 12:55 PM. When asked how often client L should wash his hands, she stated, "Every 30 minutes. I'll wash them now." The Program Manager was interviewed on 11/1/13 at 9:30 AM. She indicated client UU has a history of putting his hands in his mouth, saliva dripping on the floor and staff should be watching for saliva on the floor and washing clients' hands or items after they put them in their mouths or on the floor. She stated the facility's administrative staff conducted "random" audits of infection control practices. The Consultant DON was interviewed on 11/1/13 at 3:20 PM. When asked if there were infection control concerns regarding the clients in program room 6 who lay on the floor, she stated, "I'm at a loss as to how to answer that. If they want to be on the floor, are we going to ever keep them off the floor? We offer opportunities (to be off the floor)," and indicated clients hands should be washed or sanitized before putting their hands on other clients. She indicated client J's helmet strap did not need to be sanitized or washed since it was his personal property and indicated floors should be cleaned immediately when soiled. The facility's Infection Control Policy dated	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 340	Continued From page 470 10/14/08 was reviewed on 10/21/13 at 2:05 PM and indicated "Employees will be required to follow all precautions necessary to minimize the spread of infectious/communicable diseases. Nursing staff members, in coordination with the Administrative team, will be responsible for ensuring employee compliance...Safe Work Practices...Employees are required to follow safe work practices at all times to prevent exposure to and/or spread of infectious diseases. Specific guidelines for preventing the spread of disease are communicated during the initial employee orientation and include the following. Employees with adhere to the CDC guidelines for hand hygiene in health care settings..During cold and flu season frequent hand washing will be emphasized...The housekeeping employees will ensure that all areas of the facility are clean & appropriately disinfected...Staff Monitoring...Staff will monitor the residents on a day-to-day basis to identify possible symptoms of an infectious illness as early as possible. Staff will notify a member of the nursing staff whenever there is a reason to believe that a resident may have an infectious illness. the nurse will then be responsible for any follow-up, including control and reporting of the illness..." An attached Sanitation/Infection Control Guidelines indicated in the area of Programming items: "Each time an item is dropped or when on (sic) client has finished using that item, the staff will sanitize that item using an alcohol wipe before the item is used again...Adaptive Equipment: Adaptive equipment should also be cleaned anytime it becomes soiled using alcohol spray....Floors: Program room floors should be cleaned any time there is a spill or contamination (human waste, fluids, feces, blood, urine, emesis, etc.) (sic) the soiled area should be mopped using a clean mop head, water, containing	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

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W 340	Continued From page 471 appropriate chemical solution, and bucket... (Should any resident be observed placing hands in mouth and then placing them on the floor, tables, windows or any hard surfaces, the area should be immediately cleaned using alcohol-based wipe...."	W 340		
W 351	3.1-37(a) 483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete a dental exam within one month of admission to the facility for 1 of 3 clients admitted to the facility (client CCC). Findings include: Client CCC's record was reviewed on 10/24/13 at 8:15 A.M.. The review indicated the client was admitted to the facility on 6/17/13. Further review indicated client CCC's complete dental exam was completed on 9/6/13. The Director of Nursing was interviewed on 10/24/13 at 9:22 A.M.. When asked why client CCC, who was admitted to the facility on 6/17/13,	W 351		

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W 351	Continued From page 472 received her first complete dental exam on 9/6/13, the Director of Nursing stated, "It's difficult to get appointment with our dentist and that was the earliest we could get her in." This federal tag relates to complaint #IN00137846. 3.1-24(a)	W 351		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on record review and interview, for 3 of 10 sampled clients (clients C, D, and E), the facility failed to develop a training objective/goal to teach clients about their medications. Findings include: Client C's record was reviewed on 10/24/13 at 9:50 AM. Client C's 8/30/13 quarterly physician's orders indicated client C had diagnoses of, but not limited to, Osteoporosis (brittle bones), Seizure Disorder, Kyphosis & Scoliosis (Curving of the Spine), Contractures, Pedal Edema (Swelling of the legs/feet), Major Scoliosis Predominately in the upper Lumbar Lower Thoracic Spine measuring 36 degrees with rotation, Constipation, G Tube placement, and Arthritis. Client C's 8/30/13 "Physician's Orders"	W 371		

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W 371	Continued From page 473 indicated the use of the following medications: Docusate Sodium and Polyeth Glycol for constipation, Furosemide for Congestive Heart Failure and Pedal Edema, Levetiracetam Solution for Seizure Disorder, Meloxicam for Arthritis Pain, Montelukast for Bronchospasms, Potassium Chloride Solution for Potassium Replacement, Ranitidine Syrup for Reflux, Oxygen by nasal cannula at 2 liters, and Nutren Pulmonary at 58cc per hour for 12 hours per G Tube pump. Client C's 3/28/13 IHP (Individual Habilitation Plan) indicated objectives/goals to release her brief to staff given one verbal request and to hold unopened split gauge during G tube cleaning. Client D's record was reviewed on 10/23/13 at 9:15 AM. Client D's 5/28/13 IHP indicated objectives/goals to hold washcloth during medication administration. Client D's 8/30/13 quarterly physician's orders indicated client D had diagnoses of, but not limited to, Osteoporosis, Cerebral Palsy, Club Feet, Visually Impaired due to Retinopathy of Prematurity (blind), spastic Quadriplegia, Neuromuscular Scoliosis, Lumbar Spinal Fusion, Incontinence of Bowel and Bladder, Aspiration Precautions, Constipation, Seizure Disorder, Gastric Upset, and G Tube Placement. Client D's 8/30/13 "Physician's Orders" indicated client D was given the following routine medications of: Baclofen for Spasticity, Cymbalta for behaviors, Loratadine for Environmental Allergies, Meloxicam for Pain, Polyeth Glycol for Constipation, Ranitidine Syrup for Gastric Acid, Risperidone for Agitation, Topiramate for Seizure Disorder, Vimpat for Seizure Disorder, Diastat for Seizures lasting longer than 5 minutes, and Nutren 2.0 by G Tube at 55cc per hour for 12 hours.	W 371		

