

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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W0000	<p>This visit was for the investigation of complaint #IN00119674.</p> <p>Complaint #IN00119674: Substantiated, Federal deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W189 and W240.</p> <p>Unrelated Deficiencies cited.</p> <p>Dates of Survey: 12/18, 19, 20 and 1/7/13</p> <p>Facility Number: 012836 AIMS Number: 201091250 Provider Number: 15G809</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Vickie Kolb, Public Health Nurse Surveyor III-RN</p> <p>Quality Review completed 1/14/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed with this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and federal law that mandate submission of a Plan of Correction within specified days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (J, M, S and Z). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect and/or abuse of clients in regard to possible injuries from restraint and/or injuries of unknown source. The governing body failed to ensure the facility staff reported all allegations of abuse/neglect, and injuries of unknown source immediately to the administrator, conducted thorough investigations, and reported the results of investigations to the administrator within 5 working days. The governing body failed to ensure nursing services met the healthcare needs of clients. The governing body failed to ensure clients were not injured in restraints and to ensure protective measures were put in place to prevent harm/potential harm of clients. The governing body failed to ensure its policy and procedures included restraint techniques of extending/hyperextending arms, and to ensure the facility included the restrictive</p>	W0102	<p>The governing body will ensure facility staff report all allegations of abuse / neglect and injuries of unknown source immediately to the Administrator. Thorough investigations of these reports will be conducted and results of the investigations will be reported to the Administrator within 5 working days. This will be accomplished for all clients: 1. - Reporting format will be changed to specifically note that the Administrator was notified immediately on report all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying the Administrator, date, and time.</p> <p>· Reporting format to be completed by 1/26/13. · Responsible Party: Office Manager · Supervisors will be retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations (DOO) · Completed by 2/6/13.</p> <p>· Transition Team Coordinators (TTC), Qualified Support Professionals, Lead Direct Support Professionals, and Health Services Staff will</p>	02/06/2013			

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	<p>interventions of a jump suit in a client's behavior plan.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients A, B, C and D and for 4 additional clients J, M, S and Z. The governing body failed to implement its policy and procedures to prevent neglect and/or abuse of clients. The governing body failed to ensure staff reported all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator, failed to ensure the facility conducted thorough investigations/provide a reproducible system of its investigations, and to ensure the results were reported to the administrator within 5 business days. Please see W122.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Client Behavior and Facility Practices for 4 of 4 sampled clients A, B, C and D and 2 additional clients J and S. The governing body failed to ensure clients B, D, J and S were not injured as a result of physical restraints, and/or failed to ensure sufficient safeguards were put in place to</p>		<p>monitor the appropriate forms to ensure the proper reporting of reportable incidents and the timely (within 5 working days) the investigative reports are completed and received by Administrator. · On-going.</p> <p>2. (a) - Facility staff will receive retraining on the Handle With Care® Primary Restraint Technique (PRT), specifically with respect to the proper positioning of client arms to not be hyper-extended during a restraint procedure. · Responsible Parties: Treatment Team Coordinators (TTC) /Safety & Security to monitor PRTs on site when at all possible and to review all PRTs for appropriateness/safety by camera and/or processing of events within 24 hrs. of restraint. · Completed by 2/1/13. · National trainer (New York) from Handle With Care® will complete annual "train the trainer" for specifically identified staff on 2/4 – 2/7/13 with focus being given to de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques. · Responsible Party: Human Resources Coordinator · Additionally modified PRTs or alternate methods of addressing client behavior will</p>	

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	<p>prevent potential injury. The governing body failed to ensure its behavior management policy included restraint techniques which allowed clients' arms to be extended and/or hyperextended. The governing body failed to ensure the use of a jumpsuit to prevent client A from stripping was part of the client's behavior plan. Please see W266.</p> <p>3. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect and/or abuse in regard to reviewing/addressing a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients to ensure clients were assessed by a nurse when physically restrained and/or as recommended. The governing body failed to ensure the facility implemented its policy and procedures to ensure facility staff immediately reported all allegations/grievances of abuse, neglect and/or injuries of unknown source to the administrator, and failed to implement its policy and procedures to conduct thorough investigations in regard to allegations of neglect, abuse, and/or injuries of unknown source. The governing body failed to implement its</p>		<p>be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition.</p> <p>Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised by a PRT; Behavioral Services Coordinator to address via Behavior Support Plans (BSP) / Human Rights Committee approvals & Qualified Support Professionals (QSP) for staff training and implementation.</p> <p>To be Completed by: 2/4/13.</p> <p>A nurse will provide face-to-face client assessment within two hours following any physical restraint with a minimum of one follow-up within a 24 hour period with additional follow-up/ recommendations for further intervention as indicated.</p> <p>Responsible Party: Health Services Coordinator (DON).</p> <p>Completed/Implemented by: 1/26/13.</p> <p>PRTs will be monitored by a facility supervisor and/or nurse. /Safety & Security (SSP) to monitor PRTs on site when at all possible and to review all PRTs for appropriateness/safety by camera and/or processing of events within 24 hrs. of restraint.</p> <p>Injuries resulting</p>				

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	<p>policy and procedures to ensure results of investigation were reported to the administrator with 5 working days for clients B, C, D, J and S.</p> <p>The governing body failed to ensure facility staff immediately reported all allegations and/or injuries of unknown source to the administrator for clients A, B, D, J and S. The governing body failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients A, B, C, D, M, S and Z. The governing body failed to ensure the facility reported and/or provided evidence the administrator was notified of the results of the investigation within 5 business days for clients C, D and S.</p> <p>The governing body failed to ensure the facility's policy and procedures included specific restraint methods/techniques utilized by the facility for clients B, J and S. The governing body failed to ensure the facility reviewed and/or looked at its restraint techniques to ensure its implementation did not cause injuries/potential injuries to clients. The governing body failed to ensure the facility put in place safeguards to ensure</p>		<p>from physical restraint will be tracked by Health Services Coordinator (DON) with Quality Assurance (QA) Director to establish trends/causes and addressed. Responsible Parties: Health Services Coordinator (DON), QA Director & SSPs Completed / Implemented by: 2/6/13 (b) TBSP (BSP) has been amended to address stripping behavior with the use/wearing of a 'non-tear' jump suit as an approved reactive intervention. Responsible Party: Behavioral Services Coordinator Completed on: 1/ 2 /13. Behavioral Services Coordinator will regularly review all clients and their plans to assure that any restrictive/intrusive intervention(s) are properly incorporated into a formal BSP and approved by the Human Rights Committee (HRC) prior to implementation. On-going. Additionally in Interdisciplinary Team (IDT) meetings, QSPs and other team members will present for review and consideration any possible restrictive interventions that may be effectively incorporated into a BSP and implemented after approval of the HRC. On-going. 3. (a) - Reporting format will be changed to</p>	

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	<p>the protection of the clients to prevent injuries due to the clients' current injuries and/or health risks regarding physical restraints for clients B, D and J. The governing body failed to ensure the facility incorporated the use of a jumpsuit to, prevent the client from stripping, in the client's behavior plan. Please see W149.</p> <p>This federal tag relates to complaint #IN00119674.</p>		<p>specifically note that the Administrator was notified immediately of a pattern of injuries of unknown source to clients, who were being restrained, were not injured as a result of the restraint and/or abuse, providing name of person notifying Administrator, date, and time. · Reporting format to be completed by 1/26/13. · Responsible Party: Office Manager · Supervisors retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations (DOO) · Completed by 2/6/13. · Quality Assurance Director will monitor for a pattern of reported injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse, to assure the proper reporting of reportable incidents and the timeliness of (within 5 working days) the investigative reports are completed and received by Administrator. · On-going.</p> <p>(b) A nurse will provide face-to-face client assessment within two hours following any physical restraint with minimum of one follow-up within a 24 hour period with additional follow-up/ recommendations for further intervention as indicated. ·</p>				

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			<p>Responsible Party: Health Services Coordinator (DON).</p> <ul style="list-style-type: none"> · Completed/Implemented by: 1/26/13. · PRTs will be monitored by a facility supervisor and/or nurse /Safety & Security (SSP) to monitor PRTs on site when at all possible and to review all PRTs for appropriateness/safety by camera and/or processing of events within 24 hrs. of restraint. · Injuries resulting from physical restraint will be tracked by Health Services Coordinator (DON) with QA Director to establish trends/causes and addressed. · Responsible Parties: DON, QA Director & SSPs · Completed/Implemented by: 2/6/13 · (c) Investigations addressing a pattern of injuries of unknown source of clients who were being restrained and were not injured as a result of the restraint and/or abuse will be completed within 5 working days by a QSP/TTC or investigator designated and presented to Administrator · Responsible Parties: Administrator & Quality Assurance Director for review and action as warranted. · Date to be Completed: On-going · (d) The facility will develop and maintain a reproducible system of completed investigations 	

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			<p>(within 5 working days to provide evidence of thorough investigations regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients. · Responsible Party: TTCs / Office Manager / Quality Assurance Director · Date to be Completed: 2/6/13 · (e) The facility will to ensure the facility's policy and procedures include specific restraint methods/techniques utilized by the facility for Clients B, J and S and other clients requiring modifications of physical restraint techniques. · Responsible Party: Administrator to revise policy · Date to be Completed: 2/4/13 · The facility will ensure the facility reviews and/or looks at its restraint techniques to ensure its implementation did not cause injuries/potential injuries to clients. · Responsible Parties: Health Services Coordinator (DON); QSPs; TTC's; Director of Operations & Quality Assurance Director · Completed: 2/6/13 · (f) The facility will ensure the facility puts in place safeguards to ensure the protection of the clients to prevent injuries due to the clients' current injuries and/or health risks regarding</p>		

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			<p>physical restraints for Clients B, D and J and other clients. · Behavior Support Plans (BSP) will take into consideration individual client health/physical conditions in the development and subsequent implementation of the BSPs, including situations requiring restraint. · Clients who develop a medical condition requiring a modification of physical restraint in their BSP will have their respective BSPs modified and approved by the Human Rights Committee (HRC) prior to implementation – physical restraints in current (not yet modified) BSPs will not be implemented until revised BSPs are approved per HRC and staff who work with client are trained. · Responsible Parties: Behavioral Services Coordinator & Health Services Coordinator (DON) · Date to be Completed: 2/6/13 · (g) The Behavior Services Coordinator has incorporated the use of a “non-tear” jumpsuit to prevent Client A from stripping and tearing off clothing into the client's behavior support plan (BSP) on 1/2/13. · Behavioral Services Coordinator will regularly review all clients and plans to assure that any restrictive/intrusive</p>		

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			<p>intervention(s) are properly incorporated into a formal BSP and approved by the Human Rights Committee (HRC) prior to implementation. On-going.</p> <p>· Additionally, in IDT meetings QSPs and other team members will present for review and consideration any possible restrictive interventions that may effective incorporated into a BSP and implemented after approval of the HRC. · On-going.</p>	

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (J, M, S and Z), the facility's governing body failed to exercise general policy and operating direction over the facility to prevent neglect and/or abuse of clients in regard to possible injuries from restraint and/or injuries of unknown source. The governing body failed to exercise its policy and procedures to ensure allegations of abuse/neglect, and injuries of unknown source were immediately reported to the administrator, thorough investigations were conducted, and the results of investigations were reported to the administrator within 5 working days. The governing body failed to exercise its policy and procedures to ensure nursing services met the healthcare needs of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure clients were not injured in restraints and to ensure protective measures were put in place to prevent harm/potential harm of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure its policy and procedures</p>	W0104	<ul style="list-style-type: none"> · (a) Reporting format will be changed to specifically note that the Administrator was notified immediately of a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse, providing name of person notifying Administrator, date, and time. · Responsible Party: Office Manager · Reporting format to be completed by 1/28/13 · Supervisors retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations · To be Completed by 2/6/13. · Quality Assurance Director will monitor for a pattern of reported injuries of unknown source of clients who were being restrained and were not injured as a result of the restraint and/or abuse to assure the proper reporting of reportable incidents and the timely (within 5 working days) the investigative reports are completed and received by Administrator. · On-going. · (b) The facility will ensure facility staff report all 	02/06/2013

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	<p>included restraint techniques of extending/hyperextending arms and to ensure the facility included the restrictive interventions of a jump suit in a client's behavior plan.</p> <p>Findings include:</p> <p>1. The governing body neglected to implement its policy and procedures to prevent neglect and/or abuse in regard to reviewing/addressing a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse. The governing body neglected to implement its policy and procedures to prevent neglect of clients to ensure clients were assessed by a nurse when physically restrained and/or as recommended. The governing body neglected to implement its policy and procedures to ensure the facility staff immediately reported all allegations/grievances of abuse, neglect and/or injuries of unknown source to the administrator, and neglected to implement its policy and procedures to conduct thorough investigations in regard to allegations of neglect, abuse, and/or injuries of unknown source. The governing body neglected to implement its policy and procedures to ensure results of investigations were reported to the administrator with 5 working days for</p>		<p>allegations of abuse / neglect and injuries of unknown source, including addressing a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse immediately to the Administrator. Thorough investigations of these reports will be conducted and results of the investigations will be reported to the Administrator within 5 working days. This will be accomplished for all clients:</p> <ul style="list-style-type: none"> · Responsible Parties: QSP/TTC or investigator designated and presented to Administrator & Quality Assurance Director for review and action as warranted. · Date to be Completed: On-going · (c) The facility will exercise its policy and procedures to ensure nursing services met the healthcare needs of all clients. Reference W331. · The Health Services Coordinator (DON) who began position on 1/7/13 will assure proper and responsive health services are provided as indicated. · Date to be fully implemented: 2/7/13 · (d) Facility will exercise general policy and operating direction to prevent neglect and/or abuse of clients in regard to possible injuries from 				

