

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  05/17/2012
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NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030
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W0000	<p>This visit was for investigation of complaint #IN00107392.</p> <p>Complaint #IN00107392 - Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W149, W154, W218, and W9999.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: May 14, 15, 16, and 17, 2012.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>Provider Number: 15G580 AIM Number: 100272190 Facility Number: 000730</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 5/23/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. _____ __Beverly Sayre Cowart</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W0149	<p>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.</p> <p>Based on interview and record review, for 1 of 1 injury of unknown origin (client A), the facility neglected to implement their abuse, neglect, and mistreatment policy and procedure to thoroughly investigate client A's unknown arm bruise/fracture.</p> <p>Findings include:</p> <p>On 5/14/12 at 5:40pm, the facility's BDDS (Bureau of Developmental Disability Services) reportable incident reports from 4/1/12 through 5/14/12 were reviewed and included the following incident:</p> <p>-A 4/18/12 BDDS report for an incident on 4/17/12 at 8am, indicated "On 4/14/12 at 12:30am, [client A] was noted to have a 1cm (centimeter) x (by) 2cm red area. At 8am, [client A] was noted to have a bruise on his R (right) upper arm...After investigation staff reported that [client A] had been seen trying to get his bed rail down using his right arm. There was no bruising noted at the time staff saw trying lower his bedrail (sic). There was a 1cm x 2cm red area noted. A bruise appeared later. Nursing continued to monitor the bruise. On 4/17/12 when nursing assessed the bruise, they noted some guarding with ROM (Range of Motion) and obtained a doctor's order for [client A] to get an X-Ray." The report indicated the result of the X-Ray was a "tiny cortical break inferiority (a hairline fracture of the bone)" at the humerus (upper right arm). No documented evidence or investigation was available for review of witness statements, staff statements, client A's activity before the bruise</p>	W0149	Maintenance records were sent via surveyor requested email on 5-15-12 (Att. A). Maintenance records revealed that all clients who have bedrails were assessed per monthly monitoring. Client A's bedrails were not padded, which was indicated on the accompanying physician's order. Padded bedrails were not indicated as a necessary safety measure for Client A. The risks for placing pads on Client A's bedrails were assessed to out weigh the benefits they provide. The bedrail assessment has been modified to include whether padded bedrails are necessary for Client A and all other clients (Att. B) Additionally, witness statements were available for surveyor review and/or e-mail on 5-16-12. The facility administrator verbally offered this information to the surveyor during a conversation on the afternoon of 5-16-12. The surveyor indicated that it was too late for the Administrator to submit these documents (Att.C). Client A's activity prior to the incident is documented in staff statements that were not accepted by the surveyor (Att. C) Investigative findings from the incident report for Client A, dated 4-15-12, indicated that the noted bruise	06/16/2012			

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	<p>was found, and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/14/12 at 5:40pm, client A's 4/14/12 12:30am incident report was reviewed. Client A's 4/14/12 Incident report filed by the facility's Charge Nurse indicated "Description of initial accident/injury: R side 1 in. (inch) area (with) 1 x 2cm red area et blue (with blue) discoloration surrounding (sic)." The incident report did not indicate client A's activity before the bruise was found and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/14/12 at 1:15pm, on 5/14/12 at 5:40pm, on 5/15/12 at 9:30am, and on 5/17/12 at 4:15pm, the facility's investigation process for client A's right humerus fracture was requested from the (PD) Program Director and the Administrator. No additional information was provided for review. No documented evidence was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/14/12 at 5:40pm, client A's "Accident/Injury Treatment Sheet" for the 4/14/12 unknown injury was monitored after the injury occurred by the facility's licensed nursing staff and included the following: -On 4/15/12, no documented time, "Description of initial, accident/injury: 4 x 6 cm purple blue discoloration noted to R (upper) arm." -On 4/16/12, no documented time, "Treatment/Medication Intervention: R (upper) arm 17 cm x 10 cm purple/blue discoloration." -On 4/17/12, no documented time, "Treatment/Medication Intervention: R (upper) arm 17 cm long x 14 cm wide purple discoloration."</p>		<p>was a result of Client A attempting to get his bedrails down. Additional, nursing measures and investigation was conducted on 4-17-12 when Client A was noted to be guarding his arm and the bruise had grown larger in size. Witness statements were provided to investigative staff on 4-15-2012. Further, the facility abuse and neglect policy does not include the performed measures taken to investigate accident and incidents. The facility abuse and neglect policy includes those measures that are taken during allegations of abuse or neglect. Facility policy, investigating issues of accident and incidents are enclosed as (Att. D) Measures outlined in this policy were followed as outlined. The facility will continue to follow their current policy to investigate accident and incident reports as outlined. Additionally, the facility's Interdisciplinary Team will continue to review and monitor accidents and incidents weekly to ensure that the appropriate actions are taken regarding client accidents or incidents. The facility's Interdisciplinary Team will review the current Accident and incident policy as a proactive measure that the policy serves reporting and investigative measures that are appropriate. The facility's Interdisciplinary Team will continue to monitor all incident and accident reports on a</p>				