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W 371	Continued From page 474 Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP indicated objectives/goals to select own color of brief using eye gaze and did not indicate a medication goal/objective. An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated clients C, D, and E had medication goals. The QIDP/PD indicated clients C, D, and E's medication goal did not teach the clients about their medications.	W 371		
W 390	3.1-32(a) 483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, record review and interview for 20 of 20 medications found without labels and/or incomplete labels with no expiration dates for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no longer at the facility), the facility failed to ensure all medications not properly labeled with expiration dates and all expired medications were removed from the facility. Findings include:	W 390		

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W 390	Continued From page 475 On 10/25/13 at 11 AM while doing an inspection of the medication cart at the facility in the nursing office, a medium sized crate was sitting on the desk. Below the crate was a two drawer metal cabinet. The bottom drawer to the metal filing cabinet was opened. QMA #2 stated while picking up the crate of medication on the top of the desk, "Oh, this is outdated medications." QMA #2 looked in the bottom drawer and said "I have no idea where those came from" and "I think that might be staff's stuff." QMA #2 was asked, "What about the ones that have client names on them?" and the QMA stated, "Oh, I don't know about that" and walked out of the room with the crate of medications under her arm. After a few minutes QMA #2 came back into the nursing office and was asked what happens to the mediations that are discontinued or expired. The QMA stated, "Oh, I destroy them." When asked why the medications in the filing cabinet were not destroyed, the QMA stated, "If they are expired I should have destroyed them. I don't know why they weren't." The QMA indicated she was the only one that destroyed expired medications and/or medications that were discontinued. On 10/25/13 at 11 AM while doing an inspection of the medication cart in the nursing office, the following was found in a metal filing cabinet in the nursing office: __A zip lock baggy with 17 white pills and Zovirax (an antiviral drug) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 30 brown pills and Singulair (a medication used to treat Asthma) written in black marker on the outside of the baggy. No expiration date was found on the baggy.	W 390		

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W 390	Continued From page 476 __A zip lock baggy with over 200 white pills and Tylenol 325 written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 24 white pills and Dallergy (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A bottle of Midol Complete with 15 pills inside. __A zip lock baggy with 15 blue pills and Tylenol PM written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 4 small white pills and 3 larger light tan colored pills and Allegra (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 small yellow pills and "allergy" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 23 white pills and "400 mg (milligrams) Motrin 600 mg" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 pink pills and over 100 pink and white capsules and Benadryl (an antihistamine) written in black marker on the outside of the baggy. __A zip lock baggy with 12 brown and tan capsules and Loperamide written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A box of over the counter AZO Urinary Pain Relief. __A box of over the counter Mucinex 1200 mg tablets for decongestant. No expiration date was found on the box.	W 390		

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W 390	Continued From page 477 __A bottle of Maalox chewable tablets. No expiration date was found on the bottle Clients' medications mixed in with the bags of medications not dispensed from the pharmacy were: __A card of Loratadine (an antihistamine) pills for a client EEE who was no longer a client at the facility. No expiration date was found on the card. __A zip lock baggy with a pharmacy label of PRN (as needed) medication for client NN of Sudogest (a decongestant). There were 10 pills in the bag. The bag was labeled as being dispensed 8/31/12, but no expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was found on the baggy. __An Epipen (for an allergic reaction) for client V expired 12/2012. __A box of 2 Epipens for client that was no longer at the facility. The box indicated the medication expired 12/2012. __15 white pills were randomly laying at the bottom of the box, not in a baggy. All of the above mentioned medications, along with client II's and V's Epipens, client II's Loperamide and client NN's Sudogest and client EEE's Loratadine were mixed in with all of the bags of pills in various colors, sizes and shapes with no expiration dates, not in the original store packaging and/or with a pharmacy label with clients names and dosages.	W 390		

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W 390	Continued From page 478 During interview with the ADON (Assistant Director of Nursing) and the Nurse Consultant on 10/25/13 at 1 PM, the ADON indicated the medications in the filing cabinet in the nursing office were for the staff. The ADON stated, "The Tylenol was mine. I had a big bottle of it at home so I just dumped some in a baggy and brought it here for the staff." When asked if that was standard of practice to have medications lying around in a drawer, not in their original packaging, no pharmacy labels and no expiration dates, the ADON stated, "But those were for the staff." When asked what about the ones that were labeled for the clients, the ADON stated, "Those must have gotten mixed in there by mistake. They shouldn't have been in there. When is it wrong for staff to have medication here if they need it.?" The nurse consultant indicated all medications for the clients were to be packaged by the pharmacist and properly labeled. The nurse consultant indicated all outdated and discontinued medications should be disposed of immediately, the staff were not to keep/store medications at the facility and the staff were to keep all personal medications with their possessions while working and not intermingled with the clients' medications. The ADON indicated the facility did not have a policy in regard to staff keeping medications at the facility and/or for the destruction of outdated or discontinued client medications. 3.1-25(j) 3.1-25(o)	W 390		
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels.	W 391		