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	<p>clients B, C, D, J and S. Please see W149.</p> <p>2. The governing body failed to ensure facility staff immediately reported all allegations and/or injuries of unknown source to the administrator for clients A, B, D, J and S. Please see W153.</p> <p>3. The governing body failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients A, B, C, D, M, S and Z. Please see W154.</p> <p>4. The governing body failed to report and/or provide evidence the administrator was notified of the results of the investigation within 5 business days for clients C, D and S. Please see W156.</p> <p>5. The governing body failed to ensure specific restraint methods/techniques utilized by the facility were included in the facility's behavior management policy for clients B, J and S. Please see W276.</p> <p>6. The governing body failed to review and/or look at its restraint techniques to ensure its implementation did not cause injuries/potential injuries to clients. The</p>		<p>restraint and/or injuries of unknown source. · A nurse will provide face-to-face client assessment within two hours following any physical restraint with minimum of one follow-up within a 24 hour period with additional follow-up/ recommendations for further intervention as indicated. · Responsible Party: Health Services Coordinator (DON). · Completed/Implemented by: 1/26/13. · PRTs will be monitored by a facility supervisor and/or nurse/Safety & Security (SSP) to monitor PRTs on site when at all possible and to review all PRTs for appropriateness/safety by camera and/or processing of events within 24 hrs. of restraint. · Injuries resulting from physical restraint will be tracked by Health Services Coordinator (DON) with Quality Assurance Director to establish trends/causes and addressed. SSP will reports any concerns to QA. · Responsible Parties: Health Services Coordinator (DON) & QA Director · Completion: On-going · (e) Facility will ensure allegations of abuse/neglect, and injuries of unknown source are immediately reported to the Administrator, thorough investigations are conducted, and the results of</p>		

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	<p>governing body failed to ensure safeguards were put in place to ensure the protection of the clients to prevent injuries due to the clients' current injuries and/or health risks regarding physical restraints for clients B, D and J. Please see W285.</p> <p>7. The governing body failed to ensure the use of a jumpsuit, to prevent the client from stripping, was part of the client's behavior plan for client A. Please see W289.</p> <p>This federal tag relates to complaint #IN00119674.</p>		<p>investigations are reported to the Administrator within 5 working days. Reporting format will be changed to specifically note that the Administrator was notified immediately on report all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying Administrator, date, and time. Responsible Party: Office Manager Reporting format to be completed by 1/26/13. Supervisors will be retrained on specifics requiring reports to be completed. Responsible Party: Director of Operations (DOO) Completed by 2/6/13. Quality Assurance Director will monitor the proper reporting of reportable incidents and the timely (within 5 working days) the investigative reports are completed and received by Administrator. On-going.</p> <p>(f) The facility will exercise general policy and operating direction over the facility to ensure policy and procedures include restraint techniques of not hyper-extending arms and to ensure the facility included the restrictive interventions of a "non-tear" jump suit in a client's BSP. Facility staff will receive retraining on the Handle With Care® Primary</p>		

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			<p>Restraint Technique (PRT), specifically with respect to the proper positioning of client arms to not be hyper-extended during a restraint procedure. Responsible Parties: Treatment Team Coordinators by 2/1/13.</p> <ul style="list-style-type: none"> · National trainer (New York) from Handle With Care® will complete annual "train the trainer" on 2/4 – 2/7/13 with focus being given to de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques. Responsible Party: Human Resources Coordinator · Additionally modified PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition. · Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised by a PRT; Behavioral Services Coordinator to address via BSPs / Human Rights Committee approvals & QSPs for staff training and implementation. · Completed by: 2/4/13. · The Behavior Services Coordinator has amended Client A's TBSP (BSP) to include using/wearing 		

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			<p>a "non-tear" jump-suit as a reactive intervention to address the behavior(s) of 'tearing up/off clothing' and 'stripping naked in public areas' on 1/2/13. · Human Rights Committee (HRC) approval was also obtained for Client A's amended TBSP (BSP) on 1/2/13. · Behavioral Services Coordinator will regularly review all clients and their plans to assure that any restrictive/intrusive intervention(s) are properly incorporated into a formal BSP and approved by the Human Rights Committee (HRC) prior to implementation. On-going.</p> <p>· Additionally in IDT meetings, QSPs and other team members will present for review and consideration any possible restrictive interventions that may effective incorporated into a BSP and implemented after approval of the HRC. · On-going.</p>		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (J, M, S and Z). The facility failed to implement its policy and procedures to prevent neglect and/or abuse of clients. The facility failed to report all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator, failed to conduct thorough investigations/provide a reproducible system of its investigations, and to ensure the results were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <p>1. The facility neglected to implement its policy and procedures to prevent neglect and/or abuse in regard to reviewing/addressing a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse. The facility neglected to implement its policy and procedures to prevent neglect of clients to ensure clients were assessed by a nurse when physically restrained and/or as recommended. The facility neglected</p>	W0122	<p>· (a) All allegations of abuse, neglect and/or injuries of unknown source will be immediately reported to the Administrator, · Reporting format will be changed to specifically note that the Administrator was notified immediately of a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse, providing name of person notifying Administrator, date, and time. · Responsible Party: Office Manager · Reporting format to be completed by 1/26/13 · Supervisors will be retrained on specifics requiring reports to be completed for proper notification. · Responsible Party: Director of Operations (DOO) · To be Completed by 1/26/13. · (b) the facility will conduct thorough investigations/provide a reproducible system of its investigations and results will be reported to Administrator within 5 business days, · TTC will assure all QSPs and other designated staff who investigate receive proper training in completing</p>	02/06/2013			

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	<p>to implement its policy and procedures to ensure the facility staff immediately reported all allegations/grievances of abuse, neglect and/or injuries of unknown source to the administrator, and neglected to implement its policy and procedures to conduct thorough investigations in regard to allegations of neglect, abuse, and/or injuries of unknown source. The facility neglected to implement its policy and procedures to ensure results of investigations were reported to the administrator with 5 working days for clients B, C, D, J and S. Please see W149.</p> <p>2. The facility failed to ensure facility staff immediately reported all allegations and/or injuries of unknown source to the administrator clients A, B, D, J and S. Please see W153.</p> <p>3. The facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients A, B, C, D M, S and Z. Please see W154.</p> <p>4. The facility failed to report and/or provide evidence the administrator was notified of the results of the investigations</p>		<p>investigations and that a reproducible system of investigations is maintained. To be Completed by: 2/6/13</p> <p>The Health Services Coordinator and the Quality Assurance Director will monitor for a pattern of injuries of unknown source of clients who were being restrained and were not injured as a result of the restraint and/or abuse, to assure the proper reporting of reportable incidents and the timely (within 5 working days) the investigative reports are completed and received by Administrator. To be Completed by: 2/6/13.</p>		

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	<p>within 5 business days for clients C, D and S. Please see W156.</p> <p>This federal tag relates to complaint #IN00119674.</p>				

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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. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (J and S), the facility neglected to implement its policy and procedures to prevent neglect and/or abuse of clients in regard to reviewing/addressing a pattern of injuries of unknown source of clients, who were being restrained, to ensure the clients were not being injured as a result of the restraint. The facility neglected to implement its policy and procedures to prevent neglect of clients to ensure clients were assessed by a nurse when physically restrained and/or as recommended. The facility neglected to implement its policy and procedures to ensure the facility staff immediately reported all allegations/grievances of abuse, neglect and/or injuries of unknown source to the administrator, and neglected to implement its policy and procedures to conduct thorough investigations in regard to allegations of neglect, abuse, and/or injuries of unknown source. The facility neglected to implement its policy and procedures to ensure results of investigations were reported to the administrator with 5 working days.</p>	W0149	<p>(a) The facility will exercise general policy and operating direction over the facility to ensure policy and procedures included restraint techniques of not hyper-extending arms.</p> <p>Facility staff will receive retraining on the Handle With Care® Primary Restraint Technique (PRT), specifically with respect to the proper positioning of client arms to not be hyper-extended during a restraint procedure. Responsible Parties: Treatment Team Coordinators by 2/1/13.</p> <p>National trainer (New York) from Handle With Care® will complete annual "train the trainer" on 2/4 – 2/7/13 with focus being given to</p>	02/06/2013	

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	<p>Findings include:</p> <p>1. During the 12/19/12 observation period between 10:30 AM and 11:40 AM, at the facility, client J sat in the day room and complained of pain in her left shoulder. Client J was guarding her left arm/shoulder as the client refused to use it.</p> <p>Interview with client J on 12/19/12 at 11:24 AM stated the client started having pain in her left shoulder/arm after staff utilized "a PRT" (Primary Restraint Technique) on the client. Client J demonstrated (with her good arm) and stated "They hold my arm back behind me." Client J demonstrated her arm being held backwards in a hyperextended position. Client J indicated she had told staff about her arm/shoulder pain. Client J indicated her shoulder was hurt on 12/17/12. Client J indicated the nurse was aware of her injury. Client J stated "I have been telling them since that night. It is swollen. I can't move it." Client J indicated 2 staff were initially involved in the PRT but there were other staff around. Client J indicated she was admitted to the facility on 11/5/12 and had been restrained 2 times using the PRT restraint. Client J indicated this was the first time her shoulder/arm was hurt. Client J indicated she got upset and threw items in</p>		<p>de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques.</p> <p>Responsible Party: Human Resources Coordinator</p> <p>· Additionally modified PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition.</p> <p>· Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised in a regular PRT; Behavioral Services Coordinator to address via BSPs / Human Rights Committee approvals & QSPs for staff training and implementation.</p> <p>· Completed by:</p>		

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	<p>her room and hit staff.</p> <p>Interview with LPN #2 on 12/19/12 at 11:40 AM indicated client J had been complaining of arm pain. When asked what happened to client J's arm, LPN #2 stated "Put in PRT and has complained of pain ever since. I need to call and get X-ray." LPN #2 stated when she came in, "Night nurse gave report. She (client J) needed x-ray done." When asked if LPN #2 had called to obtain an x-ray, LPN #2 stated "Not yet. I need to call and get X-ray." LPN #2 could not explain why she had not called the doctor and/or obtained an X-ray as of 11:40 AM on 12/19/12.</p> <p>Client J's Behavioral Incident Reports (BIRS) were reviewed on 12/19/12 at 12:35 PM. Client J's 12/17/12 BIR indicated at 10:00 PM client J was placed in a PRT escort and a PRT standing restraint. The BIR indicated client J "Ran up on staff and pulled her hair...Tried to attack peer (client B) and Pull another staff's hair." The 12/17/12 BIR indicated client J was redirected to her room to calm down, and began to throw things when she went to her bedroom. The BIR indicated when staff went into the client's bedroom, the client picked up her TV and threw it at the door causing it to break. The BIR indicated client J was asked to</p>		<p>2/6/13.</p> <p>· (b) Facility will exercise general policy and operating direction to prevent neglect and/or abuse of clients in regard to possible injuries from restraint and/or injuries of unknown source.</p> <p>· A nurse will provide face-to-face client assessment within two hours following any physical restraint with minimum of one follow-up within a 24 hour period with additional follow-up/ recommendations for further intervention as indicated.</p> <p>· Responsible Party: Health Services Coordinator (DON).</p> <p>· Completed/Implemented by: 1/26/13.</p> <p>· (c) Facility will to</p>		

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	<p>go to a "calm space" to calm down but the client refused. The BIR indicated client J was then escorted by 2 staff. The 12/17/12 BIR indicated a standing PRT was done from 10:22 PM to 10:30 PM. The BIR debriefing section indicated 4 staff were involved in the "Level III Intervention." The BIR section indicated "Face to Face: Assessment of Client Following Level II Intervention (To be completed within one hour of Level III Intervention by the nurse, LDSP, (Lead Direct Support Professional) QSP (Qualified Support Professional), SSP (Safety & Security Professional) or a designated supervisor other than the person(s) implementing the restraint). Physical: (Check all that apply and provide brief description)." The BIR indicated "No Complaints" was checked. The BIR did not indicate an actual physical assessment was completed.</p> <p>Client J's record was reviewed on 12/19/12 at 11:45 AM. Client J's Progress Notes indicated the following (not all inclusive):</p> <p>-12/17/12 (4 PM to 12 AM) "...[Client J] upset over Bingo prizes and got physically aggressive with staff & (and) peer. [Client J] threw and broke several items in her room including throwing her t.v...."</p>		<p>ensure allegations of abuse/neglect, and injuries of unknown source are immediately reported to the Administrator, thorough investigations are conducted, and the results of investigations are reported to the Administrator within 5 working days.</p> <p>· Reporting format will be changed to specifically note that the Administrator was notified immediately on report all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying Administrator, date, and time.</p> <p>· Responsible Party: Office Manager</p> <p>· Reporting format to be completed by 1/26/13.</p>				

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	<p>-12/18/12 (8 AM to 4 PM) "[Client J] was in bed refusing to get up when staff arrived on the unit at 8 am. [Client J] refused breakfast but took her 8 am meds. [Client J] got up at 9:00 am complaining of shoulder pain in her left shoulder. When asked why it was hurting she stated she did not know...at 12:15pm [client J] ate 100% of her meal and returned to the unit to lay down due to discomfort in her left shoulder. She talked with LDSP (Lead Direct Support Professional) again about shoulder pain after receiving Ibuprofen (pain) & a heating pad from nursing. At 1:33pm [client J] explain (sic) to LDSP it was this time she felt her left shoulder pain could be a result of being placed in a PRT the night before. LDSP assisted [client J] with filling out a grievance form. [Client J] remained in bed the remainder of the shift being checked on by staff to ensure safety and comfort."</p> <p>Client J's Nursing Progress Notes indicated the following:</p> <p>-12/16/12 (6 PM) "Reported nose bleed @ (at) 10 AM. Monitored thru the day for further bleeding. No C/O (complaints) pain or discomfort. No further bleeding."</p>				