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	<p>-On 4/18/12 at 12:10pm, "Treatment/Medication Intervention: 20 cm x 15 cm yellow/purple discoloration." -On 4/19/12 at 12:11pm, "Treatment/Medication Intervention: Right arm remains (with) yellow/purple/dark purple discoloration." -On 4/20/12 at 12:11pm, "Treatment/Medication Intervention: Right (upper) arm 20 cm x 15 cm discoloration green/yellow et (and) purple discoloration (sic)." -On 4/21/12 at 10pm, "Treatment/Medication Intervention: 25 cm x 15 cm purple/yellow discoloration." -On 4/23/12 at 10pm, "Treatment/Medication Intervention: 25 cm x 15 cm...yellow/purple discoloration."</p> <p>Client A's record review was conducted on 5/14/12 at 5:10pm, and on 5/15/12 at 12noon. Client A's diagnoses included, but were not limited to: Seizure Disorder, Chronic Pedal Edema, Osteoporosis, Osteoarthritis right hip, Flexion Deformity, Spinal Scoliosis, Osteoarthritis to Bilateral (both) Feet, 1/30/10 Fracture to Proximal (foot) 5th (fifth) Metacarpal (toe), 2/23/05 Fracture Left Distal Radial, and 2/23/05 Fracture Ulnar. Client A's 12/27/11 "Annual Nursing Assessment" completed by the Director of Nursing indicated client A was non verbal, walked independently throughout the facility, and "Misc (Miscellaneous) Nursing Orders" Side rails up when in bed due to seizure disorder.</p> <p>On 5/14/12 at 5:10pm, client A's "Nurses Notes" indicated the following: -On 4/14/12 at 12:30am, "called to PR #4 (Program Room #4) bathroom client (client A) noted with 1 x 2 cm red area et blue R (right) rib discoloration surrounding DON (Director of Nursing), PD, Dr. (Doctor), and Administrator notified, flow sheet initiated."</p>		<p>weekly interval to ensure that all incidents are thoroughly investigated and monitored. The Program Director will be responsible. The Administrator will monitor.</p>				

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	<p>-On 4/14/12 at 12:50am, "Spoke with [client A's] mother, et notified of above."</p> <p>-On 4/14/12 8am, "noted 6 x 4 cm blue discoloration (with) purple center on R upper arm, notified Mom, DON, Admin. (Administrator), and PD."</p> <p>-On 4/16/12 at 10pm, "Area to R side of ABD (Abdominal) flesh colored. No discoloration remains. No further needed."</p> <p>-On 4/16/12 at 12:11pm, "Acetaminophen 325 mg (milligrams) [two] tabs (tablets) d/t (due to) s/s (signs/symptoms) of general discomfort" signed by the licensed nurse.</p> <p>-On 4/17/12 at 6am, "R arm ROM WNL (Range of Motion Within Normal Limits)...."</p> <p>-On 4/17/12 at 8am, "R upper arm (with) deep purple discoloration client (with) some guarding (with) ROM. Spoke with Dr. N.O. (New Order) X-Ray R humerus d/t bruising et guarding."</p> <p>-On 4/17/12 at 10am, X-Ray R arm.</p> <p>-On 4/18/12 at 11:15am, results of X-Ray was right humerus fracture.</p> <p>No documented evidence was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/17/12 at 4:35pm, an interview was conducted with the Program Director (PD) and the Administrator. The Administrator indicated no documented evidence was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly. The Administrator indicated she and the PD had spoken with the staff who saw client A trying to get his side rail down earlier in the evening. The Administrator indicated the investigation did not include witness statements, staff statements, if client A's side bed rails were</p>			

