STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of complaint #IN00125037. Complaint #IN00125037: SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W104, W149, W154, W331, and W339. Unrelated deficiencies are cited. Dates of Survey: March 13, 14, 15, 18, 19, and 26, 2013. Facility number: 000730 Provider number: 15G580 AIM number: 100272190 Surveyor: Susan Eakright, Medical Surveyor III/QMRP. The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2 Quality review completed April 4, 2013 by Dotty Walton, Medical Surveyor III.	W000000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of my proceedings and submit these responses pursuant to our regulatory obligations. _____ __Beverly Sayre Cowart	

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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W000104	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 3 of 3 sampled clients (clients A, B, and C), and eight additional clients (clients M, S, Z, BB, OO, VV, XX, and BBB), the facility's governing body failed to exercise operating direction over the facility to ensure the facility implemented their facility policy and procedure prohibiting client abuse for abuse, neglect, and/or mistreatment to implement sufficient corrective action to protect clients from continued client to client physical aggression and neglected to provide sufficient chairs for clients' programming needs. The governing body failed to ensure client A received nursing services according to his identified needs (specialized feeding requirements). Findings include: The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented their facility policy and procedure for prohibiting abuse, neglect, and/or mistreatment by failing to protect clients from continued client to client physical aggression and to provide enough chairs in program room #6. The	W000104	W104. The governing body does and will continue to provide all necessary operating direction over the facility. Operating direction will be evidenced by review and revision of nursing policy and related services related to feeding protocols, gastric tube placement and aspiration protocols. The facility's governing body (Interdisciplinary Team) did review and revise several policies and procedures following Client A's death to further ensure that proactive measures are implemented. The Incident Management Committee reviewed the investigative findings and subsequent report regarding Client A's death (Att. A). The Committee countered with suggestions of revision proactive for potential future emergent situations. Additionally, the investigator and supervisory nursing personnel discussed the feeding methods performed for Client A. The investigator and supervisory nursing personnel reviewed nursing and QMA job duties and scope of practice related to bolus/ gastric tube feedings. As a result of these discussions, the QMA and LPN responsible for bolus feedings for Client A on 2-20-2013, were administered written disciplinary	04/25/2013

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	governing body also failed to exercise facility's nursing services failure to ensure client A received nursing services according to his identified need for 3 of 3 sampled clients (clients A, B, and C) and eight additional clients (clients M, S, Z, BB, OO, VV, XX, and BBB). Please refer to W149. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility thoroughly investigated client A's 2/21/2013 incident regarding the failure to provide nursing services according to his identified feeding requirements for 1 of 3 sampled clients (client A). Please refer to W154. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met client A's identified healthcare needs in regard to implementing client A's aspiration plan (reclining the client improperly), documenting G-Tube residuals, and failing to have a licensed nurse administer his G (Gastric) tube feeding, for 1 of 1 sample client (client A) who had a G-Tube. Please refer to W331. This federal tag relates to complaint		action and re-trained on scope of practice and regulations regarding feedings (Att. B). In the future, investigative findings will be documented within the investigation. The “aspiration plan” referred to in the 2567 dated March 26 th , 2013, was not specific to Client A. Client A did not have a diagnosis of aspiration precautions (Att. C). Client A did have gastric tube placement and was previously hospitalized for aspiration pneumonia. Under these circumstances, Client A was appropriately positioned and provided the necessary measures for aspiration precautions. Facility Aspiration Policy states that clients are to be positioned at 45-90 degree angle during meals and remain at this angle for approximately 30-60 minutes following consumption (Att. D). Client A did not have/nor did he require doctor’s orders for aspiration. Per the Charting and Documentation Guidelines provided at the time of this survey, gastric tube residuals are recorded in the client record if those residuals are greater than 100 cc (Att. E). If the residual is less than 100 cc, no documentation is required. Further, the Gastric Tube Medication Policy (Att. F) and the Gastrostomy Tube Feeding, Bolus Method Policy (Att. G) , also provided at the time of the survey, was reviewed by the	

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	#IN00125037. 3.1-13(q) 3.1-13(s)		Committee. The aforementioned policies provide direction for pre-med/pre-feeding administration by means of aspirate from gastric tube and replacement of residuals or by auscultation of air bolus. Therefore, documentation of residual for Client A prior to feeding bolus on 2-20-2013, was not required. The Administrator or their designee is responsible. The IDT will monitor.	

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W000149	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, record review, and interview for 3 of 3 sampled clients (clients A, B, and C) and eight additional clients (clients M, S, Z, BB, OO, VV, XX, and BBB), the facility neglected to implement their facility policy and procedure to investigate and prohibiting client abuse, neglect, and/or mistreatment by failing to protect clients from continued client to client physical aggression and neglected to provide sufficient chairs for programming needs. The facility's nursing services neglected to ensure client A received nursing services according to his identified needs regarding client A's feeding requirements. Findings include: 1. On 3/13/13 from 11:55am until 1:50pm, program room #6 was observed at the facility. At 12:20pm, client C sat at a table inside Program Room #6. Client Z stood in Program Room #6, walked to a recliner which was in the middle of the room, and sat down. Client C got up from his seat at the table, walked over to client Z, stood over client Z, and stated "Get up. Get out." Client Z did not move from the recliner and client C struck client	W000149	W149 The Interdisciplinary Team has reviewed and revised protocols addressing sufficient and appropriate seating for all clients and common areas. To ensure that sufficient and appropriate seating is available at all times, a daily evaluation has been implemented. Daily seating evaluation will be completed on the overnight shift. Seating evaluation will include: Number of seating opportunities within all client common areas, the number of chairs out for repairs and/or cleaning and seating opportunities replaced at the time of evaluation. All documentation will be provided to maintenance personnel who will ensure that sufficient and appropriate seating opportunities are consistently available for all clients. As breakage, soiling and/or repairs may be required throughout a typical day, it will be the responsibility of floor and supervisory staff to ensure that sufficient and appropriate seating opportunities are maintained at all times. Direct care staff will be responsible for notifying maintenance personnel immediately if seating opportunities must be removed or in need of replacement. Any staff that does not comply with these	04/25/2013

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	Z on his left forearm with an open hand. Client C became verbally louder, stated "get out," and Direct Care Staff (DCS) #1 redirected client C that client Z was sitting in the chair. Client Z jumped up from the recliner, began to pace from one wall to the next wall inside program room #6, and stopped to put his face in the corner of the walls twice. Client C returned to sit in a different chair at the table. From 11:55am until 1:50pm, Program Room #6 had eight (8) chairs and ten (10) clients with two Direct Care Staff (DCS) inside the program room. Clients inside program room #6 were B, C, M, S, Z, BB, OO, VV, XX, and BBB The facility's records were reviewed on 3/13/13 at 1:50 P.M.. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/27/13 BDDS report for an incident on 2/20/13 at 10:05am, indicated client B was sitting in client C's recliner inside program room #6 and client C "placed [client C's] hand on the back of [client B] and pushed him out of the chair." The report indicated client B's "head hit the floor. [Client B] received a 2cm (centimeter) superficial laceration to the right side of his head. As [Client C] was		measures will be administered disciplinary action. Program room six has been remodeled and relocated to better facilitate space requirements and access to outside windows. During the time of the survey, this facility was in the process of expanding program room six as it was recognized that the footprint for clients and staff required modification. The Committee will continue to monitor activity within this group and continue to make modifications to promote safety and activity. Investigation into Client A's death was complete but it was pending conclusive results from the coroner, as the coroner's results were not hand delivered until 3-29-2013. Investigation into Client A's death was reviewed by the Incident Management Committee on 2-26-2013 (Att. A). The following recommendations were made by the investigator and the committee: DNR status is now posted at all facility phones and crash cart; crash cart check sheet was revised to include daily check off to assure all necessary supplies are readily available and in working order; crash cart is housed where all staff have efficient/easy access for retrieval; all staff were re-trained regarding the ability to call 911 from program room phones; all phones were marked to indicate the possibility to phone 911; all nursing personnel will participate	

