STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(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
W0000	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00113231. This visit was in conjunction with a PCR (post-certification revisit) survey to the investigation of complaint #IN00109013 completed on 6/29/12. This visit was in conjunction with a PCR survey to the PCR completed on 6/29/12 to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00108475 and #IN00107965 completed on 5/23/12. This visit resulted in an Immediate Jeopardy. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaint #IN00103890 completed on 3/26/12. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12.	W0000		

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

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

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	Complaint #IN00113231: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W104, W124, W125, W149, W159, W210, W264 and W289. Dates of Survey: 8/6, 8/7, 8/8, 8/9, 8/10 and 8/17/12 Facility number: 000622 Provider number: 15G079 AIM number: 100272170 Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, RN, Public Health Nurse Surveyor (8/6/12 to 8/9/12) Dotty Walton, Medical Surveyor III (8/6/12 to 8/9/12) Mark Ficklin, Medical Surveyor III (8/6/12 to 8/9/12) Joanna Scott, Medical Surveyor III (8/6/12 to 8/9/12) Steven Schwing, Medical Surveyor III (8/6/12 to 8/9/12) Keith Briner, Medical Surveyor III (8/6/12 to 8/9/12) These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 8/23/12 by Ruth			

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	Shackelford, Medical Surveyor III.			

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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 14 of 16 sampled clients (#1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15 and #16) and for 74 additional clients (#17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #62, #66, #73, #90, #93, #104, #119, #122, #124, #127, #128, #130, #136, #137, #139, #140, #142, #143, #144, #147, #148, #149, #150, #152, #154, #156, #157, #158, #159, #160, #161 and #162). The governing body failed to ensure the facility did not neglect clients. The governing body failed to ensure the facility provided sufficient staff to monitor and supervise clients. The governing body failed to ensure the facility developed a policy on how to keep clients safe who received medications for presedation. The governing body failed to ensure the facility provided a clean and sanitary environment. The governing body failed to ensure the facility conducted thorough investigations and did so timely. The governing body failed	W0102	**W102** I For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. For the residents named in the sample North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. Retraining has been completed with the staff assigned with regard to the resident with the fractured hand and proper use of the lift. His transfer plan has been reviewed/revised and that plan re-educated with his staff. A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Client Advocate staff have been counseled on investigations being completed on time and with thoroughness. The following residents have a one time mental anguish assessment completed; 1-9, 124, 128, 130 and 148, 10, 12, 13, 16, 17-40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 143, 144,	09/16/2012

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	to ensure clients' rights, to ensure privacy, to ensure clients participated in activities in the community and informed clients' legally sanctioned representatives of clients' restrictive programs and/or techniques. The governing body failed to ensure the facility's Qualified Developmental Disabilities Professional monitored and coordinated clients' program plans. Findings include: 1. The governing body failed to meet the Condition of Participation: Client Protections for 11 of 16 sampled clients (#2, #4, #6, #7, #8, #9, #10, #12, #14, #15 and #16) and for 12 additional clients (#41, #62, #66, #73, #104, #90, #93, #119, #124, #128, #130 and #148). The governing body failed to implement its written policy and procedures to prevent neglect of clients in regards to an elopement incident which resulted in a client missing from the facility, falls, policy development and a client's fractured hand. The governing body failed to ensure clients' rights in regard to participating in community outings/activities on a frequent basis, informing clients' legal representatives of restrictive practices, and privacy. The governing body failed to ensure clients' rights in regard to medications used for		149, 157, 158, 160, 161, 162, 73, 104. Resident 41, an emancipated adult, has not returned nor been located at this time. A North Willow Policy of Written Informed Consent and Safe Transport during sedation has been drafted. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend. Resident 104's staff have been retrained with regard to her falls plan and the plan reviewed/revised. W122 The agency has in place policies and procedures to ensure that client protections requirements are met. North Willow will follow their abuse and neglect policy. Regarding the prevention of neglect for client #41 in regard to an elopement, #73 in regard to a fractured hand, and Clients #7 and #90 in regard to injuries from falls due to medication pre-sedation as well as client #104 in regard to falls, **W149** I Corrective Action for Cited Clients: ·Resident #41 continues to be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture	

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	presedation, completing thorough investigations and to complete investigations timely. Please see W122. 2. The governing body failed to meet the Condition of Participation: Facility Staffing for 12 of 16 sampled clients (#1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13 and #16) and for 60 additional clients (#17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #66, #90, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162). The governing body failed to ensure the facility had sufficient staff to monitor/supervise clients, at the facility, on the overnight shift to prevent a client from eloping/missing from the facility. The governing body failed to ensure the facility had sufficient staffing to allow the clients to attend the facility owned workshop. The governing body failed to ensure the Qualified Developmental Disabilities Professional (QDDP) monitored and and/or coordinated clients' Individual Support Plans to meet the clients' needs in regard to active treatment services. Please see W158. 3. The governing body failed to ensure		care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. Regarding informing clients' legal representatives of behavioral status/plans, medications and/or restraints, risks and benefits and the right to refuse treatment for clients #7, #12 and #90, **W124** . The agency has in place policies and/or procedures to ensure the rights of all clients, including informing the individual or legal guardian of the client's medical condition, developmental and behavioral status, attendant risks of treatment and the right to refuse treatment. For clients #7, #12 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will	

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	sufficient staff worked on the overnight shift to monitor and supervise clients, on the first floor, to prevent elopement of client #41 who went missing. The governing body failed to ensure sufficient staff were present at the workshop to allow clients to attend the workshop on a daily basis for clients #1, #2, #3, #5, #12, #13, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162. The governing body failed to ensure each client's active treatment program was coordinated and monitored by the Qualified Developmental Disability Professional in regard to completing quarterly program reviews, following dental recommendations, completing functional assessments and program plans timely, to ensure clients and their families/health care representatives were present/attended a client's meeting, to ensure a health care representative received a copy of a client's program/behavior plans, and to address the identified behavioral needs of a client. The governing body failed to ensure the QDDP monitored and/or coordinated		request new consents reflecting their receipt of the information. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. Information regarding risks and/or benefits and the right to refuse treatment will be included. Client #12's guardian will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for sedation will be sent immediately upon the receipt of orders. Information regarding risks and/or benefits and the right to refuse treatment will be included Client #7's HCR will be contacted and notified of the use of, and definition of, four handed dentistry. The HCR will be provided with a copy of client #7's desensitization plan. The HCR will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request	

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	clients' programs in regard to implementation of objectives, conducting assessments/re-assessments, ensuring clients had/used needed adaptive equipment and to ensure the facility's Human Rights Committee reviewed the practice of dental restraints for clients #1, #2, #5, #6, #7, #8, #9, #10, #12, #16, #66 and #90. The governing body failed to implement its written policies and procedures to prevent neglect of client #41 in regard to an elopement incident which resulted in client #41 missing from the facility. The governing body failed to ensure sufficient staff worked on the over night shift to monitor/supervise clients, on the first floor, to prevent client's from eloping/leaving the facility without staff's knowledge. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client #73 in regard to a fractured hand, and to prevent neglect of clients #7 and #90 in regard to injuries which resulted from falls due to medication presedation. The governing body failed to develop a policy and/or procedure/system to ensure clients were monitored/protected when presedated for medical/dental procedures. The governing body failed to implement its policy and procedures to prevent neglect of client #104 in regard to falls.		for approval for all restraints used with client #7 will be requested. Information regarding risks and/or benefits and the right to refuse treatment will be included Regarding ensuring rights of clients in regard to pre-sedating client #10 and #90, **W125** . The agency has in place policies and/or procedures to ensure the rights of all clients in regard to pre-sedation for dental/medical appointments. For clients #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. Regarding the client #90's fall following sedation, the agency will develop a protocol to address safety measures following the administration of pre-sedation. This protocol will be developed by the IDT with both nursing and programming staff trained by 9-16-12. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental	

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	The governing body failed to ensure the facility informed the clients' legal representatives (family/Health care Representatives (HCR) and/or the guardian) of the clients' behavioral status/plan, medications and/or restraints used for sedation to ensure the clients' legal representatives understood the risks and/or benefits of the restrictive programs and/or the right to refuse treatment if desired for clients #7, #12 and #90. The governing body failed to ensure the rights of the client in regard to presedating the client for dental/medical appointments for clients #10 and #90. The governing body failed to provide privacy during showers/bathing and toileting for clients #14, #62, #66, #119, #124. The governing body failed to provide the clients with outings or community activities on a regular and ongoing basis for clients #2, #4, #6, #7, #8, #9, #10 and #16. The governing body failed to conduct a thorough investigation in regard to the allegations and/or injuries of unknown origin for clients #15, #93 and #148. The governing body failed to ensure all results/investigations were completed within 5 business days with the results reported to the administrator for clients #9, #128 and #130. Please see W104.		appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #90 by Dentist and/or IDT and client #90's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental and medical appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation and restraints used during the appointment). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline This plan will require the approval of client #90's HCR. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. For client #10, the guardians will be provided with a description of 4 handed dentistry and asked to provide informed consent on his	

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			behalf. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #10 by 9-16-12 and client #10's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline the order in which restraints will be reduced. This plan will require the approval of client #10's guardian. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. Regarding provision of privacy for clients #14, #62, #66, #119 and #124, **W130**. Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by 9-16-12.	

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			Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by 9-16-12. Regarding providing clients with outings and community activities for clients #2, #4, #6, #7, #8, #9, #10 and #16, **W136** . A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Residents 2, 4 6, 7, 8, 9, 10, and 16 have outings scheduled for September that are adequate. The QMRP responsible for those residents has been retrained of that important requirement. Regarding completion of thorough investigations regarding injuries of unknown origin for clients #15, #93 and #148, **W154**. The agency has policies in place to assure alleged violations are thoroughly investigated. For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars)	

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			for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. Regarding ensuring that investigations were completed and provided to the administrator within 5 working days for clients #9, #128 and #130, **W156**. The agency has in place policies to report the results of investigations to the administrator or designee within 5 working days. Investigations for clients #9 (7/28/12 fracture), #80 (8/1/12 injury of unknown origin), and #128 &130 (client to client) have been completed. Client advocates will be retrained on the requirement that investigations be completed within 5 working days. W158 For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. . North Willow followed their elopement policy and will follow their elopement policy. Residents number 1-10, 12, 13, 14, 16, 17-38, 40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 149,	

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			150, 152, 154, 156, 157, 158, 159, 160, 161, 162 have a one time mental anguish assessment completed. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. North Willow has a staffing procedure that is reviewed regularly with regard to census, acuity and other resident needs and updated as needed. That procedure has been re-educated with the CNA scheduler and nursing staff. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend. W104 For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. For the residents named in the sample North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. Retraining has been completed with the staff assigned with regard to the resident with the fractured hand and proper use of the lift. His transfer plan has been reviewed/revised and that plan re-educated with his staff. A policy for Community integration	

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			has been drafted and will be followed for the residents named in less than adequate outings. Client Advocate staff have been counseled on investigations being completed on time and with thoroughness. The following residents have a one time mental anguish assessment completed; 1-9, 124, 128, 130 and 148, 10, 12, 13, 16, 17-40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 143, 144, 149, 157, 158, 160, 161, 162, 73, 104. Resident 41, an emancipated adult, has not returned nor been located at this time. A North Willow Policy of Written Informed Consent and Safe Transport during sedation has been drafted. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend. Resident 104's staff have been retrained with regard to her falls plan and the plan reviewed/revised. II All residents of North Willow have the potential to be harmed by the deficient practice. III For all the residents of North Willow there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the	

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			CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. The elopement and abuse and neglect policy has been reviewed with the management staff and Quality Assurance Committee. Staff are trained on use of the lift and with regard to the method of transfer for each resident. A policy for Community integration has been drafted and will be followed for the residents of North Willow. Client Advocate staff have been counseled on investigations being completed on time and with thoroughness. Residents who require assist with transfer have had their plans reviewed/revised and staff have been re-educated on the method to transfer them. QMRPs have been trained on the Community Integration Policy. W122 North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. W130 Staff will be retrained on providing privacy during treatment and while assisting with personal care, including toileting and showering. For both those clients requiring	

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			assistance and those who are more independent, staff will be trained to take advantage of informal training opportunities throughout the day. Training to be completed by 9-16-12. W149 Corrective Action for Cited Clients: ·Resident #41 continues to be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. W124 To help prevent reoccurrence of	

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			this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. W125 To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by Social Worker/Designee and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. W136 QMRPs have been trained on the Community Integration Policy. W154 In the future, documentation review specified above will be completed for all injuries of unknown origin. The template	

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			used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. W156 To help prevent reoccurrence of the issue, the client advocates will review daily the outstanding reportable incidents, noting due dates for completion of investigations and submission of follow-up BDDS incident report if required. Documentation of these meetings will be maintained in the client advocates' office. The Executive Director will be notified of any problems arising that might prevent the completion of an investigation to determine how to proceed. W158	

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			For all the residents of North Willow there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. The elopement policy has been reviewed with the management staff and Quality Assurance Committee. W104 For all the residents of North Willow there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. The elopement and abuse and neglect policy has been reviewed with the management staff and Quality Assurance Committee. Staff are trained on use of the lift and with regard to the method of transfer for each resident. A policy for Community integration has been drafted and will be followed for the residents of North Willow. Client Advocate	

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			staff have been counseled on investigations being completed on time and with thoroughness. Residents who require assist with transfer have had their plans reviewed/revised and staff have been re-educated on the method to transfer them. IV The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. The Abuse Policy has been reviewed with the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs. QMRPs observe quarterly transfers of the residents in their caseload. Program Directors report monthly assuring that each resident attends outings and when they choose not to attend an IDT is presented that outlines reasons with corrective action per the Community Integration Policy. W122 The Abuse Policy has been	

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			reviewed with the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. W 130 Privacy will be added to the active treatment audits and environmental rounds completed by the QDDPs. Nursing staff will audit for privacy while completing daily rounds in the shower room. (see W454 for wording). Professional staff will monitor for and correct any privacy issues that arise while on the unit. W149 Corrective Measures or Systemic Changes ·Rehab Coordinator will be assigned weekly a list of residents to audit while transfers occur to ensure that proper procedure is followed. Any concerns will be reported to the Program Director for follow-up. ·A new system has been implemented to track and monitor all appointments, including the use of pre-medications for sedation. All residents identified as using pre-medications will have care plans that identify safety measures needed while sedated. Rehab Coordinator will oversee PRN adaptive equipment to make sure it is available for	

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			use for those whose plans include it (ie, wheelchair with pelvic stabilizer). Staff will be trained on this new procedure so that the risk of injury from pre-medication is lessened. W124 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. Nursing will assure appropriate consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. W125 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. As well, the PD will review annual ISPs to assure that restrictive measures are identified. W136 Program Directors report monthly	

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			assuring that each resident attends outings and when they choose not to attend an IDT is presented that outlines reasons with corrective action per the Community Integration Policy. W154 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. W156 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. W158 The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs.	

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			W104 The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs. QMRPs observe quarterly transfers of the residents in their caseload.	

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 14 of 16 sampled clients (#1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15 and #16) and for 74 additional clients (#17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #62, #66, #73, #90, #93, #104, #119, #122, #124, #127, #128, #130, #136, #137, #139, #140, #142, #143, #144, #147, #148, #149, #150, #152, #154, #156, #157, #158, #159, #160, #161 and #162), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility did not neglect clients. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility provided sufficient staff to monitor and supervise clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a policy on how to keep clients safe who received medications for presedation. The governing body failed to exercise general policy and operating	W0104	**W104** I. For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. For the residents named in the sample North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. Retraining has been completed with the staff assigned with regard to the resident with the fractured hand and proper use of the lift. His transfer plan has been reviewed/revised and that plan re-educated with his staff. A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Client Advocate staff have been counseled on investigations being completed on time and with thoroughness. The following residents have a one time mental anguish assessment completed; 1-9, 124, 128, 130 and 148, 10, 12, 13, 16, 17-40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 143, 144, 149, 157, 158, 160, 161, 162, 73,	09/16/2012

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	direction over the facility to ensure the facility provided a clean and sanitary environment. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations and did so timely. The governing body failed to exercise general policy and operating direction over the facility to ensure clients' rights, to ensure privacy, to ensure clients participated in activities in the community and informed clients' legally sanctioned representatives of clients' restrictive programs and/or techniques. The governing body failed to exercise general policy and operating direction over the facility's Qualified Developmental Disabilities Professional (QDDP) to ensure the QDDP monitored and coordinated clients' program plans. Findings include:		104. Resident 41, an emancipated adult, has not returned nor been located at this time. A North Willow Policy of Written Informed Consent and Safe Transport during sedation has been drafted. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend. Resident 104's staff have been retrained with regard to her falls plan and the plan reviewed/revised. W186 For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. . North Willow followed their elopement policy and will follow their elopement policy. Residents number 1-10, 12, 13, 14, 16, 17-38, 40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 149, 150, 152, 154, 156, 157, 158, 159, 160, 161, 162 have a one time mental anguish assessment completed. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. North Willow has a staffing procedure that is reviewed regularly with regard to census, acuity and other resident needs and updated as needed. That procedure has been re-educated with the CNA scheduler and nursing staff. Staffing has been assessed for workshop and North Willow is	

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			providing sufficient staff to attend workshop for those residents who attend. W159 QDDP will ensure that an annual ISP and required annual documentation for Clients #5 and #10 are appropriately placed in their charts . The team will review Client #10's dietary recommendation and complete an IDT with recommendations from the IDT. Staff will be trained on any changes made. The team will review Client #66's BSP and ISP to address incidents of flushing items down the toilet and complete an IDT with recommendations from the IDT. The team will implement the changes into the ISP and BSP and train staff on the implementation of the changes. Staff will be trained on any changes made. The QDDP will complete an FAS for clients #17, #10, and #90. The QDDP complete an audit to review that each client's ISP and BSP are appropriately addressing each client's needs. The team will write IDT notes for clients who need changes made to their ISP and/ or BSP. The team will implement the changes into the ISP and BSP and train staff on the implementation of the	

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			changes. The QDDP and PD will complete retraining with staff regarding active treatment. The QDDP will complete Active Treatment Observations three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #1, #2, #6, #10, #12, #14, #147, #150,#152, #154, #154, #157, #158, #159, and all remaining clients. The QDDP will review clients need for having their clothing locked. The QDDP will submit all clients who have the restriction of the locked closet to HRC for approval. The PD will complete an audit of all clients who need the restriction of four handed dentistry and submit to HRC for approval prior to the next dental appointment. The PD will prepare items for the HRC meeting no less than monthly to ensure that appropriate items are being submitted for approval. The QDDP will review the adaptive equipment for clients #2, #5, and #16. W149 Corrective Action for Cited Clients: ·Resident #41 continues to	

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			be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. W124 The agency has in place policies and/or procedures to ensure the rights of all clients, including informing the individual or legal guardian of the client's medical condition, developmental and behavioral status, attendant risks of treatment and the right to refuse treatment. For clients #7, #12 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the	

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			guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. Information regarding risks and/or benefits and the right to refuse treatment will be included. Client #12's guardian will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for sedation will be sent immediately upon the receipt of orders. Information regarding risks and/or benefits and the right to refuse treatment will be included Client #7's HCR will be contacted and notified of the use of, and definition of, four handed dentistry. The HCR will be provided with a copy of client #7's	

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			desensitization plan. The HCR will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for all restraints used with client #7 will be requested. Information regarding risks and/or benefits and the right to refuse treatment will be included W125 The agency has in place policies and/or procedures to ensure the rights of all clients in regard to pre-sedation for dental/medical appointments. For clients #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. Regarding the client #90's fall following sedation, the agency will develop a protocol to address safety measures following the administration of pre-sedation. This protocol will be developed by the IDT with both nursing and programming staff trained by 9-16-12. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for	

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			approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #90 by Dentist and/or IDT and client #90's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental and medical appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation and restraints used during the appointment). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline This plan will require the approval of client #90's HCR. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. For client #10, the guardians will be provided with a description of	

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			4 handed dentistry and asked to provide informed consent on his behalf. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #10 by 9-16-12 and client #10's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline the order in which restraints will be reduced. This plan will require the approval of client #10's guardian. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval W130 Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by 9-16-12. W136	

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			A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Residents 2, 4 6, 7, 8, 9, 10, and 16 have outings scheduled for September that are adequate. The QMRP responsible for those residents has been retrained of that important requirement. W154 The agency has policies in place to assure alleged violations are thoroughly investigated. For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. II All residents of North Willow have the potential to be harmed by the deficient practice. III For all the residents of North Willow there is a policy for elopement. North Willow	

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			followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. The elopement and abuse and neglect policy has been reviewed with the management staff and Quality Assurance Committee. Staff are trained on use of the lift and with regard to the method of transfer for each resident. A policy for Community integration has been drafted and will be followed for the residents of North Willow. Client Advocate staff have been counseled on investigations being completed on time and with thoroughness. Residents who require assist with transfer have had their plans reviewed/revised and staff have been re-educated on the method to transfer them. W186 For all the residents of North Willow there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing.	