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W 391	Continued From page 479 This STANDARD is not met as evidenced by: Based on observation, record review and interview for 20 of 20 medications found without labels and/or incomplete labels with no expiration dates for 10 of 10 sample clients (A, B, C, D, E, F, G, H, I and J) and 46 additional clients (K, L, M, N, O, P, Q, R, S, T, U,V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD and EEE (a client that is no longer at the facility), the facility failed to ensure all medications in the facility were properly packaged and/or in the original containers with the label and/or were labeled by the facility pharmacy and included exploration dates. Findings include: On 10/25/13 at 11 AM while doing an inspection of the medication cart at the facility in the nursing office, a medium sized crate was sitting on the desk. Below the crate was a two drawer metal cabinet. The bottom drawer to the metal filing cabinet was opened. QMA #2 stated while picking up the crate of medication on the top of the desk, "Oh, this is outdated medications." QMA #2 looked in the bottom drawer and said "I have no idea where those came from" and "I think that might be staff's stuff." QMA #2 was asked, "What about the ones that have client names on them?" and the QMA stated, "Oh, I don't know about that" and walked out of the room with the crate of medications under her arm. After a few minutes QMA #2 came back into the nursing office and was asked what happens to the mediations that are discontinued or expired. The QMA stated, "Oh, I destroy them." When asked why the	W 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 391	Continued From page 480 medications in the filing cabinet were not destroyed, the QMA stated, "If they are expired I should have destroyed them. I don't know why they weren't." The QMA indicated she was the only one that destroyed expired medications and/or medications that were discontinued. On 10/25/13 at 11 AM while doing an inspection of the medication cart in the nursing office, the following was found in a metal filing cabinet in the nursing office: __A zip lock baggy with 17 white pills and Zovirax (an antiviral drug) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 30 brown pills and Singulair (a medication used to treat Asthma) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with over 200 white pills and Tylenol 325 written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 24 white pills and Dallergy (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A bottle of Midol Complete with 15 pills inside. __A zip lock baggy with 15 blue pills and Tylenol PM written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 4 small white pills and 3 larger light tan colored pills and Allegra (an antihistamine) written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 small yellow pills and	W 391		

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W 391	Continued From page 481 "allergy" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 23 white pills and "400 mg (milligrams) Motrin 600 mg" written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A zip lock baggy with 18 pink pills and over 100 pink and white capsules and Benadryl (an antihistamine) written in black marker on the outside of the baggy. __A zip lock baggy with 12 brown and tan capsules and Loperamide written in black marker on the outside of the baggy. No expiration date was found on the baggy. __A box of over the counter AZO Urinary Pain Relief. __A box of over the counter Mucinex 1200 mg tablets for decongestant. No expiration date was found on the box. __A bottle of Maalox chewable tablets. No expiration date was found on the bottle Clients' medications mixed in with the bags of medications not dispensed from the pharmacy were: __A card of Loratadine (an antihistamine) pills for a client EEE who was no longer a client at the facility. No expiration date was found on the card. __A zip lock baggy with a pharmacy label of PRN (as needed) medication for client NN of Sudogest (a decongestant). There were 10 pills in the bag. The bag was labeled as being dispensed 8/31/12, but no expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was noted. __A zip lock baggy of 15 pills of Loperamide (for	W 391		

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W 391	Continued From page 482 diarrhea) on a medication card and in a zip lock bag with a pharmacy label on it and client II's name. No expiration date was found on the baggy. __An Epipen (for an allergic reaction) for client V expired 12/2012. __A box of 2 Epipens for client that was no longer at the facility. The box indicated the medication expired 12/2012. __15 white pills were randomly laying at the bottom of the box, not in a baggy. All of the above mentioned medications, along with client II's and V's Epipens, client II's Loperamide and client NN's Sudogest and client EEE's Loratadine were mixed in with all of the bags of pills in various colors, sizes and shapes with no expiration dates, not in the original store packaging and/or with a pharmacy label with clients names and dosages. During interview with the ADON (Assistant Director of Nursing) and the Nurse Consultant on 10/25/13 at 1 PM, the ADON indicated the medications in the filing cabinet in the nursing office were for the staff. The ADON stated, "The Tylenol was mine. I had a big bottle of it at home so I just dumped some in a baggy and brought it here for the staff." When asked if that was standard of practice to have medications lying around in a drawer, not in their original packaging, no pharmacy labels and no expiration dates, the ADON stated, "But those were for the staff." When asked what about the ones that were labeled for the clients, the ADON stated, "Those must have gotten mixed in there by mistake. They shouldn't have been in there. When is it wrong for staff to have medication here if they need it.?" The nurse consultant indicated all medications for	W 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 391	Continued From page 483 the clients were to be packaged by the pharmacist and properly labeled. The nurse consultant indicated all outdated and discontinued medications should be disposed of immediately, the staff were not to keep/store medications at the facility and the staff were to keep all personal medications with their possessions while working and not intermingled with the clients' medications. 3.1-25(j) 3.1-25(o)	W 391		
W 429	483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the temperature in 10 additional clients' (clients K, L, N, P, Q, U, X, BB, MM and UUU) program room at a normal comfort range. Findings include: Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM in program room 6 (clients K, L, N, P, Q, U, X, BB, MM and UUU). At 11:10 AM, staff #42 had beads of sweat running down his face. The surveyor was uncomfortably warm. At 11:26 AM, staff #42 called the maintenance supervisor. The maintenance supervisor measured the temperature of the room. It was 75.7 degrees. Staff #42 was interviewed on 10/23/13 at 11:10 AM. When asked if the temperature of the room	W 429		