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	<p>functioning properly, and client A's activity prior to the incident. The Administrator indicated no additional information was available for review. The Administrator indicated client A's arm bruise was not immediately investigated. The Administrator indicated client A's arm bruise was not investigated until after the bruises became larger and the result of the X-Ray of the right arm was a fracture. The Administrator indicated client A's injuries were not thoroughly investigated.</p> <p>The facility's records were reviewed on 5/14/12 at 2:10 P.M.. A review of the facility's "Abuse and Neglect Policy and Procedure", dated 10/04/11, indicated in part, the following: "The Program Director will then conduct a thorough investigation . . ." The policy indicated, "The Program Director will coordinate the overall investigation in conjunction with the facility administrator or the administrator's designee. The Director of Nursing and the supervisor will assist in compiling any necessary information. This information my include medical assessment of the client, interview of any potential witnesses, acquiring written statements from any involved staff members, and speaking with the client..."</p> <p>This federal tag relates to complaint #IN00107392.</p> <p>3.1-28(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, interview, and record review, for 1 of 1 injury of unknown origin (client A), the facility failed to thoroughly investigate client A's injuries.</p> <p>Findings include:</p> <p>On 5/14/12 at 5:40pm, the facility's BDDS (Bureau of Developmental Disability Services) reportable incident reports from 4/1/12 through 5/14/12 were reviewed and included the following incident:</p> <p>-A 4/18/12 BDDS report for an incident on 4/17/12 at 8am, indicated "On 4/14/12 at 12:30am, [client A] was noted to have a 1cm (centimeter) x (by) 2cm red area. At 8am, [client A] was noted to have a bruise on his R (right) upper arm...After investigation staff reported that [client A] had been seen trying to get his bed rail down using his right arm. There was no bruising noted at the time staff saw trying lower his bedrail (sic). There was a 1cm x 2cm red area noted. A bruise appeared later. Nursing continued to monitor the bruise. On 4/17/12 when nursing assessed the bruise, they noted some guarding with ROM (Range of Motion) and obtained a doctor's order for [client A] to get an X-Ray." The report indicated the result of the X-Ray was a "tiny cortical break inferiority (a hairline fracture of the bone)" at the humerus (upper right arm). No documented evidence or investigation was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly.</p>	W0154	<p>Maintenance records were sent via surveyor requested email on 5-15-12 (Att. A). Maintenance records revealed that all clients who have bedrails were assessed per monthly monitoring. Client A's bedrails were not padded, which was indicated on the accompanying physician's order. Padded bedrails were not indicated as a necessary safety measure for Client A. The risks for placing pads on Client A's bedrails were assessed to out weigh the benefits they provide. The bedrail assessment has been modified to include whether padded bedrails are necessary for Client A and all other clients (Att. B). Additionally, witness statements were available for surveyor review and/or email on 5-16-12. The facility administrator verbally offered this information to the surveyor during a conversation on the afternoon of 5-16-12. The surveyor indicated that it was too late for the Administrator to submit these documents (Att. C). Client A's activity prior to the incident is documented in staff statements that were not accepted by the surveyor (Att. C). Investigative findings from the incident report for Client A, dated 4-15-12, indicated that the noted bruise was a result of Client A</p>	06/16/2012			

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	<p>On 5/14/12 at 5:40pm, client A's 4/14/12 12:30am, Incident report was reviewed. Client A's 4/14/12 Incident report filed by the facility's Charge Nurse indicated "Description of initial accident/injury: R side 1 in. (inch) area (with) 1 x 2cm red area et blue (with blue) discoloration surrounding (sic)." The incident report did not indicate client A's activity before the bruise was found and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/14/12 at 1:15pm, on 5/14/12 at 5:40pm, on 5/15/12 at 9:30am, and on 5/17/12 at 4:15pm, the facility's investigation process for client A's right humerus fracture was requested from the (PD) Program Director and the Administrator. No additional information was provided for review. No documented evidence was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. At 2:28pm, client A's bed was against the window without side rails and client A's call light hung by the door. At 2:28pm, Housekeeping Staff #2 walked by client A's doorway, identified client A's bed against the window, and stated client A's call light was at "least eight (8) feet away from [client A's] bed." From 2:29pm until 4:15pm, Program Room #4 (PR #4) was observed. At 2:29pm, Facility Staff (FS) #1 indicated client A was out of the facility at a doctor appointment for client A's fractured arm. At 3pm, client A returned to PR #4. Client A was non verbal and walked independently throughout the program room. Client A sat at a table with his right arm folded at his elbow and client A held his arm</p>		<p>attempting to get his bedrails down. Additional nursing measures and investigation was conducted on 4-17-12 when Client A was noted to be guarding his arm and the bruise had grown larger in size. Witness statements were provided to investigative staff on 4-15-12. Further, the facility abuse and neglect policy does not include the performed measures taken to investigate accident and incidents. The facility abuse and neglect policy includes those measures that are taken during allegations of abuse or neglect. Facility policy, investigating issues of accident and incidents are enclosed as (Att. D). Measures outlined in this policy were followed as outlined. For Client C and all other clients who have a diagnosis of non-verbal and/or assessed to be unable to vocalize their wants and needs will be provided with 30 minute checks during times when clients are in bed. Additionally, those clients who are physically unable to reach or who are otherwise unable to use the call lights will also be provided with 30 minute checks while they are in bed. Thirty minute checks shall be completed by the supervisor or their designee during those identified times. The facility will continue to follow their current policy to investigate accident and incident reports as outlined. Additionally, the facility's</p>				