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			The elopement policy has been reviewed with the management staff and Quality Assurance Committee. Residents who attend workshop has been assessed and training/work methods and needs assessed for workshop. W159 The PD will complete an audit of all clients who need the restriction of four handed dentistry and submit to HRC for approval prior to the next dental appointment. The PD will prepare items for the HRC meeting no less than monthly to ensure that appropriate items are being submitted for approval. The QDDP will develop a calendar with dates for quarterlies and ISP for client's to ensure that the meetings and documentation are completed within five business days of the meeting. The QDDP will send out paperwork prior to each meeting to ensure that the client's families/ health care representative were present or notified of the meeting. The Program Director will complete weekly review of the calendar and ensure that meetings are completed on time. The QDDP and PD will complete retraining with staff regarding active treatment. The QDDP will complete Active Treatment Observations three	

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			times weekly and provide feedback to the staff at the time of the observation. The QDDP complete an audit to review that each client's ISP and BSP are appropriately addressing each client's needs. The team will write IDT notes for clients who need changes made to their ISP and/ or BSP. The team will implement the changes into the ISP and BSP and train staff on the implementation of the changes. The QDDP will submit all clients who have the restriction of the locked closet to HRC for approval. The QDDP will complete an adaptive equipment audit to ensure that remaining clients have the adaptive equipment needed. If clients do not have the required equipment the IDT will meet to determine if the need is still present for the adaptive equipment. Staff will receive retraining on the use of adaptive equipment. W149 Corrective Measures or Systemic Changes: ·Staffing levels have been evaluated building-wide to provide for adequate supervision. Staffing levels continue to be provided based on resident needs on all three shifts. ·Staff have been re-trained	

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			on utilizing two staff while operating mechanical lifts for transfers of residents. QMRP's will continue to observe both manual and mechanical transfers quarterly to identify any issues. Second floor has a newly added position for a "lift float" that is specifically used to assist with transfers that involve a mechanical lift. ·QMRP's/PD's have audited resident files to determine who receives pre-medication/sedation for medical appointments. All those identified as needing pre-medication have updated care plans relating to safety to decrease the risk of injury while sedated. W124 To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12.	

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			W125 To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by Social Worker/Designee and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. QDDPs will be trained by 9-16-12 to include information regarding the types of restraints used by an individual in annual ISPs along information as to where copies of specific plans are located. W130 Staff will be retrained on providing privacy during treatment and while assisting with personal care, including toileting and showering. For both those clients requiring assistance and those who are more independent, staff will be trained to take advantage of informal training opportunities throughout the day. Training to be completed by 9-16-12. W136	

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			QMRPs have been trained on the Community Integration Policy. W154 In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. W156 The PD will complete an audit of all clients who need the restriction of four handed dentistry and submit to HRC for approval prior to the next dental appointment. The PD will prepare items for the HRC meeting no less than monthly to ensure that	

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			appropriate items are being submitted for approval. The QDDP will develop a calendar with dates for quarterlies and ISP for client's to ensure that the meetings and documentation are completed within five business days of the meeting. The QDDP will send out paperwork prior to each meeting to ensure that the client's families/ health care representative were present or notified of the meeting. The Program Director will complete weekly review of the calendar and ensure that meetings are completed on time. The QDDP and PD will complete retraining with staff regarding active treatment. The QDDP will complete Active Treatment Observations three times weekly and provide feedback to the staff at the time of the observation. The QDDP complete an audit to review that each client's ISP and BSP are appropriately addressing each client's needs. The team will write IDT notes for clients who need changes made to their ISP and/ or BSP. The team will implement the changes into the ISP and BSP and train staff on the implementation of the changes. The QDDP will submit all clients who have the restriction of the locked closet to HRC for approval. The QDDP will complete an	

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			adaptive equipment audit to ensure that remaining clients have the adaptive equipment needed. If clients do not have the required equipment the IDT will meet to determine if the need is still present for the adaptive equipment. Staff will receive retraining on the use of adaptive equipment. IV The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. The Abuse Policy has been reviewed with the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs. QMRPs observe quarterly transfers of the residents in their caseload. W186 The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality	

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			Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs. Quality Assurance has discussed the evolving methods of training and work in the workshop and how to assure staff for training there or in any setting dedicated to education of those with vocational needs supported by this program. W159 The PD will review the Active Treatment observations weekly and retraining as needed. The QDDP will receive retraining on QDDP responsibilities. W149 Corrective Measures or Systemic Changes ·Rehab Coordinator will be assigned weekly a list of residents to audit while transfers occur to ensure that proper procedure is followed. Any concerns will be reported to the Program Director for follow-up. ·A new system has been implemented to track and monitor all appointments, including the use of pre-medications for sedation. All residents identified as using pre-medications will have care plans that identify safety measures needed while sedated. Rehab Coordinator will	

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			oversee PRN adaptive equipment to make sure it is available for use for those whose plans include it (ie, wheelchair with pelvic stabilizer). Staff will be trained on this new procedure so that the risk of injury from pre-medication is lessened. W124 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. Nursing will assure appropriate consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. W125 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. As well, the PD will review annual ISPs to assure that restrictive measures are identified. W130	

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			. Privacy will be added to the active treatment audits and environmental rounds completed by the QDDPs. Nursing staff will audit for privacy while completing daily rounds in the shower room. (see W454 for wording). Professional staff will monitor for and correct any privacy issues that arise while on the unit. W136 Program Directors report monthly assuring that each resident attends outings and when they choose not to attend an IDT is presented that outlines reasons with corrective action per the Community Integration Policy. W154 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. W156 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director.	

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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
	1. An observation was conducted on the 2nd floor of the facility on 8/6/12 from 4:51 PM to 6:20 PM and 8/7/12 from 7:25 AM to 9:35 AM. During the observations, the dining room chairs had food and liquid debris dried to the armrests, backrest, base and legs of the chairs which were used by clients #6, #7, #8, #9, #10, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117 and #118.		W156 The agency has in place policies to report the results of investigations to the administrator or designee within 5 working days. Investigations for clients #9 (7/28/12 fracture), #80 (8/1/12 injury of unknown origin), and #128 &130 (client to client) have been completed. Client advocates will be retrained on the requirement that investigations be completed within 5 working days.	

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	An interview with staff #63 was conducted on 8/6/12 at 5:24 PM. Staff #63 indicated she was not sure who was responsible for cleaning the dining room chairs. Staff #63 indicated she was concerned about the cleanliness of the chairs. Staff #63 indicated she reported her concerns to the Qualified Developmental Disabilities Professional. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure sufficient staff worked on the overnight shift to monitor and supervise clients, on the first floor, to prevent elopement of client #41 who went missing. The governing body failed to exercise general policy, budget and operating direction over the facility facility to ensure sufficient staff were present at the workshop to allow clients to attend the workshop on a daily basis for clients #1, #2, #3, #5, #12, #13, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162. Please see W186. 3. The governing body failed to exercise			

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	general policy and operating direction over the facility failed to ensure each client's active treatment program was coordinated and monitored by the Qualified Developmental Disability Professional in regard to completing quarterly program reviews, following dental recommendations, completing functional assessments and program plans timely, to ensure clients and their families/health care representatives were present/attended a client's meeting, to ensure a health care representative received a copy of a client's program/behavior plans, and to address the identified behavioral needs of a client. The governing body failed to exercise general policy and operating direction over the facility to ensure the QDDP monitored and/or coordinated clients' programs in regard to implementation of objectives, conducting assessments/re-assessments, ensuring clients had/used needed adaptive equipment and to ensure the facility's Human Rights Committee reviewed the practice of dental restraints for clients #1, #2, #5, #6, #7, #8, #9, #10, #12, #16, #66 and #90. Please see W159. 4. The governing body failed to exercise general policy and operating direction over the facility to implement its written policies and procedures to prevent neglect			

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	of client #41 in regard to an elopement incident which resulted in client #41 missing from the facility. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure sufficient staff worked on the over night shift to monitor/supervise clients, on the first floor, to prevent clients from eloping/leaving the facility without staff's knowledge. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client #73 in regard to a fractured hand, and to prevent neglect of clients #7 and #90 in regard to injuries which resulted from falls due to medication presedation. The governing body failed to exercise general policy and operating direction over the facility to develop a policy and/or procedure/system to ensure clients were monitored/protected when presedated for medical/dental procedures. The governing body failed to exercise general policy and operating direction over the facility to implement its policy and procedures to prevent neglect of client #104 in regard to falls. Please see W149. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility			

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	informed the clients' legal representatives (family/Health care Representatives (HCR) and/or the guardian) of the clients' behavioral status/plan, medications and/or restraints used for sedation to ensure the clients' legal representatives understood the risks and/or benefits of the restrictive programs and/or the right to refuse treatment if desired for clients #7, #12 and #90. Please see W124. 6. The governing body failed to exercise general policy and operating direction over the facility to ensure the rights of the client in regard to presedating the client for dental/medical appointments for clients #10 and #90. Please see W125. 7. The governing body failed to exercise general policy and operating direction over the facility to provide privacy during showers/bathing and toileting for clients #14, #62, #66, #119, #124. Please see W130. 8. The governing body failed to exercise general policy and operating direction over the facility to provide the clients with outings or community activities on a regular and ongoing basis for clients #2, #4, #6, #7, #8, #9, #10 and #16. Please see W136. 9. The governing body failed to exercise			

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	general policy and operating direction over the facility to conduct a thorough investigation in regard to the allegations and/or injuries of unknown origin for clients #15, #93 and #148. Please see W154. 10. The governing body failed to exercise general policy and operating direction over the facility to ensure all results/investigations were completed within 5 business days with the results reported to the administrator for clients #9, #128 and #130. Please see W156. This federal tag relates to complaint #IN00113231. 3.1-13(a)			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 11 of 16 sampled clients (#2, #4, #6, #7, #8, #9, #10, #12, #14, #15 and #16) and for 12 additional clients (#41, #62, #66, #73, #104, #90, #93, #119, #124, #128, #130 and #148). The facility failed to implement its written policy and procedures to prevent neglect of clients in regards to an elopement incident which resulted in a client missing from the facility, falls, policy development and a client's fractured hand. The facility failed to ensure clients' rights in regard to participating in community outings/activities on a frequent basis, informing clients' legal representatives of restrictive practices, and privacy. The facility failed to ensure clients' rights in regard to medications used for presedation, completing thorough investigations and to complete investigations timely. Findings include: 1. The facility failed to implement its written policies and procedures to prevent neglect of client #41 in regard to an elopement incident which resulted in	W0122	**W122** I The agency has in place policies and procedures to ensure that client protections requirements are met. North Willow will follow their abuse and neglect policy. Regarding the prevention of neglect for client #41 in regard to an elopement, #73 in regard to a fractured hand, and Clients #7 and #90 in regard to injuries from falls due to medication pre-sedation as well as client #104 in regard to falls, **W149** I Corrective Action for Cited Clients: ·Resident #41 continues to be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care	09/16/2012

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	client #41 missing from the facility. The facility failed to ensure sufficient staff worked on the over night shift to monitor/supervise clients, on the first floor, to prevent clients from eloping/leaving the facility without staff's knowledge. The facility failed to implement its written policy and procedures to prevent neglect of client #73 in regard to a fractured hand, and to prevent neglect of clients #7 and #90 in regard to injuries which resulted from falls due to medication presedation. The facility failed to develop a policy and/or procedure/system to ensure clients were monitored/protected when presedated for medical/dental procedures. The facility also failed to implement its policy and procedures to prevent neglect of client #104 in regard to falls. Please see W149. 2. The facility failed to inform the clients' legal representatives (family/Health care Representatives (HCR) and/or the guardian) of the clients' behavioral status/plan, medications and/or restraints used for sedation to ensure the clients' legal representatives understood the risks and/or benefits of the restrictive programs and/or the right to refuse treatment if desired for clients #7, #12 and #90. Please see W124. 3. The facility failed to ensure the rights		plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. Regarding informing clients' legal representatives of behavioral status/plans, medications and/or restraints, risks and benefits and the right to refuse treatment for clients #7, #12 and #90, **W124** . The agency has in place policies and/or procedures to ensure the rights of all clients, including informing the individual or legal guardian of the client's medical condition, developmental and behavioral status, attendant risks of treatment and the right to refuse treatment. For clients #7, #12 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental	

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	of the client in regard to presedating the client for dental/medical appointments for clients #10 and #90. Please see W125. 4. The facility failed to provide privacy during showers/bathing and toileting for clients #14, #62, #66, #119, #124. Please see W130. 5. The facility failed to provide the clients with outings or community activities on a regular and ongoing basis for clients #2, #4, #6, #7, #8, #9, #10 and #16. Please see W136. 6. The facility failed to conduct a thorough investigation in regard to the allegations and/or injuries of unknown origin for clients #15, #93 and #148. Please see W154. 7. The facility failed to ensure all results/investigations were completed within 5 business days with the results reported to the administrator for clients #9, #128 and #130. Please see W156.		appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. Information regarding risks and/or benefits and the right to refuse treatment will be included. Client #12's guardian will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for sedation will be sent immediately upon the receipt of orders. Information regarding risks and/or benefits and the right to refuse treatment will be included Client #7's HCR will be contacted and notified of the use of, and definition of, four handed dentistry. The HCR will be provided with a copy of client #7's desensitization plan. The HCR will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for all restraints used with client #7 will be requested. Information regarding risks and/or benefits and the right to refuse treatment will be included Regarding ensuring rights of clients in regard to pre-sedating client #10 and #90, **W125** .	

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			The agency has in place policies and/or procedures to ensure the rights of all clients in regard to pre-sedation for dental/medical appointments. For clients #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. Regarding the client #90's fall following sedation, the agency will develop a protocol to address safety measures following the administration of pre-sedation. This protocol will be developed by the IDT with both nursing and programming staff trained by 9-16-12. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent.	

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			The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #90 by Dentist and/or IDT and client #90's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental and medical appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation and restraints used during the appointment). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline This plan will require the approval of client #90's HCR. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. For client #10, the guardians will be provided with a description of 4 handed dentistry and asked to provide informed consent on his behalf. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #10 by 9-16-12 and client #10's IDT will meet by 9-16-12 to develop reduction	

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			plans for the restraints used for dental appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline the order in which restraints will be reduced. This plan will require the approval of client #10's guardian. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. Regarding provision of privacy for clients #14, #62, #66, #119 and #124, **W130**. Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by 9-16-12. Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by	

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			9-16-12. Regarding providing clients with outings and community activities for clients #2, #4, #6, #7, #8, #9, #10 and #16, **W136** . A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Residents 2, 4 6, 7, 8, 9, 10, and 16 have outings scheduled for September that are adequate. The QMRP responsible for those residents has been retrained of that important requirement. Regarding completion of thorough investigations regarding injuries of unknown origin for clients #15, #93 and #148, **W154**. The agency has policies in place to assure alleged violations are thoroughly investigated. For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional	

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			information. Regarding ensuring that investigations were completed and provided to the administrator within 5 working days for clients #9, #128 and #130, **W156**. The agency has in place policies to report the results of investigations to the administrator or designee within 5 working days. Investigations for clients #9 (7/28/12 fracture), #80 (8/1/12 injury of unknown origin), and #128 &130 (client to client) have been completed. Client advocates will be retrained on the requirement that investigations be completed within 5 working days. II All residents of North Willow have the potential to be harmed by the deficient practice. III North Willow has a policy of abuse and neglect. North Willow will follow their abuse and neglect policy. W130 Staff will be retrained on providing privacy during treatment and while assisting with personal care, including toileting and showering. For both those clients requiring assistance and those who are more independent, staff will be	

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			trained to take advantage of informal training opportunities throughout the day. Training to be completed by 9-16-12. W149 Corrective Action for Cited Clients: ·Resident #41 continues to be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. W124 To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and	

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GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(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
			request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. W125 To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by Social Worker/Designee and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. W136 QMRPs have been trained on the Community Integration Policy. W154 In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to	

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			include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. W156 To help prevent reoccurrence of the issue, the client advocates will review daily the outstanding reportable incidents, noting due dates for completion of investigations and submission of follow-up BDDS incident report if required. Documentation of these meetings will be maintained in the client advocates' office. The Executive Director will be notified of any problems arising that might prevent the completion of an investigation to determine how to proceed. IV The Abuse Policy has been reviewed with the Quality Assurance Committee for	

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			adequacy in meeting the needs of the residents of North Willow. W 130 Privacy will be added to the active treatment audits and environmental rounds completed by the QDDPs. Nursing staff will audit for privacy while completing daily rounds in the shower room. (see W454 for wording). Professional staff will monitor for and correct any privacy issues that arise while on the unit. W149 Corrective Measures or Systemic Changes ·Rehab Coordinator will be assigned weekly a list of residents to audit while transfers occur to ensure that proper procedure is followed. Any concerns will be reported to the Program Director for follow-up. ·A new system has been implemented to track and monitor all appointments, including the use of pre-medications for sedation. All residents identified as using pre-medications will have care plans that identify safety measures needed while sedated. Rehab Coordinator will oversee PRN adaptive equipment to make sure it is available for use for those whose plans include it (ie, wheelchair with pelvic stabilizer). Staff will be trained on	

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			this new procedure so that the risk of injury from pre-medication is lessened. W124 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. Nursing will assure appropriate consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. W125 In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. As well, the PD will review annual ISPs to assure that restrictive measures are identified. W136 Program Directors report monthly assuring that each resident attends outings and when they choose not to attend an IDT is presented that outlines reasons	

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			with corrective action per the Community Integration Policy. W154 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. W156 Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director.	

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W0124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on interview and record review for 2 of 16 sampled clients (#7 and #12) and for 1 additional client (#90), the facility failed to inform the clients' legal representatives (family/Health care Representatives (HCR) and/or the guardian) of the clients' behavioral status/plan, medications and/or restraints used for sedation to ensure the clients' legal representatives understood the risks and/or benefits of the restrictive programs and/or the right to refuse treatment if desired. Findings include: 1. Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's physician orders and/or dental notes indicated the following PRN (as needed) orders and/or restraints used: -10/10/11 Client #90 was seen at the dentist office. The 10/10/11 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North	W0124	**W124** I The agency has in place policies and/or procedures to ensure the rights of all clients, including informing the individual or legal guardian of the client's medical condition, developmental and behavioral status, attendant risks of treatment and the right to refuse treatment. For clients #7, #12 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His	09/16/2012

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	Willow with Halcion .25 mg (milligrams) 1 tablet...." The 10/10/11 note indicated "... Pt was wrapped in Rainbow (type of mechanical restraint) and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion .25 mg 1 tab (tablet) 30 minutes before dental appt. (appointment) (4/16/12)...." -4/16/12 Client #90 was seen at the dentist office. The 4/16/12 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North Willow with Halcion .25 mg (milligrams) 1 tablet...." The 4/16/12 note indicated "... Pt was wrapped in Rainbow and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion .25 mg 1 tab (tablet) 30 minutes before dental appt. (appointment) (8/13/12)...."		family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. Information regarding risks and/or benefits and the right to refuse treatment will be included. Client #12's guardian will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for sedation will be sent immediately upon the receipt of orders. Information regarding risks and/or benefits and the right to refuse treatment will be included Client #7's HCR will be contacted and notified of the use of, and definition of, four handed dentistry. The HCR will be provided with a copy of client #7's desensitization plan. The HCR will be contacted by 9-16-12 with the date of the next scheduled dental appointment and a request for approval for all restraints used with client #7 will be requested. Information regarding risks and/or benefits and the right to refuse treatment will be included II All residents of North Willow have the potential to be harmed by the deficient practice. III To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation	

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	Client #90's Inter-Disciplinary Team Review/Informed Consent Form/HRC (Human Rights Committee) Signature Sheets indicated the following: -8/5/11 Client #90 gave written consent (scribble mark) for a 10/10/11 dental procedure where Halcion .25 mg was to be given 1/2 hour prior to the appointment. -2/23/12 Client #90 gave written consent (scribble mark) for the use of Rainbow Wrap (restraint) on 2/24/12. -3/20/12 Client #90 gave written consent (scribble mark) for a pre-medication to sedate the client prior to a 4/16/12 dental appointment. Client #90's record did not indicate client #90's family/HCR was informed of the behavior management techniques/restraints used to manage the client's behavior at the dental appointments. -6/28/12 Client #90 gave written consent for the client's (no date given) Behavior Support Plan (BSP) for AWOL (absence without leave) and food stealing. The facility did not obtain written informed consent from client #90's HCR. Client #90's 3/18/11 Client Self-Determination Assessment indicated		regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. IV In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. Nursing will assure appropriate consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes.	