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	15G580		C 11/06/2013

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W 429	Continued From page 484 was ever taken, he stated, "I haven't seen anyone." When asked if the warm room temperature was reported, he stated, "Not today." During observation in program 6 from 12:20 PM to 12:35 PM, staff #35 had sweat running down his face. The thermostat in the room was set at 72 degrees. Staff #35 called for the maintenance supervisor. The temperature in the room was measured at 80.4 degrees. The temperature in the bathroom was measured at 83.8 degrees. The maintenance supervisor opened a vent in the room. Client W was interviewed on 10/24/13 at 12:25 PM. When asked if she was comfortable, client W stated, she was "hot." The Maintenance supervisor was interviewed on 10/24/13 at 12:40 PM. When asked about the room temperature regulation, he stated, "I don't know how to answer. I keep turning the thermostat up and down," and indicated the temperature varied depending upon time of day. He indicated a log was kept of room temperatures. Temperature logs for October, 2013 were reviewed on 10/24/13 at 12:35 PM. There were no records of the temperatures or the location of where temperatures were being taken. 3.1-19.(h) 3.1-19.(i) 3.1-19.(j)	W 429		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair,	W 436		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 436	Continued From page 485 and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain and teach 3 of 6 sampled clients (clients B, E, and G) and 1 additional client (client UU) with prescribed adaptive equipment to use their adaptive equipment. Findings include: 1. Observations were conducted at the facility in Program Group #1 on 10/21/13 from 11:20 AM until 12:40pm, on 10/21/13 from 1:00 PM until 3:30 PM, and on 10/22/13 from 5:45 AM until 8:42 AM, client E was observed inside the program room without her prescribed eye glasses. Client E's record was reviewed on 10/24/13 at 11:35 AM. Client E's 11/8/12 IHP (Individual Habilitation Plan) indicated she wore prescribed eye glasses. Client E's 11/8/12 IHP indicated objectives/goals dated 11/8/12 to select own color of brief using eye gaze, to use eye gaze to select shirt, to select desired flavor of toothpaste, to identify coins when shown with a dissimilar object, to select preferred DVD (movie), to respond to textured item rubbed to her hand with facial expressions, to turn her head toward television, to use eye gaze to select choice of 2 objects, and to wear her prescribed eye glasses	W 436		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 436	Continued From page 486 as tolerated. Client E's 1/25/13 vision evaluation indicated she had prescribed eye glasses. An interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted on 10/24/13 at 1:25 PM. The QIDP/PD indicated client E wore prescribed eye glasses and had a goal to wear her eye glasses. 2. Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM, on 10/22/13 from 11:28 AM until 11:35 AM, on 10/22/13 from 1:40 PM until 3:05 PM, on 10/23/13 from 10:35 AM until 12:50 PM, on 10/24/13 at 12:10 PM, and on 10/28/13 from 11:40 AM until 11:58 AM. Client B did not not wear glasses during the observations. Client UU wore glasses on 10/24/13. Staff #12 was interviewed on 10/24/13 at 12:10 PM. When asked about client UU's glasses, she indicated she had found glasses with his name on them in a storage container in the program room restroom. Client B's record was reviewed on 10/29/13 at 2:06 PM. Client B's 8/16/13 vision examination indicated he was to wear glasses. Client UU's record in program room 6 was reviewed on 10/24/13 at 12:55 PM. An undated Client Information Data Sheet indicated client UU was to wear glasses. The QIDP (Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/29/13 at 3:03 PM and indicated clients B and UU should be wearing glasses, and should be encouraged to wear them. 3. Observations were conducted in program	W 436		