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	<p>against his body.</p> <p>On 5/14/12 at 5:40pm, client A's "Accident/Injury Treatment Sheet" for the 4/14/12 unknown injury was monitored after the injury occurred by the facility's licensed nursing staff and included the following:</p> <p>-On 4/15/12, no documented time, "Description of initial, accident/injury: 4 x 6 cm purple blue discoloration noted to R (upper) arm."</p> <p>-On 4/16/12, no documented time, "Treatment/Medication Intervention: R (upper) arm 17 cm x 10 cm purple/blue discoloration."</p> <p>-On 4/17/12, no documented time, "Treatment/Medication Intervention: R (upper) arm 17 cm long x 14 cm wide purple discoloration."</p> <p>-On 4/18/12 at 12:10pm, "Treatment/Medication Intervention: 20 cm x 15 cm yellow/purple discoloration."</p> <p>-On 4/19/12 at 12:11pm, "Treatment/Medication Intervention: Right arm remains (with) yellow/purple/dark purple discoloration."</p> <p>-On 4/20/12 at 12:11pm, "Treatment/Medication Intervention: Right (upper) arm 20 cm x 15 cm discoloration green/yellow et (and) purple discoloration (sic)."</p> <p>-On 4/21/12 at 10pm, "Treatment/Medication Intervention: 25 cm x 15 cm purple/yellow discoloration."</p> <p>-On 4/23/12 at 10pm, "Treatment/Medication Intervention: 25 cm x 15 cm...yellow/purple discoloration."</p> <p>Client A's record review was conducted on 5/14/12 at 5:10pm, and on 5/15/12 at 12noon. Client A's diagnoses included, but were not limited to: Seizure Disorder, Chronic Pedal Edema, Osteoporosis, Osteoarthritis right hip, Flexion Deformity, Spinal Scoliosis, Osteoarthritis to Bilateral (both) Feet, 1/30/10 Fracture to Proximal</p>		<p>Interdisciplinary Team will continue to review and monitor accidents and incidents weekly, to ensure that the appropriate actions are taken regarding client accidents or incidents. The facility's Interdisciplinary Team will review the current Accident and incident policy as a proactive measure that the policy serves reporting and investigative measures that are appropriate. Thirty minute check sheets will be reviewed during weekly Quarterly Review meetings. This data review will ensure that the facility continues with corrective practices and that they are conducted for all clients as identified. The facility's Interdisciplinary Team will continue to monitor all incident and accident reports on a weekly interval to ensure that all incidents are thoroughly investigated and monitored. The floor supervisor will be responsible for conducting 30 minute checks for those clients while they are bed to ensure that their wants and needs are completed. The Interdisciplinary Team will be responsible for review of the completed documented to ensure that corrective practices are achieved. The Floor Supervisor is responsible . The Program Director will monitor.</p>				

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	<p>(foot) 5th (fifth) Metacarpal (toe), 2/23/05 Fracture Left Distal Radial, and 2/23/05 Fracture Ulnar. Client A's 12/27/11 "Annual Nursing Assessment" completed by the Director of Nursing indicated client A was non verbal, walked independently throughout the facility, and "Misc (Miscellaneous) Nursing Orders" Side rails up when in bed due to seizure disorder.</p> <p>On 5/14/12 at 5:10pm, client A's "Nurses Notes" indicated the following: -On 4/14/12 at 12:30am, "called to PR #4 (Program Room #4) bathroom client (client A) noted with 1 x 2 cm red area et blue R (right) rib discoloration surrounding DON (Director of Nursing), PD, Dr. (Doctor), and Administrator notified, flow sheet initiated." -On 4/14/12 at 12:50am, "Spoke with [client A's] mother, et notified of above." -On 4/14/12 8am, "noted 6 x 4 cm blue discoloration (with) purple center on R upper arm, notified Mom, DON, Admin. (Administrator), and PD." -On 4/16/12 at 10pm, "Area to R side of ABD (Abdominal) flesh colored. No discoloration remains. No further needed." -On 4/16/12 at 12:11pm, "Acetaminophen 325 mg (milligrams) [two] tabs (tablets) d/t (due to) s/s (signs/symptoms) of general discomfort" signed by the licensed nurse. -On 4/17/12 at 6am, "R arm ROM WNL (Range of Motion Within Normal Limits)...." -On 4/17/12 at 8am, "R upper arm (with) deep purple discoloration client (with) some guarding (with) ROM. Spoke with Dr. N.O. (New Order) X-Ray R humerus d/t bruising et guarding." -On 4/17/12 at 10am, X-Ray R arm. -On 4/18/12 at 11:15am, results of X-Ray was right humerus fracture. No documented evidence was available for review of witness statements, staff statements, client A's</p>						

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	<p>activity before the bruise was found, and if client A's side bedrails were padded or functioning properly.</p> <p>On 5/17/12 at 4:35pm, an interview was conducted with the Program Director (PD) and the Administrator. The Administrator indicated no documented evidence was available for review of witness statements, staff statements, client A's activity before the bruise was found, and if client A's side bedrails were padded or functioning properly. The Administrator indicated she and the PD had spoken with the staff who saw client A trying to get his side rail down earlier in the evening. The Administrator indicated the investigation did not include witness statements, staff statements, if client A's side bed rails were functioning properly, and client A's activity prior to the incident. The Administrator indicated no additional information was available for review.</p> <p>This federal tag relates to complaint #IN00107392.</p> <p>3.1-28(a)</p>			