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	"...[Client #90] is not able to make decisions regarding financial, programming, & (and) medical needs. His sisters & NW (North Willow) staff assist him in making decisions." Client #90's 3/15/12 Individual Support Plan (ISP) indicated "...Continual guardianship is needed to assist him with major life decisions. Program: Social Services will follow up with [name of client #90's sister] who will act as [client #90's] health care representative." Interview with client #90's HCR on 8/8/12 at 5:59 PM indicated she was client #90's HCR. Client #90's HCR/sister indicated she did not know the facility was sedating client #90 until recently. Client #90's HCR/sister indicated she attended a dental appointment with client #90 in 6/12. Client #90's HCR indicated the client had been sedated prior to the dental appointment and then received an IV sedation at the dentist office. The client's HCR/sister indicated client #90's wrists were also restrained/tied down. Client #90's HCR indicated client #90 had to be helped/assisted to get into the van to return to the facility. When asked if client #90's sister/HCR had been informed of the Rainbow Wrap, client #90's sister/HCR stated "No." Client #90's			

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	sister/HCR indicated she wanted to be informed of all programs, restraints and/or techniques used with the client. Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated client #90's sister had not been informed of the use of pre-medication with client #90 prior to 3/12. The QDDP #2 and administrative staff #7 indicated the client's HCR/sister had not been informed of the client's BSP (Behavior Support Plan) and/or ISP. Administrative staff #7 and QDDP #2 indicated client #90 was not able to give consent for the pre-medications and/or restraints. QDDP #2 indicated the client's family was involved in client #90's life prior to 3/21/12. 2. The record of client #12 was reviewed on 8/7/12 at 10:32a.m. Client #12's 3/13/12 ISP indicated client #12 had a guardian. Client #12's 7/16/12 physician's order indicated client #12 was to receive Halcion 25 milligrams 30 minutes prior to dental appointment. Client #12's 7/16/12 dental note indicated client #12 received Halcion prior to her 7/16/12 dental appointment. There was no documentation client #12's guardian had been informed and given consent for Halcion use prior to its use on 7/16/12.			

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	QDDP staff #5 was interviewed on 8/9/12 at 10:02a.m. QDDP staff #5 indicated there was no documentation client #12's guardian had been informed of the restrictive program (Halcion use). 3. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. The "Patient Notes Master," dated, 07/16/2012, indicated, "...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint) was sufficient to stabilize pt. and complete treatment...." An Individual Support Plan (ISP), dated 2/14/12, indicated client #7 had a Health Care Representative. The 2/14/12 ISP and/or record did not indicate client #7 and/or their HCR was informed of the 4 hand dentistry. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated, client #7 and/or their HCR was not informed of the 4 hand dentistry restraint. She stated the restraint, "involved 2 persons holding the client and 1 person working on him." This federal tag relates to complaint #IN00113231. 3.1-4(a)(1)			

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on interview and record review for 1 of 16 sampled clients (#10) and for 1 additional client (#90), the facility failed to ensure the rights of the client in regard to presedating the client for dental/medical appointments. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/5/12 reportable incident report indicated "Client (client #90) was being taken to transportation for appt (appointment) with ENT (Ear, Nose and Throat) physician when brought back to floor by staff member. CLient (sic) was noted with large abrasion to left frontal area of the head and 2 small lacerations to inner lower lip, it was stated he was getting on bus when he fell and hit the pavement." The 7/5/12 reportable incident report indicated client #90 was sent to the ER (emergency room) for evaluation and treatment.	W0125	**W125** I The agency has in place policies and/or procedures to ensure the rights of all clients in regard to pre-sedation for dental/medical appointments. For clients #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified of their behavior status/plans, medications and/or restraints used for sedation and we will request new consents reflecting their receipt of the information. Regarding the client #90's fall following sedation, the agency will develop a protocol to address safety measures following the administration of pre-sedation. This protocol will be developed by the IDT with both nursing and programming staff trained by 9-16-12. For client #90, his family will be asked to continue to provide informed consent on his behalf. This will include request for	09/16/2012

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	The facility's 7/12/12 follow-up report indicated "...Conclusion: Resident fell upon reaching steps to board van for transport. He did receive a pre-med as ordered prior to appointment...." Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's 7/20/12 physician's order indicated client #90 received Valium (sedation) 10 milligrams PRN (as needed) 1 to 2 hours prior to the ENT appointment. Client #90's physician orders and/or dental notes indicated the following PRN orders and/or restraints used: -10/10/11 Client #90 was seen at the dentist office. The 10/10/11 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North Willow with Halcion .25 mg (milligrams) 1 tablet...." The 10/10/11 note indicated "... Pt was wrapped in Rainbow (type of mechanical restraint) and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion		approval for the administration of Halcion prior to dental appointments and will clearly include information regarding the dentists' use of the rainbow wrap and four handed dentistry (with definition of the practice). His family will be provided a copy of his behavior support plan and desensitization plans and requested to provide consent. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #90 by Dentist and/or IDT and client #90's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental and medical appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation and restraints used during the appointment). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline This plan will require the approval of client #90's HCR. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. For client #10, the guardians will be provided with a description of	

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	.25 mg 1 tab (tablet) 30 minutes before dental appt. (appointment) (4/16/12). NPO (nothing by mouth) (after) Midnight except meds and bring pt. wearing absorbent pad to prevent soiling our equipment." -4/16/12 Client #90 was seen at the dentist office. The 4/16/12 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North Willow with Halcion .25 mg (milligrams) 1 tablet...." The 4/16/12 note indicated "... Pt was wrapped in Rainbow and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion .25 mg 1 tab (tablet) 30 minutes before dental appt. (appointment) (8/13/12). NPO (nothing by mouth) (after) Midnight except meds and bring pt. wearing absorbent pad to prevent soiling our equipment." -6/15/12 Client #90 was given IV (intravenous) sedation to have 2 teeth extracted.		4 handed dentistry and asked to provide informed consent on his behalf. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #10 by 9-16-12 and client #10's IDT will meet by 9-16-12 to develop reduction plans for the restraints used for dental appointments. The reduction plan will identify all the restraints used during the course of the appointment (including pre-sedation). As well, the team will identify criteria and a plan for reducing the need for restraints and this will be included in the reduction plan. The plan will outline the order in which restraints will be reduced. This plan will require the approval of client #10's guardian. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. II All residents of North Willow have the potential to be harmed by the deficient practice. III To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. Guardians/HCRs will be notified by Social	

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	Client #90's Inter-Disciplinary Team Review/Informed Consent Form/HRC (Human Rights Committee) Signature Sheets indicated the following: -8/5/11 Client #90 gave written consent (scribble mark) for a 10/10/11 dental procedure where Halcion .25 mg was to be given 1/2 hour prior to the appointment. The form indicated the facility's HRC signed the form on 9/21/11. -2/23/12 Client #90 gave written consent (scribble mark) for the use of Rainbow Wrap (restraint) on 2/24/12. The facility's HRC reviewed and/or approved the restriction on 3/21/12. -3/20/12 Client #90 gave written consent (scribble mark) for a pre-medication to sedate the client prior to a 4/16/12 dental appointment. The facility's HRC reviewed and/or approved the restriction on 3/21/12. -6/25/12 Client #90's Health Care Representative (HCR) (sister) approved the use of Valium 10 mg as a presedation medication for a 7/5/12 ENT appointment on 6/26/12. The form indicated client #90 also signed (scribble mark) the form. -6/28/12 Client #90 gave written consent		Worker/Designee and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. QDDPs will be trained by 9-16-12 to include information regarding the types of restraints used by an individual in annual ISPs along information as to where copies of specific plans are located. IV In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. As well, the PD will review annual ISPs to assure that restrictive measures are identified.	

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	for the client's (no date given) Behavior Support Plan (BSP) for AWOL (absence without leave) and food stealing. The facility's HRC reviewed and/or approved the restrictive behavior plan on 7/19/12. The facility did not obtain written informed consent from client #90's HCR. Client #90's 1/24/12 Social Assessment indicated client #90 was his own guardian. The 1/24/12 assessment indicated family and staff advocated for the client. The assessment indicated "...Social Services will follow up with [client #90's] sister, [name of sister] becoming [client #90's] Health Care Representative." Client #90's 3/18/11 Client Self-Determination Assessment indicated "...[Client #90] is not able to make decisions regarding financial, programming, & (and) medical needs. His sisters & NW (North Willow) staff assist him in making decisions." Client #90's 3/15/12 Functional Skills Assessment (FSA) indicated "Restraint Usage Medical Restraints A. Does the client require a pre-medication for medical procedures? Y (yes)...C. Does the client require the use of a 'Rainbow Wrap'? Y...." The 3/15/12 FSA did not specifically indicate how it was			

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	determined the client was assessed/needed the above mentioned restraints and/or pre-medication. Client #90's 3/15/12 Individual Support Plan (ISP) indicated "...Continual guardianship is needed to assist him with major life decisions. Program: Social Services will follow up with [name of client #90's sister] who will act as [client #90's] health care representative." Client #90's 3/15/12 ISP and 4/20/11 BSP (Behavior Support Plan) indicated the use of 4 handed dentistry had not been included in the client's ISP and/or BSP. The client's ISP and/or BSP failed to clearly indicate when the Rainbow Wrap and/or 4 handed dentistry should be used and to clearly define both restraints. The client's ISP and/or BSP also indicated the facility had failed to obtain written informed consent in regard to the client's 4 handed dentistry and/or failed to get the facility's HRC to review and/or approve the technique to ensure the client's rights were not violated. Client #90's 3/15/12 ISP and/or 4/20/11 BSP indicated the facility did not obtain a guardian for client #90 and/or obtain written informed consent from client #90's sister/HCR for the use of the Rainbow Wrap, and/or for the 8/5/11			

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	and/or 3/20/12 PRN medication used for pre-sedation. Client #90's 4/20/11 BSP indicated the client gave consent for the client's BSP. The facility failed to obtain written informed consent from a guardian and/or client #90's sister/HCR. Client #90's 3/15/12 ISP and/or 4/20/11 BSP indicated the client had an objective to open his mouth for the nurse to examine him with a toothette. Client #90's ISP and/or BSP did not indicate when and/or include a plan of reduction for the need/use of the PRN medication for sedation, the use of the Rainbow Wrap and the 4 handed dentistry. Confidential interview A indicated client #90 was not able to give consent in regard to the use of PRN pre-medication for sedation and/or for restraints used at the dentist office. Interview with client #90's HCR on 8/8/12 at 5:59 PM indicated she was client #90's HCR. Client #90's HCR/sister indicated she did not know the facility was sedating client #90 until recently. Client #90's HCR/sister indicated she attended a dental appointment with client #90 in 6/12. Client #90's HCR indicated the client had been sedated prior to the dental appointment and then received an IV			

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	sedation at the dentist office. The client's HCR/sister indicated client #90's wrists were also restrained/tied down. Client #90's HCR indicated client #90 had to be helped/assisted to get into the van to return to the facility. When asked if client #90's sister/HCR gave written consent for the use of a Rainbow Wrap (restraint), client #90's sister/HCR stated "No." Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated client #90 was not able to give written consent for the pre-medications and/or restraints. QDDP #2 and administrative staff #7 indicated client #90 was his own guardian. QDDP #2 indicated the facility had client #90 give consent for the use of the Rainbow Wrap and/or for PRN medications for sedation when the client was not able to give consent per the client's assessments. Administrative staff #7 indicated client #90's sister did not officially become client #90's HCR until 3/21/12. QDDP #2 and administrative staff #7 indicated the facility did not go back and inform and/or have the client's sister/HCR approve and sign any restrictive program concerning client #90. QDDP #2 indicated the client's family was involved in client #90's life prior to 3/21/12. QDDP #2 and administrative staff #7			

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	indicated they did not specifically know what a Rainbow Wrap was and/or know what 4 handed dentistry was. Administrative staff #7 stated she thought the Rainbow Wrap was was a type of "weighted vest." Administrative staff #7 and QDDP #2 indicated the dentist had assessed the client for the need of the pre-medication and/or restraints used. Administrative staff #7 indicated client #90 had a desensitization goal in place for the use of the pre-medication and/or restraints. Administrative staff #7 and/or QDDP #2 indicated client #90's ISP and/or BSP did not clearly define and/or indicate when the restraints would be used and/or eliminated as the client did not have plan of reduction in place for the use of the PRN medication and/or restraints. QDDP #2 and administrative staff #7 indicated they were not aware of client #90 getting a pre-medication on 6/15/12 as the client was given an IV sedation at the dentist office. Administrative staff #7 indicated she could not locate an order for the use of a PRN on that date. Administrative staff #7 and QDDP #2 indicated the facility's HRC had not reviewed the use of the 4 handed dentistry. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Dental records from 10/17/11 and 6/25/12			

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	indicated the following, "Pt (patient) was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment." There was no documentation in client #10's record indicating a description of four handed dentistry. There was no plan addressing four handed dentistry. There was no documentation in client #10's record the specially constituted committee reviewed and monitored the use of four handed dentistry. A review of client #10's Behavior Plan, dated 2/2/12, indicated there was no documentation addressing the use of four handed dentistry. Client #10's Individual Support Plan (ISP), dated 2/2/12, did not address the use of four handed dentistry. Client #10's Functional Assessment, dated 2/2/12, did not assess the use of four handed dentistry. Client #10's ISP indicated he had co-guardians. Client #10's ISP did not indicate client #10's co-guardians were informed/gave consent to use the 4 handed dentistry. An interview with Qualified Developmental Disabilities Professional (QDDP) #2 was conducted on 8/10/12 at 11:04 AM. QDDP #2 indicated the specially constituted committee did not review and monitor the use of four handed dentistry. QDDP #2 indicated the facility did not submit the clients' dental			

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	treatment forms to the committee for review. QDDP #2 indicated none of the clients had plans or assessments addressing the use of 4 handed dentistry. The facility received reports from the dentist regarding the appointment and the techniques used during the appointment. This federal tag relates to complaint #IN00113231. 3.1-3(a)(1) 3.1-3(d)			

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W0130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation, record review and interview, the facility failed to provide privacy during showers/bathing and toileting for 1 of 16 sampled clients and 4 additional clients (client #14 and additional clients #62, #66, #119, #124). Findings include: 1. During observations on 08/06/2012 at 3:10 p.m., client #66 was sitting on the toilet in the 2 West classroom with the door open. All clothing was removed except her tennis shoes. Clients #6, #7, #62, #64, #65, #67, #71 and #72 were present in the classroom. Certified Nurse Aide (CNA) #48 was reading a book aloud and did not redirect client #66 to close the bathroom door. During observations on 08/08/2012 at 3:10 p.m., client #66 was sitting on the toilet in the 2 West classroom with all her clothing removed except her tennis shoes. The bathroom door was open and clothing was hanging on the doorknob outside of the bathroom. CNAs #48, #49, and #50 were present in the classroom and did not	W0130	**W130** I. Staff working with residents #66, #62, #119, and #124 will be retrained on providing privacy while toileting. Staff working with resident #14 will be retrained on providing privacy during showering. Training to be completed by 9-16-12. II All residents of North Willow have the potential to be harmed by the deficient practice. III. Staff will be retrained on providing privacy during treatment and while assisting with personal care, including toileting and showering. For both those clients requiring assistance and those who are more independent, staff will be trained to take advantage of informal training opportunities throughout the day. Training to be completed by 9-16-12. IV. Privacy will be added to the active treatment audits and environmental rounds completed by the QDDPs.	09/16/2012

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	redirect client #66 to close the door. Clients #6, #7, #64, #65 and #67 were present in the classroom. During an interview on 08/06/2012 at 3:20 p.m., CNA #48 indicated client #66 did not like to have the door closed while she used the toilet. During an interview on 08/09/2012 at 10:20 a.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated the bathroom door should have been closed while client #66 was on the toilet. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated staff should have closed the bathroom door and ensured privacy while client #66 used the toilet. 2. During observations on 08/06/2012, at 3:25 p.m., client #62 was sitting on the toilet in the bathroom in the 2 West classroom with the door open. CNA #48 was sitting in a chair outside the bathroom door. She closed the door at 3:27 p.m. During an interview on 08/06/2012 at 3:30 p.m. Qualified Professional Disabilities Professional (QDDP) #1 stated, "We try to prompt all clients to		Nursing staff will audit for privacy while completing daily rounds in the shower room. (see W454 for wording). Professional staff will monitor for and correct any privacy issues that arise while on the unit.	

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	close the door when using the restroom." She indicated client #62 did not have a history of leaving the bathroom door open while toileting in public locations. 3. An observation was done on 8/7/12 from 6:32a.m. to 8:30a.m. The following was observed: A) At 7:34a.m. client #14 was undressed in a shower chair in a shower room with the shower curtain open. Staff #1 was bathing client #14. There were other clients and staff in the shower room and client #14 could be seen receiving his bath. Staff #2, who was in the shower room, was interviewed on 8/7/12 at 7:37a.m. Staff #2 indicated the shower curtain is supposed to be closed during client bathing to give the clients privacy. B) Client #119 was in the 3 North activity room bathroom with the bathroom door half open. Client #119 could be seen with his pants down and sitting on the toilet. There were peers in the activity room. C) Client #124 was sitting on the toilet in the 3 North activity room bathroom with the door open. Staff and peers were in the activity room and could see client #124 on the toilet. Staff #3 did not prompt client #124 to shut the bathroom door for privacy. Staff #3 was interviewed on 8/7/12 at 7:43a.m. Staff #3 indicated they had the bathroom door open to watch client #119			

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	because he takes his clothes off. 3.1-3(p)(4)			

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W0136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on record review and interview for 8 of 16 sampled clients (#2, #4, #6, #7, #8, #9, #10 and #16), the facility failed to provide the clients with outings or community activities on a regular and ongoing basis. Findings include: 1. The facility's community outing log was reviewed on 8/7/12 at 3:14 PM. The review indicated the following community based outings/activities regarding client #4: -May 2012: 5/18/12 community outing. -June 2012: no outings. -July 2012: no outings. Client #4's personal account ledger dated 3/14/12 through 8/6/12 was reviewed on 8/7/12 at 3:45 PM. Client #4's personal account ledger indicated the following: -June 2012: no outings.	W0136	**W136** I A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Residents 2, 4 6, 7, 8, 9, 10, and 16 have outings scheduled for September that are adequate. The QMRP responsible for those residents has been retrained of that important requirement. II All residents of North Willow have the potential to be harmed by the deficient practice. III QMRPs have been trained on the Community Integration Policy. IV Program Directors report monthly assuring that each resident attends outings and when they choose not to attend an IDT is presented that outlines reasons with corrective action per the Community Integration Policy.	09/16/2012

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	-July 2012: 7/19/12 community outing. Interview with AS (Administrative Staff) #5 on 8/7/12 at 3:45 PM indicated the clients should be going on community outings or participating in community based events minimally one time per month. 2. The review of the community outings for clients #2 and #16 was conducted on 8/8/12 at 2:00 PM. The record indicated client #2 used a motorized wheelchair and had the following community outings for January through July 2012: January 23 - (no destination noted) February 8 - Library March 20 - Walk April 2 - Walk April 20 - Walk April 23 - hospital to visit mother May 3 - Walk May 14 - Walk June 26 - Walk The record review conducted on 8/7/12 at 9:41 AM indicated client #16 used a non-powered wheelchair and had the following community outings for January through July 2012: January 11 - Park February 27 - Walk March 13 - Walk			

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	April 13 - Walk May 30 - Walk June 18 - Walk July 26 - Walk Interview with client #2 on 8/6/12 at 4:20 PM indicated she didn't get to go to day program or on outings because they didn't have seat belts that would work with her wheelchair. Interview with staff QDDP #6 on 8/9/12 at 12:20 PM indicated the facility had two vehicles that could accommodate wheelchairs. The big bus was one and it was used to transport to the workshop and the other coach had to be used for medical appointments. The staff QDDP #6 indicated the facility policy was one outing per month and that was why he made sure they got to go for a walk. 3. A review of client #8's record was conducted on 8/8/12 at 1:01 PM. Client #8 attended community outings, since January 2012, on the following dates: 2/8/12 (downtown drive), 3/14/12 (park and fast food restaurant), 3/30/12 (park), 5/23/12 (park), 5/30/12 (department store), 6/5/12 (walk) and 6/22/12 (fast food restaurant). A review of client #9's record was conducted on 8/8/12 at 11:02 AM. Client			

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	#9 attended 3 community outings since January 1, 2012 on 4/26/12 (parks), 5/30/12 (park)and 6/22/12 (drive). There was no documentation she attended outings on additional dates since January 2012. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Client #10 attended community outings, since January 2012, on the following dates: 1/25/12 (bus ride), 3/6/12 (park), 3/26/12 (restaurant), 4/30/12 (fast food restaurant), 5/30/12 (restaurant), 6/28/12 (fast food restaurant), and 7/24/12 (park). An interview with staff #62 was conducted on 8/9/12 at 11:03 AM. Staff #62 indicated the goal was to get the clients into the community a minimum of one time per month. An interview with QDDP #3 was conducted on 8/10/12 at 9:32 AM. The QDDP indicated the goal was to get the clients into the community one time per month. 4. Client #6's record was reviewed on 08/08/2012 at 1:12 p.m. The record indicated client #6 went to fast food restaurants on 01/27/2012, 02/17/2012, 03/28/2012 and 07/10/2012. The record indicated client #6 took community rides			