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 436	Continued From page 487 room 4 on 10/21/13 from 1:37 P.M. until 3:03 P.M. At 2:35 P.M. client G was given yogurt and juice for snack. DCS #11 used a curved adaptive spoon to feed client G her yogurt. DCS #11 did not encourage client G to feed herself. Observations of client G's evening meal were conducted on 10/21/13 at 4:45 P.M. client G was provided with a built up straight handled fork and knife and a right curved built up handle spoon. Client G ate her mechanical soft meal using the fork and her fingers. Staff did not encourage her to utilize her spoon instead of her fork. Client G dropped food on herself, her chair and the floor. Staff prompted her to not eat the dropped food. Client G's record was reviewed on 10/23/13 at 11:23 A.M. Client G's record included an IPP dated 12/6/12. Client G's IPP included the following goal: Will use her spoon throughout her meal for at least 90 out of 90 of the documented data opportunities with a monthly average of verbal prompts for 3 consecutive months by 12/12. Client G's Physician's Orders (PO) dated 8/30/13 indicated she was to use a right curved built up handle spoon. An interview was conducted with the PD/QIDP on 10/30/13 at 3:47 P.M. The PD/QIDP stated, " Yes, [client G] should use her spoon at every meal and at snacks. Staff should not be feeding her with it. They could use it, but need to at least encourage her to use it on her own first. "	W 436		
W 454	3.1-39(a) 483.470(I)(1) INFECTION CONTROL	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 488 The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, record review, and interview for 3 of 10 sampled clients (J, B, H), and 10 additional clients (L, S, V, Y, AA, DDD, II, UU, VV, XXX), the facility failed to implement and follow Universal Precautions and promote hand washing to prevent the spread of infection. Findings include: Observations were completed on 10/21/13 from 4:40 PM until 6:05 PM. Client J lay on the floor in program room 6 and had the strap of his helmet in his mouth. Client J's helmet strap was not sanitized after the helmet was removed from his head in the dining room. Client J rubbed his eye with his left middle finger which was reddened around the nail bed. Client J put his helmet strap back in his mouth after his helmet was placed back on his head, and left the dining room without washing his hands. Staff #57 was interviewed on 10/21/13 at 5:32 PM. He indicated client J often chewed on his shirt in addition to his helmet strap and stated, "He got it from staff," and indicated one of the staff assigned to client J's program room also chewed on his shirt. Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Client UU walked around the recreation room after breakfast with his fingers in his mouth food and saliva dripped from his mouth the size of a quarter on the floor. The surveyor pointed out the saliva on the floor to staff	W 454		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 489 and it was then cleaned with a mop bucket. Client UU then continued to walk around the room with saliva dripping from his hands and was not prompted to wash his hands. Client G knocked a basket of toys on the floor and books and a bean bag were on the floor. Client BB kicked the toys and books on the floor as she walked around. Client Y lay on the floor in the recreation room. The program materials were not sanitized and client Y was not prompted to wash his hands. During observations on 10/22/13 from 11:28 AM until 11:35 AM, client J had the strap of his helmet in his mouth, client UU had his hand in his mouth, and client Y lay on the floor. Client J's helmet strap was not cleaned, and clients UU and Y were not asked to wash their hands. During observations on 10/22/13 from 1:40 PM until 3:05 PM, client AA had a scab at the L top of his knuckle on his index finger, and was lying on the bare tiled floor. Client J had 2 parallel red marks under his left arm 1 inch in length and crawled on the floor. Client VV had holes in his shirt. When staff #38 asked him if he chewed on it, client VV nodded his head "yes." Client UU had his hands in his mouth. There were smudges of opaque material on two windows in the room. Staff #80 cleaned the windows after the surveyor asked about the smudges. Client UU put a block in his mouth, and staff #65 stated, "[Client UU]. Don't put that in your mouth." The block was not cleaned it after client UU took it out of his mouth. Client UU's hands dripped saliva and he put his hand back in his mouth. No hand washing was observed. Staff #68 was asked about the block client UU put in his mouth, and staff #68 stated, "Oh [client UU]. You're a mess," and washed the block.	W 454		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 454	Continued From page 490 Staff #80 was interviewed on 10/22/13 at 2:45 PM. He indicated the smudges on the window were from client H putting his hands on the window. Observations were completed on 10/23/13 from 10:35 AM until 12:50 PM. Client AA had a red open abrasion 1.5 by 2 cm (centimeter) along the bottom of his elbow. Client DDD crawled on the floor from one chair to another chair. Client UU had 5 red marks on his face 1/8 of an inch or less. Client UU had a red mark on his right arm 1 inch in diameter. Client DDD crawled on the floor, and was redirected from sitting in the path of the doorway. Clients H, II and J lay on the floor during the observation. Client AA had a scabbed abrasions on his L index finger 1/8 inch and on his left thumb. Client AA put his hand in his mouth. In the dining room, client AA ate food that spilled onto a non-skid mat from his plate. Client J sat with his helmet strap in his mouth. Client UU, DD, H, II and J were not prompted to wash their hands. Staff #80 was interviewed on 10/23/13 at 10:50 AM and stated client UU's marks were "acne." When asked if client UU had any other skin issues, he indicated client UU had ringworm and it was being treated by the nursing staff. During the observation, client UU walked around the room with his hands in his mouth. Staff #35 was interviewed on 10/23/13 at 11:05 AM. He indicated client UU had ringworm and when asked if he knew the location of his ringworm, stated, "Yeah-on his head I think." He indicated prevention of ringworm included hand washing.	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 491 Staff #494 was interviewed on 10/23/13 at 10:52 AM. When asked if client UU's ringworm was contagious, she stated, "Yes," and indicated the ringworm was located on client UU's lower legs. Interview with the DON (Director of Nurses) on 10/24/13 at 3:35 PM. The DON indicated client DDD did not have a plan in place in regard to the cellulitis. The DON stated the staff "try to keep it covered but he won't leave anything on it." The DON stated client DDD was in the same activity group room as another client that currently had "ring worm" and another client that had skin issues. The DON stated, "This same room of clients recently had issues with MRSA (Methicillin-resistant Staphylococcus aureus) and we also tested those clients recently for scabies, but their tests came back negative." The ADON (Assistant Director of Nurses) was interviewed on 10/25/213 at 11:35 AM. She indicated client DDD's cellulitis had been treated with antibiotics and it was not cultured as to type of infection. She indicated client DDD's doctor had not indicated he was to keep the wound bandaged, but stated, "We did it anyway." She indicated client DDD had removed his bandage. On 10/25/13 at 6 PM, client DDD was observed sitting in a chair in group 6 activity room. Client DDD had a small red raised swollen area with a dark center on the outer aspect of his lower right arm above his wrist. No seeping was noted and area was not covered. The facility nurse was called to come to the room to look at client DDD's arm. RN #1 placed a Band-Aid over the area. RN #1 stated, "He won't keep it covered. We try, but he just pulls it off again. The area looks like it's	W 454		