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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, for 1 of 2 sample clients (client A), the facility failed to ensure bed rail assessments were accurately completed.</p> <p>Findings include:</p> <p>On 5/14/12 at 5:40pm, the facility's BDDS (Bureau of Developmental Disability Services) reportable incident reports from 4/1/12 through 5/14/12 were reviewed and included the following incident:</p> <p>-A 4/18/12 BDDS report for an incident on 4/17/12 at 8am, indicated "On 4/14/12 at 12:30am, [client A] was noted to have a 1cm (centimeter) x (by) 2cm red area. At 8am, [client A] was noted to have a bruise on his R (right) upper arm...After investigation staff reported that [client A] had been seen trying to get his bed rail down using his right arm." The report indicated "At (the) time staff saw trying lower his bedrail (sic). There was a 1cm x 2cm red area noted. A bruise appeared later." The report indicated the results of the X-Ray was a "tiny cortical break inferiority (a hairline bone fracture)" at the humerus (upper right arm). No documented evidence was available for review to determine if client A's side bedrails were padded or if the rails were functioning properly.</p> <p>On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. At 2:28pm, client A's bed was against the window without side rails and client A's call light hung by the door. At 2:28pm, Housekeeping Staff</p>	W0218	<p>The facility did complete a bedrail assessment for Client A for his annual Habilitation Review and an additional assessment was completed following investigation of the incident reported on 4/18/12 for Client A. Both bedrail assessments (dated 12-27-11/4-21-12) were sent by requested email to the surveyor on 5-16-12 (Att. E). Additionally, maintenance records were also sent via surveyor requested email on 5-15-12 (Att. A ). Maintenance records revealed that all clients who have bedrails were assessed per monthly monitoring. Client A's bedrails were not padded, which was indicated on the accompanying physician's order. Padded bedrails were not indicated as a necessary safety measure for Client A. The risks for placing pads on Client A's bedrails were assessed to outweigh the benefits they may provide. The bedrail assessment has been modified to include whether padded bedrails are necessary for Client A and all other clients (Att. B). Finally, Client A's seizure records were sent to the surveyor through an email request dated 5-15-12 (Att. F) The facility bedrail assessment has been updated to include data which indicates whether the client requires</p>	06/16/2012			

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	<p>#2 walked by client A's doorway, identified client A's bed against the window, and stated client A's call light was at "least eight (8) feet away from [client A's] bed." From 2:29pm until 4:15pm, Program Room #4 (PR #4) was observed. At 2:29pm, Facility Staff (FS) #1 indicated client A was out of the facility at a doctor appointment for client A's fractured arm. At 3pm, client A returned to PR #4. Client A was non verbal and walked independently throughout the program room. Client A's sat at a table with his right arm folded at his elbow and client A held his arm against his body.</p> <p>Client A's record review was conducted on 5/14/12 at 5:10pm, and on 5/15/12 at 12noon. Client A's diagnoses included, but were not limited to; Seizure Disorder, Chronic Pedal Edema, Osteoporosis, Osteoarthritis right hip, Flexion Deformity, Spinal Scoliosis, Osteoarthritis to Bilateral (both) Feet, 1/30/10 Fracture to Proximal (foot) 5th (fifth) Metacarpal (toe), 2/23/05 Fracture Left Distal Radial, and 2/23/05 Fracture Ulnar. Client A's 12/27/11 "Annual Nursing Assessment" completed by the Director of Nursing indicated client A was non verbal, walked independently throughout the facility, and "Misc (Miscellaneous) Nursing Orders" side rails up when in bed due to seizure disorder. Client A's 2/29/12 "Physician Orders" indicated "(since) 5/16/2002 side rails up when in bed due to seizure disorder." Client A's record did not indicate the date of his last seizure.</p> <p>Client A's 12/27/11 "Informed Consent Assessment" completed by the Qualified Mental Retardation Professional indicated client A "is non verbal but is able uses (sic) gestures and vocalization to communicate his wants and needs" Client A's 12/27/11 "Professional Assessment Summary" indicated client A was able to get his</p>		<p>padded bedrails or other positioning systems while the client is in bed. Additionally, all clients will be reassessed with the updated bed rail assessment to ensure that the appropriate positioning devices are in place. The bedrail assessment shall be included in each client's quarterly review process to ensure that the assessment is accurate. Maintenance will continue to monitor all bedrail systems on a monthly schedule and/or more frequently as needed. Client A did have a Physical Therapy assessment as part of his annual habilitation plan. Client A's annual habilitation plan was emailed to the surveyor by request on 5-15-12 (Att. G). Client A's bed rail assessment was completed by the Director of Nursing as a part of his annual nursing review. The bedrail assessment was reviewed by the Interdisciplinary Team during Client A's annual habilitation meeting without revisions required during the review. The facility bedrail assessment has been updated to include data which indicates whether the client requires padded bedrails or other positioning systems while the client is in bed. The bedrail assessment shall be included in each client's quarterly review process to ensure that the assessment is accurate. The facility's Interdisciplinary Team will continue to review all clients</p>		