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	sitting down in the chair, he accidentally put his foot on [Client B's] head." The report indicated staff were to ensure enough chairs for clients and staff to sit in were inside the program room to remedy the client to client aggression. -A 2/26/13 BDDS report for an incident on 2/25/13 at 2:30pm, indicated client C was in program room #6 and "there was not an available chair for him to sit in. He backed against the wall, slid down the wall, and dropped to the floor causing a bruise on his buttocks. He received a 13cm x (by) 10cm bruise to his L (left) buttock and an 8cm x 5cm bruise to his R (right) buttock." As a remedy the report indicated staff were to ensure enough chairs for clients and staff to sit in were inside the program room. On 3/14/13 at 11:15am, an interview with the Administrator, the Program Director, and the QMRP (Qualified Mental Retardation Professional) was conducted. The three administrative staff indicated the facility staff did not ensure program room #6 had enough chairs during the 3/13/13 observations and on 2/26/13 and 2/7/13 to support the clients who attended programming in that room. The three indicated clients B, C, M, S, Z, BB, OO, VV, XX, BBB, and DDD attended programming inside program room #6.		in random/un-disclosed emergency mock drills. The investigation folder did contain the results for the Incident Management Committee as listed. The “aspiration plan” referred to in the 2567 dated March 26 th , 2013, was not specific to Client A. Aspiration precautions identified and numbered in the 2567 were a listing of 17 Client’s individual doctors’ orders. The precautions listed were items that appear to be copied and pasted from other client’s doctor’s orders (Att. H). Client A did NOT have a diagnosis of aspiration precaution (Att. C). But, Client A was a gastric tube client that had been previously hospitalized for aspiration pneumonia. Per the facility Aspiration Policy (Att. D), Client A was in the proper position to receive medications, bolus feeding, mealtime nutrition and his evening snack. Facility Aspiration Policy states that clients are to sit at a 45-90 degree angle during meals and for 30-60 minutes following oral consumption. Under these guidelines and circumstances, Client A was appropriately provided the necessary measures of safety for oral consumption. Additionally, the investigation indicated that Client A was reclined slightly during presentation of his HS snack. Further interview and investigation asked participating	

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	The QMRP indicated client C had hit other clients in the past six (6) months. 2. The facility's records were reviewed on 3/13/13 at 1:50 P.M. A review of the BDDS reports from 2/1/2013 to 3/13/2013 indicated the following: -A BDDS report on 2/4/13 for an incident on 2/3/13 at 7pm, indicated client VV was "looking out the window in the program room (program room #6). [Client OO] wanted to look out the window too. [Client VV] wouldn't (sic) move and a bean bag was also in the way. [Client OO] became agitated and bit [client VV] on the right shoulder causing a 3cm (centimeter) x 3.5cm reddened area with the edges open." On 3/14/13 at 11:15am, an interview with the Administrator, the Program Director, and the QMRP was conducted. The three administrative staff indicated client OO had been biting when he did not feel well and wanted to look out the window. The three administrative staff indicated the facility staff inside program room #6 were asked to monitor client OO closer. The QMRP indicated client OO had bitten other clients in the past six (6) months. The facility's records were reviewed on 3/13/13 at 11am. A review of the		staff what degree of angle Client A was in during their interaction. Within 5 degrees of variation, all six staff members stated that Client A was positioned at/between 60 and 65 degrees when Client A was provided with oral nutritional support and/or gastric tube bolus. Per the final autopsy report, Client A died of natural causes, not as a result of aspiration. Per the Charting and Documentation Guidelines (Att. E) provided at the time of the survey, gastric tube residuals are recorded in the client record if they are greater than 100cc. If residual is less than 100cc, no documentation is required. Also, as quoted from the Gastrostomy Tube Medication Policy (Att. F) and the Gastrostomy Tube Feeding, Bolus Method Policy 6 (Att. G), gastric tube placement should be assessed per pre-medication/pre-feeding administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus. Tube placement may be and is most often verified by air bolus within this facility and the verification of placement is signed for on the individual client treatment record. Documentation of medication administration is completed by signing the medications of the individual client's MAR. Further, the job description for QMA's provided at the time of the survey, states that QMAs are to pass PO	

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	facility's 4/26/11 "Abuse and Neglect Policy and Procedure" indicated in part, the following: "Staff will ensure the protection and treatment of all clients by refraining from the use of physical, verbal, sexual, or psychological abuse of any client. The facility shall act proactively to assure that clients are free from serious and immediate threat to their physical and psychological health and safety. The facility will further ensure that all clients are free from neglect. Neglect will include the failure to provide appropriate care, food, medical care or supervision." 3. The facility's records were reviewed on 3/13/13 at 1:50 P.M.. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/21/13 BDDS report for an incident on 2/20/13 at 9:25pm, indicated client A became non responsive and was pronounced dead at 9:25pm inside program room #6 by the Coroner who was onsite. The report indicated "the first nurse called Emergency Services at approximately 7:54pm," EMS arrived at 8pm, and CPR (Cardiopulmonary Resuscitation) had been initiated by the nurses at the facility. The report indicated a facility "staff member gave [client A]		and gastric tube medications (pills and liquid) and chart as needed as indicated in job duty #3. To clarify the statement “The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings.” The DON and ADON were aware of the regulation as evidenced by administration of disciplinary action taken for the LPN in charge and the QMA who administered the bolus feeding. Disciplinary action was administered on 2-21-2013 (the day after the incident) for the LPN in charge and the QMA administering the bolus feeding to Client A. The Program Director is responsible. The IDT will monitor	

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	his PM (evening) snack pureed graham cracker. [Client A] ate the snack slow, but ate it all. He was fed a little at a time and smiled at the staff member when he was shown the empty cup." The report indicated client A had been hospitalized on 2/5/13 for Enterobacter (bacterial) Pneumonia and UTI (Urinary Tract Infection) and client A had returned to the facility on 2/13/13 being treated with antibiotics. -The investigation for client A's 2/20/13 incident indicated client A had consumed less than twenty-five percent (<25%) of his pureed supper meal. The investigation indicated the police and the coroner were investigating client A's death and waiting for additional information. The facility's investigation did not indicate a result to their investigation. On 3/13/13 at 2:45pm, the 2/22/13 "Police Report" for client A's incident on 2/20/13, indicated a list of facility staff who were interviewed on 2/20/13, each staff member's statements to police, and indicated the following. -Direct Care Staff (DCS) #3 stated "that after dinner [client A] kept on sleeping and was never wet. Around 7:30pm, [QMA (Qualified Medication Aide)] came in with snacks the same as last night, puree graham crackers (sic).			