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	<p>-12/18/12 (9 AM) "C/O Lt (left) shoulder Disc. (discomfort). ROM (range of motion) Refused. No edema 0 (zero) redness bruising noted by report. Client threw TV last evening. Will monitor Heat Applied." Client J's record neglected to indicate any additional documentation and/or monitoring of the client's shoulder as there was no additional nursing documentation in the client's record as of 12/19/12 at 11:45 AM. Client J's faxed physician orders from 11/12 to 12/12 indicated the facility neglected to inform client J's doctor of the client's shoulder complaints, and/or neglected to obtain an x-ray of the client's shoulder as of 12/19/12 at 11:45 AM. Client J's nursing notes neglected to indicate any additional monitoring and/or documentation in regard to the client's shoulder pain/discomfort as of 12/19/12 at 11:45 AM as there were no additional nurse notes to review.</p> <p>Client J's 11/13/12 Transition Behavioral Support Plan (TBSP) indicated "Level III Intervention" (physical restraint) could be used with client J when she became aggressive, demonstrated property destruction and/or self-injurious behavior. Client J's 11/13/12 TBSP indicated a Standing PRT Escort, Standing PRT and/or a Sitting PRT could be utilized. Client J's 11/13/12 TBSP indicated</p>						

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	<p>"...staff may immediately utilize a different physical restraint in an attempt to avert the crisis by using a Standing PRT or Sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others involved.) [Client J] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by 'Handle With Care'...."</p> <p>Client J's 11/13/12 Transition Support Plan (TSP) neglected to indicate the facility and/or the client's interdisciplinary team reviewed the incident/allegation of possible abuse/injury from restraint.</p> <p>The facility's reportable incident reports were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports from 10/12 to 12/12 indicated the allegation of possible abuse had not been reported to the administrator, and/or neglected to indicate the facility had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
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	<p>initiated an investigation in regard to the allegation of possible abuse/injury in restraint.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and #2 on 12/19/12 at 2:45 PM indicated the facility's nurse had ordered an X-ray for client J's shoulder. TCC #1 and #2 did not know why the X-ray had not been ordered prior to 12/19/12 when questioned by the surveyor. TTC #1 and #2 did not know why there was no additional monitoring or follow-up documented by nursing staff as of 12/19/12. TTC #1 indicated she was not aware of the allegation of possible abuse/injury in restraint with client J until 12/19/12. TTC #1 indicated client J's QSP was made aware of the grievance/allegation on 12/18/12. TTC #1 indicated client J's QSP (QSP #2) was in the process of filing a state reportable incident report on 12/19/12. TTC #1 indicated client J's grievance was not seen as an allegation of possible abuse, and/or as injury from restraint as the client had thrown her TV that night. When asked if the administrator had been made aware of the allegation, TTC #1 indicated she was just made aware of the allegation on 12/19/12. TTC #1 indicated the administrator would have been made aware through an e-mail. TTC #1 did not provide any documentation the</p>						

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	<p>administrator was immediately informed of the grievance/allegation/injury of unknown source made by client J on 12/18/12.</p> <p>Interview with RN #1 on 12/20/12 at 10:30 AM indicated client J had an X-ray done on 12/19/12. RN #1 indicated the results of the X-ray were negative for a fracture or dislocation. RN #1 indicated client J was instructed to move her arm but the client would state "It hurts."</p> <p>Interview with LPN #1, QSP #2 and TTC #1 and #2 on 12/20/12 at 3:00 PM indicated client J was restrained on 12/17/12 due to aggressive behaviors toward others and property destruction. TTC #1 indicated the facility's Security and Safety Professional did the assessment of the client after the incident on 12/17/12. TTC #1 stated no "Client Injury Report" was completed. TTC #1 indicated client J did not have any complaints after she was restrained on 12/17/12. When asked if a physical assessment had been completed, TTC #1 stated "No Complaints checked." TTC #1 indicated the facility did not do an actual physical assessment of the client. LPN #1 indicated client J complained of the injury to her left shoulder on 12/18/12. LPN #1 stated "Nurse came right away" and a heating pad was applied. TTC #1 and</p>						

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	<p>QSP #2 indicated the client's IDT had not reviewed the incident to ensure protective measures were put in place until the facility determined if the injury was a result from the PRT.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/16/12 reportable incident report indicated "[Client B] complained of pain in her left shoulder to nurse at 12:00 PM on 11/15/2012. Nurse then contacted [client B's] primary care physician and he ordered an x-ray to be completed on her left shoulder. Mobile x-ray technician came to the facility and performed an x-ray at 2:07 AM on 11/12.2012 (sic). Results from the x-ray state: 'There is a suggestion of a fracture of the distal third of the clavicle with no displacement of the left shoulder. The acromioclavicular and coracoclavicular joints are normal.' Conclusion from the radiologist performing the examination stated: 'Questionable clavicle fracture as described above. Dedicated clavicle series recommended.' [Client B's] primary care physician was faxed the report from the radiologist at 3am on 11/16/2012. Primary care physician ordered a dedicated clavicle series to be performed. Nurse contacted the mobile x-ray company and they are scheduled to</p>				

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	<p>come to the facility to perform this examination as soon as possible...Additionally, [client B] will be seen and evaluated by primary care physician on 11/17/2012...."</p> <p>The facility's 11/21/12 follow-up report indicated "Results of the dedicated clavicle series state: '2 views of the left clavicle demonstrate no fracture, dislocation or bony reaction. Acromioclavicular articulation is normal.' The conclusion from the radiology report states: 'No fracture or dislocation in clavicle.' [Client B] notified staff that she has had issues with injuring her shoulder in the past. Physical therapy appointment was scheduled by WTS to further provide support for [client B's] symptoms. The initial evaluation by the therapist was completed on 11/20/2012 and states 'demonstrates weakness and decreased range of motion.' [Client B] was given four exercises by the physical therapist to do at WTS, three times a day, using a rolled up towel. Staff will assist [client B] in completing these exercises...." The facility's 11/16/12 reportable incident report and/or 11/21/12 follow-up report neglected to conduct a thorough investigation in regard to the client's injury of unknown source, and/or to ensure the client had not been injured/re-injured while being restrained</p>						

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	<p>when using the PRTs.</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/11/12 at 1:05 PM, "Res (resident) placed in PRT @ (at) 1253 related to self harm et. (and) able to process out by 1pm 0 (zero) distress. Res moved to OBS (observation) room."</p> <p>-11/12/12 at 5:30 PM, "Placed in PRT due to self injurious bx (behavior). Reopened areas to Lt (left) arm & leg. Areas cleansed. Per [name of doctor] moved Suicide I."</p> <p>-11/13/12 at 12 AM, "...Remains on Level I suicide precautions (with) staff in reach. Will monitor Tylenol given effectively for c/o pain in shoulder at 9:25 pm. Reports hx (history) of collar bone fx (fracture) in past and having chronic pain."</p> <p>-11/15/12 at 12 PM, "New order per [name of doctor]. X-ray Lt shoulder c/o disc (complaints of discomfort). S1 (Slight) edema to the front of the shoulder. Client stating difficulty (with) ROM (range of motion). Also stated she has fx'ed (fractured) before. [Name of xray company] notified."</p>			
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	<p>-11/16/12 at 5:30 AM, "Complaints of pain (L) (left) shoulder, x-ray done this shift, results came back positive, res has a fx, results faxed to MD (Medical Doctor), to await new orders, res given tylenol prn (as needed) for pain."</p> <p>-11/16/12 at 12 PM, "[Name of doctor] called r/t (related to) Xray results et. recommended dedicated clavicle series. [Name of xray company] called...."</p> <p>-11/16/12 at 7:40 PM, "[Name of xray company] here to complete clavicle (L) arm."</p> <p>-11/16/12 at 11:30 PM, "Received X-ray results showing 0 fracture/dislocation seen in (L) arm. Will continue to monitor and medicate for pain."</p> <p>-11/19/12 at 10 AM, "Spoke with [name of doctor]. No new orders related to X-ray results."</p> <p>-11/19/12 at 5:00 PM, "New Order per [name of doctor]. PT (Physical Therapy) eval (evaluation) related to Lt shoulder."</p> <p>-11/19/12 at 5:05 PM, "Scheduled PT 11-20-12 at [name of company]."</p> <p>-11/25/12 at 3:00 AM, client B</p>			

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	<p>complained of pain in the side of her left shoulder. The note indicated Tylenol was given to client B for pain.</p> <p>Client B's physician's orders and/or faxed orders indicated the following (not all inclusive):</p> <p>-11/15/12 "X-ray LT Shoulder C/O Disc. SI edema to the front of the shoulder difficulty with ROM"</p> <p>-11/16/12 X-Ray (clavicle series) related to recommendation"</p> <p>-11/19/12 "PT Eval Due to Hx (history) of Fx to Lt Shoulder C/O Disc"</p> <p>Client B's 11/17/12 Medical Visit Summary form indicated client B saw her primary care doctor as the client continued to complain of pain and the X-ray showed no fracture. Client B's medical visit form indicated "Will allow for normal healing and allow patient to take Non-Narcotic pain medication for now in view of No Fracture noted on X-ray."</p> <p>Client B's 11/16/12 Radiology Report indicated "Results: There is suggestion of a fracture of the the (sic) distal third of the clavicle with no displacement of the left shoulder. The acromioclavicular and</p>			

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	<p>coracoclavicular joints are normal. Conclusion: Questionable clavicle fracture as described above. Dedicated clavicle series recommended." Client B's 11/16/12 Radiology report indicated "Results: 2 views of the left clavicle demonstrate no fractures, dislocation or bony reaction. Acromioclavicular articulation is normal. Conclusion: No fracture or dislocation in clavicle."</p> <p>Client B's 11/20/12 Medical Visit Summary form indicated client B saw a PT for evaluation of the client's left shoulder. The form indicated the client had a history of clavicle fracture. The 11/20/12 form indicated "Initial evaluation performed (sic) Pt (patient) demonstrates weakness, decreased ROM. HEP (exercises) provided and explained to pt. transportation present." The form indicated PT would follow-up.</p> <p>Client B's 11/7/12 Transition Behavioral Support Plan (TBSP) Level II section indicated "In certain instances, a client may exhibit maladaptive behaviors that are dangerous to the client or others. In these situations, to be referred to as 'crisis situation', it may be necessary for staff to intercede in the treatment process by implementing physical restraint, environmental restraint, or a PRN psychotropic intervention...." Client B's</p>						

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	<p>TBSP indicated facility staff could utilize a Standing PRT Escort, Standing PRT, Sitting PRT when client B demonstrated self-harm behavior and/or physical aggression. Client B's 11/7/12 TBSP indicated "[Client B] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by 'Handle With Care' and WTS. (Please see WTS Physical Restraint policy for an explanation of each technique and its proper implementation)...Staff debriefing should be done following each occurrence of restraint and/or emergency intervention. Debriefing with [client B] should be done following her release from restraint/emergency intervention...."</p> <p>Client B's BIRs were reviewed on 12/19/12 at 12:35 PM. Client B's BIRs indicated the following (not all inclusive):</p> <p>-11/11/12 Client B tried to cut herself with a fork. The 11/11/12 BIR indicated facility staff utilized PRT Escort, Standing PRT and Sitting PRT with the client. The 11/11/12 Face to Face Assessment indicated client B had no complaints. No actual physical assessment was documented for client B. The 11/11/12 BIR indicated 3 staff were involved in the Standing PRT with a monitor and two staff and a monitor were</p>						

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	<p>involved in the PRT escort and Sitting PRT.</p> <p>-11/12/12 Client B was scratching her legs and arms attempting to self harm. The BIR indicated a Sitting PRT was utilized by 3 staff and a monitor. The BIR indicated a "Face to Face" assessment was completed and there were no complaints. The 11/12/12 BIR indicated an Illness and Injury Report was also completed. The BIR indicated client B's arms and legs were assessed and the areas were cleansed.</p> <p>-11/27/12 Client B threw shoes at staff and hit the TV 2 times in the day room. The BIR indicated client B did not respond to verbal redirection. The BIR indicated 2 staff utilized a PRT Escort with a monitor and 3 staff utilized a Sitting PRT with a monitor. The 11/27/12 BIR indicated a "Change in breathing" was checked. The BIR indicated "Breathing hard" in the section entitled "Signs of tension in the client." The BIR indicated "No complaints" was checked in the Face to Face Assessment. The 11/27/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/27/12 BIR did not indicate the PRT was modified.</p> <p>-11/29/12 Client B "charged staff</p>			

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	<p>swinging her fist" and hit staff in their upper torso. The BIR indicated 3 staff placed the client in a Sitting PRT with a monitor. The BIR indicated "No complaints" was checked in the Face to Face assessment. The 11/29/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/29/12 BIR did not indicate the PRT was modified.</p> <p>-11/30/12 Client B refused to leave her bedroom door open to be monitored. The client attempted to barricade the door and yelled at staff to get out of her room. Client B threw shoes at the staff when they attempted to keep the door open. The BIR indicated client B was placed in a Standing PRT and a PRT Escort by 2 staff with a monitor. The BIR indicated "No complaints" was checked in the Face to Face assessment. The 11/30/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/30/12 did not indicate the PRT was modified.</p> <p>Client B's 12/7/12 Transitional Support Plan (TSP) indicated client B's interdisciplinary team (IDT) did not meet to review the client's behavioral incidents and/or restraints. The above mentioned BIRs indicated the facility restrained client B on 11/27, 11/29 and 11/30/12</p>						

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	<p>after the client was found to have a shoulder injury on 11/16/12 and saw a PT for evaluation/treatment on 11/20/12. The facility and/or the client's IDT neglected to review the use of the PRTs with client B to ensure sufficient safeguards were put in place to protect the client from injury and/or re-injury. The facility neglected to modify the PRT to protect the client.</p> <p>Interview with LPN #1, TTC #1 and #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior where PRT had been used with the client. LPN #1 indicated client B received PT for her shoulder. LPN #1 stated client B received "Strengthening exercises of shoulder due to weakening of muscles." LPN #1 and QSP #1 indicated client B had a history of clavicle fractures as reported by the client. TTC #1 indicated the facility did not conduct an investigation in regard to client B's injury of unknown source and/or to ensure the re-injury or injury was not due to the PRT done on 11/11 or 11/12/12. When asked if client B's IDT reviewed/looked at the use of the PRT with client B, TTC #1 and QSP #1 stated "No." LPN #1 stated client B's IDT "Should have looked at." LPN #1 indicated the PRT should probably not be done with client B due to the client's shoulder injury. When asked if client B</p>						