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	to parks on 04/11/2012 and 06/12/2012. The record indicated he went to a coffee/doughnut shop on 05/30/2012 and walked in his neighborhood on 06/12/2012 and 07/31/2012. 5. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. The record indicated community rides to parks on 01/16/2012 and 06/21/12. The record indicated client #7 went to a coffee/doughnut shop on 2/15/2012 and to restaurants on 03/27/2012, 05/20/2012, 05/29/2012, and 07/09/2012. The record indicated client #7 shopped for clothing items from an "on-site" clothing distributor on 6/7/2012. During an interview on 08/09/2012 at 10:20 a.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated client #7 purchased clothing from a company that brought selections to the facility for purchase. She stated, " We are required to take them in the community once a month," when asked how frequently clients participated in community outings/activities. 3.1-3(m) 3.1-3(u)(1) 3.1-3(u)(2)			

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W0149	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. Based on observation, interview and record review for 1 of 16 sampled clients (#7) and for 4 additional clients (#41, #73, #90 and #104), the facility neglected to implement its written policies and procedures to prevent neglect of client #41 in regard to an elopement incident which resulted in client #41 missing from the facility. The facility neglected to ensure sufficient staff worked on the over night shift to monitor/supervise clients, on the first floor, to prevent clients from eloping/leaving the facility without staff's knowledge. The facility neglected to implement its written policy and procedures to prevent neglect of client #73 in regard to a fractured hand, and to prevent neglect of clients #7 and #90 in regard to injuries which resulted from falls due to medication presedation. The facility neglected to develop a policy and/or procedure/system to ensure clients were monitored/protected when presedated for medical/dental procedures. The facility also neglected to implement its policy and procedures to prevent neglect of client #104 in regard to falls. Findings include:	W0149	**W149** I Corrective Action for Cited Clients: ·Resident #41 continues to be missing from the facility. ·Resident #73's staff has been re-trained on the use of TWO staff while operating mechanical lifts for transfers of residents. His hand continues to heal with the use of the splint and a fracture care plan is in place to address the injury. ·Resident #90's head abrasion has healed. His ENT appointment has since occurred without any complication. Resident #90 also has an updated fall care plan that addresses the use of pre-medications for medical appointments. ·Resident #7's fall care plan has been updated to address the use of pre-medications for medical appointments. II Other Clients Potentially at Risk: ·All residents might be at risk for this deficient practice.	09/16/2012

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	1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 8/6/12 reportable incident report indicated "Staff was unable to locate resident at 5:10 AM after last observing him in the dining area asking for a drink at 5:00 AM. Nursing was notified. Staff searched the building and the grounds without locating the resident. The police were notified. The search/investigation continues at this time. [Client #41] is ambulatory and verbal. His diagnosis includes Mild Intellectual Disabilities, and Unorganized Schizophrenia, Unspecified Type. Resident displays Compulsive Behaviors. Resident is an emancipated adult." Upon arriving at the facility on 8/6/12 at 12:45 PM through the front door, the facility did not have a front door monitor (a staff who monitored the front door and and exits) sitting in the lobby area of the first floor. The facility's attached 8/6/12 Missing Person Form indicated client #41 was last seen at 5:00 AM entering the first floor dining room. The 8/6/12 missing person's report indicated client #41 was wearing a "...windbreaker pants + (plus) jacket (either navy or black)...." The 8/6/12 missing person report indicated client #41		III Corrective Measures or Systemic Changes: ·Staffing levels have been evaluated building-wide to provide for adequate supervision. Staffing levels continue to be provided based on resident needs on all three shifts. ·Staff have been re-trained on utilizing two staff while operating mechanical lifts for transfers of residents. QMRP's will continue to observe both manual and mechanical transfers quarterly to identify any issues. Second floor has a newly added position for a "lift float" that is specifically used to assist with transfers that involve a mechanical lift. ·QMRP's/PD's have audited resident files to determine who receives pre-medication/sedation for medical appointments. All those identified as needing pre-medication have updated care plans relating to safety to decrease the risk of injury while sedated. IV Corrective Measures or Systemic Changes ·Rehab Coordinator will be assigned weekly a list of	

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	did not have a history of elopement, and the weather condition was "cool temps." The report indicated client #41's suspected method of leaving the facility was through the back patio over the privacy fence. The 8/6/12 missing person's report indicated "...Resident medical concerns (medication needs, physical condition) enlarged testicle-was seen by doctor on 8/3/12 & (and) an ultrasound was recommended...." An attached 8/6/12 Behavior Incident Report indicated "All clients were in there (sic) rooms. Above (client #41) wanted a cup, which he was given. He then went in dining rm (room) to get some water. After 10 min. (minute) time this staff thought it was taking a long time to get his water and went to look for him in the dining area and he was not there." The attached 8/6/12 witness statement written by Certified Nursing Aide (CNA) #70 indicated no other clients were up on the unit which client #41 lived on. The 8/6/12 witness statement indicated "I (CNA #70) saw him (client #41) come down the hall and go to the dining room. I followed him and asked what he needed. He said he needed a drink but just stood there. I then asked him if he needed a cup...He wouldn't take the cup from me, but reached over me taking a cup for himself...I returned to South hall to check		residents to audit while transfers occur to ensure that proper procedure is followed. Any concerns will be reported to the Program Director for follow-up. ·A new system has been implemented to track and monitor all appointments, including the use of pre-medications for sedation. All residents identified as using pre-medications will have care plans that identify safety measures needed while sedated. Rehab Coordinator will oversee PRN adaptive equipment to make sure it is available for use for those whose plans include it (ie, wheelchair with pelvic stabilizer). Staff will be trained on this new procedure so that the risk of injury from pre-medication is lessened.	

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	on [clients #58 and #59]. They were both up. [Client #52] was also awake...I sat down South hall with the girls, but I kept looking for [client #41] to come out of the dining room...." Client #41's record was reviewed on 8/6/12 at 5:16 PM. Client #41's 4/16/10 Admission Staffing indicated the client was admitted on 4/16/10 to the facility from a behavioral unit at a local hospital. The 4/16/10 admission staffing indicated client #41 recently had right lung pneumonia, TB (not infectious) and Hyponatremia due to malnutrition. The 4/16/10 admission staffing indicated the following under the section entitled "Behavior/Psych Concerns Please check all that apply:" Yes was checked for AWOL (Absence without leave). Client #41's 5/4/11 Social Assessment indicated client #41 did not have any known family. The social assessment indicated client #41 would isolate himself from his peers, and ..."[Client #41] does not start a conversation, he acts upon initial conversation...." The 5/4/11 assessment indicated "He (client #41) would be considered at risk in the community due to his marked deficits...." The social assessment indicated client #41 was an "Emancipated Adult" (own guardian).			

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	Client #41's June 2012 physician's orders indicated client #41's diagnoses included, but were not limited to, Mild Mental Retardation, Disorganized Schizophrenia, Electrolyte and Fluid Disorder. Client #41's June 2012 physician's orders indicated client #41 received Zyprexa 20 milligrams at bed time for "Chronic Paranoia and Germ phobia." Client #41's 6/19/12 physician's orders indicated the client's Zyprexa was increased on 6/19/12 from 15 milligrams to 20 milligrams due to the client's increased paranoid schizophrenia. Client #41's 6/19/12 Psychiatrist Consult And Follow-Up Form indicated "Yes, [client #41] continues to display signs and symptoms of Schizophrenia on a daily basis. For a short amount of time [client #41] showed some very positive social interaction with his staff and his peers on the north hall where he resides...." The psychiatric consult indicated the psychiatrist increased client #41's Zyprexa due to the client's "symptoms of paranoia." Client #41's 7/10/12 Psychiatrist Consult And Follow-Up Form indicated "...Team requests medication review. Pt (patient) continues to refuse all attempts to join peers & (and) staff (with) activity. Also			

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	multiple incidences (sic) of refusing shower &/or changing into clean clothes. In room, states he 'needs money to go shopping.' " The form indicated client #41's medication was not changed on 7/10/12. Client #41's 8/2/12 physician's progress note indicated the client's doctor attempted to examine client #41's scrotum. The 8/2/12 progress note indicated the client's doctor documented client #41 refused to allow the doctor to examine the client's scrotum. The 8/2/12 progress note indicated client #41's scrotum was "baseball size." The 8/2/12 progress note indicated client #41's doctor recommended and wrote an order for client #41 to obtain an ultrasound under sedation. Client #41's 5/8/12 Psychiatric Intervention Plan (PIP) indicated the client demonstrated psychosis which included "...delusions, hallucinations, disorganized speech and language. Repetitive behavior, inability to focus, attention deficit. (Auditory hallucinations, thought disorder delusions) negative symptoms such as (demotivation, self-neglect and emotion)...." Client #41's 5/8/12 Individual Support			

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	Plan (ISP) indicated client #41 "Needs a highly supervised residential setting to prevent him from returning to the streets. He needs close supervision and assistance with his medical care needs...." The facility's CNA Night Shift Schedules were reviewed on 8/6/12 at 6:30 PM. The facility's staffing schedule for the night shift (10:30 PM to 6:30 AM) from 7/23/12 to 8/6/12 indicated 3 staff worked on the second and third floors of the building. The night staffing schedules indicated one staff worked on each of the three units on the second and third floors. The staffing schedule indicated 2 CNA staff worked, on the first floor, to monitor and supervise 47 clients who lived on the 3 units. The CNA staffing schedule indicated a "Building Float" staff was to work/cover all 3 floors during the night shift. The bottom of the CNA Night Shift Schedule indicated "Building Float-will relieve all the staff in the building for their 30 minutes break. 15 minutes break will need to be co-coordinated by nursing to ensure that the units are covered, nursing may have to assist with this as well. Please Note that Nightshift can NOT work over the numbers unless approved by the ED (Executive Director)." The facility's staffing schedule from 7/23/12 to 8/6/12 indicated the facility was to have a minimum of 8			

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	CNA staff and 1 building float staff working to monitor/supervise 163 clients in the facility from 10:30 PM to 6:30 AM. The facility's CNA night staffing schedule indicated no CNA building float staff worked on 8/5/12 and only 2 CNA staff worked on the first floor. The 7/23/12 to 8/6/12 staffing schedule indicated one staff worked/monitored the West hallway clients (18 clients) and one staff monitored/supervised clients (29 clients) on the North and South hallways. Client #41 resided/lived on the North hallway. The facility's 7/23/12 to 8/6/12 CNA night shift staffing schedules indicated the facility did not have sufficient staffing levels to monitor and/or supervise clients, on the first floor, as no building float staff worked on the following: -7/26/12 -7/27/12 -7/30/12 -7/31/12 -8/4/12 -8/5/12 The facility's Front Door Monitor book was reviewed on 8/6/12 at 6:20 PM and on 8/7/12 at 3:10 PM. The facility's front door monitor book for 2012 indicated a door monitor was posted at the front door of the facility on 8/5/12 (Sunday) from 6:30 AM to 8:30 PM. The door monitor			

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	book indicated the facility did not have a front door monitor on 8/6/12 until 2:30 PM. The bottom of the Front Door Monitor Check Sheets indicated "General Instructions: Check each door, redirect any resident noted in area near doors. Report immediately to nurse if any resident is redirected and write a B.I.R. (Behavior Incident Report)." The forms also indicated the front floor monitor was to remind the nurse on the first floor west hallway to lock the front door at 5:00 PM. Interview with administrative staff #1 on 8/6/12 at 4:50 PM stated "[Client #41] walked off and is missing from the facility." Administrative staff #1 indicated client #41 left the facility in the morning and had not been located. Administrative staff #1 indicated the police had been notified. Interview with staff #71 on 8/6/12 at 6:20 PM indicated she was the front door hall monitor for the first floor. Staff #71 indicated she had been sitting in the lobby area monitoring the front door and exits since 3:00 PM. Staff #71 indicated she was to monitor clients if they tried to leave the facility and visitors coming into the facility. When asked if a monitor had been in place prior to the start of her shift, staff #71 indicated she did not relieve anyone when she came to monitor the			

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	front door. Staff #71 indicated the door monitor worked from 6:30 AM to 8:30 PM every day. Staff #71 was not able to locate a monitor sheet for the day/morning shift for 8/6/12. Interview with administrative staff #5 on 8/6/12 at 6:30 PM indicated client #41 walked down the North hallway and asked staff for a drink of water. Administrative staff #5 indicated the CNA went to the South hallway unit and when the CNA went to the dining room to check on client #41 he was not in the dining room. Administrative staff #5 indicated the cup client #41 had was found sitting on a table in the patio area. Administrative staff #5 stated the facility thought client #41 left through the patio door and "scaled fence." Administrative staff #5 indicated the patio door was unlocked. Administrative staff #5 indicated client #41 had not attempted to leave/elope from the facility since the client was admitted to the facility in 2010. Administrative staff #5 indicated client #41 did not have any family and did not have visitors. When asked if client #41 had pedestrian safety skills, administrative staff #5 stated "I would probably say pretty good." Administrative staff #5 indicated the front door monitor worked from 6:30 AM to 8:30 PM on the weekends.			

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	Administrative staff #5 indicated a front door monitor was placed at the door on 8/6/12 after client #41 left the facility. Interview with administrative staff #5 and Qualified Developmental Disabilities Professional (QDDP) #7 on 8/6/12 at 6:45 PM indicated the front door monitor was placed on the front door of the first floor after 2:30 PM when the evening shift started. QDDP #7 and administrative staff #5 indicated it was not unusual for client #41 to wake up and ask for something to drink. QDDP #7 indicated client #41 would be dressed with his shoes on. QDDP #7 and administrative staff #5 indicated it was not normal for the client to wear a jacket when he came out of his room in the morning. Administrative staff #5 stated client #41 had lived on the streets in the past and was "homeless." Administrative staff #5 stated client #41 had been found "wandering at a gas station" in the past and was admitted to a local hospital as the client was "homeless" and sick. Administrative staff #5 indicated client #41 would not ask for help. QDDP #7 and administrative staff #5 did not know why Yes had been checked for AWOL behavior on client #41's admission papers. QDDP #7 indicated client #41 did not have a behavior plan for elopement as the client had not demonstrated elopement			

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	behavior since his admission. QDDP #7 and administrative staff #5 indicated it was thought client #41 had $5 to $10 dollars on him when he left. QDDP #7 indicated client #41 had not been spending his money/allowance. When asked if client #41 was medically compromised, administrative staff #5 stated "Without Zyprexa he is medically compromised." Administrative staff #5 indicated client #41 had an enlarged scrotum and was due to have an ultrasound. Administrative #5 indicated client #41 did not have any identification on him. When asked how many staff were working when client #41 left the facility, administrative staff #5 stated "Two staff plus float." Administrative staff #5 indicated a nurse was also on the first floor doing tube feedings. Interview with administrative staff #1, the Director of Nursing (DON), administrative staff #5 and corporate staff #1 on 8/6/12 at 8:20 PM indicated client #41 was missing from the facility. The DON indicated she was called on 8/6/12 at 5:29 AM and was told the client was missing. Administrative staff #1 indicated she was called around 5:26 AM on 8/6/12. Administrative staff #1 indicated the staff searched the building for client #41 with no success and then called the police. Administrative staff #1			

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	indicated the facility's administrative staff then started searching for client #41 outside the facility and downtown. Administrative staff #1 indicated client #41 had lived on the streets before as a homeless person. Administrative staff #1 indicated the client had not attempted to elope from the facility since he had been admitted. Administrative staff #1 indicated it was not normal for client #41 to wear a jacket/coat at 5:00 AM in the morning. Administrative staff #1 stated "In hindsight, it looks like he planned this." Administrative staff #1 indicated client #41 had been asking for money, and not spending his money. Administrative staff #1 indicated client #41 had asked about group home placement in the last couple of months. When asked how many staff were working on the first floor, when client #41 left the facility, administrative staff #1 stated "Two CNAs and a nurse. The floater did not come in until 5:30 AM." Administrative staff #1 indicated one staff worked on the West hall and one staff worked on the North and South hallways. Administrative staff #1 indicated there were 3 clients up on the South hallway where the one staff was located. Administrative staff #1 indicated the facility put a monitor on the front door after the 8/6/12 incident occurred. Administrative staff stated the front door monitor would be in "place for 24 hours a			

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	day even though the facility suspected the client left through the patio door as there were "scuff marks" on the white vinyl privacy fence. Administrative staff #1 indicated the facility was also conducting evaluations of other clients to see if anyone was at risk for eloping/leaving the facility. Interview with QDDP #6 on 8/7/12 at 9:40 AM indicated he filled out the 4/16/12 admission staffing report. QDDP #6 indicated client #41 was admitted to the facility from a behavioral unit. QDDP #6 stated when the hospital staff brought the client to the facility, they had indicated the client was "a high risk for AWOL in returning to the streets." QDDP #6 indicated client #41 had not tried to elope/go AWOL from the facility since he was admitted. Interview with administrative staff #1 on 8/7/12 at 2:40 PM indicated the first floor only had 2 staff working at night versus three staff which worked on the other 2 floors of the building. Administrative staff #1 indicated this was due to the fact there were more clients on the second and third floors and less clients on the first floor. When asked if the facility had considered if they had sufficient staffing since client #41 was able to get out of the building on 8/6/12, administrative staff #1			

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	indicated the facility had looked at the staffing but did not change the staffing level. Administrative staff #1 indicated the clients on the North and South halls of the first floor did not require staff to lift them. Administrative staff #1 indicated there were 4 clients (#3, #20, #34 and #56), who were considered an elopement risk on the first floor. Administrative staff #1 indicated client #41 was at risk in the community as the client had been in the facility for 2 years and became dependent on staff. Administrative staff #1 indicated client #41 did not have any form of identification on him when he left. Administrative staff #1 indicated client #41 was at risk for potential harm. Interview with administrative staff #6 on 8/8/12 at 9:02 AM indicated the facility was to have a building float staff on the night shift. Administrative staff #6 indicated there was no building float staff on 8/4 and/or 8/5/12 as the new person hired to work as the float staff got her hours mixed up and did not come into work. Administrative staff #6 indicated the facility also did not have a building float staff on the night shifts on 7/26, 7/27, 7/30 and 7/31/12. Interview with CNA #73 on 8/9/12 at 8:25 AM stated client #41 "never displayed signs of wanting to leave."			

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	When asked if client #73 normally wore his jacket, CNA #73 stated "No, only wore coat or jacket in the winter time." CNA #73 indicated client #41 would sleep in his clothes and only worked on Monday, Wednesday and Friday. Interview with CNA #72 on 8/9/12 at 8:28 AM indicated client #41 did not give an indication he wanted to leave. Interview with administrative staff #1 on 8/9/12 at 8:22 AM indicated client #41 had not been found/located. 2. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/21/12 reportable incident report indicated "CNA noted clients (sic) [client #73] left hand swollen. nurse (sic) order x-ray of hand, results left third metacarpus fracture. sent (sic) to [name of hospital] e.r. (emergency room)." The facility's 7/27/12 follow-up report indicated "...Based on interviews, it appears the fracture occurred sometime during the hoyer transfer...." Client #73's record was reviewed on 8/9/12 at 8:32 AM. Client #73's 7/21/12 Radiology Report indicated "There is a nondisplaced, oblique fracture through the			

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	third metacarpus which appears acute. There is no obvious dislocation or intra-articular extension." Client #73's 7/21/12 Patient Discharge Disposition Form indicated "...Hand fracture needs to follow up with hand surgery within 7 days...." The form indicated the client was referred to a hand surgeon. Client #73's 8/2/12 Physician's Orders indicated the client saw the hand surgeon on 8/2/12. The note indicated "Continue splint. Will discuss management options w/patients brother." Client #73's 1/27/12 Occupation Therapy (OT) Evaluation indicated client #73's diagnosis included, but was not limited to, Infantile Cerebral Palsy. Client #73's OT evaluation indicated client #73 utilized a wheelchair and required total assistance with a Hoyer lift for transfers with 2 staff. Client #73's 7/25/12 Interdisciplinary Team (IDT) Plan of Care Addendum indicated "The team met to discuss the conclusions from the investigation of [client #73's] hand fracture on 7/21/12. The injury was first reported around lunch on that day. [Client #73] and his roommate both reported that the injury occurred due to the lift. The staff			

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	transferring [client #73] on the day of the injury reported that he did not cry in pain or mention discomfort. The staff was not following company policy of having two staff present during all Hoyer transfers. Staff training is in place and staff have been made available to assist in all Hoyer transfers." Interview with LPN #74 on 8/9/12 at 8:42 AM indicated client #73 saw the hand surgeon on 8/2/12. LPN #74 indicated the doctor indicated the client's hand would heal with the hand splint, but wanted to discuss other options with the client's brother. LPN #74 indicated client #7 required a 2 person transfer with a Hoyer Lift. Interview with administrative staff #2, #3 and #4 on 8/9/12 at 11:35 AM indicated client #73's hand was fractured by the CNA when the CNA was using the Hoyer Lift with the client. Administrative staff #2, #3 and #4 indicated the CNA did not use a second staff person to assist her with client #73 when using the Hoyer Lift. Administrative staff #2, #3 and #4 indicated client #73 and the client's roommate indicated client #73's hand was hurt when the CNA used the Hoyer Lift. Administrative staff #2, #3 and #4 indicated the CNA was retrained on 7/28/12.			