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	[Client A] eat them slow but he did eat it all. [DCS #3] stated that he fed him little bites and he was awake looking at [DCS #3]. [Client A] smiled when he showed [client A] the empty cup and tapped his leg. Then [QMA] came in and bulse (sic) him. Then 20 minutes later is when [DCS #3] noticed that [client A] was pale and his lips were white. [DCS #3] asked [LPN (Licensed Practical Nurse) #1] what's wrong with [client A]. [DCS #3] felt [client A's] face and it was so cold." -QMA "stated that the last she (sic) seen [client A] was about 7:30pm. She had given him his bolis (sic) feeding. At that time he was leaned back in his chair and she thought he was sleeping. Approximately 10 minutes later the nurses were calling for equipment and items they needed and they were doing CPR on [client A]." On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) on 2/21/13 at 3:07pm, with DCS #3 indicated the following interview. -"7:35, fed snack, alert, gave little bites, showed him [client A] empty cup, he smiled...chair reclined, eyes shut, mouth half open."			

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	On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) and the Assistant Director of Nursing (ADON) on 2/22/13 at 10:50pm, with the QMA indicated the following interview. -"At 7p-7:30p (sic), passed snacks...7:30p-7:40p (sic) gave [client A's] meds (medications) and water flush in his w/c (wheelchair). [Client A] was reclined back in his w/c and appeared to be asleep. Had on C collar. He did not move, flinch during meds passed. Passed G-tube meds to assist nurse on duty (sic)." Client A's record was reviewed on 3/13/13 at 2:50pm. Client A's record indicated hospitalizations on 2/5/13 until 2/13/13 diagnosed with Enterobacter Pneumonia and Urinary Tract Infection. Client A was hospitalized from 11/7/12 until 11/9/12 diagnosed with Pneumonia. Client A's record indicated 12/31/12 "Aspiration Plan" which indicated "When you finish feeding someone at 11:30am, they should not lie down until at least 12pm...9. Aspiration Risk. Must sit up after meals and snacks 30 minutes. 10. Aspiration Precautions. Sit at a 90 degree angle for all oral intake and 30-60 minutes after meal, Reflux/Aspiration			

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	Precautions...14. Aspiration Precautions. Aspiration Precautions. Sit up 30 minutes after all meals. 15. Aspiration Precautions sit upright for 30 minutes after all p.o. (by mouth) intake." Client A's record on 3/13/13 at 2:50pm, included client A's 12/21/12 "Physician's Order" which indicated "11/22/12 Puree diet, 11/12/12 bolus 1 can of Nutren (nutritional tube feeding) 2.0 if patient eats <50% (less than fifty percent) at each meal." Client A's diagnoses included but were not limited to G-tube placement, history of Failure to Thrive, Seizure Disorder, Severe Mental Retardation, Autism Spectrum Disorder, Incontinence of bowel and bladder, and Reflux. Client A's record did not have documentation that his G-tube residuals were recorded on 2/20/13. On 3/14/13 at 11:55am, an interview with the QMA was conducted. The QMA indicated she passed client A's G-tube medications and stated "I saw the juice box feeding, administered the feeding" after client A's medication administration, and flushed the tube with water. The QMA indicated she did not record residuals for client A's G-tube and indicated she could not remember what they were. The QMA stated "I know I shouldn't have, I just gave it" the G-tube			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/26/2013
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	feeding because she saw it on the medication cart after supper. On 3/13/13 at 3:30pm, the facility's 10/14/2008 "Gastrostomy Tube Medication Policy" was reviewed and indicated "...6. Verify tube placement and then check for tube potency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...16. Document medication administration." On 3/13/13 at 3:30pm, the facility's 2/5/2009 "Gastrostomy Tube Feeding, Bolus Method" Policy was reviewed and indicated "...6. Verify tube placement and then check for tube patency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med/pre-feed administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...14. Document medication administration." On 3/13/13 at 3:30pm, the facility's undated "QMA Job Description" indicated the QMA was to administer medications and did not indicate the QMA was to administer G-Tube feedings or medications.			

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	On 3/13/13 at 3:30pm, the facility's undated "Nurse Responsibilities 9pm-5am (shift)" indicated "...4. Administer GT (G-Tube) medications...5. Document, chart assessments...17. Clean feeding pumps...." The facility's undated "Nurse Responsibilities 5am-1pm (shift)" indicated "...4. Bolus residents per physicians orders (Bolus feedings administered to clients) (sic)...6. Administer GT (G-Tube) medications...7. Document...." On 3/14/13 at 12pm, an interview with administrative staff of the Administrator, the Program Director, the QMRP (Qualified Mental Retardation Professional), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) was conducted. The administrative staff indicated the police and the coroner were still investigating the incident and waiting for additional information before their results were completed. The administrative staff indicated the facility did not have results of their internal investigation completed. The administrative staff indicated client A should have been upright in his wheelchair after eating. The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings. The DON indicated			

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	client A had no G-Tube residuals documented on 2/20/13. This federal tag relates to complaint #IN00125037. 3.1-28(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review, and interview for 1 of 3 sampled clients (client A), the facility failed to thoroughly investigate client A's 2/21/2013 incident regarding the failure to provide nursing services according to his identified feeding requirements. Findings include: The facility's records were reviewed on 3/13/13 at 1:50 P.M. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/21/13 BDDS report for an incident on 2/20/13 at 9:25pm, indicated client A became non responsive and was pronounced dead at 9:25pm inside program room #6 by the Coroner who was onsite. The report indicated "the first nurse called Emergency Services at approximately 7:54pm," EMS arrived at 8pm, and CPR (Cardiopulmonary Resuscitation) had been initiated by the nurses at the facility. The report indicated a facility "staff member gave [client A] his PM (evening) snack pureed graham	W000154	W154 . Investigation into Client A's death was complete but it was pending conclusive results from the coroner, as the coroner's results were not hand delivered until 3-29-2013. Investigation into Client A's death was reviewed by the Incident Management Committee on 2-26-2013 (Att. A). The following recommendations were made by the investigator and the committee: DNR status is now posted at all facility phones and crash cart; crash cart check sheet was revised to include daily check off to assure all necessary supplies are readily available and in working order; crash cart is housed where all staff have efficient/easy access for retrieval; all staff were re-trained regarding the ability to call 911 from program room phones; all phones were marked to indicate the possibility to phone 911; all nursing personnel will participate in random/un-disclosed emergency mock drills. The investigation folder did contain the results for the Incident Management Committee as listed. The "aspiration plan" referred to in the 2567 dated March 26 th , 2013, was not specific to Client A. Aspiration precautions identified and numbered in the 2567 were a	04/25/2013