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	<p>had been restrained since 11/16/12, QSP #1 stated "She (client B) has had 5 incidents where she was restrained. Not sure." When asked if the client's IDT had modified the PRT to ensure client B's protection, QSP #1 and TTC #1 stated "No." When asked if the facility had identified any clients who had physical limitations where the PRT could not be used, LPN #1, TTC #1, QSP #1 and #2 stated "No at this point and time." TTC #1 indicated the facility did not hyperextend clients' arms, but the clients' arms would be held back if the client tried to pinch and hit others and themselves. TTC #1 indicated additional staff could assist to hold the client's legs, head and/or etc, as needed. TTC #1 indicated the PRT was designed for 2 staff to implement.</p> <p>Interview with Behavior Specialist (BS) #1 and TTC #1 on 12/20/12 at 5:15 PM indicated the PRT was part of the Handle With Care physical intervention techniques. TTC #1 and BS #1 indicated the Sitting PRT and Standing PRT were part of the facility's behavioral management policy. When asked if hyperextending the clients' arms was a part of the technique/policy, TTC #1 and BS #1 indicated they thought it was part of the program and policy. When the TTC #1 and BS #1 went to review the Handle With Care program book and</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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	<p>behavior management policy, TTC #1 and BS #1 indicated they were not able to locate where the clients' arms should be extended/hyperextended. TTC #1 indicated the policy did say other staff could be used.</p> <p>The facility's policy and procedures were reviewed on 12/18/12 at 12:15 PM and 12/19/12 at 11:58 AM. The facility's revised 10/12 Physical Restraint Policy indicated the facility utilized the Active Physical Restraint of PRT which was part of the Handle With Care Behavior Management System. The 10/12 policy defined and described the following restraints used by the facility:</p> <p>"1. PRT Escort-used for escorting a client when he or she is a danger to his/herself (sic) or others for the purpose of removing the client from the milieu and getting the client to the Calm Space where he or she can calm down. A PRT Escort may also be used when a client is refusing to move on his own in an emergency evacuation. One person- staff is located behind the client with arms over client's arms and hands interlocked between the client's shoulder blades. Two person - staff are behind the client on each side of the client. The outside arm of each staff is located over the client's arm with the hand over the client's shoulder blade; the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	inside arm of each staff member is holding the client's wrist. 2. Sitting PRT - used when the client is a danger to his/herself (sic) or others, when a client drops his or her weight during a PRT Escort, when a client refuses to walk in a PRT Escort, or when a client is too aggressive to be moved using the PRT Escort. The Primary staff member who initiates the restraint is behind the client with arms over client's arms and hands interlocked between the client's shoulder blades; this staff member takes a deep step back and brings the client gently to the floor. The Secondary staff secures the client's legs by laying his or her torso (face down) across the client's legs; the Secondary staff will bend his or her knee closest to the client's feet bringing it toward the torso for additional support and stability. Other staff may be required to assist the Primary and Secondary staff to keep the client from injuring his/herself (sic) or others. 3. Standing PRT- This is a transitional restraint technique to be used for a short period of time when a client is a danger to self or others. A standing PRT may be implemented for a short period of time until another staff arrives to fulfill the role of Secondary staff in a Sitting PRT. Staff is located behind the client with arms over client's arms and hands interlocked between the client's shoulder blades; a wall is used to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
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	<p>assist with containing the client until the client can be transitioned to a Sitting PRT. Whenever possible cushion will immediately be placed between the client and the wall...." The 10/12 policy neglected to indicate how the facility would handle/address injuries from the use of the restraint. Also, the revised 10/12 policy did not indicate clients' arms should be extended backwards/hyperextended when doing PRTs.</p> <p>The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights...." The facility's June 2012 policy entitled Employee Conduct indicated "Each person receiving services from WTS will receive humane care and protection from harm...." The policy indicated clients had the right to be free from neglect.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports indicated the following:</p> <p>-11/9/12 "[Client B] was in her room</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>listening to music and trying to calm herself after a phone call with her father that didn't go well. She was upset and crying. [Client B] spoke at length with her QSP (Qualified Support Professional) and staff to help her regain control of her emotions. When staff went to assist with another client's aggressive behavior, [Client B] intentionally scratched her arms and legs. [Client B] was seen by the nurse, treated and evaluated. The Doctor gave orders for her to be placed on Level 2 Suicide Precautions...Level 2 Precautions-clients must remain in staff sight at all times...."</p> <p>-11/10/12 "[Client B] was in her room reading, staff checking on her every 15 minutes. At 8:10PM (sic) [client B] told staff to get out of her room. When staff asked her what was the matter they found that [client B] had bent her glasses and removed the lenses. She began crying and would not answer any questions. Staff notice (sic) that [client B's] arms were very red and continued to ask what was wrong and what was bothering her. [Client B] cursed and began using the lenses to scrape her arm. Staff attempted to remove the lenses but [client B] refused. Staff radioed for the Safety & (and) Security Professional to assist and [client B] began biting herself. Staff continued to engage [client B]. The SSP</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>arrived and spoke with [client B] and helped her made (sic) a good decision and gave the lenses to staff. [Client B] refused to come out of her room so staff sat outside her door for 5 minutes at which time [client B] wanted to speak with staff and stated that she doesn't like to be alone,...[Client B] asked staff to take dangerous object from her room...[Client B] was seen by the nurse, treated and evaluated. The Doctor gave orders for her to be placed on Level 2 Suicide Precautions...Level 2 Suicide Precautions-clients must remain in staff sight at all times. In order to prevent self harm they are only allowed access to their personal items when staff are present but cannot have sharps, belts or any items which can be used to injure themselves. During hours of sleep clients on Level 2 Suicide Precautions will sleep in the observation room on their unit to ensure they do not have access to any objects with which to harm themselves."</p> <p>The facility's 11/16/12 follow-up report indicated "Staff involved in this incident report were not providing appropriate supervision to [client B], who had been placed on a Level 2 Suicide Precaution per order from psychiatrist on 11/9/12. The facility neglected to provide documentation of an investigation in regard to the possible neglect/lack of -</p>						

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	<p>staff supervision.</p> <p>-11/11/12 "[Client B] was being monitored by staff due to previous self injuring behaviorShe (sic) was in her room and staff discovered she had a fork and was putting it in her mouth trying to harm herself (sic) Staff removed the fork and informed the nurse who evaluated [client B]. [Client B] was taken to the observation room so staff could make sure she was safe...." The 11/11/12 reportable incident report indicated client B "...started clawing at arm to open old wound. Did not respond to redirection and placed in PRT (Primary Restraint Technique). In dining room at 5:04 pm, [client B] had a strange facial expression on her face. When asked if ok, she shook her head no. Placed Hoodie over her head. Continued to monitor client. When asked to remove Hoodie, staff saw she had a spoon in her mouth. Staff able to get spoon from her. Remains on Level 2 Suicide Precautions...."</p> <p>The facility's 11/16/12 follow-up report indicated "Investigation into this incident confirmed that staff was providing appropriate line of sight supervision for [client B] as she remained on Level 2 Suicide Precaution. [Client B] will smuggle items to use for self-harming purposes inside her clothes and has</p>				

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	become very adept at doing this quickly and subtlety (sic), even though staff have her in eye sight. She was putting dishes away after a meal and snuck utensils into the sleeves of her shirt. She then used the utensils later to attempt to engage in self harm. The reason she was initially informed she could not stay in her own room is because Level 2 Precaution (which she was still on) states that you cannot have access to your personal items. [Client B's] personal items were still inside her room as she had been sleeping in the observation room. Since at that time [client B] refused to move to the observation room, staff informed her that in order to keep her safe and due to the guidelines of Level 2 Suicide precautions, they would have to remove all her belongings from her room. Once the items were removed, [client B] was able to be in her room as long as she remained in staff sight...She was evaluated by her psychiatrist on 11/14/2012 and he removed her from Level 2 Suicide Precautions and instead placed her on a Self-Harm Observation until she is deemed safe to be on a less restrictive plan. Per orders from the psychiatrist, [client B] is to remain in staff sight at all times, can have no personal items in her room, she cannot wear hooded shirts or heavy jackets, or long sleeve shirts. She is also restricted						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>from all sharps and pens. She cannot have plastic silverware and must keep her arms out of her shirt at all times. She is able to sleep in her room again, but cannot have any personal items inside the room." The facility's 11/16/12 follow-up report and/or reportable incident reports from 10/12 to 12/12 neglected to indicate any additional information/interviews and/or documentation of an investigation in regards to how the client acquired silverware 2 different times on the same day while on Level 2 Suicide Precautions.</p> <p>Client B's Behavioral Incident Reports (BIR) were reviewed on 12/19/12 at 12:35 PM. Client B's 11/11/12 BIR, at 12:40 PM, indicated "Staff was monitoring [client B] for self harm because of previous incident of self harm. She was in her room laying down. Staff discovered she had a plastic fork in her mouth trying to commit suicide. The fork was removed from her mouth and the nurse was notified. [Client B] was informed that she would need to move to the observation room to monitor for any further suicidal attempts but she refused. Her personal items were then removed from her room. [Client B] was upset by this. She started clawing at her veins through old wounds. Staff asked her to stop and attempted to redirect her but she</p>			
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	<p>became combative against staff. [Client B] was then put in a PRT and was escorted to the calm space, she was in a standing position and she dropped down to the floor. Staff then had her in a sitting PRT...."</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's 11/11/12 Progress Notes for 8 AM to 4 PM indicated client B went to her bedroom and tried to self harm with a plastic fork. The progress note indicated client B tried to cut herself and was placed in a PRT. Client B's 11/11/12 Progress Note for 4 PM to 12 AM indicated "...By 5:05 pm [client B] attempted to harm herself, later calmed down after staff redirected her...."</p> <p>Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/9/12 at 9:30 PM, "Res noted to have scratched bilateral forearms superficially and excessively. States 'I do SIB (self-injurious behavior) (sic) this how I handle my stress'. Assessed for suicidal ideation. Client denied...Client to see [name of doctor] in am." The 11/9/12 nurse note did not indicate client B was placed on any special precautions/monitoring.</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>-11/10/12 at 7:30 AM, "Saw [name of doctor] this am. Noted scratches. Stated Tylenol (pain reliever) was effective for headache...Will monitor."</p> <p>-11/10/12 at 9:15 AM, Client B was sitting in the day room rocking and covering her face. The note indicated another client's screaming was making client B have "anxiety." The 11/10/12 note indicated client B requested something to "calm" her.</p> <p>-11/10/12 at 10:20 AM, "Went to unit to check on Res. Asleep in bed. States 'I feel much better'...."</p> <p>Client B's 11/10/12 nurse notes neglected to indicate client B had been placed on any special precautions or monitoring due to the client's self harm behavior.</p> <p>-11/11/12 at 12:50 PM, "Called to res (resident) room (sic) res (sic) had been scratching her arms @ (at) wrists (sic) res (sic) also reported to have stuck a fork plastic (sic) in her mouth trying to cut it...placed on Level II suicide precaution. Staff aware."</p> <p>-11/11/12 at 1:05 PM, "Res placed in PRT @12:53 related to self harm et. able (sic) to process out by 1 pm...moved to</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>OBS (observation) room."</p> <p>-11/11/12 at 7:21 PM, "Res monitor closely by staff. Will place her hands inside her shirt asked per staff to take her hands out (sic). Res also had a spoon in her hoodie pocket from dinner taken per writer."</p> <p>Client B's 11/11/12 faxed physician orders and record indicated on 11/11/12 at 12:50 PM, client B was placed on "...Level II suicide precautions related to self harm et. suicidal gestures (stuck a fork) in her mouth." Client B's 11/12/12 5:30 faxed orders indicated "PRT Due to injurious bx (behavior) to self Move to Suicide I."</p> <p>Client B's 11/7/12 Transitional Behavioral Support Plan (TBSP) indicated client B was admitted to the facility on 11/7/12. Client B's 11/7/12 TBSP indicated client B demonstrated "...Self-Injurious Behavior (SIB): defined as cutting/scratching her arms and legs, biting herself, stabbing herself with multiple household objects (caps to shampoo bottles, broken plastic spoons, CDs, plastic combs, etc.) It was also indicated that [client B] tends to barricade herself in her room so that staff cannot intervene. This is accomplished by pushing heavy pieces of furniture in</p>			
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>front of the door." Client B's 11/7/12 TBSP also indicated client B demonstrated "...Suicide attempts: defined as gestures/attempts to take one's life. (Noted history of attempted overdose with anti-coagulants)." Client B's 11/7/12 TBSP indicated "...Since [client B] has a history of cutting herself with sharp objects it is recommended that sharps not be easily accessible for [client B] and that staff count sharp items before and after [client B] uses them and supervise her at all times when she's using a sharp item. Again, because of her extensive history of using silverware as an instrument for self-harm, [client B] should only use metal spoons at meal times. [Client B] should never be allowed to use knives. Silverware should be counted before and after meals to ensure that [client B] taking any utensils with her (sic)..." Client B's record neglected to indicate facility staff documented they monitored/counted utensils before and/or after meals to ensure the client did not take the items to harm herself.</p> <p>Client B's 11/15/12 Human Rights (HR) Review Sheet indicated "Remove items from bedroom if she displays self harm. After 24 hours on no self harm her personal items she did not use to harm herself will be returned. The items used</p>			
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	<p>for self harm will be removed for 30 days. [Client B] will have no clothing in bedroom. She will have the choice from two outfits from storage closet." Client B's record neglected to indicate any interdisciplinary team (IDT) meeting notes, and/or neglected to indicate the client's IDT met after each incident, and/or neglected to review client B's TBSP to see if the TBSP addressed and/or met the client's needs in regard to supervision to prevent self harm. Client B's 11/17/12 TBSP, record and/or 11/15/12 HR Review Sheet neglected to indicate how facility staff were to specifically monitor client B when in the dining room. Client B's 11/15/12 HR Sheet and/or record neglected to specifically indicate how facility staff were to monitor client B while in her bedroom on Level II Suicide Precautions to prevent incidents of self harm.</p> <p>The facility's inservice training records were reviewed on 12/20/12 at 4:30 PM. The facility's 11/16/12 Precautions for [Client B] indicated one staff (staff #1) was re-trained on 11/16/12 on monitoring client B due to the 11/10/12 incident. The 11/16/12 sheet indicated the one staff was retrained on Level 1 Suicide precautions, Level II Suicide Precautions and "Self Harm Observation (Specific to [client B])...." The 11/16/12 inservice</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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	<p>record indicated "...Additionally, per HRC (Human Rights Committee) approved BSP (Behavior Support Plan) [client B] is to only use metal spoons at meal times and staff must count silverware to ensure she is not bringing these items back to the hall." The 11/16/12 training record indicated the facility neglected to retrain all staff, who worked with client B, to ensure client B was supervised/monitored to prevent self harm incidents.</p> <p>Interview with LPN #1, Transitional Treatment Coordinator (TTC) #1, #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior. LPN #1 indicated client B scratched her arms on 11/9/12. LPN #1 indicated client B stated she was "stressed." QSP #1 indicated client B was on level II suicide precautions on 11/10/12. QSP #1 indicated client B took the lenses out of her glasses on 11/10/12 and attempted to cut herself. QSP #1, LPN #1 and TTC #1 indicated client B was on level II precautions (line of sight) when client B obtained a plastic fork and placed it in her mouth in her bedroom. TTC #1 and QSP also indicated client B was on line of sight (level II precautions) when she obtained a spoon and placed it her mouth in the dining room. QSP #1 indicated facility</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	<p>staff were present in the dining room when client B placed the spoon in her mouth. TTC #1 and QSP #1 did not indicate how client B was able to get hold of a spoon after the client had obtained a fork. TTC #1 indicated the facility did not conduct an investigation in regard to neglect/supervision of client B obtaining a spoon. TTC #1 did not provide a documented investigation in regard to the 11/11/12 fork incident/allegation of possible neglect. TTC #1 and QSP #1 indicated two staff were retrained in regard to monitoring client B as it was determined the staff did not monitor client B on 11/11/12 with the incident in regard to the fork. TTC #1 and QSP #1 indicated only the two staff involved were re-trained and all staff, who worked with client B, were not re-trained on monitoring client B. QSP #1 indicated facility staff were to count the silverware before and after the client was in the dining room. QSP #1 indicated facility staff started counting the silverware on 11/12/12. When shown client B's 11/7/12 TBSP, QSP #1 and TTC #1 indicated facility staff should have been counting the silverware prior to the 11/11/12 incidents. QSP #1 indicated there was one staff person at each table. QSP #1 and TTC #1 indicated facility staff did not document their counting the silverware. QSP #1</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>and TTC #1 indicated the clients' IDT met every morning to review incidents and/or issues. QSP #1 and TTC #1 indicated client B's IDT met in regard to her self harm incidents. QSP #1 and TTC #1 indicated client B's IDT meeting notes were not part of the client's record. QSP #1 and TTC #1 further indicated the client's IDT did not review client B's TBSP in regard to how staff were to monitor the client in the dining room and/or in her bedroom, when on suicide precautions, to prevent the client from harming herself. TTC #1 and QSP #1 indicated client B's doctor wrote an order to remove items from the client's bedroom, and the doctor wrote an order for client B to not wear long sleeves and/or a hoodie.</p> <p>The facility's policy and procedures were reviewed on 12/18/12 at 12:15 AM and on 12/19/12 at 11:58 AM. The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights..." The facility's June 2012 policy entitled Employee Conduct indicated "Each person receiving services from WTS will receive humane care and protection from harm...." The policy</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>indicated clients had the right to be free from neglect.</p> <p>4. During the 12/18/12 observation period between 4:14 PM and 6:40 PM, at the facility, the following was observed: __5:13 PM client S began yelling and hitting th hallway coming from the dining room. Client S calculator, breaking it and began swinging at th to spit on them. Client S was physically restrain and forced down to the floor in a sitting positior (Qualified Support Professional) #3, was on his behind client S with his arms over and under cli and interlocked at client S's shoulder blades beh TTC (Transitional Team Coordinator) #1 was o behind QSP #3, holding client S's hands tightly. arms were being extended backwards, behind hi hyperextended upward position. Client S's hand red in color indicating decreased circulation. Cl body was slightly bent forward with 2 staff layi client S's legs and feet. Another staff held client and chin as the client was trying to bite and spit holding him. LPN (Licensed Practical Nurse) # and watching the restraint. LPN #1 would speak client to try and calm the client. Client S was fig and trying to get out of the hold, at one point cli "Let go of my neck." __At 5:25 PM, LPN #1 asked client S to count to 10 to see if the client was calm. Client S counted to 10 and the staff removed their hands from client S's head. Client S was asked to count to 10 again and the client began struggling trying to get out of his restraint and trying to bite</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>the staff. The staff grabbed client S's head as the staff struggled to regain control. The staff tightened their holds on the client to maintain the original restraint position as the client was struggling to get free. The client yelled, "I don't want her here!" referring to TTC #1.</p> <p>__At 5:30 PM the staff then changed positions to continue the sitting restraint with client S. Client S continued to have his arms hyperextended behind him with one staff person remaining at the client's back with their arms over and under the client's arms and the staff's arms interlocked behind client S. TTC #1 was rubbing client S's hands and wrists. The client stated, "I don't want her here!" Both of client S's hands and wrists were bluish red in color. Client S moaned, "My arms hurt." The client requested to be able to rock. The restraint was maintained with 5 staff and LPN #1 monitoring.</p> <p>__At 5:35 PM, client S complained his right arm was hurting. Client S stated "My arm hurt. My arm hurt." Client S's arms remained hyperextended behind him with the client's upper body slightly bent forward. A staff continued to be at client S's back with the staff's arms under and over the client's and interlocked behind client S. The staff continued to try to have client S count with them but the client continued to struggle. Client S attempted to bite his knee.</p>				