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	3. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/5/12 reportable incident report indicated "Client (client #90) was being taken to transportation for appt (appointment) with ENT (Ear, Nose and Throat) physician when brought back to floor by staff member. CLient (sic) was noted with large abrasion to left frontal area of the head and 2 small lacerations to inner lower lip, it was stated he was getting on bus when he fell and hit the pavement." The 7/5/12 reportable incident report indicated client #90 was sent to the ER for evaluation and treatment. The facility's 7/12/12 follow-up report indicated "...Conclusion: Resident fell upon reaching steps to board van for transport. He did receive a pre-med as ordered prior to appointment. The recommendation of the team is to use a wheelchair for transport and take extra care as needed when residents are pre-medicated." Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's 7/20/12 physician's order indicated client #90 received Valium (sedation) 10 milligrams PRN (as needed) 1 to 2 hours prior to the			

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	ENT appointment. Client #90's Patient Discharge Disposition Form indicated "Diagnosis Fall, Head Injury, Abrasion of scalp." The discharge form indicated a CT (cat scan) of client #90's brain and head without contrast was done at the hospital. Client #90's nurse Progress Notes indicated the following (not all inclusive): -7/5/12 at 6:07 PM, "Change of Condition...Assessment: large abrasion to left frontal area of head measuring 9.2cm (centimeters) x (by) 3.8cm x ud irregular in shape wound bed beefy red, lower lip noted with 2 small lacerations measuring 1cm x .2cm x ud lower lip was bleeding quite a bit, area to the head was cleansed gently and 3 x 4 gauzes were placed and secured with kerlix wrap around head, neuro checks were initiated, no deficits were noted had been previously medicated for his ENT appt but still able to nod yes and no and answer 3-4 word sentences...." -7/5/12 at 11:35 PM, "Resident brought back by the EMT (emergency medical technicians) from ER [name of hospital] around 1830pm (6:30 PM). A new order for Bacitracin ointment BID (two times a day) to the scalp of the head was given.			

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	VitalS (signs) were as follows BP (blood pressure) 138/85 P (pulse) 80 R(respirations) 18 T (temperature) 98.9. No bleeding or discharge noted on scalp area of the head. Resident spent the remainder of part of the shift doing his daily activities in the classroom. No vomiting or signs of fever noted. Still to monitor ambulation as gait remains poor." Client #90's 7/12/12 IDT note indicated "...Nursing noted [client #90] had been pre-medicated for his ENT appointment prior to leaving the building. Staff will be cautioned to take extra care with pre-medicated individuals, which may warrant the use of a PRN wheelchair. Care Plan written by nursing. The Team will continue to monitor." Client #90's 3/15/12 Individual Support Plan (ISP) indicated client #90 was at risk for falls. Client #90's 2/11/12 Risk Plan indicated "At risk for falls related to: Fell in the past 31-180 days." The 2/11/12 falls plan indicated the following interventions: "-Activity Programming-exercise, TV programs -Footwear to prevent slipping -Keep environment well lit and free of			

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	clutter -Prompt client to hold onto the arms of chair when getting up." Client #90's 3/15/12 ISP and/or 2/11/12 risk plan for falls neglected to indicate how facility staff were to transport and/or assist client #90 to ambulate to prevent the client from falling when the client received a PRN medication for sedation prior to medical and/or dental appointments. Interview with client #90's family on 8/8/12 at 5:59 PM indicated client #90 fell while being sedated for a medical appointment. Client #90's family indicated client #90 should have been placed in a wheelchair for transportation as the client was sedated for a doctor's appointment. Client #90 family stated "He fell on his head. No one was holding on o him and they tell me he was medicated." Client #90's family indicated the facility sedated the client for dental appointments as well as the client would hit/touch others. Interview with administrative staff #7 and QDDP #2 on 8/9/12 at 9:32 AM indicated client #90 fell trying to get on the van to go to a doctor's appointment. Administrative staff #7 indicated client			

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	#90 was not placed in a wheelchair to be transported to the van on 7/5/12. Administrative staff #7 indicated another staff person took client #90 to the van. Administrative staff #7 and QDDP #2 indicated client #90 was normally transported in a wheelchair due to the sedation. QDDP #2 indicated client #90's ISP and/or record did not indicate how client #90 was to be monitored/transported for safety when sedated. Administrative staff #7 indicated the facility did not have a policy/procedure and/or system in place in regard to how clients were to be monitored/protected when they received medications for sedation to prevent injuries/falls. The facility's policy and procedures were reviewed on 8/6/12 at 1:40 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The facility's May 2001 policy indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...." 4. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. The "Patient			

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	Notes Master," dated, 07/16/2012, indicated, "...Special needs-slight anxiety/combative pt (patient) was presedated by home (facility) -(sic) with Halcion .25 mg (milligrams) 3 tabs (tablets)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold) was sufficient to stabilize pt. and complete treatment...." A "Progress Note," dated 07/16/2012 at 12:30 p.m. indicated, "...client got out of the prn (as needed) wheel chair while in the dining room before staff could get to him, he fell on the floor on his rt (right) side...client had a dental appt (appointment) with a premed of halcion 0.25 mg, 3 tab @ (at) 10:45 a.m. client was unsteady and sleepy...." During an interview with LPN #74 on 8/9/12 at 8:42 AM indicated client #7 did not have a seat belt on the day client #7 stood up and fell from his wheelchair. LPN #74 indicated the client was placed in the wheelchair due to the client's being unsteady from the presedation. During an interview on 08/09/2012 at 10:00 a.m. the Director of Nursing (DoN) indicated the wheelchair seat belt should			

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	have been fastened to prevent falling until the effects of the sedative had worn off. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated there was not a protocol for monitoring/ensuring safety of a client following medical procedures with sedation. The facility's policy and procedures were reviewed on 8/6/12 at 1:40 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The facility's May 2001 policy indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...." 5. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/21/12 reportable incident report indicated on 7/21/12 at 4:27 AM, client #104 fell while ambulating in the hallway attempting to leave the unit. Client #104 struck the right side and right forehead after shuffling her feet when verbally redirected to remain on the unit. Nursing staff was notified and client #104			

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	was noted to have bruising and edema to her right forehead and brow. The Fall Report, undated, indicated in the conclusion, "[Client #104's] discolorations are resolving at this time without complication. There are no further injuries noted. Insomnia is included in [client #104's] diagnosis. AWOL is addressed in her Behavior Service Plan. Staff had been directed to remove socks from [client #104] at bedtime to decrease possibility of slipping. Sleep study continues at this time. There are no further recommendations at this time." The Change in Condition Report, dated 7/21/12, indicated client #104 had a history of falls. Observations were conducted on the 2nd floor of the facility on 8/6/12 from 3:47 PM to 6:20 PM, 8/7/12 from 7:25 AM to 9:35 AM and 8/8/12 from 8:30 AM to 9:50 AM. During the observations, client #104 had bruising noted around both of her eyes, light brown in color. Client #104 was seated in a wheelchair with a name different from her own embroidered on the backrest of the wheelchair. A review of client #104's record was conducted on 8/8/12 at 9:54 AM. The record contained no team meeting notes discussing the fall. Her Physician's			

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	Orders, dated 7/12, indicated she may use a wheelchair as needed. A Physical Therapy Discharge and Recommendations, dated 4/24/12, indicated the following, "Promote ambulation safely on even surfaces and HHA (hand held assistance) with gait belt as able." An interview with staff #65 was conducted on 8/8/12 at 10:51 AM. Staff #65 indicated the wheelchair client #104 was using was a loaner. Staff #65 indicated client #104 was measured for a wheelchair on 7/11/12. Staff #65 indicated client #104 needed a loaner wheelchair 24 hours a day. An interview with staff #62 was conducted on 8/9/12 at 11:03 AM. Staff #62 indicated client #104 was in Physical Therapy (PT) for awhile. PT was discontinued due to client #104's uncooperativeness and not walking. Staff #62 had been using a wheelchair. Staff #62 indicated client #104 had been walking more and staff should be using a gait belt. Staff #62 indicated there was no plan in place for staff to implement regarding the use of a gait belt, when to walk with client #104 and how far. The facility's policy and procedures were reviewed on 8/6/12 at 1:40 PM. The			

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	facility's May 2001 policy entitled Reporting Alleged Violations indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The facility's May 2001 policy indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...." This federal tag relates to complaint #IN00113231. 3.1-28(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review of 3 of 37 allegations of neglect, abuse and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to the allegations and/or injuries of unknown origin for clients #15, #93 and #148. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/28/12 reportable incident report indicated "Client (client #93) noted with 3cm. (centimeter) discolored area to back R. (right) hand. Nursing notified. No c/o (complaints of) discomfort. No open areas, VS (vital signs) stable. No c/o discomfort. No other injuries noted. Client has self injurious behavior in his Behavior Management Plan. The area of the discoloration is an area client puts in his mouth and bites often. Investigation in progress...." The facility's 8/3/12 follow-up report indicated "...Conclusion: The team met to discuss [client #93's] unknown injuries to his top R. hand.. 1. The team is aware	W0154	**W154** I The agency has policies in place to assure alleged violations are thoroughly investigated. For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. II All residents of North Willow have the potential to be harmed by the deficient practice. III In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates.	09/16/2012

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	that the client has self injurious behavior in his BSP (Behavior Support Plan). Client does bite the top of his R. hand often. The team feels this incident was caused by self injurious behavior...." The 8/3/12 follow-up report indicated the facility did not interview any clients and only interviewed 2 staff (an LPN and the Program Director). The 8/3/12 follow-up report and/or investigation did not indicate any additional interviews were conducted. Interview with administrative staff #3 on 8/9/12 at 11:35 AM indicated administrative staff did not interview any clients as the clients were non-verbal in communication. Administrative staff #3 indicated she did interview other staff, but did not document the interviews. 2. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's reportable incident reports indicated the following: -7/18/12 Client #148 was found to have a scratch to her upper right arm. The facility's undated investigation indicated the client most likely caused the injury herself. The facility's undated investigation indicated the client was not interviewed as the client was non-verbal.		For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director.	

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	The facility's undated investigation did not indicate any additional clients were interviewed. -7/15/12 Client #15 was found to have 3 pink abrasions to his left knee. The reportable incident report indicated the client was with his parents on 7/14/12. The reportable incident reports indicated the client's parents indicated the client did not injure himself when he was with them. The undated investigation indicated the client did not have any "maladaptive behaviors." The undated investigation indicated "The team feels that it (sic) likely [client #15] bumped his knee on a table/chair while walking about." The undated investigation indicated client #15 was "not appropriate for interview." The facility's investigation did not indicate any additional clients were interviewed. Interview with administrative staff #3, #4 and #5 on 8/9/12 at 11:35 AM indicated no additional clients were interviewed for the above mentioned 7/18 and 7/5/12 injuries of unknown origin. 3.1-28(d)			

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 3 of 37 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to ensure all results/investigations were completed within 5 business days with the results reported to the administrator for clients #9, #128 and #130. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/28/12 reportable incident report indicated "Client (client #9) walking down hallway toward dining room and suddenly showed signs of discomfort in her left foot. Client sat down on floor and pointed to her left foot and would not stand. A portable X-ray was taken on 7/28/12 of Lt (left) foot and ankle. Results showed no fracture or dislocation. on (sic) 7/29/12 client continues to show S/S (signs/symptoms) of discomfort to left foot and leg and resistance to bear weight on leg. Client PRN (as needed) Tylenol for discomfort	W0156	**W156** I The agency has in place policies to report the results of investigations to the administrator or designee within 5 working days. Investigations for clients #9 (7/28/12 fracture), #80 (8/1/12 injury of unknown origin), and #128 &130 (client to client) have been completed. Client advocates will be retrained on the requirement that investigations be completed within 5 working days. II All residents of North Willow have the potential to be harmed by the deficient practice. III To help prevent reoccurrence of the issue, the client advocates will review daily the outstanding reportable incidents, noting due dates for completion of investigations and submission of follow-up BDDS incident report if required. Documentation of these meetings will be maintained in the client advocates' office. The Executive Director will be notified of any problems arising that might prevent the completion of an investigation to determine how to proceed.	09/16/2012

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	and sent to [name of hospital] for further evaluation." The facility's 7/30/12 follow-up report indicated "This is a follow up to the ER (emergency room) visit on 7/29/12 to report a fracture. [Client #9]...returned from [name of hospital] 7/29/12 with a diagnosis of fracture to left ankle...[Client #9] was noted to have maladaptive behaviors on 7/27/12. [Client #9] is non-verbal and ambulatory. She has a diagnosis including Osteoporosis, Epilepsy, and Unspecified Thrombocytopenia. Investigation in progress...." Review of the facility's 7/28/12 reportable incident report and 7/30/12 follow up report indicated, the facility was still conducting an investigation in regard to the client's fracture of unknown origin as of 8/9/12. Interview with administrative staff #3, #4, and #5 on 8/9/12 at 11:35 AM indicated the facility was still conducting an investigation in regard to the client's fracture. Administrative staff #3 stated client #9's fracture was most likely the result of the client's "behavior of getting on the floor and stomps her feet." 2. The facility BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed		IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director.	

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	on 8/6/12 at 6:20 PM. The BDDS reports indicated the following: -8/2/12 BDDS report indicated on 8/1/12, client #80 was being showered when staff identified an abrasion on his upper left thigh. The BDDS report indicated the origin of the injury was not known. The BDDS report included a Verification of Investigation (VI) form dated 8/2/12. The VI did not indicate the outcome of the investigation regarding the source of client #80's abrasion on his upper left thigh. -8/2/12 BDDS report indicated on 8/1/12, client #128 hit his peer client #130 twice. The review did not indicate an investigation regarding this incident of client to client aggression. Interview with Administrative Staff (AS) #2 on 8/9/12 at 12:30 PM indicated the results of investigations should be completed within five business days of the incident. AS #2 indicated the facility had not completed the investigations in regard to above mentioned 8/1/12 and 8/2/12 incidents. 3.1-28(e)			

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W0158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Facility Staffing for 13 of 16 sampled clients (#1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13, #14 and #16) and for 66 additional clients (#17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #66, #90, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #147, #149, #150, #152, #154, #156, #157, #158, #159, #160, #161 and #162). The facility failed to ensure the facility had sufficient staff to monitor/supervise clients, at the facility, on the overnight shift to prevent a client from eloping/missing from the facility. The facility failed to ensure the facility had sufficient staffing to allow the clients to attend the facility owned workshop. The facility failed to ensure the Qualified Developmental Disabilities Professional (QDDP) monitored and and/or coordinated clients' Individual Support Plans to meet the clients' needs in regard to active treatment services. Findings include:	W0158	**W158** I. For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. . North Willow followed their elopement policy and will follow their elopement policy. Residents number 1-10, 12, 13, 14, 16, 17-38, 40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 149, 150, 152, 154, 156, 157, 158, 159, 160, 161, 162 have a one time mental anguish assessment completed. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. North Willow has a staffing procedure that is reviewed regularly with regard to census, acuity and other resident needs and updated as needed. That procedure has been re-educated with the CNA scheduler and nursing staff. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend. II All residents of North Willow have the potential to be harmed by the deficient practice. III. For all the residents of North Willow there is a policy for elopement. North Willow	09/16/2012

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	1. The facility failed to ensure sufficient staff worked on the overnight shift to monitor and supervise clients, on the first floor, to prevent elopement of client #41 who went missing. The facility to ensure sufficient staff were present at the workshop to allow clients to attend the workshop on a daily basis for clients #1, #2, #3, #5, #12, #13, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162. Please see W186. 2. The facility failed to ensure each client's active treatment program was coordinated and monitored by the Qualified Developmental Disability Professional in regard to completing quarterly program reviews, following dental recommendations, completing functional assessments and program plans timely, to ensure clients and their families/health care representatives were present/attended a client's meeting, to ensure a health care representative received a copy of a client's program/behavior plans, and to address the identified behavioral needs of a client.		followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. The elopement policy has been reviewed with the management staff and Quality Assurance Committee. IV The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs.	

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	The facility failed to ensure the QDDP monitored and/or coordinated clients' programs in regard to implementation of objectives, conducting assessments/re-assessments, ensuring clients had/used needed adaptive equipment and to ensure the facility's Human Rights Committee reviewed the practice of dental restraints for clients #1, #2, #5, #6, #7, #8, #9, #10, #12, #16, #66 and #90. Please see W159.			

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W0159	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. Based on record review and interview, the facility failed for 11 of 16 sampled clients (#1, #2, #5, #6, #7, #8, #9, #10, #12, #14 and #16) and for 10 additional clients (#66, #90, #147, #150, #152, #154, #156, #157, #158 and #159) to ensure each client's active treatment program was coordinated and monitored by the facility's Qualified Developmental Disability Professional (QDDP) in regard to completing quarterly program reviews, following dental recommendations, completing functional assessments and program plans timely, to ensure clients and their families/health care representatives were present/attended a client's meeting, to ensure a health care representative received a copy of a client's program/behavior plans, and to address the identified behavioral needs of a client. The QDDP failed to monitor and/or coordinate clients' programs in regard to implementation of clients' objectives, to conduct assessments/re-assessments, needed adaptive equipment was available/used, and to ensure the facility's Human Rights Committee (HRC) reviewed facility's practice of dental	W0159	**W 159** I QDDP will ensure that an annual ISP and required annual documentation for Clients #5 and #10 are appropriately placed in their charts . The team will review Client #10's dietary recommendation and complete an IDT with recommendations from the IDT. Staff will be trained on any changes made. The team will review Client #66's BSP and ISP to address incidents of flushing items down the toilet and complete an IDT with recommendations from the IDT. The team will implement the changes into the ISP and BSP and train staff on the implementation of the changes. Staff will be trained on any changes made. The QDDP will complete an FAS for clients #17, #10, and #90. The QDDP complete an audit to review that each client's ISP and BSP are appropriately addressing each client's needs. The team will write IDT notes for clients who need changes made to their ISP and/ or BSP. The team will implement the changes	09/16/2012

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	restraints. Findings include: 1. Record review for client #5 was done on 8/7/12 at 3:02p.m. Client #5's QDDP program reviews indicated client #5 had an individual support plan (ISP) dated 7/13/12. There were no documented QDDP program reviews during the time period of 7/13/11 through 7/13/12. QDDP staff #4 was interviewed on 8/9/12 at 10:33a.m.. QDDP staff #4 indicated the QDDP should be reviewing the clients' programs at least quarterly. QDDP staff #4 indicated quarterly QDDP program reviews had not been done for client #5 during the past 12 months.		into the ISP and BSP and train staff on the implementation of the changes. The QDDP and PD will complete retraining with staff regarding active treatment. The QDDP will complete Active Treatment Observations three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #1, #2, #6, #10, #12, #14, #147, #150,#152, #154, #154, #157, #158, #159, and all remaining clients. 8. The QDDP will review clients need for having their clothing locked. The QDDP will submit all clients who have the restriction of the locked closet to HRC for approval. The PD will complete an audit of all clients who need the restriction of four handed dentistry and submit to HRC for approval prior to the next dental appointment. The PD will prepare items for the HRC meeting no less than monthly to ensure that appropriate items are being submitted for approval. The QDDP will review the adaptive equipment for clients #2, #5, and #16. II All residents of North Willow have the potential to be harmed	

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			by the deficient practice. III The PD will complete an audit of all clients who need the restriction of four handed dentistry and submit to HRC for approval prior to the next dental appointment. The PD will prepare items for the HRC meeting no less than monthly to ensure that appropriate items are being submitted for approval. The QDDP will develop a calendar with dates for quarterlies and ISP for client's to ensure that the meetings and documentation are completed within five business days of the meeting. The QDDP will send out paperwork prior to each meeting to ensure that the client's families/ health care representative were present or notified of the meeting. The Program Director will complete weekly review of the calendar and ensure that meetings are completed on time. The QDDP and PD will complete retraining with staff regarding active treatment. The QDDP will complete Active Treatment Observations three times weekly and provide feedback to the staff at the time of the observation. The QDDP complete an audit to review that each client's ISP and BSP are appropriately addressing each client's needs.	

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			The team will write IDT notes for clients who need changes made to their ISP and/ or BSP. The team will implement the changes into the ISP and BSP and train staff on the implementation of the changes. The QDDP will submit all clients who have the restriction of the locked closet to HRC for approval. The QDDP will complete an adaptive equipment audit to ensure that remaining clients have the adaptive equipment needed. If clients do not have the required equipment the IDT will meet to determine if the need is still present for the adaptive equipment. Staff will receive retraining on the use of adaptive equipment. IV The PD will review the Active Treatment observations weekly and retraining as needed. The QDDP will receive retraining on QDDP responsibilities.	
	2. A review of client #8's record was conducted on 8/8/12 at 1:01 PM. Client #8's Individual Support Plan (ISP) was dated 7/21/11 and his Functional Assessment (FA) was dated 7/21/11. There was no documentation in his record indicating the ISP and FA were updated since 7/21/11.			