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	cracker. [Client A] ate the snack slow, but ate it all. He was fed a little at a time and smiled at the staff member when he was shown the empty cup." The report indicated client A had been hospitalized on 2/5/13 for Pneumonia and UTI (Urinary Tract Infection) and client A had returned to the facility on 2/13/13 being treated with antibiotics. -The investigation for client A's 2/20/13 incident indicated client A had consumed less than twenty-five percent (<25%) of his pureed supper meal. The investigation indicated the police and the coroner were investigating client A's death and waiting for additional information. The facility's investigation did not indicate a result to their investigation. On 3/13/13 at 2:45pm, the 2/22/13 "Police Report" for client A's incident on 2/20/13, indicated a list of facility staff who were interviewed on 2/20/13, each staff member's statements to police, and indicated the following. -Direct Care Staff (DCS) #3 stated "that after dinner [client A] kept on sleeping and was never wet. Around 7:30pm, [QMA (Qualified Medication Aide)] came in with snacks the same as last night, puree graham crackers (sic). [Client A] eat them slow but he did eat it all. [DCS #3] stated that he fed him little		listing of 17 Client's individual doctors' orders. The precautions listed were items that appear to be copied and pasted from other client's doctor's orders (Att. H). Client A did NOT have a diagnosis of aspiration precaution (Att. C). But, Client A was a gastric tube client that had been previously hospitalized for aspiration pneumonia. Per the facility Aspiration Policy (Att. D), Client A was in the proper position to receive medications, bolus feeding, mealtime nutrition and his evening snack. Facility Aspiration Policy states that clients are to sit at a 45-90 degree angle during meals and for 30-60 minutes following oral consumption. Under these guidelines and circumstances, Client A was appropriately provided the necessary measures of safety for oral consumption. Additionally, the investigation indicated that Client A was reclined slightly during presentation of his HS snack. Further interview and investigation asked participating staff what degree of angle Client A was in during their interaction. Within 5 degrees of variation, all six staff members stated that Client A was positioned at/between 60 and 65 degrees when Client A was provided with oral nutritional support and/or gastric tube bolus. Per the final autopsy report, Client A died of natural causes, not as a result of	

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	bites and he was awake looking at [DCS #3]. [Client A] smiled when he showed [client A] the empty cup and tapped his leg. Then [QMA] came in and bulse (sic) him. Then 20 minutes later is when [DCS #3] noticed that [client A] was pale and his lips were white. [DCS #3] asked [LPN (Licensed Practical Nurse) #1] what's wrong with [client A]. [DCS #3] felt [client A's] face and it was so cold." -QMA "stated that the last she (sic) seen [client A] was about 7:30pm. She had given him his bolis (sic) feeding. At that time he was leaned back in his chair and she thought he was sleeping. Approximately 10 minutes later the nurses were calling for equipment and items they needed and they were doing CPR on [client A]." On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) on 2/21/13 at 3:07pm, with DCS #3 indicated the following interview. -"7:35, fed snack, alert, gave little bites, showed him [client A] empty cup, he smiled...chair reclined, eyes shut, mouth half open." On 3/13/13 at 1:50pm, a review of the		aspiration. Per the Charting and Documentation Guidelines (Att. E) provided at the time of the survey, gastric tube residuals are recorded in the client record if they are greater than 100cc. If residual is less than 100cc, no documentation is required. Also, as quoted from the Gastrostomy Tube Medication Policy (Att. F) and the Gastrostomy Tube Feeding, Bolus Method Policy 6 (Att. G), gastric tube placement should be assessed per pre-medication/pre-feeding administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus. Tube placement may be and is most often verified by air bolus within this facility and the verification of placement is signed for on the individual client treatment record. Documentation of medication administration is completed by signing the medications of the individual client's MAR. Further, the job description for QMA's provided at the time of the survey, states that QMAs are to pass PO and gastric tube medications (pills and liquid) and chart as needed as indicated in job duty #3. To clarify the statement "The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings." The DON and ADON were aware of the regulation as evidenced by administration of disciplinary action taken for the	

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	facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) and the Assistant Director of Nursing (ADON) on 2/22/13 at 10:50pm, with the QMA indicated the following interview. -"At 7p-7:30p (sic), passed snacks...7:30p-7:40p (sic) gave [client A's] meds (medications) and water flush in his w/c (wheelchair). [Client A] was reclined back in his w/c and appeared to be asleep. Had on C collar. He did not move, flinch during meds passed. Passed G-tube meds to assist nurse on duty (sic)." Client A's record was reviewed on 3/13/13 at 2:50pm. Client A's record indicated hospitalizations on 2/5/13 until 2/13/13 diagnosed with Enterobacter Pneumonia and Urinary Tract Infection. Client A was hospitalized from 11/7/12 until 11/9/12 diagnosed with Pneumonia. Client A's record indicated 12/31/12 "Aspiration Plan" which indicated "When you finish feeding someone at 11:30am, they should not lie down until at least 12pm...9. Aspiration Risk. Must sit up after meals and snacks 30 minutes. 10. Aspiration Precautions. Sit at a 90 degree angle for all oral intake and 30-60 minutes after meal, Reflux/Aspiration Precautions...14. Aspiration Precautions. Aspiration Precautions. Sit up 30 minutes		LPN in charge and the QMA who administered the bolus feeding. Disciplinary action was administered on 2-21-2013 (the day after the incident) for the LPN in charge and the QMA administering the bolus feeding to Client A. The Program Director is responsible. The IDT will monitor.	

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	after all meals. 15. Aspiration Precautions sit upright for 30 minutes after all p.o. (by mouth) intake." Client A's record on 3/13/13 at 2:50pm, included client A's 12/21/12 "Physician's Order" which indicated "11/22/12 Puree diet, 11/12/12 bolus 1 can of Nutren (nutritional tube feeding) 2.0 if patient eats <50% (less than fifty percent) at each meal." Client A's diagnoses included but were not limited to G-tube placement, history of Failure to Thrive, Seizure Disorder, Severe Mental Retardation, Autism Spectrum Disorder, Incontinence of bowel and bladder, and Reflux. Client A's record did not have documentation that his G-tube residuals were recorded on 2/20/13. On 3/14/13 at 11:55am, an interview with the QMA was conducted. The QMA indicated she passed client A's G-tube medications and stated "I saw the juice box feeding, administered the feeding" after client A's medication administration, and flushed the tube with water. The QMA indicated she did not record residuals for client A's G-tube and indicated she could not remember what they were. The QMA stated "I know I shouldn't have, I just gave it" the G-tube feeding because she saw it on the medication cart after supper.			