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>__ At 5:40 PM the Administrator arrived on site. Client S stated to the Administrator, "They put my arms behind me." and "They were holding me too tight." The staff continued to maintain their hold on client S with the client's arms hyperextended behind his back.</p> <p>__ At 5:45 LPN #1 checked the client and TTC #1 started rubbing the client's right hand. The client was asked to count to 10 and the hyperextension of his arms was released as the client was allowed to bring his arms down to his side. The client again complained of arm pain.</p> <p>__ At 5:47 PM client S began hitting himself, fighting the staff and trying to bite the staff and himself. The Administrator and another staff immediately lay across client S's legs as the client continued to struggle to stay free from being restrained again. The client grabbed at his clothes and managed to pull his shirt off while laying down on the floor. The staff were able to reestablish their hold and pulled client S back up to a sitting position. Client S's arms were again hyperextended behind him with a staff kneeling behind client S with the staff's arms over and under the client's arms at shoulder area and the staff's arms interlocked behind the client. The client stated, "I want my mommy." The Administrator prompted the client to count to try to calm himself.</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>__At 5:48 PM LPN #1 left to call the doctor. The staff asked client S, "Are you not going to bite?" and "Are you going to be good?" The staff noted client S's left wrist was bleeding as another staff ran to get the first aid kit. The staff indicated client S had bitten himself. Client S's arms were brought forward as the staff continued to restrain the client from movement. Client S was observed to have a large reddened area across his neck and shoulders from the struggle/restraint.</p> <p>__At 6:01 PM LPN #1 returned and tried to place a gauze dressing over client S's wound on his left wrist. Client S struggled as LPN #1 managed to place a large band-aid over the wound. Client S was observed to have several small yellowish brown bruises up and down his inner left arm. The client continued to struggle with the staff as the Administrator and another staff lay across client S's legs and a staff remained behind client S with their arms under and over client S's arms. LPN #1 indicated she had called the doctor and client S could have Benadryl.</p> <p>__At 6:06 PM LPN #1 gave client S an IM (Intra-muscular) medication/shot to calm him. Client S was crying, "I want my mommy."</p> <p>__At 6:09 PM client S began to calm and all staff removed their restraint on the client. Client S refused to get up and continued to lie on the floor. The</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>Administrator and 3 staff remained with client S as he lay on the floor in the hallway. One of the staff placed a pillow under his head.</p> <p>__ At 6:15 PM client S continued to lay calmly on the floor as the staff prompted the client to go to bed.</p> <p>The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM. Client S's BIRs (Behavior Incident Reports) were reviewed on 12/20/12 at 11 AM. The reports indicated:</p> <p>__ The BDDS (Bureau of Developmental Disabilities Services) report of 11/15/12 at 8:10 PM indicated the nurse found bruises on client S's left side of his chest and left arm. "The 3 bruises are located on [client S's] left inner arm (1 cm, dark purple in color), above left breast (6 cm x 3 cm, purple and yellow in color), and below left breast (10 cm x 3 cm, purple and yellow in color)." The report indicated client S first indicated his roommate had injured him then said it was not his roommate. The report indicated the client was assessed by LPN #1 and QSP #3. QSP #3 indicated "the bruising did not look as if it was inflicted by a fist or hand. The bruises appeared to be linear as if they were caused by an object possibly resulting from a fall." The report indicated the results of the</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>investigation reflect "that there is still no known cause from the bruising. Daily body checks will be implemented at night to check for any bruising that may have occurred for the next 30 days. [Client S] will be monitored for complaints of pain and proper healing." The facility's investigative report in regards to this incident failed to indicate the results of this investigation were reported to the administrator.</p> <p>__The BDDS report of 11/16/12 at 4:54 PM indicated client S went out of bounds from the dining hall during dinner. When staff followed him, client S began swinging at the staff and attempting to hit, kick and bite staff. Client S was placed in a sitting PRT (Primary Restraint Technique). Then at 5:35 PM client S walked out of bounds from the hall and staff followed him. Client S began cursing the staff and went to the fire extinguisher by the door to the small gym and started punching it, punching the wall, and biting himself. Client S then started pulling at the door of the fire extinguisher. When directed to stop, client S became more agitated and got in the staff's face, throwing punches and trying to bite the staff. Client S calmed for a short period then punched the staff that was trying to calm him. The report indicated client S was placed in a sitting PRT for 1 minute, released and then again placed in a sitting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>PRT for another 15 minutes.</p> <p>__ The BIR of 11/16/12 indicated the face to face assessment was conducted by SSP #3 at 11/16/12 at 7:15 PM. The assessment indicated client S had no complaints. The BIR did not indicate client S was assessed for injury within 1 hour of being placed in PRT.</p> <p>__ The BDDS report of 11/17/12 at 4 PM indicated the nurse noted swelling and bruising to client S's right hand. The nurse notified the physician and the client was sent to the Emergency Room for assessment. The client was diagnosed with a contusion on his right hand. The report indicated if client S's hand was not better in 9 days he was to seen by a doctor specializing in hands.</p> <p>__ The BIR of 11/18/12 at 5:59 PM indicated client S was found in the hall banging his head into the fire extinguisher case. Staff attempted to redirect client S. Client S stopped and entered his room where the staff found client S stabbing himself in the arm with an ink pen. Staff intervened and placed client S in a PRT escort. Client S tried to kick the staff and was "dropped to the floor in a sitting PRT." Once out of PRT client S returned to the hallway and proceeded to hit the window in the biohazard room door. The report indicated the face to face assessment was conducted by LPN #3 at 11/18/12 at 6:30 PM. The assessment</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated client S was complaining of his right hand hurting. The staff gave client S an ice pack.</p> <p>__The BDDS 11/19/12 follow up report indicated client S "injured his hand during a property destruction behavior in which he punched a fire extinguisher box without warning that took place the evening before." (The BDDS report indicated this happened on the 16th & was not discovered until 24 hours later).</p> <p>__The BIR of 11/19/12 at 9:07 PM indicated client S entered the day room and approached client T and spit on him. Client T retaliated by slapping client S. The staff separated clients S and T. Client S approached client T. Staff were unable to redirect client S and placed client S in a sitting PRT. Client S's "positioning didn't allow proper coverage on his legs and he was able to bite each of his legs above the knees." Client S was returned to a standing PRT against the wall. The report indicated only 2 staff participated and monitored the use of the PRT. The report indicated RN #2 conducted a face to face assessment on 11/19/12 at 11:45 PM. RN #2 indicated client S had 2 bite marks on knees with minor cuts. RN #2 indicated the areas were cleansed and would be monitored for signs and symptoms of infection. The report did not indicate the face to face assessment was completed within 1 hour of client S being put into</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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	<p>PRT. The facility records failed to indicate the client to client abuse in regards to clients S and T was immediately reported to the administrator and/or investigated.</p> <p>__The BDDS report of 11/21/12 at 10:45 AM indicated client S wanted to take a walk in the community, when the staff denied his request, client S walked to the steel exit door and started kicking the door. The staff got in front of the door and client S began kicking and biting the staff. The client was placed in a sitting PRT for 10 minutes. A face to face assessment was conducted by client S's Lead DSP. The report indicated client S had no injuries.</p> <p>__The BDDS report of 11/22/12 at 12:20 PM indicated the staff noted two bruises on client S's shoulders. Client S made allegations a staff had "hurt him bad" in the hallway. "Prior to reviewing the videotape footage, safety and security and QSP went back to talk to [client S] in an attempt to get more information about the situation. [Client S] then said that the staff had a pocketknife and threatened to kill him with it. [Client S] stated that this took place while he was roommates with a prior peer." The report indicated while questioning one of the staff, the staff indicated client S was "upset one day, he attempted to call 911" and became angry when he was redirected and hit another</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>staff over the head with the phone. Client S was placed in a PRT. The report indicate client S's bruising "appears to be within this week." The facility records and/or client S's BIRs neglected to indicate an incident of client S attempting to call 911, hitting staff with the telephone and being placed in a PRT. The facility investigative reports neglected to indicate evidence of an investigation in regards to the allegations client S had made of staff abuse.</p> <p>__The BDDS 11/22/12 follow up report indicated the facility "has implemented daily body checks to be performed by the nurse to monitor this situation and to ensure that [client S] is free from abuse/neglect or making future false allegations. (WTS) will continue to use videotape footage also to investigate allegations. During the investigation, while [client S] was talking to the police officer, he stated that he got the bruises on his shoulders from banging his shoulders into the wall. This would be congruent with the fact that the bruises were linear in shape. [Client S] did not have a date that he alleged he was restrained, but he did state a room and a person." "The only time that [client S] was restrained by (initials of staff) in the hallway was in the prior week. The PRT did not involve any inappropriate actions, and the bruising was too new to result from a PRT that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>took place over a week prior to the date the bruising was noticed." __The BDDS report of 11/26/12 at 1:30 PM indicated client S had soiled his clothing and was excused from his activity to return to his unit to shower. Client S became angry and "punched the shower wall and fell." The report indicated client S was seen by a nurse. Client S became angry again after being asked to help clean up his mess from soiling his clothes and closed his bedroom door and began punching the door. The client calmed and opened the door. While the staff was cleaning the bathroom, client S found the back to a battery supply and cut his arm with it. The client indicated he was going to kill himself. The staff verbally redirected client S to listen to music as a calming/coping technique. While listening to music, client S began punching items and re-injured his hand and throwing chairs. One of the chairs caused "two six inch cuts on his left arm as it scraped his arm while attempting to launch it." The staff immediately intervened and client S began scratching, biting and head butting the staff. The client was placed in a standing PRT and then a sitting PRT for "approximately 5 minutes." The report indicated the client was seen by the nurse for bruising on his hand. The client was seen by his psychiatrist and was placed on a Level II</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>suicide precaution for 72 hours.</p> <p>__The BIR of 11/26/12 at 2:30 PM indicated BS (Behavior Specialist) #1 conducted a face to face assessment of client S. The BS #1 indicated client S was "complaining of pain in his right hand and client S had scrapes and bruises to his right hand and left arm elbow area scratches." The report indicated the nurse was notified to provide first aid.</p> <p>__The BDDS report of 11/27/12 at 7:10 PM indicated client S became upset when he was denied going to the vending machine because of being on Level II Suicide Precautions. Client S began kicking and hitting, attempting to hit staff with a wooden door from a cabinet. Client S was placed in a sitting PRT for 4 minutes. The report indicated SSP (Safety and Security Professional) #2 conducted a face to face assessment and noted client S was alert and had no complaints but was agitated, sad and irritated. Later at 10:25 PM client S became upset with another client and threw a cup of water on the other client. Client S was redirected out of the room and as the client was walking down the hallway, he attempted to pull the fire extinguisher from the box on the wall. The staff redirected client S to stop pulling on the fire extinguisher and client S turned and began pushing and fighting with the staff. Client S was placed in a standing PRT for 4 minutes, PRT escort</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>for 2 minutes and then to a sitting PRT for 7 minutes before calming. The report indicated SSP #2 again conducted a face to face assessment with client S and noted client S complained of a headache and dizziness, but was alert, cooperative and had appropriate thought processes. The report did not indicate the client was physically assessed for bodily injuries or seen by a nurse after complaint of pain.</p> <p>__The BDDS report of 11/29/12 at 7:30 PM indicated client S became upset that he had no money to use in the vending machine. Client S began hitting the staff. Client S was placed in a sitting PRT for "approximately" 10 minutes. The report indicated SSP (Safety and Security Personnel) #2 conducted a face to face assessment with client S and noted client S had no complaints, was alert, but was still a little irritated and sad. The report neglected to indicate the client was physically assessed for bodily injuries.</p> <p>__The BIR of 11/29/12 at 2:30 PM indicated SSP #2 conducted the face to face assessment at 9:30 PM. The report neglected to indicate the face to face assessment was completed within 1 hour of client S being put into PRT.</p> <p>__The BDDS report of 11/30/12 at 4:45 PM indicated client S sat down in the hallway to the dining room and refused to go to the dining room. Client S stood up and threw his slippers at the staff "in a</p>						