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	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 492 ready to pop." During observations on 10/28/13 from 11:40 AM until 11:58 AM, client DDD had a raised area of skin with a small open area uncovered by a dressing. While in the dining room, client DDD had a urination accident. The chair client DDD was sitting in was pushed away from the table, after he left the dining room but was not sanitized at 11:45 AM. The chair had cracks in the vinyl, exposing the padding underneath. Staff #495 was interviewed on 10/28/13 at 11:42 AM and stated, client DDD "keeping ripping it off" when asked about bandaging client DDD's open area, and "I didn't realize he had it off." Staff #62 was interviewed on 10/28/13 at 11:55 AM, about the chair client DDD was sitting in sitting to one side of the dining room. She indicated the chair was available for use for any clients to sit in. The Dietary Manager was interviewed on 10/28/13 at 11:58 AM. She indicated staff should have notified her of the soiled chair and it would be sanitized and cracks repaired. On 10/28/13 at 12:55 PM client DDD was observed sitting in a chair in group 6 activity room. Client DDD was observed putting both of his hands down his pants. Client DDD's was wearing a long sleeve shirt. Staff #93 was asked to roll up client DDD's sleeve on his right arm. The area noted on client DDD's lower arm on 10/25/13 had burst. The area was now red and swollen with a dark center that had scabbed over. Staff #93 stated, "He picks at it all the time and won't leave a band aide on. He takes it off as	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15G580		C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 493 soon as we put it on." Staff #93 called the nurse to come put another band aide over client DDD's area on his lower arm. 2. During observations in program room 5 on 10/29/13 from 12:45 PM to 12:55 PM, client L placed his hand down his pants, then placed the same hand in his mouth. Staff #45 prompted client L to take his hands out his pants and his mouth, but did not prompt or assist client L to wash or sanitize his hands. There was a 6 inch in diameter slimy pool of liquid on the floor in front of client L's chair. When the surveyor pointed out the spot on the floor, staff #45 called to have housekeeping clean the liquid up with a mop and bucket. Staff #45 was interviewed on 10/29/13 at 12:55 PM. When asked how often client L should wash his hands, she stated, "Every 30 minutes. I'll wash them now." The Program Manager was interviewed on 11/1/13 at 9:30 AM. She indicated client UU has a history of putting his hands in his mouth, saliva dripping on the floor and staff should be watching for saliva on the floor and washing clients' hands or items after they put them in their mouths or on the floor. She indicated the facility's administrative staff conducted "random" audits of infection control practices. The Consultant DON was interviewed on 11/1/13 at 3:20 PM. When asked if there were infection control concerns regarding the clients in program room 6 who lay on the floor, she stated, "I'm at a loss as to how to answer that. If they want to be on the floor, are we going to ever keep them off the floor? We offer opportunities (to be off the	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 454	Continued From page 494 floor)," and indicated clients hands should be washed or sanitized before putting their hands on other clients. She indicated client J's helmet strap did not need to be sanitized or washed since it was his personal property and indicated floors should be cleaned immediately when soiled. The CDC (Centers for Disease Control) Outpatient management of skin and soft tissue infections in the era of community-associated MRSA (ADA:07-0827:10/07:df was reviewed on 11/3/13 at 112:11 PM and indicated the following: "Patient presents with signs/symptoms of skin infection: -Redness -Swelling -Warmth -Pain/tenderness -Complaint of "spider bite" ...Is the lesion purulent (i.e., are any of the following signs present? -Fluctuance-palpable fluid filled cavity, moveable, compressible -Yellow or white center -Central point or "head" -Draining pus Possible to aspirate pus with needle and syringe Yes 1. Drain the lesion 2. Send wound drainage for culture and susceptibility testing 3. Advise patient on wound care and hygiene 4. Discuss follow-up plan with patient..." Client UU's nursing notes for 10/16/13 were reviewed on 10/24/13 at 4:00 PM. The note indicated at 8:00 AM 1 cm (centimeter) to 1/1/2 cm areas. Red. Slightly raised to outer margins. Dry flaky skin to the center (above L (left) knee. Low inner Rt (right) calf, Rt. calf. N.O. (new orders) per [Dr.] clotrimazole (anti-fungal) cream	W 454		

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	15G580		C 11/06/2013

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ARCADIA DEVELOPMENTAL CENTER	303 FRANKLIN ARCADIA, IN 46030

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W 454	Continued From page 495 apply topically to affected area BID (twice daily) x (for) 2 weeks." Another nursing note dated 10/16/13 at 11:50 AM indicated client UU was diagnosed with tinea corporis (ringworm) and continue treatment with prescribed lotrimine (anti-fungal). Client DDD's record was reviewed on 11/3/13 at 1:57 PM. A nursing note dated 10/24/13 "approximately 6:15 AM staff reported area R (right) FA (forearm), MD (medical doctor) assessed, area raised/red/edematous/warm to touch/circular, 6 cm x 6 cm with pink/rd scab .5 x .5 (measurement type not indicated) noted within area. MD determined to be cellulitis...Bactrim DS (Sulfa anti-biotic) x 10 days. Order to keep scab covered with bandaid...." An Accident/Injury Treatment Flow Sheet dated 10/24/13 at 7:00 PM indicated "Pink/Red raised circular area 6 cm x 6 cm with small .5 x.5 cm red scab. No drainage noted; area slightly warm to touch. Treatment/Medication Intervention: Keep bandaid over scab..." The facility's Infection Control Policy dated 10/14/08 was reviewed on 10/21/13 at 2:05 PM and indicated "Employees will be required to follow all precautions necessary to minimize the spread of infectious/communicable diseases. Nursing staff members, in coordination with the Administrative team, will be responsible for ensuring employee compliance...Safe Work Practices...Employees are required to follow safe work practices at all times to prevent exposure to and/or spread of infectious diseases. Specific guidelines for preventing the spread of disease are communicated during the initial employee orientation and include the following. Employees with adhere to the CDC guidelines for hand	W 454		