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	On 3/13/13 at 3:30pm, the facility's 10/14/2008 "Gastrostomy Tube Medication Policy" was reviewed and indicated "...6. Verify tube placement and then check for tube potency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...16. Document medication administration." On 3/13/13 at 3:30pm, the facility's 2/5/2009 "Gastrostomy Tube Feeding, Bolus Method" Policy was reviewed and indicated "...6. Verify tube placement and then check for tube patency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med/pre-feed administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...14. Document medication administration." On 3/13/13 at 3:30pm, the facility's undated "QMA Job Description" indicated the QMA was to administer medications and did not indicate the QMA was to administer G-Tube feedings or medications. On 3/13/13 at 3:30pm, the facility's			

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	undated "Nurse Responsibilities 9pm-5am (shift)" indicated "...4. Administer GT (G-Tube) medications...5. Document, chart assessments...17. Clean feeding pumps...." The facility's undated "Nurse Responsibilities 5am-1pm (shift)" indicated "...4. Bolus residents per physicians orders (Bolus feedings administered to clients) (sic)...6. Administer GT (G-Tube) medications...7. Document...." On 3/14/13 at 12pm, an interview with administrative staff of the Administrator, the Program Director, the QMRP (Qualified Mental Retardation Professional), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) was conducted. The administrative staff indicated the police and the coroner were still investigating the incident and waiting for additional information before their results were completed. The administrative staff indicated the facility did not have results of their investigation completed. The administrative staff indicated client A should have been upright in his wheelchair after eating. The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings. The DON indicated client A had no G-Tube residuals documented on 2/20/13.			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients B and C) and eight additional clients (clients M, S, Z, BB, OO, VV, XX, and BBB), the facility failed to implement sufficient corrective action to protect clients from continued client to client physical aggression (biting, hitting, and lacerations). The facility failed to supply adequate seating (chairs) as recommended for program areas (program room #6). Findings include: 1. Observations on 3/13/13 at 12:20pm, client C sat at a table inside Program Room #6. Client Z stood in Program Room #6, walked to a recliner which was in the middle of the room, and sat down. Client C got up from his seat at the table, walked over to client Z, stood over client Z, and stated "Get up. Get out." Client Z did not move from the recliner and client C struck client Z on his left forearm with an open hand. Client C became verbally louder, stated "get out," and Direct Care Staff (DCS) #1 redirected client C that client Z was sitting in the chair. Client Z jumped up from the recliner, began to pace from one wall to the next wall inside	W000157	W157 To ensure that sufficient and appropriate seating is available at all times, a daily evaluation has been implemented. Daily seating evaluation will be completed on the overnight shift. Seating evaluation will include: Number of seating opportunities within all client common areas, the number of chairs out for repairs and/or cleaning and seating opportunities replaced at the time of evaluation. All documentation will be provided to maintenance personnel who will ensure that sufficient and appropriate seating opportunities are consistently available for all clients. As breakage, soiling and/or repairs may be required throughout a typical day, it will be the responsibility of floor and supervisory staff to ensure that sufficient and appropriate seating opportunities are maintained at all times. Direct care staff will be responsible for notifying maintenance personnel immediately if seating opportunities must be removed or in need of replacement. Any staff that does not comply with these measures will be administered disciplinary action.	04/25/2013

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	program room #6, and stopped to put his face in the corner of the walls twice. Client C returned to sit in a different chair at the table. From 11:55am until 1:50pm, Program Room #6 had eight (8) chairs and ten (10) clients with two Direct Care Staff (DCS) inside the program room. Clients inside program room #6 were B, C, M, S, Z, BB, OO, VV, XX, and BBB The facility's records were reviewed on 3/13/13 at 1:50 P.M. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/27/13 BDDS report for an incident on 2/20/13 at 10:05am, indicated client B was sitting in client C's recliner inside program room #6 and client C "placed [client C's] hand on the back of [client B] and pushed him out of the chair." The report indicated client B's "head hit the floor. [Client B] received a 2cm (centimeter) superficial laceration to the right side of his head. As [Client C] was sitting down in the chair, he accidentally put his foot on [Client B's] head." The report indicated staff were to ensure enough chairs for clients and staff to sit in were inside the program room to remedy the client to client physical aggression.		Program room six has been remodeled and relocated to better facilitate space requirements and access to outside windows. During the time of the survey, this facility was in the process of expanding program room six as it was recognized that the footprint for clients and staff required modification. The Committee will continue to monitor activity within this group and continue to make modifications to promote safety and activity. The Program Director is responsible.The IDT will monitor.	

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	-A 2/26/13 BDDS report for an incident on 2/25/13 at 2:30pm, indicated client C was in program room #6 and "there was not an available chair for him to sit in. He backed against the wall, slid down the wall, and dropped to the floor causing a bruise on his buttocks. He received a 13cm x (by) 10cm bruise to his L (left) buttock and an 8cm x 5cm bruise to his R (right) buttock." The report indicated staff were to ensure enough chairs for clients and staff to sit in were inside the program room to remedy the client to client physical aggression. On 3/14/13 at 11:15am, an interview with the Administrator, the Program Director, and the QMRP (Qualified Mental Retardation Professional) was conducted. The three administrative staff indicated their recommended remedy of additional seating to address client to client physical aggression. The three administrative staff indicated the facility staff did not ensure program room #6 had enough chairs to support the clients who attended programming in that room. The three indicated clients B, C, M, S, Z, BB, OO, VV, XX, BBB, and DDD attended programming inside program room #6. The QMRP indicated client C had hit other clients in the past six (6) months. 2. The facility's records were reviewed on			

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	3/13/13 at 1:50 P.M.. A review of the BDDS reports from 2/1/2013 to 3/13/2013 indicated the following: -A BDDS report on 2/4/13 for an incident on 2/3/13 at 7pm, indicated client VV was "looking out the window in the program room (program room #6). [Client OO] wanted to look out the window too. [Client VV] wouldn't (sic) move and a bean bag was also in the way. [Client OO] became agitated and bit [client VV] on the right shoulder causing a 3cm (centimeter) x 3.5cm reddened area with the edges open." On 3/14/13 at 11:15am, an interview with the Administrator, the Program Director, and the QMRP was conducted. The three administrative staff indicated client OO had been biting when he did not feel well and wanted to look out the window. The three administrative staff indicated the facility staff inside program room #6 were asked to monitor client OO closer. The QMRP indicated client OO had bitten other clients in the past six (6) months. No additional corrective action was documented. 3.1-28(a)			

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W000249	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 2 of 3 sampled clients (clients B and C) and eight additional clients (clients M, S, Z, BB, OO, VV, XX, and BBB), the facility failed to ensure clients' training and behavioral objectives were implemented and failed to ensure active treatment was provided during formal and informal opportunities. Findings include: On 3/13/13 from 11:55am until 1:50pm, Program Room #6 had eight (8) chairs and ten (10) clients with two Direct Care Staff (DCS) inside the program room. Clients inside program room #6 were B, C, M, S, Z, BB, OO, VV, XX, and BBB. At 12:20pm, client C sat at a table inside Program Room #6. Client Z stood in Program Room #6, walked to a recliner which was in the middle of the room, and sat down. Client C got up from his seat at the table, walked over to client Z, stood over client Z, and stated "Get up. Get out." Client Z did not move from the	W000249	W249. All clients are and will continue to offered active treatment opportunities as outlined in each client's active treatment schedule. For clients located in program room six, clients were engaged in leisure time training/opportunities during the observation period conducted at lunch. Per the active treatment schedule, clients are engaged in mealtime activities that are leisure based to facilitate opportunities for downtime and structuring these times appropriately. To facilitate increased activity and staff participation, staff will be trained in the appropriate techniques to facilitate client participation as designed in the active treatment program. Topic areas and techniques to address training includes: defining active treatment, teaching strategies, review of the individual data sheet, review of behavior management programs and their purpose, alternative training interventions, providing	04/25/2013