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	<p>very aggressive manner" and walked toward the dining room. He entered the dining room and sat at another table that was not assigned to him. Client S began biting himself and would not stop with verbal redirection. Client S picked up a chair to try to harm staff. Client S was placed in a sitting PRT for 5 minutes.</p> <p>__The BIR of 11/30/12 at 4:35 PM indicated LDSP (Lead Support Personnel) conducted a face to face assessment. The report indicated client S complained "arms hurt" and client S had a cut under his nose. The report neglected to indicate nursing had assessed client S's injuries. The BDDS report and/or or BIR neglected to indicate the facility conducted an investigation into client S's injuries of unknown source and/or in regard to injuries as a result of the restraint.</p> <p>__The BIR of 12/10/12 at 8:15 PM indicated client S became upset and pacing up and down the halls, kicking objects in the hall. Client S entered the storage room and began "tossing his peers belongings." Client S sat on the floor and began kicking the staff. Client S got up and proceeded to the dayroom. Client S continued to be aggressive toward staff. Client S was placed in PRT for 8 minutes. The report indicated a face to face assessment was conducted by SSP #2 at 10:20 PM. The report indicated no physical complaints. The report neglected</p>				

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	<p>to indicate the face to face assessment was completed within 1 hour of client S being put into PRT.</p> <p>__ The BIR of 12/10/12 at 8:31 PM indicated client S began digging at a wound on his knee. The report indicated the staff attempted to redirect without success and the client was placed in a standing PRT for 3 minutes then to a sitting PRT for 13 minutes. The report indicated a face to face assessment was conducted by SSP #2 at 10:22 PM. The report indicated no physical complaints.</p> <p>Client S's record was reviewed on 12/19/12 at 12 PM. Client S's BSP (Behavior Support Plan) of 12/4/12 indicated "in certain instances, a client may exhibit maladaptive behaviors that are dangerous to the client or other. In these situation, to be referred to as crisis situations, it may be necessary for staff to intercede in the treatment process by implementing physical restraint, environmental restraint, or a PRN (as needed) psychotropic intervention. At no times should these treatment techniques be implemented longer than necessary for the client to gain self-control and focus on appropriate alternatives to the behavior(s). Interventions written under level three should only be utilized in a crisis situation and with prior approval and thoroughly documented on an Incident Report.</p>				

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	<p>Sometimes with a client in a crisis situation, a standing PRT escort isn't feasible, as it becomes more dangerous to try to move the client from the original place of escalation. If [client S] refuses to comply with the request in step 2 and remains a danger to himself or escalates while in the 'calm space' (isolation), staff may immediately utilize a different physical restraint technique (see below) or enter the 'calm space' isolation and employ a physical restraint in an attempt to avert the crisis by using a standing PRT or sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others in (sic) involved). (Client S) has no known condition that would prohibit the use of any of the physical restraint techniques utilized by "Handle With Care." The BSP indicated "Physical restraint CANNOT exceed 30 minutes." And, "if a client is unable to regain self-control within ten (10) minutes of the expiration of the approved</p>			

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	<p>timeframe.... a licensed nurse will be notified to authorize a time extension."</p> <p>Client S's "Client Report of Illness or Injury" body scans indicated: __ 11/10/12 at 4:20 PM indicated right side of client S's face noted with reddened area to cheek and ear. The report indicated client S didn't know what happened and couldn't remember if he had put something on his face. __ 11/11/12 at 6:48 PM indicated client S had scratches on his left wrist from self injurious behavior. __ 11/16/12 at 6:10 PM indicated client S had a scratch on his face, 3 scratches up and down his left inner forearm, 2 scratches on his right hand, 1 scratch to client S's right buttocks and an old bruise on client S's left chest. The report indicated client S did not know how he was injured. __ 11/17/12 at 4:38 PM indicated "hand appeared injured." The report indicated the client complained of pain while making a fist. Client S's right middle finger was not straight, blue discoloration to knuckles and slight swelling. The report indicated the client's physician was notified and had an order for the client to have his hand x-rayed. __ 11/18/12 at 6:10 PM client S had stabbed his left inner forearm with a pen three times. The report also indicated an</p>						

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	<p>injury to client S's right hand. Client S was placed on Level II Suicide precautions.</p> <p>__ 11/19/12 at 9:10 PM indicated client S had bite marks on both knees with cuts. The report indicated the injury was self inflicted.</p> <p>__ On 11/22/12 at 12:20 PM client S was noted to have a 4 cm yellowish green bruise on client S's right shoulder, a 2 cm yellowish purple bruise on client S's left shoulder, four 1 cm purple bruises on client S's left inner upper arm, two 3 cm scratches with 4 cm bruising around the scratches on client S's inner left upper arm and a 2 1/2 cm scratch on client S's mid to lower right back. The report did not indicate how client S obtained these injuries.</p> <p>__ 12/10/12 at 8:21 PM client S bit himself on the left knee "during PRT." The facility records failed to indicate client S's injuries of unknown source reported on 11/10/12 and 11/22/12 were investigated.</p> <p>Client S's Nursing Progress Notes indicated:</p> <p>__ 11/10/12 at 4:30 PM indicated client S had a reddened area of irritation to his right cheek and ear. The note indicated client S stated "I don't know what happened." The note indicated client S didn't remember if he had applied</p>			

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	<p>something to his face.</p> <p>__ 11/15/12 at 8:10 AM indicated client S was observed to have a 1 cm bruise on left upper inner arm, a 6 cm by 3 cm bruise above left breast, a 10 cm by 3 cm bruise below left breast.</p> <p>__ 11/16/12 at 2 PM indicated client S continued to complain of pain to his left breast area.</p> <p>__ 11/16/12 at 11:30 PM indicated chest x-ray results returned with no rib fracture. The note indicated client S had not complained of any pain "this shift, but staff reported seeing bruises."</p> <p>__ 11/17/12 at 6 PM indicated client S's right hand was swollen and discolored. The client's right middle finger was curved.</p> <p>__ 11/17/12 at 9:30 PM indicated client S returned from the hospital with a diagnosis of hand contusion. Ice applied to the affected area.</p> <p>__ 11/21/12 at 11 AM indicated client S reported no suicidal thoughts. Physician assessed and discontinued suicide precautions.</p> <p>__ 11/22/12 at 3 PM indicated client S had multiple bruises across both shoulders, back side, right arm and small bruises to left arm with small bruise center of back.</p> <p>__ 11/26/12 Level II Precautions in place due to self injurious behaviors.</p> <p>__ 12/18/12 at 5:10 PM indicated client S was "placed in PRT due to severe</p>			