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	An interview with Qualified Mental Retardation Professional (QMRP) #2 was conducted on 8/10/12 at 11:04 AM. QMRP #2 indicated client #8's ISP was held on 7/24/12 however the documentation was not in the record. QMRP #2 indicated she was waiting on her supervisor to review the ISP prior to putting the plan in the record. QMRP #2 indicated part of this documentation included the FA. An interview with staff #62 was conducted on 8/10/12 at 5:55 PM. Staff #62 indicated client #8's record should contain the current ISP and FA within 5 business days of the meeting. 3. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Client #10 had a training objective in his ISP, dated 2/2/12, to purchase a soda of his choice one time per week. A dietary consult, dated 8/2/12, indicated the following, "Nourishment: 4 oz (ounces) ice cream @ 10 A.M. & 2 P.M." Dental exams, dated 6/25/12 and 10/17/11, indicated the following, "...avoid sweet foods and drinks especially soda and fruit juices." An interview with the Qualified Mental Retardation Professional (QMRP) #3 was conducted on 8/9/12 at 11:03 AM.			

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	QMRP #3 indicated the recommendations from the dentist were generic, not individualized. QMRP #3 indicated the team needed to follow-up and review the recommendations. The QMRP #3 indicated client #10 purchased one soda per week and receives ice cream twice a day. An interview with staff #62 was conducted on 8/9/12 at 11:03 AM. Staff #62 indicated the recommendations from the dentist were generic and everyone had the recommendation to avoid sweet foods and drinks especially soda and fruit juices. 4. During observations on 08/06/2012 at 3:10 p.m., client #66 was sitting on the toilet in the 2 West classroom with the door open. All clothing was removed except her tennis shoes. Clients #6, #7, #62, #64, #65, #67, #71 and #72 were present in the classroom. Certified Nurse Aide (CNA) #48 was reading a book aloud and did not redirect client #66 to close the bathroom door. During observations on 08/08/2012 at 3:10 p.m., client #66 was sitting on the toilet in the 2 West classroom with all her clothing removed except her tennis shoes. The bathroom door was open and clothing was hanging on the doorknob outside of			

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	the bathroom. CNAs #48, #49, and #50 were present in the classroom and did not redirect client #66 to close the door. Clients #6, #7, #64, #65 and #67 were present in the classroom. Client #66's record was reviewed on 08/08/2012 at 4:00 p.m. The Behavior Support Plan (BSP), dated 06/12/2012, indicated, "...[Client #66] will shred her clothing, at times she will come out into the hallway nude...Should Clothes Stripping/Public Nudity occur: 1. Redirect [client #66] back into her room and gesture for her to go into the bathroom...." The BSP did not address placing/flushing clothing items in the toilet or closing the bathroom door for privacy while using the toilet in a public location such as the classroom. Behavioral Incident Reports, dated 07/13/2012 at 8:05 p.m., 07/20/2012 at 6:20 a.m. and 4:05 p.m., indicated client #66 flushed or placed articles of clothing in the toilet. During an interview on 08/06/2012 at 3:20 p.m., CNA #48 indicated client #66 did not like to have the door closed while she used the toilet. During an interview on 08/09/2012 at 10:20 a.m., Qualified Developmental			

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	Disabilities Professional (QDDP) #1 indicated client #66's Individual Support Plan (ISP) did not specifically address closing the door when she toilets or flushing her clothes. 5. Interview with client #90's family/Health Care Representative (HCR) on 8/8/12 at 5:59 PM indicated the facility had an ISP (Individual Support Plan) meeting/quarterly review without the client and/or the HCR being present. Client #90's sister indicated the client and she were at the dentist office on 6/15/12 where client #90 was having some dental surgery. Client #90's HCR/sister indicated the facility sent out a letter for client #90's 2012 ISP/quarterly meetings at the end of 2011. Client #90's HCR/sister indicated the facility did not change the client's meeting even though the client was at his dental appointment. Client #90's HCR indicated the meeting was over once the client returned to the facility. Client #90's HCR indicated she was told she needed to call ahead of time to reschedule meetings if she wanted to attend. Client #90's HCR indicated she did not have a copy of the client's ISP and/or BSP. Client #90's HCR indicated she wanted to attend the client's meetings. Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's 6/15/12			

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	dental record indicated the client was at the dentist office on 6/15/12 having IV (intravenous) sedation done for some tooth extractions. Client #90's 6/15/12 ISP Quarterly attendance roster indicated client #90 and/or his HCR were not present at the meeting. Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated client #90 and the client's sister/HCR were not present at the 6/15/12 quarterly meeting. Administrative staff #7 indicated the client's sister could have the meeting rescheduled if she was not able to attend. Administrative staff #7 and QDDP #2 indicated client #90's HCR did not have a copy of client #90's ISP and/or BSP as the client was his own guardian. 6. The facility's QDDP failed to monitor clients' programs in regard to assessing and/or re-assessing clients when needed for clients #17, #10 and #90. Please see W210. 7. The QDDP failed to monitor clients' program plans to ensure facility staff implemented clients' Individual Support Plans when formal and/or informal training opportunities existed for clients #1, #2, #6, #9, #10, #12, #14, #147, #150,			

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	#152, #154, #156, #157, #158 and #159. Please see W249. 8. The QDDP failed to ensure the facility's Human Rights Committee reviewed the facility's systemic restriction in regard to locking the clients' clothes and in regard to the use of 4 handed dentistry for clients #7, #10 and #90. Please see W264. 9. The facility's QDDP failed to monitor/coordinate clients' program plans in regard to ensuring clients had and/or used the recommended needed adaptive equipment for clients #2, #5 and #16. Please see W436. This federal tag relates to complaint #IN00113231. 7-4(a)(2)			

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W0186	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. Based on observation, interview and record review for 6 of 16 sampled clients (#1, #2, #3, #5, #12 and #13) and for 58 additional clients (#17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162), the facility failed to ensure sufficient staff worked on the overnight shift to monitor and supervise clients, on the first floor, to prevent elopement of client #41 who went missing. The facility to ensure sufficient staff were present at the workshop to allow clients to attend the workshop on a daily basis. The facility failed to ensure sufficient staff to meet the training needs of clients. Findings include:	W0186	**W186** I. For all the residents named in the sample of the Condition of Client Protection there is a policy for elopement. . North Willow followed their elopement policy and will follow their elopement policy. Residents number 1-10, 12, 13, 14, 16, 17-38, 40, 42-59, 66, 90, 122, 127, 128, 136, 137, 139, 140, 142, 143, 144, 149, 150, 152, 154, 156, 157, 158, 159, 160, 161, 162 have a one time mental anguish assessment completed. North Willow has a scheduler employed to assure adequate CNA staff are scheduled. North Willow has a staffing procedure that is reviewed regularly with regard to census, acuity and other resident needs and updated as needed. That procedure has been re-educated with the CNA scheduler and nursing staff. Staffing has been assessed for workshop and North Willow is providing sufficient staff to attend workshop for those residents who attend.	09/16/2012

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	1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 8/6/12 reportable incident report indicated "Staff was unable to locate resident at 5:10 AM after last observing him in the dining area asking for a drink at 5:00 AM. Nursing was notified. Staff searched the building and the grounds without locating the resident. The police were notified. The search/investigation continues at this time. [Client #41] is ambulatory and verbal. His diagnosis includes Mild Intellectual Disabilities, and Unorganized Schizophrenia, Unspecified Type. Resident displays Compulsive Behaviors. Resident is an emancipated adult." Upon arriving at the facility on 8/6/12 at 12:45 PM through the front door, the facility did not have a front door monitor (a staff who monitored the front door and and exits) sitting in the lobby area of the first floor. The facility's attached 8/6/12 Missing Person Form indicated client #41 was last seen at 5:00 AM entering the first floor dining room. The 8/6/12 missing person's report indicated client #41 was wearing a "...windbreaker pants + (plus) jacket (either navy or black)...." The 8/6/12 missing person report indicated client #41		II All residents of North Willow have the potential to be harmed by the deficient practice. III. For all the residents of North Willow there is a policy for elopement. North Willow followed their elopement policy and will follow their elopement policy. Numbers of staff required for each living area have been reviewed and reviewed with the CNA scheduler. The Nursing staff have been provided with a procedure to follow for staffing. The elopement policy has been reviewed with the management staff and Quality Assurance Committee. Residents who attend workshop has been assessed and training/work methods and needs assessed for workshop. IV The policy for elopement has been reviewed by the Quality Assurance Committee for adequacy in meeting the needs of the residents of North Willow. Staffing numbers and procedure has been reviewed with Quality Assurance Committee as well as nursing staff. Management and IDTs review needs of residents on a continual basis and make recommendation/request for staffing as a result of change in condition and situation of the residents needs. Quality Assurance has discussed the evolving methods of training and work in the workshop and how to	

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	did not have a history of elopement, and the weather condition was "cool temps." The report indicated client #41's "...Suspected method of leaving the facility was through the back patio over the privacy fence...." An attached 8/6/12 Behavior Incident Report indicated "All clients were in there (sic) rooms. Above (client #41) wanted a cup, which he was given. He then went in dining rm (room) to get some water. After 10 min. (minute) time this staff thought it was taking a long time to get his water and went to look for him in the dining area and he was not there." The attached 8/6/12 witness statement written by Certified Nursing Aide (CNA) #70 indicated no other clients were on up the unit which client #41 lived on. The 8/6/12 witness statement indicated "I (CNA #70) saw him (client #41) come down the hall and go to the dining room. I followed him and asked what he needed. He said he needed a drink but just stood there. I then asked him if he needed a cup...He wouldn't take the cup from me, but reached over me taking a cup for himself...I returned to South hall to check on [clients #58 and #59]. They were both up. [Client #52] was also awake...I sat down South hall with the girls, but I kept looking for [client #41] to come out of the dining room...."		assure staff for training there or in any setting dedicated to education of those with vocational needs supported by this program.	

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	Client #41's record was reviewed on 8/6/12 at 5:16 PM. Client #41's 4/16/10 Admission Staffing indicated the client was admitted on 4/16/10 to the facility from a behavioral unit at a local hospital. The 4/16/10 admission staffing indicated client #41 recently had right lung pneumonia, TB (not infectious) and Hyponatremia due to malnutrition. The 4/16/10 admission staffing indicated the following under the section entitled "Behavior/Psych Concerns Please check all that apply:" Yes was checked for AWOL (Absence without leave). Client #41's 5/4/11 Social Assessment indicated client #41 did not have any known family. The social assessment indicated client #41 would isolate himself from his peers, and ..."[Client #41] does not start a conversation, he acts upon initial conversation...." The 5/4/11 assessment indicated "He (client #41) would be considered at risk in the community due to his marked deficits...." Client #41's June 2012 physician's orders indicated client #41's diagnoses included, but were not limited to, Mild Mental Retardation, Disorganized Schizophrenia, Electrolyte and Fluid Disorder. Client #41's June 2012 physician's orders indicated client #41 received Zyprexa 20			

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	milligrams at bed time for "Chronic Paranoia and Germ phobia." Client #41's 7/10/12 Psychiatrist Consult And Follow-Up Form indicated "...Team requests medication review. Pt (patient) continues to refuse all attempts to join peers & (and) staff (with) activity. Also multiple incidences (sic) of refusing shower &/or changing into clean clothes. In room, states he 'needs money to go shopping.' " Client #41's 5/8/12 Psychiatric Intervention Plan (PIP) indicated the client demonstrated psychosis which included "...delusions, hallucinations, disorganized speech and language. Repetitive behavior, inability to focus, attention deficit. (Auditory hallucinations, thought disorder delusions) negative symptoms such as (demotivation, self-neglect and emotion)...." Client #41's 5/8/12 Individual Support Plan (ISP) indicated client #41 "Needs a highly supervised residential setting to prevent him from returning to the streets. He needs close supervision and assistance with his medical care needs...." The facility's CNA Night Shift Schedules were reviewed on 8/6/12 at 6:30 PM. The			

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	facility's staffing schedule for the night shift (10:30 PM to 6:30 AM) from 7/23/12 to 8/6/12 indicated 3 staff worked on the second and third floors of the building. The night staffing schedules indicated one staff worked on each of the three units on the second and third floors. The staffing schedule indicated 2 CNA staff worked, on the first floor, to monitor and supervise 47 clients who lived on the 3 units. The CNA staffing schedule indicated a "Building Float" staff was to work/cover all 3 floors during the night shift. The bottom of the CNA Night Shift Schedule indicated "Building Float-will relieve all the staff in the building for their 30 minutes break. 15 minutes break will need to be co-coordinated by nursing to ensure that the units are covered, nursing may have to assist with this as well. Please Note that Nightshift can NOT work over the numbers unless approved by the ED (Executive Director)." The facility's staffing schedule from 7/23/12 to 8/6/12 indicated the facility was to have a minimum of 8 CNA staff and 1 building float staff working to monitor/supervise 163 clients in the facility from 10:30 PM to 6:30 AM. The facility's CNA night staffing schedule indicated no CNA building float staff worked on 8/5/12 and only 2 CNA staff worked on the first floor. The 7/23/12 to 8/6/12 staffing schedule indicated one			

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	staff worked/monitored the West hallway clients #2, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32 and #33 and one staff monitored/supervised clients #1, #3, #4, #34, #35, #36, #37, #38, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58 and #59 on the North and South hallways. Client #41 resided/lived on the North hallway. The facility's 7/23/12 to 8/6/12 CNA night shift staffing schedules indicated the facility did not have sufficient staffing levels to monitor and/or supervise clients, on the first floor, as no building float staff worked on the following: -7/26/12 -7/27/12 -7/30/12 -7/31/12 -8/4/12 -8/5/12 The facility's Front Door Monitor book was reviewed on 8/6/12 at 6:20 PM and on 8/7/12 at 3:10 PM. The facility's front door monitor book for 2012 indicated a door monitor was posted at the front door of the facility on 8/5/12 (Sunday) from 6:30 AM to 8:30 PM. The door monitor book indicated the facility did not have a front door monitor on 8/6/12 until 2:30			

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	PM. The bottom of the Front Door Monitor Check Sheets indicated "General Instructions: Check each door, redirect any resident noted in area near doors. Report immediately to nurse if any resident is redirected and write a B.I.R. (Behavior Incident Report)." The forms also indicated the front floor monitor was to remind the nurse on the first floor west hallway to lock the front door at 5:00 PM. Interview with administrative staff #1 on 8/6/12 at 4:50 PM stated "[Client #41] walked off and is missing from the facility." Administrative staff #1 indicated client #41 left the facility in the morning and had not been located. Administrative staff #1 indicated the police had been notified. Interview with staff #71 on 8/6/12 at 6:20 PM indicated she was the front door hall monitor for the first floor. Staff #71 indicated she had been sitting in the lobby area monitoring the front door and exits since 3:00 PM. Staff #71 indicated she was to monitor clients if they tried to leave the facility and visitors coming into the facility. When asked if a monitor had been in place prior to the start of her shift, staff #71 indicated she did not relieve anyone when she came to monitor the front door. Staff #71 indicated the door monitor worked from 6:30 AM to 8:30			

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	PM every day. Staff #71 was not able to locate a monitor sheet for the day/morning shift for 8/6/12. Interview with administrative staff #5 on 8/6/12 at 6:30 PM indicated client #41 walked down the North hallway and asked staff for a drink of water. Administrative staff #5 indicated the CNA went to the South hallway unit and when the CNA went to the dining room to check on client #41 he was not in the dining room. Administrative staff #5 indicated the cup client #41 had was found sitting on a table in the patio area. Administrative staff #5 stated the facility thought client #41 left through the patio door and "scaled fence." Administrative staff #5 indicated the patio door was unlocked. Administrative staff #5 indicated the front door monitor worked from 6:30 AM to 8:30 PM on the weekends. Administrative staff #5 indicated a front door monitor was placed at the door on 8/6/12 after client #41 left the facility. Interview with administrative staff #5 and Qualified Developmental Disabilities Professional (QDDP) #7 on 8/6/12 at 6:45 PM indicated the front door monitor was placed on the front door of the first floor after 2:30 PM when the evening shift started. QDDP #7 and administrative			

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	staff #5 indicated it was not unusual for client #41 to wake up and ask for something to drink. QDDP #7 indicated client #41 would be dressed with his shoes on. QDDP #7 and administrative staff #5 indicated it was not normal for the client to wear a jacket when he came out of his room in the morning. Administrative #5 indicated client #41 did not have any identification on him. When asked how many staff were working when client #41 left the facility, administrative staff #5 stated "Two staff plus float." Administrative staff #5 indicated a nurse was also on the first floor doing tube feedings. Interview with administrative staff #1, the Director of Nursing (DON), administrative staff #5 and corporate staff #1 on 8/6/12 at 8:20 PM indicated client #41 was missing from the facility. The DON indicated she was called on 8/6/12 at 5:29 AM and was told the client was missing. Administrative staff #1 indicated she was called around 5:26 AM on 8/6/12. Administrative staff #1 indicated the staff searched the building for client #41 with no success and then called the police. Administrative staff #1 indicated the facility's administrative staff then started searching for client #41 outside the facility and downtown. Administrative staff #1 indicated it was			

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	not normal for client #41 to wear a jacket/coat at 5:00 AM in the morning. Administrative staff #1 stated "In hindsight, it looks like he planned this." Administrative staff #1 indicated client #41 had been asking for money, and not spending his money. Administrative staff #1 indicated client #41 had asked about group home placement in the last couple of months. When asked how many staff were working on the first floor, when client #41 left the facility, administrative staff #41 stated "Two CNAs and a nurse. The floater did not come in until 5:30 AM." Administrative staff #1 indicated one staff worked on the West hall and one staff worked on the North and South hallways. Administrative staff #1 indicated there were 2 to 3 clients up on the South hallway where the one staff was located. Administrative staff #1 indicated the facility put a monitor on the front door after the 8/6/12 incident occurred. Administrative staff stated the front door monitor would be in "place for 24 hours a day" even though the facility suspected the client left through the patio door as there were "scuff marks" on the white vinyl privacy fence. Interview with QDDP #6 on 8/7/12 at 9:40 AM indicated he filled out the 4/16/12 admission staffing report. QDDP #6 indicated client #41 was admitted to			

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	the facility from a behavioral unit. QDDP #6 stated when the hospital staff brought the client to the facility, they had indicated the client was "a high risk for AWOL in returning to the streets." Interview with administrative staff #1 on 8/7/12 at 2:40 PM indicated the first floor only had 2 staff working at night versus three staff which worked on the other 2 floors of the building. Administrative staff #1 indicated this was due to the fact there were more clients on the second and third floors and less clients on the first floor. When asked if the facility had considered if they had sufficient staffing since client #41 was able to get out of the building on 8/6/12, administrative staff #1 indicated the facility had looked at the staffing but did not change the staffing level. Administrative staff #1 indicated the clients on the North and South halls of the first floor did not require staff to lift them. Administrative staff #1 indicated there were 4 clients (#3, #20, #34 and #56), who were considered an elopement risk on the first floor. Interview with administrative staff #6 on 8/8/12 at 9:02 AM indicated the facility was to have a building float staff on the night shift. Administrative staff #6 indicated there was no building float staff on 8/4 and/or 8/5/12 as the new person			

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	hired to work as the float staff got her hours mixed up and did not come into work. Administrative staff #6 indicated the facility also did not have a building float staff on the night shifts on 7/26, 7/27, 7/30 and 7/31/12. Interview with administrative staff #1 on 8/9/12 at 8:22 AM indicated client #41 had not been found/located. 2. An observation was done on 8/8/12 on 3 North at 2p.m. All 3rd floor workshop employees were on the 3rd floor unit. Staff #4 was interviewed on 8/8/12 at 2p.m. Staff #4 indicated clients on 3rd floor were supposed to go to the workshop today at 1p.m. Staff #4 indicated none of the clients on 3rd floor went to the workshop today. Staff #4 indicated the clients did not go to the workshop on 8/8/12 due to the lack of facility staff available to supervise the workshop. Interview of client #162 on 8/8/12 at 2:24p.m. indicated he was supposed to go to the workshop today. Client #162 stated they didn't go to work today and stayed "here." Client #162 indicated there was paid work available at the workshop. Interview with Day Services Manager #26			

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	(DSM) on 8/9/12 at 10:15 AM indicated the second work crew or third floor clients would arrive at the workshop in the afternoon after lunch. DSM #26 indicated the workshop would bring 10 clients from the third floor not 17. DSM #26 stated, "We can't bring the rest of them over unless there is enough staff. Lately, its just been me (DSM #26) and a CNA (Certified Nurse Aide). When we have enough staff we can have the 17 residents from the third floor here. Today, we will only have 10 but if we get enough staff we can bring more." Record review of the 3rd floor workshop client employees was done on 8/8/12 at 2:50p.m. The client list indicated clients #5, #12, #13, #122, #127, #128, #136, #137, #139, #140, #142, #143, #144, #149, #157, #158, #160, #161 and #162 were scheduled to work at the workshop on 8/8/12 at 1p.m. 3. During the observation period on 8/6/12 from 2:50 PM to 6:30 PM clients #2 and 16 were in their room at 2:50 PM. Client #2 was sitting in her wheelchair and client #16 was in bed. Client #2 indicated she used to go to the workshop, but didn't get to go now and had to stay back but only had activity in the morning. Staff #37 was in a another room and staff #38 was in the activity room. Two staff			

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	were noted working on the unit with 19 clients (#2, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33). Client #2 went to another unit at 3:30 PM. Client #16 was pushed in her wheelchair to the activity room at 4:05 PM while a volunteer with a dog was visiting. Staff #37 and #38 were not noted to interact with client #2 and client # 16 between 2:50 PM and 3:45 PM. The daily activity schedule undated with ISP (Individual Support Plan) Date of 4/12/12 for client #2 was reviewed on 8/7/12 at 9:34 AM. The activity schedule indicated for the time between 11:30 AM to 3:00 PM the activity was "Toileting, Programming/Recreation and Nap (optional)." The daily activity schedule with ISP date of 12/6/11 for client #16 was reviewed on 8/8/12 at 9:41 AM. The activity schedule included the following 11:30 AM to 3:00 PM activity as "Toileting, Recreational Activity, Nap (optional), Snack." Interview with Staff #38 on 8/6/12 at 3:40 PM indicated the ladies on the unit got showers between 3:00 PM and 3:30 PM and the men got their showers at 3:30 PM. Staff #38 also indicated one staff was supposed to stay in the activity room when a client was there.			