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	recliner and client C struck client Z on his left forearm with an open hand. Client C became verbally louder, stated "get out," and Direct Care Staff (DCS) #1 redirected client C that client Z was sitting in the chair. Client Z jumped up from the recliner, began to pace from one wall to the next wall inside program room #6, and stopped to put his face in the corner of the walls twice. Client C returned to sit in a different chair at the table. On 3/13/13 from 11:55am until 12:07pm, Program Room #6 was observed. At 11:55am, clients B, C, M, S, Z, and VV sat inside without activity with DCS #1 and the television was on. At 12:07pm, DCS #2 entered program room #6, walked to client M, removed client M's hands from inside client M's pants, and washed client M's hands with a cloth. At 12:07pm, client C was offered to count coins with DCS #1. From 11:55am until 12:40pm, client M had a wash cloth hanging from his mouth and client M chewed on the wash cloth without redirection and without replacement activity offered. From 11:55am, until 1:50pm, clients B, M, S, Z, BB, OO, VV, XX, BBB, and DDD sat, paced, stood in the corners of the room, and were not offered or prompted for activity by the facility staff. During the observation period clients were assisted by other staff		opportunities for client choice and active participation to mesh active treatment with everyday events. Small group training will be provided to all direct care staff. As a result of this training, staff will be better informed and possess increased ability to implement developed objectives through activities that promotes client participation and inclusion of their identified needs, interests and completing custodial tasks. The Program Director will be responsible.The IDT will monitor.	

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	entering and leaving the room to leave the room, eat lunch in the dining room, then return to program room #6 and sat or paced in program room #6 without activity. On 3/13/13 at 1:50pm, the QMRP (Qualified Mental Retardation Professional) provided an undated "Daily Activity Schedule" for Program Room (PR) #6 to follow; clients B, C, M, S, Z, BB, OO, VV, XX, BBB, and DDD which indicated: 5:00-7:30 AM - "Get up, Toileting, Dressing for the day, structured leisure activity (Sorting, coloring, sensory stim (Stimulation) activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorter, etc...), Medication Goal, Breakfast, Eating Goal" 7:30-8:00 AM - "Toothbrushing, toileting, etc" 8:00-9:00 AM - "Economics, Academics" 9:00-10:00 AM - "Communication, Attending" 10:00-10:30 AM - "Choice of Activity (TV, puzzles, book, magazines, radio, leisure)" 10:30-11:00 AM - "Toileting, Group Activity" 11:00-12:30 PM -" Lunch, Eating Goals, Structured Leisure (Sorting, coloring, sensory stim (Stimulation) activity, playing ball, identify colors/shapes, look			

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	at pictures in books/magazines, blocks, shape sorter, etc..." 12:30-1:00 PM - "Recreation, Group Activity" 1:00-1:30 PM - "Toileting, Group Activity" 1:30- 2:30 PM - "Leisure, Manipulation" 2:30-3:30 PM - "Communication, Attending" 3:30-4:00 PM - "Toileting, Group Activity" 4:00-5:30 PM - "Dinner, Eating, Goals, Structure Recreation sorting, coloring, sensory stim activity, playing ball, identify colors/shapes, look at pictures in books/magazines, blocks, shape sorter, etc..." 5:30-7:00 PM - "Recreation, Leisure, Choice of Activities, TV, Parties If Scheduled, Movies, Group Activity" 7:00-8:30 PM - "Snack Time, Dressing For Bed, Toothbrushing, Choice Of Recreation, Toileting, etc" On 3/14/13 at 11:15am, an interview with the Qualified Mental Retardation Professional (QMRP) was conducted and the QMRP indicated all DCS should offer activity and ensure that active treatment programs were trained/provided during formal and informal opportunities. Client B's records were reviewed on 3/14/13 at 10:00am. Client B's 9/8/12 ISP			

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	(Individual Support Plan) indicated goals/objectives to use communication board to express needs, to pull pants down to undress, to turn on water and wet his toothbrush before brushing, to brush hair daily, to sort objects into two (2) piles of two (2) colors, to sort two sets of coins into piles according to size, to touch/feel a variety of textures, to hold head up for four minutes, and to participate in an informal social activity. Client C's records were reviewed on 3/14/13 at 9:30am. Client C's 12/11/12 ISP indicated goals/objectives to flush toilet 1 time after toileting, to tie the laces of one shoe, to obtain all supplies required for toothbrushing, to wash hands thoroughly, to identify a coin when presented with dissimilar items, to tell staff what he should do when the fire alarm goes off, to respond by stopping when asked by staff to stop a behavior, and to place his clean laundry into his closet/dresser. Client C's 11/17/2011 BSP (Behavior Support Plan) indicated client C had targeted behaviors of "Anti Social: elopement, spitting, groping women's breasts, playing in water, physical aggression, hitting and pushing staff/clients, and pulling clients from chairs." Client C's BSP indicated client C "Once every 2 hours, staff will afford [client C] the opportunity to leave the			

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	program room, if he chooses, for 10 minutes. Staff should accompany [client C] when he leaves the program room. Prior to his reward. [Client C] must refrain from any of the targeted behaviors for the previous 2 hours...Should [client C] be observed exhibiting one to the target behaviors (sic), staff should tell him it's not nice...Encourage [client C] to apologize to his victim." 3.1-32(a) 3.1-33(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 1 of 1 sample client (client A) who had a medical emergency, the facility failed to provide nursing services according to client A's identified need by failing to implement client A's aspiration plan (reclining client improperly), document residuals, and to have a licensed nurse administer his G (Gastric) tube feeding. Findings include: 1. The facility's records were reviewed on 3/13/13 at 1:50 P.M. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/21/13 BDDS report for an incident on 2/20/13 at 9:25pm, indicated client A became non responsive and was pronounced dead at 9:25pm inside program room #6 by the Coroner who was onsite. The report indicated "the first nurse called Emergency Services at approximately 7:54pm," EMS arrived at 8pm, and CPR (Cardiopulmonary Resuscitation) had been initiated by the nurses at the facility. The report indicated a facility "staff member gave [client A]	W000331	W331 The "aspiration plan" referred to in the 2567 dated March 26 th , 2013, was not specific to Client A. Aspiration precautions identified and numbered in the 2567 were a listing of 17 Client's individual doctors' orders (Att. H). The precautions listed were items that appear to be copied and pasted from other client's doctor's orders. Client A did NOT have a diagnosis of aspiration precaution. But, Client A was a gastric tube client that had been previously hospitalized for aspiration pneumonia. Per the facility Aspiration Policy (Att. D), Client A was in the proper position to receive medications, bolus feeding, mealtime nutrition and his evening snack. Facility Aspiration Policy states that clients are to sit at a 45-90 degree angle during meals and for 30-60 minutes following oral consumption. Under these guidelines and circumstances, Client A was appropriately provided the necessary measures of safety for oral consumption. Additionally, the investigation indicated that Client A was reclined slightly during presentation of his HS snack. Further interview and investigation asked participating staff what	04/25/2013