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	<p>agitation, aggression SIB, multi intervention non effective. Client (S) emotional, crying. Requesting certain staff at different times. Would be effective for a short period of time. Attempted to release but would restart with kicking and attempting to bite." The note indicated the nurse called the physician to get an order for a PRN and to extend the restraint over 30 minutes. The note indicated the client had a bite to left wrist, area was cleansed and covered. ___12/18/12 at 6 PM indicated client S was in route to bedroom "calm." The nursing progress notes failed to indicate a physical assessment of client S for injuries after the witnessed PRT of 12/18/12.</p> <p>Client S's physician order of 11/16/12 indicated an order for the client to have a chest x-ray of his left chest "related to bruising and pain."</p> <p>Client S's record neglected to indicate the facility assessed and monitored client S's injuries due to self injurious behaviors, aggression and physical restraint. The client's record neglected to indicate nursing services was performing daily body checks as indicated on the 11/15/12 BDDS report and on the follow up BDDS report of 11/22/12.</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>Interview with LPN #1 and TTC #1 on 12/20/12 at 3:00 PM indicated the face to face assessments were to be done within one hour after any client was placed in a PRT. LPN #1 indicated nursing staff did not always do the face to face assessments. TTC #1 stated several staff were qualified to do the face to face assessments, "It doesn't have to be a nurse." LPN #1 indicated if the client did not voice any complaints after a PRT, then there would be no need to do a hands on full body assessment for injury. LPN #1 indicated only areas of the clients' bodies were assessed if the client voiced a complaint of pain. LPN #1 indicated if a physical assessment was conducted it would be documented in the nursing progress notes. LPN #1 indicated she did not do a full body assessment of client S after being placed in a PRT on 12/18/12. When LPN #1 was asked if she had assessed client S's back due to the redness noted across his shoulders and neck, LPN #1 stated, "No." TTC #1 indicated all injuries of unknown origin and allegations of abuse were to be investigated. TTC #1 indicated all investigations had been provided for review.</p> <p>5. The facility's reportable incident reports were reviewed on 12/18/12 at 11:30 AM. The reports indicated on 11/26/12 at 8:57 PM client C was in the dayroom playing</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>cards while another client was watching the television. Client C asked the other client to turn the television down. When the other client did not respond to client C's request, client C hit the other client. The facility records failed to indicate an investigation in regards to the allegation of client to client abuse reported on 11/26/12.</p> <p>Client C's record was reviewed on 12/19/12 at 3 PM. Client C's Progress Notes indicated on 12/3/12 on the 4 PM - 12 AM shift, another client accused client C of stealing \$7 from him. The staff "looked at the cameras and discovered he (client C) did take the money." The facility records failed to indicate the allegation of theft was investigated.</p> <p>Client C's progress notes indicated: ___ On 12/8/12 on the 12 AM - 8 AM shift, client C complained to the staff "that his (client C's) arm was hurting." The note indicated the staff called the nurse and the situation was handled. ___ On 12/8/12 on the 8 AM - 4 PM shift, client C complained of not feeling well and was checked by the nurse. ___ On 12/12/12 on the 8 AM - 4 PM shift, client C was in the dining room and said he didn't feel well. The staff encouraged him to finish eating. Client C continued to complain he didn't feel well.</p>			
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>Client C's Nursing Progress Notes indicated:</p> <p>__ On 12/10/12 at 5 PM indicated client C had "punched peer in face" causing injury to his right hand, middle digit.</p> <p>__ On 12/3/12 at 6:30 PM indicated client C was upset due to being confronted with stealing a peer's money. "Multi staff involved in intervention. Client (C) at one point had keys and electric razor in hand - Threats and action made to throw at this nurse. Client (C) placed in PRT but immediately released."</p> <p>Client C's BIRs indicated:</p> <p>__ On 11/27/12 at 7:05 PM client C became upset when the client asked for his vending machine money. Staff gave client C the \$2.50 that was in the client's pouch. Client C stated "there should be more money." The staff showed the pouch to client C to prove that was all of the money in client C's pouch. The LDSP told client C he would have to look into what happened to his money. Client 2 ripped the \$2 in half and gave them back to the staff stating he didn't want them. Client C began throwing chairs and overturning tables. Client C exited into the hallway and approached the fire exit and began striking it with his hand. Client C turned around and began kicking the glass, after 3 strikes breaking it. Client C was placed</p>			
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	<p>in a PRT at which time he requested to go to a calming area.</p> <p>__ On 12/3/12 at 6:35 PM client C went into the day room with a piece of metal and threatened to cut him - self with it. Client C was redirected but went to his room and got other items to harm himself. Client C began to attempt to harm himself again. The staff took the items and placed client C in a standing PRT for 1 minute then escorted client C to the quiet room where he calmed immediately.</p> <p>__ On 12/3/12 at 9:17 PM client C became verbally and physically aggressive toward the staff. Client C was placed in a standing PRT and was escorted to a calm area.</p> <p>Client C's BSP (Behavior Support Plan) of 12/14/12 indicated a crisis situation defined as any situation where client C continued to behave dangerously and prevention techniques, de-escalation procedures, replacement behaviors and response suppression procedures have been attempted and failed to avert the dangerous behavior, restrictive behavioral controls may be utilized by staff." The BSP indicated: Level Three step one indicated the client was to be asked to go to a "Calm Space (Isolation)." Step two indicated if client C refused to go on his own to a calm</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>space, the staff were to accompany client C. Step three indicated if client C refused to comply with steps one and two, the staff were to use a Standing PRT Escort. Step four indicated if the staff were unable to escort client C safely then staff could utilize a different physical restraint technique. The BSP indicated the staff could utilize a standing PRT or Sitting PRT. The BSP indicated client C has an internal bladder stimulator due to loss of a kidney as a result of a car accident. "Restraints involving sitting or laying down should be done carefully so that the stimulator is not dislodged." The BSP indicated nursing staff was to be notified as soon as possible for assessment due to possible dislodging of urinary stimulator/probe. Client C's BSP did not indicate how the staff were to "carefully" restrain client C.</p> <p>Client C's record did not indicate nursing had completed a physical assessment to ascertain the placement of client C's urinary stimulator/probe post PRT on 12/3/12 at 6:35 PM and 9:17 PM and on 11/27/12.</p> <p>Interview with client C on 12/19/12 at 11 AM indicated since his arrival to the facility in November client C has been restrained twice. The client stated, "They (staff) held my arms back behind me real</p>			
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	<p>hard and it hurt my arms." Client C stated he had seen other clients restrained like he was and "It hurts your arms."</p> <p>Interview with LPN #1 and TTC #1 on 12/20/12 at 3:00 PM indicated if a physical assessment had been conducted post PRT it would be documented in the nursing progress notes. TTC #1 indicated there were no restrictions that would refrain the staff from putting client C into a sitting PRT.</p> <p>6. The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM.</p> <p>__ On 11/16/12 at 4:50 PM client D was in the dining room and walked over to a female client's table. The staff redirected client D and client D became angry with the staff, began cursing, yelling and "hitting staff." The report indicated client D was placed in a sitting PRT. The report indicated the client was in this hold for 16 minutes.</p> <p>__ On 11/27/12 at 2:30 PM client D used the telephone at the facility to call 911. The client told the dispatcher he did not feel safe and had been threatened by his peer. The police arrived and the client told the police "he was tired of being threatened and attacked by his peers." After the police left the building client D was asked why he felt he was being</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>threatened and unsafe. "He talked about two of his peers who had been agitated and physically disruptive in the past 24 hours. [Client D] was reminded that he was never the object of their agitation or aggression and that he had not been physically or verbally threatened since admission to WTS more than 6 weeks ago." The report indicated this was client D's 3rd time of calling 911 and reporting false alarms. Due to this pattern client D's phone use was to be monitored. The facility records did not indicate client D's allegations of being threatened by his peers had been investigated by the facility.</p> <p>__The 12/3/12 follow up report indicated client D "stated he felt unsafe due to peer's agitated state and physically disruptive behavior which was directed at staff not at clients. Although [client D] was never the focus of his peer's agitation or aggression, [client D] makes all incidents on the unit about him and personalizes all issues his peers are having." The facility records neglected to indicate client D's continued allegations of being threatened by his peers had been investigated by the facility.</p> <p>__The 12/14/12 facility investigative report indicated client D "came running out of his room agitated with his roommate. [Client D] told the Lead Direct Support Professional that he was</p>						

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	<p>moving out of their room. Client D's roommate came after him also agitated and before staff could step between the two the roommate swung at [client D]. Staff immediately stepped between the two and separated them. Both clients quickly calmed in different areas of the unit. [Client D] reported that he had been hit in the eye and was evaluated by the nurse. There was some blood in the eye and for safety it was determined to send him [client D] out to the (name of hospital) for treatment. At the hospital [client D] was told he had hyphema (bleeding in the eye) and needed to be evaluated by an eye specialist at [name of hospital] [Client D] told the emergency room staff that he did not feel safe and he was not going to [name of hospital] until he could press charges against his roommate." The report indicated the actions taken: The IDT evaluated the incident and decided to do a permanent room change for [client D] and his roommate. "They are now on different halls and during the Life Skills day are on a 10 foot restriction from each other."</p> <p>Client D's record was reviewed on 12/20/12 at 1:30 PM.</p> <p>__ Client D's Medical Visit Summary of 11/17/12 indicated the client saw his doctor due to "c/o (complaint of) right wrist pain to shoulder R/t (related to</p>			
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	<p>PRT (Primary Restraint Technique)." The record indicated the client was to have an x-ray of his right hand and shoulder.</p> <p>__ Client D's Radiology Report of 11/17/12 indicated the results of the x-ray of client D's right shoulder were "Modest degenerative joint disease of the right shoulder, otherwise, no fracture or dislocation seen." The result of the x-ray of client D's right hand was "Modest degenerative joint disease, otherwise, no fracture seen."</p> <p>__ Client D's BSP (Behavior Support Plan) of 12/14/12 indicated "a crisis situation defined as any situation where client D continued to behave dangerously and prevention techniques, de-escalation procedures, replacement behaviors and response suppression procedures have been attempted and failed to avert the dangerous behavior, restrictive behavioral controls may be utilized by staff." The BSP indicated: Level Three step one indicated the client was to be asked to go to a "Calm Space (Isolation)." Step two indicated if client D refused to go on his own to a calm space, the staff were to accompany client D. Step three indicated if client D refused to comply with steps one and two, the staff were to use a Standing PRT Escort. Step four indicated if the staff were unable to escort the client safely then a</p>				

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	<p>Standing PRT, Sitting PRT, or Modified PRT was to be used. The BSP indicated client D "has no known condition that would prohibit the use of any of the physical restraint techniques utilized by Handle With Care ."</p> <p>Client D's Nursing Progress Notes indicated: ___ On 10/3/12 at 4 PM client D reported bruising to both lower knees. The note indicated the nurse notified the physician. ___ On 10/4/12 at 11:30 AM client D "showed this nurse (LPN #1) and staff" bruising to both knees and a bruise on the client's left thigh. The note indicated client D stated he "doesn't know how he got them." ___ On 10/11/12 at 10:15 AM the nurse was called to assess client D due to the client's complaint of bruised and swollen left knee. The note indicated the bruises were noted previously on 10/3/12. The note indicated client D stated, "Nothing happened to my legs." "Now states staff at [name of hospital] threw me against the wall." The note indicated the bruises were not noted on client D's admission to the facility on 9/20/12. ___ On 10/13/12 at 9:45 AM the facility doctor assessed client D due to the client being aggressive toward another peer. The note indicated client D had an abrasion to his chin.</p>			
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	<p>__ On 10/13/12 at 10 AM (late entry) indicated RN #1 assessed client D post altercation with another client at 9:30 PM on 10/12/12. The note indicated the nurse evaluated client D's chin, right ankle and knee and provided first aid.</p> <p>__ On 10/17/12 at 7:30 AM, RN #1 indicated she looked at client D's eyes. "The eyes appear to have bilateral bags/darkened rings. Denies pain. States abrasion below right eye. No S/S (signs or symptoms) of infection noted. Will fax [name of physician] to make aware and monitor." The note indicated client D informed RN #1 of previous issues with his back. Client D indicated "I may need to get it popped. My hips rotate and I've had to go to [name of hospital] in past for my back." The note indicated "will monitor."</p> <p>__ On 10/29/12 at 12:30 PM LPN #1 indicated the client was placed in PRT due to verbal aggression leading to physical aggression of the staff. The note indicated client D had redness to his left side of his neck that was fading and a small scratch to the left side of his face and one on his left hand.</p> <p>__ On 11/7/12 at 5:30 AM indicated client D complained at 10 PM "one of his peers [name of peer] had pushed client D with a piece of furniture against him [client D] at right hip and groin area." The note indicated the nurse assessed</p>			
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	<p>client D and gave the client something for pain.</p> <p>__ On 11/10/12 at 8 AM the client was seen by his physician with orders given for client D's allergies.</p> <p>__ On 11/11/12 at 8 AM indicated client D was complaining of swelling in his left hip. The nurse indicated a bruise on the side of client D's left thigh that was "healing well."</p> <p>__ On 11/17/12 at 1 PM indicated client D's physician was notified of client D's complaints of right wrist pain radiating to the client's shoulder. The note indicated the physician ordered for the client to have x-rays to rule out a fracture. The note indicated client D was using his right hand.</p> <p>__ On 11/17/12 at 7 PM indicated client D's x-rays were completed.</p> <p>__ On 11/1/12 at 2:48 AM indicated nursing had received the results of client D's x-rays of his hand and shoulder. "Results of (R) right hand showed modest Osteoarthritis but no fracture/dislocation seen. View of right shoulder demonstrate no fracture, dislocation or bony reaction. Conclusion shows modest degenerative joint disease of the right shoulder. Also (R) wrist demonstrates no fracture, dislocation or bony reaction as well. Will fax [client D's physician] all results and await response."</p>			
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	<p>__ On 12/14/12 at 9 PM indicated client D "assaulted by a peer in the left eye. Pupils non-reactive to light and accommodation. Sclera red from blood. Client D states unable to see."</p> <p>__ On 12/14/12 at 9:10 PM indicated nursing had called the doctor and received an order to transport the client to the ER (Emergency Room) for evaluation, treatment and safety and security."</p> <p>__ On 12/15/12 at 4:30 AM client D returned to the facility.</p> <p>__ On 12/15/12 at 9 AM the client was seen by his physician. Left pupil with darkened area, no drainage or sensitivity noted. Pupil remains dilated.</p> <p>__ On 12/15/12 at 10:20 PM client D was educated on the importance of closing his left eye before reapplying the eye patch to prevent patch from pressing against and injuring cornea. Client D "states still unable to see."</p> <p>__ On 12/17/12 at 1 PM client D was seen by an ophthalmologist. The doctor indicated the client was to wear his eye patch for "full time" for 2 days, then at night for 2 weeks.</p> <p>Client D's record neglected to indicate the IDT (Interdisciplinary Team) had reviewed client D's BSP in regards to the use of restraints and how client D was to be restrained if needed due to client D's</p>				

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	<p>recent diagnosed health issues in regards to client D's right hand, right shoulder, left eye and complaints of pack and hip pain.</p> <p>Interview with LPN #1 on 12/20/12 at 3:00 PM indicated she was not aware of the results of client D's x-rays. When asked if client D should be put in PRT for behavior management given the results of his x-rays, LPN #1 stated, "No." LPN #1 indicated client D's BSP needed to be reviewed and revised to include client D's medical issues.</p> <p>7. The facility failed to ensure facility staff immediately reported all allegations and/or injuries of unknown source to the administrator clients A, B, D, J and S. Please see W153.</p> <p>8. The facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients A, B, C, D, M, S and Z. Please see W154.</p> <p>9. The facility failed to report and/or provide evidence the administrator was notified of the results of the investigations within 5 business days for</p>						

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	<p>clients C, D and S. Please see W156.</p> <p>The facility's policy and procedures were reviewed on 12/18/12 at 12:15 AM and on 12/19/12 at 11:58 AM. The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights...." The 8/12 revised policy indicated "...If an allegation is made, the Qualified Support Professional (QSP) or Safety/Security Professional (SSP) will ensure the individual is moved to a safe location. The QSP or SSP will notify all appropriate WTS staff including the Executive Director/Administrator who is responsible for ensuring that all investigations are completed thoroughly and that records of the investigation are maintained. The QSP or SSP will immediately notify Nursing staff to ensure the client receives appropriate medical care...A complete copy of each investigation and the results of the investigation must be reported to the Executive Director/Administrator or Designee within 5 working days of the incident...."</p> <p>The facility's June 2012 policy entitled</p>						

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	<p>Employee Conduct indicated "Each person receiving services from WTS will receive humane care and protection from harm...." The policy indicated clients had the right to be free from neglect.</p> <p>This federal tag relates to complaint #IN00119674.</p>			
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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on 11 of 25 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure facility staff immediately reported all allegations and/or injuries of unknown source to the administrator for clients A, B, D, J and S.</p> <p>Findings include:</p> <p>1. During the 12/19/12 observation period between 10:30 AM and 11:40 AM, at the facility, client J sat in the day room and complained of pain in her left shoulder. Client J was guarding her left arm/shoulder as the client refused to use it.</p> <p>Interview with client J on 12/19/12 at 11:24 AM stated the client started having pain in her left shoulder/arm after staff utilized "a PRT" (Primary Restraint Technique) on the client. Client J demonstrated (with her good arm) and stated "They hold my arm back behind me." Client J demonstrated her arm being held backwards in a hyperextended</p>	W0153	<p>The administration will ensure facility staff report all allegations of abuse / neglect and injuries of unknown source immediately to the Administrator. This will be accomplished for all clients:</p> <p>- Reporting format will be changed to specifically note that the Administrator was notified immediately of all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying Administrator, date, and time.</p> <p>Reporting format to be completed by 1/26/13.</p> <p>Responsible Party: Office Manager</p>	02/06/2013	

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	<p>position. Client J indicated she had told staff about her arm/shoulder pain. Client J indicated her shoulder was hurt on 12/17/12. Client J indicated the nurse was aware of her injury. Client J stated "I have been telling them since that night. It is swollen. I can't move it." Client J indicated 2 staff were initially involved in the PRT but there were other staff around. Client J indicated she was admitted to the facility on 11/5/12 and had been restrained 2 times using the PRT restraint. Client J indicated this was the first time her shoulder/arm was hurt. Client J indicated she got upset and threw items in her room and hit staff.</p> <p>Interview with LPN #2 on 12/19/12 at 11:40 AM indicated client J had been complaining of arm pain. When asked what happened to client J's arm, LPN #2 stated "Put in PRT and has complained of pain every since. I need to call and get X-ray."</p> <p>Client J's record was reviewed on 12/19/12 at 11:45 AM. Client J's 12/18/12 Progress Note indicated "[Client J] was in bed refusing to get up when staff arrived on the unit at 8 am. [Client J] refused breakfast but took her 8 am meds. [Client J] got up at 9:00 am complaining of shoulder pain in her left shoulder. When asked why it was hurting she stated</p>		<ul style="list-style-type: none"> · Supervisors will be retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations (DOO) · Completed by 2/6/13. 	