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W 454	Continued From page 496 hygiene in health care settings..During cold and flu season frequent hand washing will be emphasized...The housekeeping employees will ensure that all areas of the facility are clean & appropriately disinfected...Staff Monitoring...Staff will monitor the residents on a day-to-day basis to identify possible symptoms of an infectious illness as early as possible. Staff will notify a member of the nursing staff whenever there is a reason to believe that a resident may have an infectious illness. the nurse will then be responsible for any follow-up, including control and reporting of the illness..." An attached Sanitation/Infection Control Guidelines indicated in the area of Programming items: "Each time an item is dropped or when on (sic) client has finished using that item, the staff will sanitize that item using an alcohol wipe before the item is used again...Adaptive Equipment: Adaptive equipment should also be cleaned anytime it becomes soiled using alcohol spray....Floors: Program room floors should be cleaned any time there is a spill or contamination (human waste, fluids, feces, blood, urine, emesis, etc.) (sic) the soiled area should be mopped using a clean mop head, water, containing appropriate chemical solution, and bucket... (Should any resident be observed placing hands in mouth and then placing them on the floor, tables, windows or any hard surfaces, the area should be immediately cleaned using alcohol-based wipe...." 3.1-18(L)	W 454		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and	W 460		

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W 460	Continued From page 497 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review for 2 of 2 sampled clients (clients E and F) and 3 additional clients (clients Q, JJ, and ZZ) who were to receive thickened liquids during meals, the facility failed to ensure clients E, F, Q, JJ, and ZZ received the recommended thickness of their liquids diet as prescribed. Findings include: During observations at the facility's dining room on 10/21/13 from 11:20am until 12:20 PM, clients E, F, Q, JJ, and ZZ were served their meal trays at the lunch meal of unthickened Tomato Soup by the facility staff. On 10/21/13 at 11:20 AM, client F was assisted by FS #58 inside the dining room to the table. Facility Staff #58 obtained client F's meal tray of pureed consistency foods, unthickened Tomato Soup in a bowl, and pudding thickened liquids. FS #58 fed the unthickened Tomato Soup to client F with a spoon until client F's food was consumed. On 10/21/13 at 11:45 AM, client ZZ was assisted at the dining room table by Facility Staff (FS) #58. FS #58 obtained client ZZ's meal tray from the dining room Dietary Department window, served client ZZ the meal tray with unthickened Tomato Soup and nectar thickened liquids, and client ZZ consumed the tray items. At 11:45 AM, FS #58 indicated client ZZ and F's Tomato Soup did not match the same consistencies as each clients' thickened liquids on the same meal tray from the	W 460		

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W 460	Continued From page 498 dietary department. On 10/21/13 at 12:00 noon, FS #62 and FS #82 assisted client E in her wheel chair to the dining room table. FS #82 obtained client E's meal tray of ground grill cheese, unthickened Tomato Soup in a bowl, and stated "honey" thickened drinks in glasses. At 12:00 noon, FS #82 indicated client E's Tomato Soup did not look thickened with the same consistency as her drinks. FS #82 fed client E the unthickened Tomato Soup. On 10/21/13 at 12:10 PM, FS #58 served, fed, and stated client JJ his unthickened Tomato Soup and client JJ's "honey" thickened drinks in glasses at the dining room table. At 12:10 PM, FS #58 stated client JJ's drinks on his meal tray were "honey" thickened and his Tomato Soup was a "regular" consistency. On 10/21/13 at 12:10 PM, the CDM (Certified Dietary Manager) sat at the dining room table and assisted client Q with her meal tray. The CDM served client Q the meal tray which included unthickened Tomato Soup in a bowl and nectar thickened liquid drinks in glasses. Client Q began to consume her Tomato Soup. At 12:15 PM, the CDM went to the cook at the window inside the dietary department and asked if the Tomato Soup had been thickened. The cook responded "No" and the CDM instructed him the Tomato Soup was a liquid and needed thickened with the same consistency as the other liquids on each meal tray. At 12:15 PM, client Q's Tomato Soup was replaced with a bowl of "nectar" thickened Tomato Soup and the same consistency as her liquid drinks on the tray. On 10/21/13 at 12:40pm, an interview with the	W 460		

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W 460	Continued From page 499 CDM was conducted. The CDM indicated the Tomato Soup was not thickened for clients E, F, Q, JJ, and ZZ on 10/21/13 at the noon meal. The CDM stated clients E and JJ "required honey thickened" liquids. The CDM stated client F "required pudding thickened" liquids. The CDM stated clients Q and ZZ "required nectar thickened" liquids. The CDM reviewed the undated facility's "Information" sheet for "Thickened Liquids" and indicated the sheet included a guideline for staff to follow "...Thickened Liquids: Honey Thick [Clients E and JJ], Nectar Thick [Clients Q and ZZ], (and) Pudding Thick [Client F]." The CDM indicated clients E, F, Q, JJ, and ZZ had physician's orders on 8/30/2013 which included the same thickness of liquids on the information sheet. The CDM stated clients E, F, Q, JJ, and ZZ "all" had aspiration precautions and medically required thickened liquids. On 10/24/13 at 1:25 PM, an interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director of Nursing (D.O.N.) was conducted. The QIDP and the D.O.N. both indicated clients E, F, Q, JJ, and ZZ were to have received thickened liquids because of aspiration precautions. The D.O.N. indicated each clients' meal tray should have followed the agency guidelines for thickened liquids. On 10/21/13 at 12:40 PM, on 10/24/13 at 1:25 PM, and on 10/25/13 at 10:15 AM, the facility's guidelines for thickened liquids was requested from the CDM and the D.O.N. and no policy or procedure were available for review. Client F's record was reviewed on 10/23/13 at 1 PM. indicated client F physician's orders for 2013 indicated client F was on aspiration precautions	W 460		