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	3-1-13(b) 3-1-37(a)			

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W0210	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. Based on interview and record review for 2 of 16 sampled clients (#7 and #10), and for 1 additional client (#90), the facility's interdisciplinary teams (IDTs) failed to assess and/or re-assess the clients in regard to the need for the use of pre-medications and/or restraints. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/5/12 reportable incident report indicated "Client (client #90) was being taken to transportation for appt (appointment) with ENT (Ear, Nose and Throat) physician when brought back to floor by staff member. CLient (sic) was noted with large abrasion to left frontal area of the head and 2 small lacerations to inner lower lip, it was stated he was getting on bus when he fell and hit the pavement." The 7/5/12 reportable incident report indicated client #90 was sent to the ER (emergency room) for evaluation and treatment.	W0210	**W210** I The IDT will assess the need for clients #7, #10, and #90 in regard to the need for the use of pre-medications and/ or restraints. If the team feels the need for these restrictions then the PD will submit paperwork for HRC approval prior to the next appointment. II All residents of North Willow have the potential to be harmed by the deficient practice. III The PD will complete an audit of remaining clients who receive pre- medication, the rainbow wrap, or four handed dentistry and submit documentation to HRC prior to next appointment . IV The QDDP's will be retrained on the assessment of clients in regard to the need for the use of pre- medications and or restraints prior to appointments.	09/16/2012

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	The facility's 7/12/12 follow-up report indicated "...Conclusion: Resident fell upon reaching steps to board van for transport. He did receive a pre-med as ordered prior to appointment...." Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's 7/20/12 physician's order indicated client #90 received Valium (sedation) 10 milligrams PRN (as needed) 1 to 2 hours prior to the ENT appointment. Client #90's physician orders and/or dental notes indicated the following PRN orders and/or restraints used: -10/10/11 Client #90 was seen at the dentist office. The 10/10/11 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North Willow with Halcion .25 mg (milligrams) 1 tablet...." The 10/10/11 note indicated "... Pt was wrapped in Rainbow and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion .25 mg 1 tab (tablet) 30 minutes before			

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	dental appt. (appointment) (4/16/12). NPO (nothing by mouth) (after) Midnight except meds and bring pt. wearing absorbent pad to prevent soiling our equipment." -4/16/12 Client #90 was seen at the dentist office. The 4/16/12 dental note indicated "Medical History Review: Special needs high anxiety/combative pt. (patient) was presedated by home-North Willow with Halcion .25 mg (milligrams) 1 tablet...." The 4/16/12 note indicated "... Pt was wrapped in Rainbow and stabilized...Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt. and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment...Next visit: 6 mos (months)...Please presedate with Halcion .25 mg 1 tab (tablet) 30 minutes before dental appt. (appointment) (8/13/12). NPO (nothing by mouth) (after) Midnight except meds and bring pt. wearing absorbent pad to prevent soiling our equipment." Client #90's 3/15/12 Functional Skills Assessment (FSA) indicated "Restraint Usage Medical Restraints A. Does the client require a pre-medication for medical procedures? Y (Yes)...C. Does			

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	the client require the use of a 'Rainbow Wrap'? Y...." The 3/15/12 FSA did not specifically indicate how it was determined the client was assessed/needed the above mentioned restraints and/or pre-medication. The 3/15/12 FSA did not indicate the client had been assessed for the need to use 4 handed dentistry. Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated they did not specifically know what a Rainbow Wrap was and/or know what 4 handed dentistry was. Administrative staff #7 stated she thought the Rainbow Wrap was a type of "weighted vest." Administrative staff #7 and QDDP #2 indicated the dentist had assessed the client for the need of the pre-medication and/or restraints used. Administrative staff #7 and QDDP #2 indicated client #90's IDT had not assessed the client for the need of the pre-medication/restraints. 2. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. A "Social Assessment," dated 01/24/2012, did not indicate client #7 had been assessed for restraint necessity during dental procedures.			

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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
	The "Patient Notes Master," dated, 07/16/2012, indicated, "...Special needs-slight anxiety/combative pt (patient) was presedated by home (facility) -(sic) with Halcion .25 mg (milligrams) 3 tabs (tablets)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold) was sufficient to stabilize pt. and complete treatment...." An "INTER-DISCIPLINARY TEAM REVIEW/INFORMED CONSENT FORM/HRC SIGNATURE SHEET," dated 06/13/12, indicated the specially constituted/Human Rights Committee (HRC) approved the Rainbow Wrap restraint and pre-procedural Halcion. The record did not indicate the committee reviewed and/or approved use of the 4 hand dentistry restraint. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated client #7 had not been assessed to determine if the 4 hand dentistry restraint was necessary to complete dental care. She stated the restraint, "involved 2 persons holding the client and 1 person working on him." 3. A review of client #10's record was			

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	conducted on 8/9/12 at 8:58 AM. Dental records from 10/17/11 and 6/25/12 indicated the following, "Pt (patient) was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment." There was no documentation in client #10's record indicating a description of four handed dentistry. A review of client #10's Behavior Plan, dated 2/2/12, indicated there was no documentation addressing the use of four handed dentistry. Client #10's Individual Support Plan (ISP), dated 2/2/12, did not address the use of four handed dentistry. Client #10's Functional Assessment, dated 2/2/12, did not assess the use of four handed dentistry. An interview with Qualified Developmental Disabilities Professional (QDDP) #2 was conducted on 8/10/12 at 11:04 AM. QDDP #2 indicated none of the clients had plans or assessments addressing the use of 4 handed dentistry. The QDDP indicated the facility received reports from the dentist regarding the appointment and the techniques used during the appointment. This federal tag relates to complaint #IN00113231. 3.1-31(a)			

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W0249	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. Based on observation, record review and interview for 7 of 16 sampled clients, (#1, #2, #6, #9, #10, #12 and #14) and 8 additional clients (#147, #150, #152, #154, #156, #159, #157 and #158), the facility failed to ensure clients' Individual Program Plan/Behavior Support Plan objectives/methods were implemented during formal and informal training opportunities. Findings include: 1. Observations were conducted on the south wing of the facility's third floor on the afternoon of 8/06/12 from 3:00 PM until 6:40 PM. Some clients (clients #13, #14, #15, #149, #153, #156, #159, and #160) were in a classroom. Client #155 walked from the classroom to his bedroom and back repeatedly, but was not consistently engaged in a meaningful activity. Client #14 was hanging his head down, sitting in the southwest corner of the classroom with his behavioral one to	W0249	**W249** I. 1. Staff retrained on BSP/DAS/active treatment for residents #13, #14, #15, #149, #153, #156, #159 and #160. Staff have also been retrained on hand washing prior to meals for residents #13, #14, #15, #149, #153, #156, #159, #160, #147, #150, #152, #154, #157, #158, and #163. Staff were retrained on active treatment/DAS for residents #150, #152, #154, #157, #158, and #163. 2. Staff was retrained on the mealtime goal for resident #10, as well as how to provide active treatment while in the dining room for meals. 3. Staff was retrained on the mealtime goal for resident #9, as well as how to provide active treatment while in the dining room for meals.	09/16/2012

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	one staff, CNA #15. CNA #15 did not prompt client #14 to participate in activities. At 4:17 PM on 8/6/12, client #159 was lying in the doorway of his bedroom (335) face down and his whole body was shaking. No staff was present with him. LPN #12 checked on client #159 who stated twice: "Leave me alone, go." LPN #12 stated the shaking exhibited by client #159 was a "behavior" instead of a medical issue such as a seizure. Clients #13, #14, #15, #149, #153, #155, #156, #159, and #160 were not prompted by CNA (certified nursing assistant) staff #14, #15, #16 or #17 to wash their hands prior to going to the dining room from the classroom area at 6:00 PM for the evening meal. Client #151, who was dependent upon staff for assistance in all areas of adult daily living skills, did not receive assistance to wash his hands prior to being assisted to the dining room. Clients #147, #150, #152, #154, #157, #158, and #163 came from their bedrooms to the dining area. CNA staff did not prompt them to wash their hands nor did staff inquire if their hands had been washed prior to the meal. An observation was done on 8/08/12 from 6:00 AM until 10:30 AM. Clients #147, #150, #152, #154, #157, #158, and #163 came from their bedrooms to the dining		4 and 5. Staff was retrained on DAS for resident #2 and #1. 6. Staff was retrained on the mealtime goal for resident #6, as well as how to provide active treatment while in the dining room for meals. 7. Nursing staff has been retrained on running medication goals at each training opportunity. II All residents of North Willow have the potential to be harmed by the deficient practice. III. Staff have been retrained on the importance of following the DAS and providing both formal and informal training opportunities for the residents. Staff have been retrained to follow the BSP for the residents and to write BIRS when necessary. Nursing staff has been retrained on running medication goals at each opportunity. IV. QMRPs complete active treatment audits 3x/week to ensure that CNA's are engaging the residents in active treatment/following	

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	area for breakfast at 8:30 AM until 9:15 AM and then they returned to their bedroom areas. Clients #150, #152, #154, #157, #158, and #163 were not consistently prompted by CNAs #18, #19 and #21 to participate in activities/leave their bedrooms. Staff #20, client #14's one on one staff, was leafing through a magazine and did not engage the client in an activity except for bathing at 7:00 AM and mealtime at 8:30 AM. Review (8/07/12 12:00 PM) of client #159's Individual Program Plan/ISP, Behavior Support Plan/BSP dated 10/18/11 indicated if he had behaviors, they should be addressed by a one on one staff who would be available to engage him in activity to decrease physical aggression and self isolation. Clients #147, #150, #152, #154, #156, #157 and #158 Daily Activity Schedules/DAS, which accompanied their Individual Support Plans/ISPs, were reviewed on 8/09/12 at 1:00 PM: Client #147's DAS/ISP was dated 9/08/11. Client #150's DAS/ISP was dated 4/05/12. Client #152's DAS/ISP was dated 2/20/12. Client #154's DAS/ISP was dated 1/25/12.		DAS. QMRPs audit program books 3x week to ensure staff are running goals and documenting progress. PD's are notified for appropriate follow-up. Nursing MARs are audited weekly. QMRP/designee audit mealtimes and will prompt staff about handwashing for residents. Professional and supervisory staff are present on the floor around the clock and provide oversight, training and correction when needed.	

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	Client #156's DAS/ISP was dated 1/12/12. Client #157's DAS/ISP was dated 3/29/12. Client #158's DAS/ISP was dated 8/11/11. The review indicated clients were supposed to be supervised and engaged in a daily routine of therapeutic training activities in the areas of hygiene, mealtime and prevocational (table games, computer skills) skills. Review of client #14's record on 8/7/12 at 1:30 PM and on 8/9/12 at 1:00 PM indicated he had an ISP 6/26/12 and a DAS dated 11/02/11. The ISP indicated the client's one to one staff was to deal with aggression and sexually inappropriate behaviors. 2. An observation was conducted on the 2nd floor of the facility on 8/6/12 from 4:51 PM to 6:20 PM. At 4:57 PM, client #10 was served by staff #59 a piece of pureed cake and pureed beet and onion salad. At 5:07 PM, staff #59 served client #10 his pureed turkey wrap. Staff #59 did not prompt client #10 to serve himself or to assist her with serving himself. On 8/7/12 at 7:47 AM, client #10's juice and milk were poured by staff #60. At 7:55 AM, staff #60 put butter and sugar onto client #10's hot cereal and then staff #60			

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	stirred the cereal. Client #10 picked up his spoon but then dropped it into his cereal while pointing to the sugar. Staff #60 stated to client #10, "I already put it in for you." The staff did not prompt client #10 to serve himself during dinner and breakfast. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Client #10's Individual Support Plan, dated 2/2/12, indicated he had a training objective to learn to serve himself at meals. An interview with Qualified Developmental Disabilities Professional (QDDP) #3 was conducted on 8/9/12 at 11:03 AM. QDDP #3 indicated the staff should implement client #10's goal to learn to serve himself at every meal. 3. An observation was conducted on the 2nd floor of the facility on 8/6/12 from 4:51 PM to 6:20 PM. At 6:00 PM, client #9 started eating dinner. Client #9 ate her dinner without receiving prompts from staff, the QMRP or the Program Director to swallow completely after every bite. On 8/7/12 at 8:32 AM, client #9 started eating her breakfast. Client #9 finished eating breakfast at 8:59 AM. Client #9 did not receive prompts from staff to swallow completely after every bite.			

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	Client #9 received no prompts from staff. A review of client #9's record was conducted on 8/8/12 at 11:02 AM. Client #9's Individual Support Plan (ISP), dated 1/19/12, indicated she had a training objective to swallow completely after every bite. The goal training sheet indicated, "Run this goal daily at meals...". The goal indicated for the procedure, "1. Gain [client #9's] attention. 2. Encourage [client #9] to take appropriately sized bites. Prompt if necessary (this includes the napkin). 3. Prompt her to do a double swallow after every bite to make sure she had cleared her esophagus before taking her next bite. Use the least amount of prompting needed to get [client #9] to complete this task...". An interview with QDDP #2 was conducted on 8/10/12 at 11:04 AM. QDDP #2 indicated the staff should implement client #9's training objective to swallow completely after every bite at every meal. An interview with staff #62 was conducted on 8/10/12 at 5:55 PM. Staff #62 indicated the staff should implement client #9's goal as written. 4. During the observation period on 8/6/12 from 2:50 PM to 6:30 PM, client			

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	#2 was observed in her bedroom at 2:50 PM. Client #2 was looking at things on her dresser. At 3:30 PM client #2, in a motorized wheelchair, went to another unit. At 3:35 PM client #2 went to the shower room and had a shower with assistance from staff #37. At 4:20 PM client #2 came to the activity room and stayed 3 minutes and left to go back to her room. Client #2 did not participate in any activity until 5:30 PM when she went to the dining room for dinner. The record review for client #2 was conducted on 8/7/12 at 9:34 AM. The ISP (Individual Support Plan) dated 4/12/12 indicated the following formal goals for client #2: 1. Attend to task for 15 minutes. 2. Brush all areas of her teeth. 3. Participate as much as she is able during bathing. 4. Purchase healthy food/snack from the vending machine. 5. Comply to her regular/small portion diabetic diet. 6. Read a short story book. The informal goals to be worked on were toileting skills, hair and finger nail care, selection of clothing, dressing skills, socialization skills, writing letters to family, tidying up room, laundry skills, checking around when wheeling herself and recreational activities.			

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	5. Observations were conducted on the first floor North wing unit on 8/6/12 from 1:18 PM through 1:47 PM. Client #1 was laying in his bed with no activity. CNA (Certified Nursing Aide) #27 and #28 did not prompt or encourage client #1 to participate in activity or training. Observations were conducted on the first floor North wing unit on 8/6/12 from 3:06 PM through 4:31 PM. Client #1 was laying in his bed with no activity. CNA #27, CNA #28 and/or AS (Administrative Staff) #5 did not prompt or encourage client #1 to participate in activity or training. Observations were conducted on the first floor North wing unit on 8/6/12 from 4:59 PM through 5:30 PM. At 4:59 PM client #1 was seated in the unit cafeteria eating his evening meal. At 5:17 PM client #1 finished his evening meal and returned to his bedroom and laid down in his bed with no activity. CNA #27 and CNA #28 did not prompt or encourage client #1 to participate in activity or training. Client #1's record was reviewed on 8/8/12 at 9:57 AM. Client #1's ISP (Individual Support Plan) dated 2/17/12 indicated the following training objectives:			

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	1. Will take a shower. 2. Will brush his teeth. 3. Will read/identify functional words and community signs/symbols. 4. Will make a list with a budget for a shopping trip. 5. Will cooperate with ROM (Range of Motion) using a sticker chart. 6. Will participate in some kind of exercise. Interview with (administrative staff) AS #5 on 8/8/12 at 1:22 PM indicated client #1 had formal and informal training objectives that should be implemented throughout the day. AS #5 indicated client #1 preferred to spend time alone in his room but should be encouraged to participate in activities and programming. 6. During observations on 08/07/2012 at 8:45 a.m., client #6 had cereal and milk spilling from his mouth. His mouth and chin were covered with food. Certified Nurse Aide (CNA) # 51 did not prompt client #6 to use his napkin. Client #6's record was reviewed on 08/08/2012 at 1:12 p.m. The Individual Support Plan (ISP), dated 03/10/2012, indicated client #6 had a goal for wiping his mouth with a napkin. During an interview on 08/09/2012 at			

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	10:20 a.m., Unit Director (UD) #2 indicated the ISP objective for wiping mouth with a napkin should have been implemented during breakfast on 08/07/2012. 7. An observation was done on 8/6/12 from 3:18p.m. to 6:42p.m. At 4:20p.m, client #12 received her medications which included the medication Zyprexa. Client #12 was not asked to identify her Zyprexa medication during the medication pass. Record review for client #12 was done on 8/7/12 at 10:32a.m. Client #12's 3/13/12 ISP indicated she had a training program to identify Zyprexa during the medication pass. Staff QDDP #5 was interviewed on 8/9/12 at 10:02a.m. QDDP #5 indicated client #12 had a training program to identify Zyprexa. QDDP #5 indicated the training program should have been implemented when opportunity was present. 3.1-23(a) 3.1-33(a) 3.1-37(a)			

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on interview and record review for 2 of 13 sampled clients (#7 and #10) and for 1 additional client (#90) with restrictive programs, the facility failed to have its Human Rights Committee (HRC) review restrictive dental practices and/or locked wardrobes of clients to ensure the rights of clients were not violated. Findings include: 1. Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's physician orders indicated client #90 saw his dentist on 10/10/11 and on 4/16/12 where 4 hand dentistry was used with the client during the dental visits. The 10/10/11 and 4/16/12 dental notes indicated "...Four handed dentistry was sufficient to stabilize pt. and complete dental treatment...." Client #90's 3/15/12 Individual Support Plan (ISP) and/or 4/20/11 Behavior Support Plan (BSP) indicated the use of 4	W0264	**W264** I The agency's human rights committee does review, onitor and make suggestions to the facility regarding the use of restrictive programs. The Human Rights Committee will be informed at our next scheduled meeting (September 20, 2012) of the practice of 4 handed dentistry specifically, as well as any other restraints that might be requested. For clients #7, #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified that their current ISP, BSP and/or reduction plan will be updated to include details of any restrictive measures being used. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. II All residents of North Willow have the potential to be harmed	09/16/2012

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	handed dentistry had not been included in the client's ISP and/or BSP. The client's ISP and/or BSP also indicated the facility failed to have the facility's HRC review the restrictive technique/procedure (4 handed dentistry) to ensure the client's rights were not violated. Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated they did not know what 4 handed dentistry was. Administrative staff #7 and QDDP #2 indicated the facility's HRC had not reviewed the use of the 4 handed dentistry to ensure the rights of the client.		by the deficient practice. III To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. The QMRP/PD will review progress notes regarding appointments to monitor for the use of any unapproved restraints. Guardians/HCRs will be notified by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. QDDPs will be trained by 9-16-12 to include information regarding the types of restraints used by an individual in annual ISPs along information as to where copies of specific plans are located. IV In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will	

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			assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes	
	2. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Dental records from 10/17/11 and 6/25/12 indicated the following, "Pt (patient) was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment." There was no documentation in client #10's record indicating a description of four handed dentistry. There was no documentation in client #10's record the specially constituted committee reviewed and monitored the use of four handed dentistry. Client #10's ISP indicated he had co-guardians. An interview with Qualified Developmental Disabilities Professional (QDDP) #2 was conducted on 8/10/12 at 11:04 AM. QDDP #2 indicated the specially constituted committee did not review and monitor the use of four handed dentistry. QDDP #2 indicated the facility did not submit the clients' dental treatment forms to the committee for review. QDDP #2 indicated none of the			

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	clients had plans or assessments addressing the use of 4 handed dentistry. The QDDP indicated the facility received reports from the dentist regarding the appointment and the techniques used during the appointment. An interview with staff #62 was conducted on 8/10/12 at 5:55 PM. Staff #62 indicated there was no plan for client #10 receiving four handed dentistry. Staff #62 indicated the facility did not have guardian or HRC consent for the use of four handed dentistry. Staff #62 indicated the use of four handed dentistry had not been presented to the specially constituted committee for review and monitoring. 3. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. The "Patient Notes Master," dated, 07/16/2012, indicated, "...Special needs-slight anxiety/combative pt (patient) was presedated by home (facility) -(sic) with Halcion .25 mg (milligrams) 3 tabs (tablets)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold) was sufficient to stabilize pt. and complete treatment...." An "INTER-DISCIPLINARY TEAM			

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	REVIEW/INFORMED CONSENT FORM/HRC SIGNATURE SHEET," dated 06/13/12, indicated the specially constituted/Human Rights Committee (HRC) approved the Rainbow Wrap restraint and pre-procedural Halcion. The record did not indicate the committee reviewed and/or approved use of the 4 hand dentistry restraint. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated, the specially constituted/Human Rights Committee (HRC) had not approved the 4 hand dentistry restraint. She stated the restraint, " involved 2 persons holding the client and 1 person working on him." This federal tag relates to complaint #IN00113231.			