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	his PM (evening) snack pureed graham cracker. [Client A] ate the snack slow, but ate it all. He was fed a little at a time and smiled at the staff member when he was shown the empty cup." The report indicated client A had been hospitalized on 2/5/13 for Pneumonia and UTI (Urinary Tract Infection) and client A had returned to the facility on 2/13/13 being treated with antibiotics. -The investigation for client A's 2/20/13 incident indicated client A had consumed less than twenty-five percent (<25%) of his pureed supper meal. 2. On 3/13/13 at 2:45pm, the 2/22/13 "Police Report" for client A's incident on 2/20/13, indicated a list of facility staff who were interviewed on 2/20/13, each staff member's statement to police, and indicated the following. -Direct Care Staff (DCS) #3 stated "that after dinner [client A] kept on sleeping and was never wet. Around 7:30pm, [QMA (Qualified Medication Aide)] came in with snacks the same as last night, puree graham crackers (sic). [Client A] eat them slow but he did eat it all. [DCS #3] stated that he fed him little bites and he was awake looking at [DCS #3]. [Client A] smiled when he showed [client A] the empty cup and tapped his		degree of angle Client A was in during their interaction. Within 5 degrees of variation, all six staff members stated that Client A was positioned at/between 60 and 65 degrees when Client A was provided with oral nutritional support and/or gastric tube bolus. Per the final autopsy report, Client A died of natural causes, not as a result of aspiration. Per the Charting and Documentation Guidelines (Att. E) provided at the time of the survey, gastric tube residuals are recorded in the client record if they are greater than 100cc. If residual is less than 100cc, no documentation is required. Also, as quoted from the Gastrostomy Tube Medication Policy (Att. F) and the Gastrostomy Tube Feeding, Bolus Method Policy 6 (Att. F), gastric tube placement should be assessed per pre-medication/pre-feeding administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus. Tube placement may be and is most often verified by air bolus within this facility and the verification of placement is signed for on the individual client treatment record. Documentation of medication administration is completed by signing the medications of the individual client's MAR. Further, the job description	

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	leg. Then [QMA] came in and bulse (sic) him. Then 20 minutes later is when [DCS #3] noticed that [client A] was pale and his lips were white. [DCS #3] asked [LPN (Licensed Practical Nurse) #1] what's wrong with [client A]. [DCS #3] felt [client A's] face and it was so cold." -QMA "stated that the last she seen (sic) [client A] was about 7:30pm. She had given him his bolis (sic) feeding. At that time he was leaned back in his chair and she thought he was sleeping. Approximately 10 minutes later the nurses were calling for equipment and items they needed and they were doing CPR on [client A]." 3. On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) on 2/21/13 at 3:07pm, with DCS #3 indicated the following interview. -"7:35, fed snack, alert, gave little bites, showed him [client A] empty cup, he smiled...chair reclined, eyes shut, mouth half open." 4. On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation		for QMA's provided at the time of the survey, states that QMAs are to pass PO and gastric tube medications (pills and liquid) and chart as needed as indicated in job duty #3. To clarify the statement "The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings." The DON and ADON were aware of the regulation as evidenced by administration of disciplinary action taken for the LPN in charge and the QMA who administered the bolus feeding. Disciplinary action was administered on 2-21-2013 (the day after the incident) for the LPN in charge and the QMA administering the bolus feeding to Client A. The Director of Nursing is responsible.The IDT will monitor.	

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	Professional) and the Assistant Director of Nursing (ADON) on 2/22/13 at 10:50pm, with the QMA indicated the following interview. -"At 7p-7:30p (sic), passed snacks...7:30p-7:40p (sic) gave [client A's] meds (medications) and water flush in his w/c (wheelchair). [Client A] was reclined back in his w/c and appeared to be asleep. Had on C collar. He did not move, flinch during meds passed. Passed G-tube meds to assist nurse on duty (sic)." Client A's record was reviewed on 3/13/13 at 2:50pm. Client A's record indicated hospitalizations on 2/5/13 until 2/13/13 diagnosed with Enterobacter Pneumonia (a lung inflammation due to gram negative bacteria) and Urinary Tract Infection. Client A was hospitalized from 11/7/12 until 11/9/12 diagnosed with Pneumonia. Client A's record indicated 12/31/12 "Aspiration Plan" which indicated "When you finish feeding someone at 11:30am, they should not lie down until at least 12pm...9. Aspiration Risk. Must sit up after meals and snacks 30 minutes. 10. Aspiration Precautions. Sit at a 90 degree angle for all oral intake and 30-60 minutes after meal, Reflux/Aspiration Precautions...14. Aspiration Precautions. Aspiration Precautions. Sit up 30 minutes after all meals. 15. Aspiration Precautions sit			

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	upright for 30 minutes after all p.o. (by mouth) intake." Client A's record on 3/13/13 at 2:50pm, included client A's 12/21/12 "Physician's Order" which indicated "11/22/12 Puree diet, 11/12/12 bolus 1 can of Nutren (nutritional tube feeding) 2.0 if patient eats <50% (less than fifty percent) at each meal." Client A's diagnoses included but were not limited to G-tube placement, history of Failure to Thrive, Seizure Disorder, Severe Mental Retardation, Autism Spectrum Disorder, Incontinence of bowel and bladder, and Reflux. Client A's record did not have documentation that his G-tube residuals were recorded on 2/20/13. On 3/14/13 at 11:55am, an interview with the QMA was conducted. The QMA indicated she passed client A's G-tube medications and stated "I saw the juice box feeding, administered the feeding" after client A's medication administration, and flushed the tube with water. The QMA indicated she did not record residuals for client A's G-tube and indicated she could not remember what they were. The QMA stated "I know I shouldn't have, I just gave it" the G-tube feeding because she saw it on the medication cart after supper.			

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	On 3/13/13 at 3:30pm, the facility's 10/14/2008 "Gastrostomy Tube Medication Policy" was reviewed and indicated "...6. Verify tube placement and then check for tube potency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...16. Document medication administration." On 3/13/13 at 3:30pm, the facility's 2/5/2009 "Gastrostomy Tube Feeding, Bolus Method" Policy was reviewed and indicated "...6. Verify tube placement and then check for tube patency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med/pre-feed administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...14. Document medication administration." On 3/13/13 at 3:30pm, the facility's undated "QMA Job Description" indicated the QMA was to administer medications and did not indicate the QMA was to administer G-Tube feedings or medications. On 3/13/13 at 3:30pm, the facility's undated "Nurse Responsibilities 9pm-5am			

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	(shift)" indicated "...4. Administer GT (G-Tube) medications...5. Document, chart assessments...17. Clean feeding pumps...." The facility's undated "Nurse Responsibilities 5am-1pm (shift)" indicated "...4. Bolus residents per physicians orders (Bolus feedings administered to clients) (sic)...6. Administer GT (G-Tube) medications...7. Document...." On 3/14/13 at 12pm, an interview with administrative staff of the Administrator, the Program Director, the QMRP (Qualified Mental Retardation Professional), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) was conducted. The administrative staff indicated client A should have been upright in his wheelchair after eating. The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings. The DON indicated the QMA did not follow 12/31/12 aspiration plan and did not follow G tube feeding protocol for a nurse to administer the G tube feeding. The DON indicated client A had no G-Tube residuals documented on 2/20/13. This federal tag relates to complaint #IN00125037.			