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W 460	Continued From page 500 and was to have a pureed diet with pudding thick liquids at all times. Client JJ's record was reviewed on 10/24/13 at 2 PM. Client JJ's physician's orders for 2013 indicated client JJ was on aspiration precautions and was to have a Pureed diet, double portions and honey thick liquids at all times.	W 460		
W 488	3.1-20(a) 483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed for 5 of 10 sampled clients (clients B, F, H, I, and J) to ensure they participated in meal preparation consistent with their developmental level. Findings include: 1. Observations were conducted at the facility on 10/21/13 between 1 PM and 6 PM. __At 4:45 PM staff #57 walked behind client I with his arms interlocked under client I's arms, his knees touching the back of her legs and step by step, staff #57 verbally and physically prompted client I to take a step and to continue toward the dining room. Client I was prompted to the sink inside the dining room to wash her hands and then escorted to a table with 2 chairs. Staff #57 pulled out one of the chairs and assisted client I to sit down. Staff #36 brought a high sided divided	W 488		

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W 488	Continued From page 501 plate and youth silverware to the table and sat them down in front of client I. Staff #36 then placed a clothing protector on client I. Client I then sat and waited. Staff #36 stated, "I'm waiting on [client Q] to get here before I get their food. We do family style dining and the two of them eat together." At 5 PM client Q arrived and sat down at the table with client I. Staff #36 went up to returned the dining room serving counter and brought back client I's food and pre-filled 6 ounce drinking glasses with thickened liquids. Staff #36 served client I pureed chicken and then, with hand over hand assistance client I placed a serving of mixed vegetables on her plate. Staff #36 then picked up client I's youth silverware and began feeding client I her evening meal. Staff #36 prompted client I to pick up her spoon twice during the meal and once provided hand over hand assistance for client I to feed herself. At 5:30 PM staff #36 stated the staff were to prompt client I to feed herself, "But she doesn't want to and we just end up feeding her." __At 5:24 PM staff #57 pushed client F to the dining room via a wheel chair. Staff #57 positioned client F at one of the dining room tables and left the room to escort another client to the dining room. Client F sat without interaction from staff until 5:33 PM when staff 57 cleansed client F's hands with a hand sanitizer. Staff #57 placed a clothing protector on client F and then brought client F's high sided divided plate and silverware to the table and placed them in front of client F. At 5:35 PM staff #44 brought client F's food to the table and served client F pureed chicken, vegetables and chocolate cake. Staff #44 placed prefilled 6 ounce drinking glasses with thickened liquid on the table in front of client F. As soon as the food was in client F's plate, client F began feeding himself, taking large bites, eating	W 488		

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W 488	Continued From page 502 at a fast pace with lots of food spillage onto his face, chest and lap. Staff #44 got a napkin and wiped client F's face. At 5:45 PM client F dropped his spoon on the floor. Staff #36 stated, "That's a sign that he's done eating." Client F's plate and tableware was removed from the table and taken to the dining room serving counter. Client F was then cleaned up and escorted out of the dining room. The staff did not prompt client F to slow his pace of eating or to take smaller bites. Client F's record was reviewed on 10/23/13 at 1 PM. Client F's ISP of 2/14/13 indicated client F was to continue to assist with mealtime preparations and family style dining. Client I's record was reviewed on 10/23/13 at 2 PM. Client I's ISP of 11/8/12 indicated client F was to continue to assist with mealtime preparations and family style dining. Interview with the facility administrator on 10/21/13 at 12:15 PM indicated the facility provided family style dining to the clients for the evening meals. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/24/13 at 1 PM indicated family style dining was to be provided each evening meal. The QIDP indicated client I required prompting to eat her meal herself and the staff were to frequently provide verbal and physical prompts while she ate. The QIDP indicated client F was to be prompted to eat at an appropriate pace and to take small bites. Interview with a dietary staff on 10/29/13 at 4 PM indicated the clients were assigned dining partners. The clients were brought to the dining	W 488		

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W 488	Continued From page 503 room 1 table of clients at a time and the staff placed each client's dining equipment on the table. After all the clients assigned to the table arrive, the staff then take the food to the table for the clients and help the clients to serve themselves if able. The dietary staff indicated the food was prepared in the kitchen as per each client's physician order specified and thickeners were added prior to giving them to the clients. 2. Observations were completed on 10/21/13 from 4:40 PM to 6:05 PM. Staff #47 fed client J and squeezed ketchup on his food. Staff set client H's place setting for him as he sat at the table. Client B's chicken was cut up by staff #498. Staff #38 was interviewed on 10/21/13 at 5:00 PM and stated, she had assisted client J "hand over hand" with serving his food. Staff #498 was interviewed on 10/21/13 at 5:20 PM and indicated client B had asked her to cut up his food. Client B was interviewed on 10/21/13 at 5:20 PM and shook his head "No" when asked if he wanted to learn to cut up his food. Staff #47 was interviewed on 10/21/13 at 5:55 PM and indicated client J was normally fed his evening meal and when asked if client J could squeeze a ketchup bottle, stated, "He could, but it would go everywhere." Observations were completed on 10/22/13 from 6:15 AM to 7:40 AM. Staff #38 fed him his breakfast without encouraging him to use his spoon. Client J's record was reviewed on 10/24/13 at	W 488		

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W 488	Continued From page 504 1:20 PM. Client J's Adaptive Skills Assessment dated 2/12/13 indicated he was able to scoop and serve food with hand over hand assistance. Dietary staff #71 was interviewed on 10/21/13 at 5:25 PM and indicated client TT had helped prepare the food earlier that day, but otherwise all the food had been prepared by staff. The QIDP(Qualified Intellectual Disabilities Professional)/Program Director was interviewed on 10/29/13 at 3:03 PM. She indicated clients B, H, and I should be encouraged to participate in their mealtime with assistance. She indicated client J should be encouraged to take bites of food. 3.1-20(a)	W 488		