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W0289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 4 of 13 sampled clients (#7 and #10) and for 1 additional client (#90) with behavior intervention techniques, the facility failed to ensure restrictive interventions were part of the clients' Individual Support Plans/Behavior Support Plans (ISPs/BSPs). Findings include: 1. Client #90's record was reviewed on 8/8/12 at 8:01 AM. Client #90's physician orders indicated client #90 saw his dentist on 10/10/11 and on 4/16/12 where 4 hand dentistry was used with the client during the dental visits. The 10/10/11 and 4/16/12 dental notes indicated "...Four handed dentistry was sufficient to stabilize pt. and complete dental treatment...." Client #90's 3/15/12 Individual Support Plan (ISP) and/or 4/20/11 Behavior Support Plan (BSP) indicated the use of 4 handed dentistry had not been included in the client's ISP and/or BSP.	W0289	**W289** I The agency has in place policies to incorporate interventions to manage inappropriate client behavior into an individual's program plan. For clients #7, #10 and #90, the clients' legal representatives (family/Health Care Representative (HCR) and/or the guardian) will be notified that their current ISP, BSP and/or reduction plan will be updated to include details of any restrictive measures being used. For client #90, the guardians will be provided with a description of 4 handed dentistry and asked to provide informed consent on his behalf. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. For client #7, the guardians will be provided with a description of 4 handed dentistry and asked to provide informed consent on his behalf. Once that written approval is obtained, the plan will be presented to the agency's	09/16/2012

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	Interview with administrative staff #7 and Qualified Developmental Disabilities Professional (QDDP) #2 on 8/9/12 at 9:32 AM indicated they did not know what 4 handed dentistry was. Administrative staff #7 and QDDP #2 indicated the use of the 4 handed dentistry was not part of client #90's ISP/BSP.		HRC for review and approval. For client #10, the guardians will be provided with a description of 4 handed dentistry and asked to provide informed consent on his behalf. Once that written approval is obtained, the plan will be presented to the agency's HRC for review and approval. The agency will develop an assessment to determine the need for the use of sedation and/or restraints during medical care by 9-16-12. The assessment will be administered for client #90 by 9-16-12, client #7 by 9-16-12 and client #10 by 9-16-12. All individuals who are sedated and/or restrained for medical/dental care will be assessed by 9-16-12 and the IDTs will make recommendations accordingly. II All residents of North Willow have the potential to be harmed by the deficient practice. III To help prevent reoccurrence of this issue, the DNS/Designee will contact the dentists' offices and request confirmation regarding all restraints/sedation used for each patient the dentist sees. The QMRP/PDs will review progress notes regarding appointments to monitor for the use of any unapproved restraints. Guardians/HCRs will be notified	

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			by 9-16-12 and consent for specific restraints will be requested and, after receipt, reviewed by the HRC. QDDPs and PDs will be retrained on the need to have consent for all restrictive measures prior to their implementation. Training to be completed by 9-16-12. QDDPs will be trained by 9-16-12 to include information regarding the types of restraints used by an individual in annual ISPs along information as to where copies of specific plans are located. I V In the future, the PD/QDDP will review scheduled appointments and monitor that consents are received. A schedule of appointments is maintained and a line will be added to note if sedation or restraints are planned and consents received. Nursing will assure appropriate orders and consents are in place before administering pretreatment sedation and note that approval was in place when documenting on the sedation in the nursing notes. As well, the PD will review annual ISPs to assure that restrictive measures are identified.	
	2. Client #7's record was reviewed on 08/08/2012 at 10:49 a.m. The "Patient Notes Master," dated, 07/16/2012, indicated, "...Special needs-slight			

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	anxiety/combative pt (patient) was presedated by home (facility) -(sic) with Halcion .25 mg (milligrams) 3 tabs (tablets)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold) was sufficient to stabilize pt. and complete treatment...." An "INTER-DISCIPLINARY TEAM REVIEW/INFORMED CONSENT FORM/HRC SIGNATURE SHEET," dated 06/13/12, indicated the specially constituted/Human Rights Committee (HRC) approved the Rainbow Wrap restraint and pre-procedural Halcion. The record did not indicate the committee reviewed and/or approved use of the 4 hand dentistry restraint. During an interview on 08/09/2012 at 10:20 a.m., Unit Director (UD) #2 indicated, the specially constituted/Human Rights Committee (HRC) had not approved the 4 hand dentistry restraint. She stated the restraint, " involved 2 persons holding the client and 1 person working on him." 3. A review of client #10's record was conducted on 8/9/12 at 8:58 AM. Dental records from 10/17/11 and 6/25/12			

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	indicated the following, "Pt (patient) was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment." There was no documentation in client #10's record indicating a description of four handed dentistry. There was no plan addressing four handed dentistry. A review of client #10's Behavior Plan, dated 2/2/12, indicated there was no documentation addressing the use of four handed dentistry. Client #10's Individual Support Plan (ISP), dated 2/2/12, did not address the use of four handed dentistry. An interview with Qualified Developmental Disabilities Professional (QDDP) #2 was conducted on 8/10/12 at 11:04 AM. QDDP #2 indicated none of the clients had plans or assessments addressing the use of 4 handed dentistry. The QDDP indicated the facility received reports from the dentist regarding the appointment and the techniques used during the appointment. This federal tag relates to complaint #IN00113231. 3.1-35(b)(1)			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed for 3 of 160 medications passed (#120, #123 and #160), to ensure clients #120, #123 and #160 received their medication without error. Findings include: 1. An observation was done at the facility on 8/7/12 from 6:32a.m. to 8:30a.m. Client #120 was observed to receive medication at 7:07a.m. Client #120 did not receive the medication Lactulose 15ml (milliliters). Client #120's 8/12 medication administration record (MAR) was reviewed on 8/7/12 at 7:12a.m. The MAR indicated client #120 had physician's orders to receive Lactulose 15ml at 7a.m. for constipation. Record review for client #120 was done on 8/8/12 at 11:08a.m. Client #120 had 7/27/12 physician's orders to receive Lactulose 15ml. at 7a.m. for constipation. Interview on 8/7/12 at 7:49a.m. of LPN staff #5 indicated client #120 should have	W0369	**W369** I. Resident #123 On 8/7/2012, a client did not receive a 7AM scheduled dose of Atenolol 25 mg. This medication is scheduled QD at 8AM. This medication error was pointed out to the administering nurse following observation of the medication pass. The nurse immediately administered the medication within the allocated time frame of 1 hour after the appointed medication administration time. Resident #160 On 8/8/2012, the client did not have the prescribed dosage of Sorbitol available for the scheduled medication administration time of 8:00 AM. This medication is scheduled QD at 8AM. The nurse immediately reordered the medication from pharmacy. The missed dose was administered later the same afternoon. Resident #120 The client did not receive a scheduled 8:00 AM dose of Lactulose 15 ml for constipation. This medication is scheduled QD at 8 AM. The required dose of	09/16/2012

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	received Lactulose 15ml. during the 7a.m. medication pass. LPN Staff #5 stated the medication was out of stock and should be at the facility by the "end of the day." 2. Observation was done at the facility on 8/7/12 from 6:32a.m. to 8:30a.m. Client #123 was observed to receive medication at 7:15a.m. Client #123 did not receive the medication, Atenolol. Client #123 completed his medication pass and had left the area. LPN staff #5 was ready to move on to the next client. Client #123's 8/12 (MAR) was reviewed on 8/7/12 at 7:21a.m. The MAR indicated client #123 had physician's orders to receive Atenolol 25mg (milligrams) at 7a.m. for Ischemic heart disease. Record review for client #123 was done on 8/8/12 at 11:12a.m. Client #123 had 7/28/12 physician's orders to receive Atenolol at 7a.m. Interview on 8/7/12 at 7:22a.m. of LPN staff #5 indicated client #123 should have received Atenolol 25mg. during the 7a.m. medication pass. LPN Staff #5 indicated the medication had not been passed to client #123.		Lactulose was not available at the time the medication was to be administered. The nurse immediately ordered the Lactulose from the pharmacy, and QD dosages were resumed on 8/8/2012. Per facility procedure, DQI Medication error reports were submitted for each of the above issues. Physicians, and Families were notified of these specific events. II All residents of North Willow have the potential to be harmed by the deficient practice. III. Measures for systemic changes in the facility to ensure deficient practice does not recur. · The facility nursing staff will be re-educated on the process of re-ordering medications not included on the Automatic Anniversary Cycle of reordering. · Re-educate the nursing staff on what constitutes a medication error, and the proper steps of notification and documentation to complete when medication errors are identified. · Re-educate licensed nurses on how identify when scheduled medications on the MAR are scheduled to be administered to a client in a specific timeframe.	

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	3. During observations of the morning medication administration on 8/08/12 at 8:45 AM, RN #11 prepared client #160's medications and discovered his bottle of Sorbitol liquid (medication used for constipation) did not contain the required dosage prescribed of 30 milliliters/ml. RN #11 checked extra medication stores, but the Sorbitol was not available and could not be administered. Review of client #160's 8/12 MAR/medication		IV. Corrective action(s) will be monitored as follows: · The Night Shift Nursing staff will have a nightly audit for the medication carts which will include · Reviewing medications ordered, received, and disposed of on the medication carts. Other concerns to be reviewed during the medication cart audit include: · Security/Storage of medications, Emergency Medication Services, Packaging and labeling of medications, and other reviews of pertinent infection control practices. · Ensure that all medications are dispensed by the nursing staff as ordered, by re-educating licensed nursing on the Five Client Rights of Medication Administration, and Documentation.	

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	administration record on 8/8/12 at 10:00 AM indicated he received 30 ml. at 7:00 AM daily. Interview with RN #11 on 8/09/12 at 7:20 AM indicated the Sorbitol was not available for administration until 5:00 PM on 8/08/12.			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 3 of 16 sampled clients (clients #2, #5 and #16), the facility failed to insure client #2 wore her left hand splint, client #5 had hearing aids and client #16 had glasses. Findings include: 1. During the observation period on 8/6/12 from 2:50 PM to 6:30 PM, client #2 was not wearing glasses. During the observation period on 8/7/12 from 7:00 AM to 9:35 AM, client #2 was not wearing glasses. The record review for client #2 was conducted on 8/8/12 at 9:34 PM. The examination dated 4/18/12 indicated client #2 needed glasses and wrote a new prescription. There was no indication the prescription had been ordered. Interview with staff QDDP (Qualified Developmental Disability Professional) #6 and staff #40, Social Worker, on	W0436	**W436:** I Corrective Action for Cited Clients: ·Resident #2's plan was reviewed and the team met regarding glasses use. The resident, LG, and IDT are in agreement to decline the recommendation for eyeglasses at this time, as the resident wishes to not wear them and does not have any difficulty performing daily tasks without them (ie, reading, playing cards, completing ADL's, etc). ·Resident #16's plan was reviewed and the team met regarding splint use. Staff have been re-trained on the schedule of use for the splint. ·Resident #5's plan was reviewed and the team met regarding hearing aid use. The audiologist has been contacted to re-evaluate the resident's concern that he didn't want to wear the hearing aids because "they did not fit."	09/16/2012

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	8/9/12 at 12:20 PM indicated client #2 did not have glasses because she does not like to wear them. Staff #40 indicated she was not aware the client was supposed to have glasses. 2. During the observation period on 8/6/12 from 2:50 PM to 6:30 PM, client #16 was not wearing a left hand splint. During the observation period on 8/7/12 from 7:00 AM to 9:35 AM, client #16 was not observed wearing a left hand splint. The record review for client #16 was conducted on 8/8/12 at 9:41 AM. The Occupation Therapy Evaluation dated 11/29/11 indicated client #16 had a hand splint. The Individual Support Plan (ISP) dated 12/6/11 indicated client #16 had a left hand splint with schedule of use of 24/7. Interview with staff QDDP #6 on 8/9/12 at 12:20 PM indicated client #16 was supposed to wear a left hand splint.		A plan has been developed to train Resident #5 to wear them once appropriate adjustments are made for the fit. II Other Clients Potentially at Risk: ·All residents might be at risk for this deficient practice. III Corrective Measures or Systemic Changes: ·QMRP's and CNA's have been retrained on following the schedule of use for adaptive equipment for residents, and this information will be present on both CNA assignment sheets and Client Specific Training/High Risk Plans. IV Corrective Measures or Systemic Changes ·Program Directors/QMRP's have audited resident files to formulate a comprehensive list of those residents that require adaptive equipment recommended by Optometry, Audiology, or Therapies. Any resident that has demonstrated refusals to wear adaptive equipment will have a formal program to address this area. Additionally, the active treatment audit has been revised to include checking off that residents are	

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			wearing their adaptive equipment as ordered.	
	3. An observation was done at the facility on 8/6/12 from 3:18p.m. to 6:42p.m. Client #5 did not wear nor was he observed to be prompted to wear hearing aids. Record review of client #5 was done on 8/7/12 at 3:02p.m. Client #5's 6/11/11 audiological note indicated client #5 had hearing aids. Client #5 had a 10/11 nursing note that indicated client #5 refuses hearing aids. Client #5's 7/13/12 ISP did not have documentation of a training program in place to address his refusal to wear his hearing aids. The ISP did not have documentation past training had been tried and was unsuccessful. Interview on 8/9/12 at 10:33p.m. of QDDP staff #4, indicated client #5 had hearing aids but did not have a training program in place to address his refusal of wearing his hearing aids. Client #35 was interviewed on 8/9/12 at 10:58a.m. Client #5 indicated he had hearing aids but didn't wear them because of the way they fit. 3.1-39(a)			

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W0454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview, the facility failed to ensure a sanitary environment for dining and failed to ensure a sanitary environment for showering/bathing for 11 of 16 sampled clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15) and 106 additional clients (client #25, #26, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, #148, #149, #150, #151, #152, #153, #154, #155, #156, #157, #158, #159, #160, #161, #162 and #163). Findings include: 1. During observations on 08/06/2012 at 1:20 p.m., the 2nd floor shower room had	W0454	**W454** I. None of the 11 sampled clients or the potential 106 other clients who had access to observed area sustained any injury or ill effects related to alleged unsanitary environment for dining/bathing. II All residents of North Willow have the potential to be harmed by the deficient practice. III. Facility nursing staff will be re-educated on the following according to facility protocol and practices to ensure sanitary living conditions * Proper disposal of gloves, briefs and trash * Proper use and disposal of soiled items, ie; linens, dressing, gloves, etc. * Facility practices related to urinal care and storage * Facility practice to ensure that tables are cleaned and sanitized prior to meal services. * Proper toileting protocols related to flushing, cleaning etc. * Submitting Work Orders	09/16/2012

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	a bandage saturated with red drainage on the floor in the first shower stall on the west side of the room. The toilet had not been flushed of feces and toilet paper. The toilet seat was heavily soiled with brown smears. A pair of used disposable gloves and a wet wash cloth were on the floor in the last stall on the west side of the room. A towel soiled with brownish/yellow stains was on the shower chair in the last stall on the west side of the room which clients #6, #7, #8, #9, #10, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117 and #118 had access to. 2. During observations on 08/06/2012 at 5:00 p.m. and 08/07/2012 at 7:45 a.m., 29 of 31 dining chairs in the 2nd floor dining room had food residue on the arms, legs, and seat of the chairs which clients #6, #7, #8, #9, #10, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109,		IV. Facility nursing staff will be required to make rounds daily on their shifts to ensure that facility practices are maintained. Nursing management will conduct random audits 2-3 x weekly to ensure that facility practices and protocols are being maintained. Said audit sheets will be signed and submitted to DNS for validation. DNS/Designee will conduct daily walking rounds (Monday - Friday). Violations of practice/protocols will be subject to disciplinary processes. W454 - Sanitary environment - **Housekeeping** I. None of the 11 sampled clients or the potential 106 other clients who had access to observed area sustained any injury or ill effects related to alleged unsanitary environment for dining/bathing. II All residents of North Willow have the potential to be harmed by the deficient practice. II. Facility housekeeping staff will be re-educated on the following according to facility protocol and practices to ensure sanitary living conditions. * General cleaning	

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	#110, #111, #112, #113, #114, #115, #116, #117 and #118 had access to. 3. During observations on 08/06/2012 at 5:45 p.m., client #6 wore tennis shoes and put his left foot on the dining table. LPN #52 redirected client #6 from putting his foot on the table but did not sanitize the table before placing food serving bowls on the table. During an interview on 08/06/2012 at 1:30 p.m., Certified Nurse Aide (CNA) # 52 indicated the shower room should have been cleaned after each resident bath/shower/use. He indicated the CNA who provided care was responsible for cleaning the room. During an interview on 08/06/2012 at 6:15 p.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated housekeeping was responsible for cleaning the dining chairs. She indicated the chairs should have been cleaned after each meal. During an interview on 08/09/2012 at 10:20 a.m. QDDP #1 indicated the table should have been sanitized before food serving bowls were placed on the table.		protocols as they relate to hard surfaces, floors, walls, furniture and resident rooms. * Deep clean schedules for routine cleaning of all areas. * Proper cleaning expectations. * Attention to detail, ie; missing or torn curtains, linens etc. * How to complete work orders. III. Housekeeping staff will clean dining room chairs and surrounding areas after each meal to ensure that areas are free of food and debris. Housekeeping Supervisor/Designee will perform dining room audits 2 x day x 7 days a week to ensure that areas are free of food and debris. Shower room cleaning will be increased from one time daily to two times daily to assist with sanitation. All areas have been scheduled for deep cleaning. The Administrator will oversee said schedule. All areas will be deep cleaned by 09/30/2012 and maintained on a continuous rotation and as needed.	

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			All floors have been scheduled for stripping and waxing. The Administrator will oversee said schedule. All floors to be completed by 09/30/2012 and maintained on a continuous rotation and as needed. The curtains in room 327 have been replaced. W454 - Sanitary environment - Maintenance I. None of the 11 sampled clients or the potential 106 other clients who had access to observed area sustained any injury or ill effects related to alleged unsanitary environment for dining/bathing. II. Facility staff have been re-educated on how to complete and submit work orders. III. The Vent fan in room 327 A work order has been submitted and the fan will be repaired or replaced. All rooms have been checked to ensure that vent fans are secured. The Sprinkle Head in room 331 has been checked and no debris remain on it. All Sprinkler Heads have been checked to	

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			ensure that they are free of debris.	
	4. An observation was done at the facility on 8/7/12 from 6:32a.m. to 8:30a.m. At 7:37a.m., the 3rd floor shower room had used plastic gloves on the floor in the first shower and a brown stained washcloth on the 2nd shower floor. All clients on the 3rd floor (#5, #11, #12, #13, #14, #15, #119 through #163) had access to the shower room. Interview of staff #2 on 8/7/12 at 7:37a.m. indicated the shower room floor was to be kept clean. 5. On 8/6/12 from 3:00 PM until 6:40 PM the physical environment of the third floor southern wing was observed. The floor of the common hallway which led into individual classrooms/bedrooms was dusty, had black streaks on it and was dull looking. Clients #13 and #151's bedroom/bathroom number 327 had a full trash can with used latex gloves in it and the cover to the ventilating fan was unattached and on the floor of the bathroom. Only one window curtain was on the western window. Client room number 331's toilet was not			

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	flushed and had yellow and brown stains on the seat, this affected clients #154 and #155. Bedroom number 333's bathroom sprinkler had a cotton gauze like material strip hanging from it, this affected clients #15 and #156. Classroom number 328's floor was covered in black streaks. The un-numbered classroom on the western side's bathroom trash was overflowing with latex gloves and the bathroom had a strong odor. Interview with Administrator #8 on 8/9/12 at 5:30 PM indicated the facility should have a pair of draperies at client bedroom windows. The interview indicated the facility employed housekeeping personnel who were to ensure cleanliness of floors and bathrooms and to do trash removal. 6. Observations were conducted of clients' #25 and #26 bedroom, number 107, on 8/9/12 at 1:19 PM. Clients' #25 and #26 restroom had a plastic portable male urinal container sitting on the bathroom sink. The container had yellow liquid in it and urine odor emanated from the container. 3.1-18(l) 3.1-21(i)(3)			