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	<p>desired item, use a communication board, take himself to the bathroom independently, and "has been assessed to use a call light and communicating his wants and needs. Previous data suggests that [client A] has the ability to use the call light, understands what it is used for, and will readily use it to joke with staff during times for toileting." Client A's Professional Assessment did not indicate physical therapy had reviewed client A's side bed rail use.</p> <p>Client A's 4/21/12 "Side Rail Assessment" indicated client A was non verbal, independent with mobility (walking), the side bed rails were "used only at night," bed rails did not assist client A to move within the bed, "had experienced injury from the use of bed rails," and "Recommendations: D/C (discontinue) bedrails, risk out weighs benefit of side rails. [Signed by the Director Of Nursing]."</p> <p>An interview was conducted with the QMRP (Qualified Mental Retardation Professional) on 5/15/12 at 9:30am. The QMRP indicated client A had a previous side bed rail assessment on 12/2011 which indicated the use of his side bed rails because client A had a seizure disorder diagnosis. The QMRP indicated client A's last seizure was before the year of 2000. The QMRP indicated client A's side bed rails were removed after the assessment on 4/21/12 because the rails were restrictive and client A can get up and take himself to and from the bathroom during the night. The QMRP stated client A's side bed rail assessment before 4/21/12 "was not" accurate. The QMRP stated client A's use of side bed rails before 4/21/12 was a "restraint" and limited his independent mobility. The QMRP stated client A's 4/21/12 "Side Rail Assessment" indicated side bed rails were "used only at night." The QMRP stated she did not know why client A's assessment</p>		<p>bedrail assessments annually and during scheduled quarterly review meetings to ensure that assessment is accurate. Additionally, all clients will be reassessed with the updated bed rail assessment to ensure that the appropriate positioning devices are in place The Quarterly Review Committee will review at least 3 times yearly and during their annual Individual Hibilitation Plan meeting. QMRP's are responsible. The Administrator or thier designated person will monitor.</p>	

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	<p>documented that client A "used (side bed rails) only at night" because client A "did not have them now."</p> <p>This federal tag relates to complaint #IN00107392.</p> <p>3.1-35(2)(b)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 2 of 3 sample clients (clients A and B), the facility failed to implement Individual Support Plan (ISP) goals and objectives when opportunities existed.</p> <p>Findings include:</p> <p>1. On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. From 2:29pm until 4:15pm, Program Room #4 (PR #4) was observed. At 2:29pm, Facility Staff (FS) #1 indicated client A was out of the facility at a doctor appointment for client A's fractured arm. At 3pm, client A returned to PR #4. Client A was non verbal and walked independently throughout the program room. Client A sat on a regular chair at a table with his right arm folded at his elbow and no cushion on the chair was observed.</p> <p>Client A's record review was conducted</p>	W0249	<p>For Client A, staff will be retrained in the appropriate times and techniques for placement of adaptive equipment as documented on each client's treatment sheets. Advanced documentation on each client's treatment sheet will be reviewed and in-serviced during an all staff in service on 5-15-12 and 5-30-12 (Att..K) As a result, staff will be trained to implement the necessary measures for timely documented application of adaptive devices. Additionally, the staff member responsible for completing advanced documentation regarding Client A's pad was given a written counseling. (Att. (J) Client B's urinary tract infection was resolved on 4-14-12 (Att. H) per documentation in nursing services notes. Client B was not prescribed nor did he have a UTI on 5-14-2012 as indicated. Additionally, Client B does have the ability to indicate his need to toilet and/or independently use the bathroom. Client B does, however, require staff supervision when toileting as a measure to</p>	06/16/2012			

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	<p>on 5/14/12 at 5:10pm, and on 5/15/12 at 12noon. Client A's diagnoses included, but were not limited to; Flexion Deformity and Spinal Scoliosis. Client A's 2/29/12 "Physician Orders" indicated an order dated "10/06/2006 use pad in w/c (wheel chair) or regular chair." Client A's 12/27/11 "Annual Nursing Assessment" completed by the Director of Nursing indicated "Treatment Orders...use pad in wheel chair or regular chair."</p> <p>On 5/14/12 at 3pm, client A's 5/14/2012 data "Treatment Record" indicated the following data documentation as completed for evening shift located in program room #4 a program for client A to "use pad in w/c (wheelchair) or regular chair."</p> <p>On 5/15/12 at 9:30am, an interview was completed with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated client A should have had a pad positioned on the chair inside program room #4 for him to sit on.</p> <p>2. On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. From 2:29pm until 4:15pm, Program Room #4 (PR #4) was observed. From 2:29pm until 4:15pm, client B was not offered or encouraged to use the bathroom. At</p>		<p>monitor the Client's desire to excessively drink. Client B will continue to be encouraged to independently use the bathroom with appropriate monitoring for fluid consumption. For Client A and all other clients, staff will be trained in the appropriate times and techniques for placement of adaptive equipment as documented on each client's treatment sheets. Advanced documentation on each client's treatment sheet will be reviewed and in-serviced during an all staff in-service on 5-15-12 and 5-30-12 (Att. K). As a result, staff will be trained to implement the necessary measures for timely documented application of adaptive devices. Should advance documentation occur in the future, the staff member responsible shall be issued a written warning for the documented offense. For Client B and all other clients, staff will be trained in the appropriate times and techniques for toileting and supervision. To ensure that advance documentation does not recur in the future, supervisory staff will conduct random assessment of program books and other modes of staff documentation (Att. I). These random audits will be conducted at varied times and days to further ensure that this issue does not recur. Additionally, random audits will also be completed to assess client</p>				