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W000339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. Based on record review and interview, for 1 of 1 sample client (client A) who had G-Tube feedings administered by non-licensed medical staff, the facility failed to provide nursing services according to client A's identified need by failing to have a licensed nurse administer his G (Gastric) tube feeding. Findings include: 1. The facility's records were reviewed on 3/13/13 at 1:50 P.M.. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/2013 to 3/13/2013 indicated the following: -A 2/21/13 BDDS report for an incident on 2/20/13 at 9:25pm, indicated client A became non responsive and was pronounced dead at 9:25pm inside program room #6 by the Coroner who was onsite. The report indicated "the first nurse called Emergency Services at approximately 7:54pm," EMS arrived at 8pm, and CPR (Cardiopulmonary Resuscitation) had been initiated by the nurses at the facility. -The investigation for client A's 2/20/13	W000339	W339 The "aspiration plan" referred to in the 2567 dated March 26 th , 2013, was not specific to Client A. Aspiration precautions identified and numbered in the 2567 were a listing of 17 Client's individual doctors' orders (Att. H). The precautions listed were items that appear to be copied and pasted from other client's doctor's orders. Client A did NOT have a diagnosis of aspiration precaution. But, Client A was a gastric tube client that had been previously hospitalized for aspiration pneumonia. Per the facility Aspiration Policy (Att. D), Client A was in the proper position to receive medications, bolus feeding, mealtime nutrition and his evening snack. Facility Aspiration Policy states that clients are to sit at a 45-90 degree angle during meals and for 30-60 minutes following oral consumption. Under these guidelines and circumstances, Client A was appropriately provided the necessary measures of safety for oral consumption. Additionally, the investigation indicated that Client A was reclined slightly during presentation of his HS snack. Further interview and investigation	04/25/2013

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	incident indicated client A had consumed less than twenty-five percent (<25%) of his pureed supper meal. 2. On 3/13/13 at 2:45pm, the 2/22/13 "Police Report" for client A's incident on 2/20/13, indicated a list of facility staff who were interviewed on 2/20/13, each staff member statements to police, and indicated the following. -Direct Care Staff (DCS) #3 stated "...Around 7:30pm, [QMA (Qualified Medication Aide)] came in with snacks the same as last night, puree graham crackers (sic)...Then [QMA] came in and bulse (sic) him...." -QMA "stated that the last she seen (sic) [client A] was about 7:30pm. She had given him his bolis (sic) feeding. At that time he was leaned back in his chair and she thought he was sleeping. Approximately 10 minutes later the nurses were calling for equipment and items they needed and they were doing CPR on [client A]." 3. On 3/13/13 at 1:50pm, a review of the facility's hand written "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) on 2/21/13 at 3:07pm, with DCS #3 indicated the following		asked participating staff what degree of angle Client A was in during their interaction. Within 5 degrees of variation, all six staff members stated that Client A was positioned at/between 60 and 65 degrees when Client A was provided with oral nutritional support and/or gastric tube bolus. Per the final autopsy report, Client A died of natural causes, not as a result of aspiration. Per the Charting and Documentation Guidelines (Att. E) provided at the time of the survey, gastric tube residuals are recorded in the client record if they are greater than 100cc. If residual is less than 100cc, no documentation is required. Also, as quoted from the Gastrostomy Tube Medication Policy (Att. F) and the Gastrostomy Tube Feeding, Bolus Method Policy 6 (Att. F), gastric tube placement should be assessed per pre-medication/pre-feeding administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus. Tube placement may be and is most often verified by air bolus within this facility and the verification of placement is signed for on the individual client treatment record. Documentation of medication administration is completed by signing the medications of the individual client's	

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	interview. -"7:35, fed snack...chair reclined, eyes shut, mouth half open." 4. On 3/13/13 at 1:50pm, a review of the facility's handwritten "Investigative Interview" completed by the QMRP (Qualified Mental Retardation Professional) and the Assistant Director of Nursing (ADON) on 2/22/13 at 10:50pm, with the QMA indicated the following interview. -"At 7p-7:30p (sic), passed snacks...7:30p-7:40p (sic) gave [client A's] meds (medications) and water flush in his w/c (wheelchair). [Client A] was reclined back in his w/c and appeared to be asleep...He did not move, flinch during meds passed. Passed G-tube meds to assist nurse on duty (sic)." Client A's record was reviewed on 3/13/13 at 2:50pm. Client A's record indicated hospitalizations on 2/5/13 until 2/13/13 diagnosed with Enterobacter Pneumonia (a lung inflammation due to gram negative bacteria) and Urinary Tract Infection. Client A was hospitalized from 11/7/12 until 11/9/12 diagnosed with Pneumonia. Client A's record indicated 12/31/12 "Aspiration Plan" which indicated "When you finish feeding someone at 11:30am, they should not lie down until at least 12pm...9. Aspiration		MAR. Further, the job description for QMA's provided at the time of the survey, states that QMAs are to pass PO and gastric tube medications (pills and liquid) and chart as needed as indicated in job duty #3. To clarify the statement "The DON and ADON indicated they were unaware the QMA should not have administered G-Tube feedings." The DON and ADON were aware of the regulation as evidenced by administration of disciplinary action taken for the LPN in charge and the QMA who administered the bolus feeding. Disciplinary action was administered on 2-21-2013 (the day after the incident) for the LPN in charge and the QMA administering the bolus feeding to Client A. The Director of Nursing is responsible.The IDT will monitor.	

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	Risk. Must sit up after meals and snacks 30 minutes. 10. Aspiration Precautions. Sit at a 90 degree angle for all oral intake and 30-60 minutes after meal, Reflux/Aspiration Precautions...14. Aspiration Precautions. Aspiration Precautions. Sit up 30 minutes after all meals. 15. Aspiration Precautions sit upright for 30 minutes after all p.o. (by mouth) intake." Client A's record on 3/13/13 at 2:50pm, included client A's 12/21/12 "Physician's Order" which indicated "11/22/12 Puree diet, 11/12/12 bolus 1 can of Nutren (nutritional tube feeding) 2.0 if patient eats <50% (less than fifty percent) at each meal." Client A's diagnoses included, but were not limited, to G-tube placement, history of Failure to Thrive, Seizure Disorder, Severe Mental Retardation, Autism Spectrum Disorder, Incontinence of bowel and bladder, and Reflux. Client A's record did not have documentation that his G-tube residuals were recorded on 2/20/13. On 3/14/13 at 11:55am, an interview with the QMA was conducted. The QMA indicated she passed client A's G-tube medications and stated "I saw the juice box (Tube) feeding, administered the feeding" after client A's medication administration, and flushed the tube with			

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	water. The QMA indicated she did not record residuals for client A's G-tube and indicated she could not remember what they were. The QMA stated "I know I shouldn't have, I just gave it" the G-tube feeding because she saw it on the medication cart after supper. On 3/13/13 at 3:30pm, the facility's 10/14/2008 "Gastrostomy Tube Medication Policy" was reviewed and indicated "...6. Verify tube placement and then check for tube potency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...16. Document medication administration." On 3/13/13 at 3:30pm, the facility's 2/5/2009 "Gastrostomy Tube Feeding, Bolus Method" Policy was reviewed and indicated "...6. Verify tube placement and then check for tube patency with approx. 30cc warm/tepid tap water. Tube placement should be assessed per pre-med/pre-feed administration by means of aspirate from gastric tube and replacement of residual or auscultation of air bolus...14. Document medication administration." On 3/13/13 at 3:30pm, the facility's			

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