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	<p>4:15pm, FS #3 and FS #4 both indicated client B had not been prompted and had not been assisted to the bathroom. At 4:15pm, FS #4 stated "It was before 2pm, probably closer to 1pm" when client B last went into the bathroom.</p> <p>On 5/14/12 at 5:40pm, and on 5/15/12 at 10:30am, client B's record was reviewed. Client B's 2/13/12 ISP (Individual Support Plan) indicated a tracking sheet for bowel and bladder incontinence to document client B being prompted every two hours to go to the bathroom if he had not toileted within the two hour period. Client B's record indicated on 2/13/12 he was readmitted to the facility with a Urinary Tract Infection (UTI). Client B's record indicated he was currently receiving an oral antibiotic for his urinary tract infection.</p> <p>On 5/15/12 at 9:30am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated client B was being treated for a urinary tract infection and should have been reminded to use the bathroom every two hours if client B had not gone to the bathroom. The QMRP indicated client B's toileting program was not implemented by the facility staff.</p> <p>3.1-35(a)</p>		<p>toileting needs and time of bathroom use are appropriate. Audits will be conducted at various times and dates to further ensure that this issue does not recur. Random, in-service training will be completed by the staff trainer to further ensure that these strategies are practiced and understood. In addition, staff will be in-serviced during an all staff in-service meeting to further ensure retention of this information. Staff trainer is responsible. Program Director will monitor.</p>		

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W0252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on observation, record review, and interview, for 2 of 3 sample clients (clients A and B), the facility failed to ensure client A and B's program documentation was accurate and reflected actual individual performance.</p> <p>Findings include:</p> <p>On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. From 2:29pm until 4:15pm, client B was observed inside Program Room #4 (PR #4) with Facility Staff (FS) #3 and FS #4. From 2:29pm until 4:15pm, client B was not offered or encouraged to use the bathroom. At 2:29pm, Facility Staff (FS) #1 indicated client A was out of the facility at a doctor appointment for client A's fractured arm. At 3pm, client A returned to PR #4. Client A was non verbal and walked independently throughout the program room. Client A's sat on a regular chair at a table with his right arm folded at his elbow and no cushion on the chair was observed. At 3:00pm, PR #4's program data</p>	W0252	<p>For Client A and B, staff have been trained in the appropriate times and techniques for documentation and implementation of client objectives and performances as documented on each client's treatment sheets. Advanced documentation on each client's treatment sheet have been reviewed and in-serviced during an all staff in-service on 5-15-12 and 5-30-12 (Att.K) As a result, staff will be trained to implement the necessary measures for timely documented performance skills of individual clients. Additionally, the staff member responsible for completing advanced documentation regarding client A and B was given a written counseling. For Client A and B and all other clients, staff have been trained in the appropriate times and techniques for documentation and implementation of client objecties and performances as documented on each client's treatment sheets. Advanced documentation on each client's treatment sheet have been reviewed and in-serviced during an all staff in-service on 5-15-12 and 5-30-12 (Att. K). As a result, staff will be trained to implement</p>	06/16/2012	

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	<p>documentation for clients A and B was reviewed. At 3pm, FS #3 and FS #4 both stated they documented program data "already." At 3pm, FS #4 stated the staff document client A and B's program data before the programs were completed because "we get busy later." At 4:15pm, FS #3 and FS #4 both indicated client B had not been prompted and had not been assisted to the bathroom. At 4:15pm, FS #4 stated "it was before 2pm, probably closer to 1pm" when client B last went into the bathroom.</p> <p>On 5/14/12 at 3pm, client A's program documentation in program room #4 indicated the following for 5/14/12: -Client A's 5/14/2012 program data for objectives/goals was documented by the facility staff for day and evening shifts to pull up his pants after assisted toileting was independent, put his shirt on in the correct orientation was demonstration required to complete task, to participate in 15 (minutes) of uninterrupted activity was demonstration required to complete task, to place his prepared toothbrush into his mouth to assist with brushing was physical guidance required, to appropriately manipulate desired leisure activity for 3 minutes was demonstration required to complete task, to reach for and grasp connect 4 stand was demonstration required to complete task, to grasp a</p>		<p>the necessary measures for timely documented performance and skills of individual clients. An audit sheet has been developed to ensure the documentation is completed in an appropriate manner. (Att. I ) The Floor Supervisor in charge of the shift will audit the program books, including but not limited to Flow Sheets, Treatment Records, Program Data Sheets and I&amp;O Sheets, two times per shift. The Floor Supervisor will fill out the check sheet for each audit and turn it into the Program Director at the end of their shift. The Program Director will review the audit sheets. Should advance documentation occur in the future, the staff member responsible shall be issued a written warning for the documented offense and disciplinary action taken. To ensure that advance documentation does not recur in the future, supervisory staff will conduct random assessment of program books and other modes of staff documentation. These random audits will be conducted at varied times and days to further ensure that this issue does not recur. Random, in-service training will be completed by the staff trainer to further ensure that these strategies are practiced and understood. In addition, staff will be in-serviced during an all staff in-service meeting to further</p>		

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NAME OF PROVIDER OR SUPPLIER  ARCADIA DEVELOPMENTAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030			
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	<p>musical object was independent, to grasp the toothpaste was demonstration required to complete the task, to grasp a puzzle was independent, (and) to grasp coins was demonstration required to complete the task.</p> <p>-Client A's 5/14/2012 data "PM Flow Sheet" for toileting indicated: at 2pm, at 3pm, at 4pm, at 5pm, at 6pm, and at 7pm, "Alternate seating." The schedule indicated at 8pm, bathroom.</p> <p>-Client A's 5/14/2012 data "Treatment Record" indicated the following data documentation as completed for evening shift: Oral hygiene, Knee high ted hose on in AM (morning) and off at bedtime for Pedal Edema, elevate bed 30 degrees, use pad in w/c (wheelchair) or regular chair, wear Bil (bilateral) AFO (leg braces) during ambulation, extra depth shoes to accommodate toes and AFO brace, soft suede or leather upper, Aspiration precautions-monitor during meals."</p> <p>On 5/14/12 at 3pm, client B's program documentation in program room #4 indicated the following for 5/14/12: -Client B's 5/14/2012 data "PM Flow Sheet" for toileting indicated: at 2pm, at 3pm, at 4pm, at 5pm, at 6pm, and at 7pm, "Alternate seating." The schedule</p>		ensure retention of this information. The Floor Supervisor is responsible. Program Director will monitor.				

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	<p>indicated at 8pm, bathroom.</p> <p>-Client B's 5/14/2012 program data for objectives/goals was documented by the facility staff as "Independent" for day and evening shifts to wash hands after toileting, to look in the mirror while staff assist with shaving, to make brushing motions to his front teeth, to replace lid on deodorant after application, to select by grasping his underwear, to screw lids on 3 specimen cups, to fold his own underwear, to interact with staff in appropriate manner, to identify by pointing a coin when presented with dissimilar items, to point to bed sign when he needs to go to his room for a nap.</p> <p>-Client B's 5/14/2012 program data for objectives/goals was documented by the facility staff as "Verbal" prompt needed of detailed instructions to perform the task of handing a photo card to staff.</p> <p>-Client B's 5/14/12 "Treatment Record (for program room #4)" data for tasks completed in the evening were: oral hygiene and apply facility lotion to dry skin.</p> <p>-Client B's 5/14/12 "Intake and Output" record indicated "2-3pm 120cc (intake), 3-4pm 120cc (intake), 4-5pm 720cc</p>			

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	<p>(intake), 5-6pm a line through the box, 6-7pm 120cc (intake), (and) 7-8pm a line through the box, (and) total intake 1080/total 112."</p> <p>On 5/15/12 at 9:30am, an interview was completed with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated client A and B's data should not have been recorded before the programs were implemented. The QMRP indicated the data was not recorded accurately.</p> <p>On 5/17/12 at 4:35pm, an interview was conducted with the Program Director (PD) and the Administrator. The Administrator and the PD both indicated client A and B's program data should not have been recorded before the programs were implemented.</p> <p>3.1-35(a)</p>						

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W9999	<p>State Findings</p> <p>3.1-19 Environment and physical standards Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1</p> <p>Sec. 19. (k) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>Sec. 19. (u) The nurses station must be equipped to receive resident calls through a communication system from the following:</p> <p>(1) Resident rooms. (2) Toilet and bathing facilities. (3) Activity, dining, and therapy areas.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review, and interview, for 1 of 1 sample client (client C) who used bed side rails with no call light communication device observed near the client bed, the facility failed to ensure client C had access to communicate her identified need to the nursing staff.</p>	W9999	<p>For Client C and all other clients who have a diagnosis of non-verbal and/or assessed to be unable to vocalize their wants and needs will be provided with 30 minute checks during times when clients are in bed. Additionally, those clients who are physically unable to reach or who are otherwise unable to use the call lights will also be provided with 30 minute checks while they are in bed. Thirty minute checks shall be completed by the supervisor or their designee during those identified times. Thirty minute check sheets will be reviewed during weekly Quarterly Review meetings. This data review will ensure that the facility continues with corrective practices and that they are conducted for all clients as identified. The floor supervisor or their disignee will be responsible for conducting 30 minute checks for those clients while they are in bed to ensure that their wants and needs are completed. The Interdisciplinary Team will be responsible for review of the completed documents to ensure that corrective practices are achieved. Floor Supervisor responsible to supervise. Program Director will monitor.</p>	06/16/2012			

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	<p>Findings include:</p> <p>On 5/14/12 from 2:10pm until 4:15pm, observation and interview were completed at the facility. At 2:10pm, client C was in her bed with two side bed rails up on each side of her bed and the call light was located beside the door across the bedroom. At 2:10pm, client C was non verbal, had contractures of her arms/hands, and had a G-tube (Gastro-tube for stomach feeding) operating. Client C had a tracheotomy (a hole in the windpipe to breathe) and a oxygen tank beside her bed.</p> <p>An interview was conducted with the QMRP on 5/15/12 at 9:30am. The QMRP indicated client C was non verbal, had contractures, and her call light to alert the nursing staff of her wants and needs was located at the door of her bedroom. The QMRP indicated client C could not reach or access the call light communication device.</p> <p>This federal tag relates to complaint #IN00107392.</p> <p>3.1-19(u)</p>				