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	<p>she did not know...at 12:15pm [client J] ate 100% of her meal and returned to the unit to lay down due to discomfort in her left shoulder. She talked with LDSP (Lead Direct Support Professional) again about shoulder pain after receiving Ibuprofen (pain) & a heating pad from nursing. At 1:33pm [client J] explain to LDSP it was this time she felt her left shoulder pain could be a result of being placed in a PRT the night before. LDSP assisted [client J] with filling out a grievance form. [Client J] remained in bed the remainder of the shift being checked on by staff to ensure safety and comfort."</p> <p>The facility's reportable incident reports were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports from 10/12 to 12/12 indicated the allegation of possible abuse had not been reported to the administrator.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and #2 on 12/19/12 at 2:45 PM indicated the facility's nurse had ordered an X-ray for client J's shoulder. TTC #1 indicated she was not aware of the allegation of possible abuse/injury in restraint with client J until 12/19/12. TTC #1 indicated TTC #1 indicated client J's QSP was made aware of the grievance/allegation on 12/18/12.</p>			

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	<p>TTC #1 indicated client J's QSP (QSP #2) was in the process of filing a state reportable incident report on 12/19/12. TTC #1 indicated client J's grievance was not seen as an allegation of possible abuse, and/or as injury from restraint as the client had thrown her TV that night. When asked if the administrator had been made aware of the allegation, TTC #1 indicated she was just made aware of the allegation on 12/19/12. TTC #1 indicated the administrator would have been made aware through an e-mail. TTC #1 did not provide any documentation the administrator was immediately informed of the grievance/allegation/injury of unknown source made by client J on 12/18/12.</p> <p>2. During observation on 12/18/12 between 4:14 PM and 6:40 PM, at the facility, client B asked nursing staff for ice to place on her ankle. Nursing staff provided ice in a towel for the client's ankle. Interview with the client indicated she was kicked in the ankle during an altercation with a peer.</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's 12/15/12 Nursing Notes indicated client B "C/O (complaint of) LT (left) ankle disc (discomfort). Slight edema inner aspects. Ice applied elevates (sic) [Name of</p>						

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	<p>doctor] Assessed New order X-Ray Lt Ankle/heel (sic)...." The 12/15/12 nursing note and/or record did not indicate how client B injured her ankle.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports from 10/12 to 12/12 indicated the facility staff did not report the 12/15/12 injury of unknown source to the administrator.</p> <p>Interview with LPN #1, Treatment Team Coordinator (TTC) #1 and the Qualified Support Professional (QSP) #1 on 12/20/12 at 3:00 PM indicated client B had been involved in client to client altercations. When asked how client B injured her ankle, LPN #1 stated "Client to Client. Not sure." When asked if the injury of unknown source had been reported to the administrator, TTC #1 indicated she would have to check. TTC #1 did not provide any additional documentation the injury of unknown source had been reported to the administrator.</p> <p>3. Client A's record was reviewed on 12/20/12 at 1:13 PM. Client A's 11/30/12 Progress Notes indicated "...[Client A] started to strip naked. Staff escorted her back to her room. [Client A] took off all</p>				

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	<p>her clothes and refused to dress. She urinated all over her floor, clothes and bed covers. Staff noticed an open sore on her back. The nurse was called. Staff had to hold [client A] so the nurse could attend to her back...."</p> <p>Client A's 11/30/12 nursing note indicated client A refused to let the nurse treat the area. The 11/30/12 nursing note and/or progress note did not indicate how client A received the injury of unknown origin to her back.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports from 10/12 to 12/12 indicated the facility staff did not report the 11/30/12 injury of unknown source to the administrator.</p> <p>Interview with LPN #1, Treatment Team Coordinator (TTC) #1 and the Qualified Support Professional (QSP) #1 on 12/20/12 at 3:00 PM indicated client A would demonstrate self injurious behavior of pinching and scratching herself. LPN #1 indicated client A would not let the LPN assess her. When asked how the client received the injury, QSP #1 stated "I don't know about that." When asked if client A's injury of unknown source had been reported to the administrator, TTC</p>			

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	<p>#1 stated "No."</p> <p>4. Client D's Nursing Progress Notes indicated:</p> <p>__ On 10/3/12 at 4 PM client D reported bruising to both lower knees. The note indicated the nurse notified the physician.</p> <p>__ On 10/4/12 at 11:30 AM client D "showed this nurse (LPN #1) and staff" bruising to both knees and a bruise on the client's left thigh. The note indicated client D stated he "doesn't know how he got them."</p> <p>__ On 10/11/12 at 10:15 AM the nurse was called to assess client D due the client's complaint of bruised and swollen left knee. The note indicated the bruises were noted previously on 10/3/12. The note indicated client D stated, "Nothing happened to my legs." "Now states staff at [name of hospital] threw me against the wall." The note indicated the bruises were not noted on client D's admission to the facility on 9/20/12.</p> <p>__ On 11/7/12 at 5:30 AM indicated client D complained at 10 PM "one of his peers [name of peer] had pushed client D with a piece of furniture against him [client D] at right hip and groin area." The note indicated the nurse assessed client D and gave the client something for pain.</p> <p>__ On 11/11/12 at 8 AM indicated client D was complaining of swelling in his left hip. The nurse indicated a bruise on the</p>			
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>side of client D's left thigh that was "healing well."</p> <p>The facility records did not indicate client D's injuries of unknown origin were reported on 10/3/12, 10/4/12, 10/11/12 and 11/11/12 and allegations of abuse on 11/7/12 were reported immediately to the administrator.</p> <p>Interview with TTC (Transitional Team Coordinator) #1 on 12/20/12 at 3:00 PM indicated all injuries of unknown origin and allegations of abuse were to be immediately reported to the administrator. The TTC #1 indicated all facility reportable incidents had been provided for review.</p> <p>5. The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM.</p> <p>__The BDDS (Bureau of Developmental Disabilities Services) report of 11/22/12 at 12:20 PM indicated the staff noted two bruises on client S's shoulders. Client S made allegations a staff had "hurt him bad" in the hallway. "Prior to reviewing the videotape footage, safety and security and QSP went back to talk to [client S] in an attempt to get more information about the situation. [Client S] then said that the staff had a pocketknife and threatened to kill him with it. [Client S] stated that this</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>took place while he was roommates with a prior peer." The report indicated while questioning one of the staff, the staff indicated client S was "upset one day, he attempted to call 911" and became angry when he was redirected and hit another staff over the head with the phone. Client S was placed in a PRT. The report indicate client S's bruising "appears to be within this week."</p> <p>Client S's record was reviewed on 12/19/12 at 12 PM. Client S's "Client Report of Illness or Injury" body scans indicated: ___ 11/10/12 at 4:20 PM indicated right side of client S's face noted with reddened area to cheek and ear. Client S indicated he didn't know what happened and couldn't remember if he had put something on his face. Client S's BIRs (Behavior Incident Reports) were reviewed on 12/20/12 at 11 AM. ___ On 11/22/12 at 12:20 PM client S was noted to have a 4 cm yellowish green bruise on client S's right shoulder, a 2 cm yellowish purple bruise on client S's left shoulder, four 1 cm purple bruises on client S's left inner upper arm, two 3 cm scratches with 4 cm bruising around the scratches on client S's inner left upper arm and a 2 1/2 cm scratch on client S's mid to lower right back. The report did not</p>						

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	<p>indicate the origin of the injuries.</p> <p>The facility records did not indicate client S's injuries of unknown origin of 11/10/12 and 11/22/12 and allegations of abuse on 11/7/12 were reported immediately to the administrator.</p> <p>Interview with TTC (Transitional Team Coordinator) #1 on 12/20/12 at 3:00 PM indicated all injuries of unknown origin and allegations of abuse were to be immediately reported to the administrator. TTC #1 indicated all facility reportable incidents had been provided for review.</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 interview and record review for 21 of 25 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients A, B, C, D, M, S and Z.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/16/12 reportable incident report indicated "[Client B] complained of pain in her left shoulder to nurse at 12:00 PM on 11/15/2012. Nurse then contacted [client B's] primary care physician and he ordered an x-ray to be completed on her left shoulder. Mobile x-ray technician came to the facility and performed an x-ray at 2:07 AM on 11/12.2012 (sic). Results from the x-ray state: 'There is a suggestion of a fracture of the distal third of the clavicle with no displacement of the left shoulder. The</p>	W0154	<p>Facility will develop and maintain a reproducible system of completed investigations (within 5 working days to provide evidence of thorough investigations regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients.</p> <p>Responsible Party: TTCs / Office Manager / Quality Assurance Director</p> <p>Date to be Completed: 2/6/13</p>	02/06/2013			

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	<p>acromioclavicular and coracoclavicular joints are normal.' Conclusion from the radiologist performing the examination stated: 'Questionable clavicle fracture as described above. Dedicated clavicle series recommended.' [Client B's] primary care physician was faxed the report from the radiologist at 3am on 11/16/2012. Primary care physician ordered a dedicated clavicle series to be performed. Nurse contacted the mobile x-ray company and they are scheduled to come to the facility to perform this examination as soon as possible...Additionally, [client B] will be seen and evaluated by primary care physician on 11/17/2012...."</p> <p>The facility's 11/21/12 follow-up report indicated "Results of the dedicated clavicle series state: '2 views of the left clavicle demonstrate no fracture, dislocation or bony reaction. Acromioclavicular articulation is normal.' The conclusion from the radiology report states: 'No fracture or dislocation in clavicle.'" [Client B] notified staff that she has had issues with injuring her shoulder in the past. Physical therapy appointment was scheduled by WTS to further provide support for [client B's] symptoms. The initial evaluation by the therapist was completed on 11/20/2012 and states 'demonstrates weakness and</p>						

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	<p>decreased range of motion.' [Client B] was given four exercises by the physical therapist to do at WTS, three times a day, using a rolled up towel. Staff will assist [client B] in completing these exercises..." The facility's 11/16/12 reportable incident report and/or 11/21/12 follow-up report failed to indicate the facility conducted a thorough investigation in regard to the client's injury of unknown source, and/or ensure the client had not been injured/re-injured while being restrained when using the PRTs.</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/11/12 at 1:05 PM, "Res (resident) placed in PRT @ (at) 1253 related to self harm et. (and) able to process out by 1pm 0 (zero) distress. Res moved to OBS (observation) room."</p> <p>-11/12/12 at 5:30 PM, "Placed in PRT due to self injurious bx (behavior). Reopened areas to Lt (left) arm & leg. Areas cleansed. Per [name of doctor] moved Suicide I."</p> <p>-11/13/12 at 12 AM, "...Remains on Level I suicide precautions (with) staff in reach.</p>				

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	<p>Will monitor Tylenol given effectively for c/o pain in shoulder at 9:25 pm. Reports hx (history) of collar bone fx (fracture) in past and having chronic pain."</p> <p>-11/15/12 at 12 PM, "New order per [name of doctor]. X-ray Lt shoulder c/o disc (complaints of discomfort). S1 (Slight) edema to the front of the shoulder. Client stating difficulty (with) ROM (range of motion). Also stated she has fx'ed (fractured) before. [Name of xray company] notified."</p> <p>-11/16/12 at 5:30 AM, "Complaints of pain (L) (left) shoulder, x-ray done this shift, results came back positive, res has a fx, results faxed to MD (Medical Doctor), to await new orders, res given tylenol prn (as needed) for pain."</p> <p>-11/16/12 at 12 PM, "[Name of doctor] called r/t (related to) Xray results et. recommended dedicated clavicle series. [Name of xray company] called..."</p> <p>-11/16/12 at 7:40 PM, "[Name of xray company] here to complete clavicle (L) arm."</p> <p>-11/16/12 at 11:30 PM, Received X-ray results showing 0 fracture/dislocation seen in (L) arm. Will continue to monitor and medicate for pain."</p>			

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	<p>-11/19/12 at 10 AM, "Spoke with [name of doctor]. No new orders related to X-ray results."</p> <p>-11/19/12 at 5:00 PM, "New Order per [name of doctor]. PT (Physical Therapy) eval (evaluation) related to Lt shoulder."</p> <p>-11/19/12 at 5:05 PM, "Scheduled PT 11-20-12 at [name of company]."</p> <p>Client B's 11/20/12 Medical Visit Summary form indicated client B saw a PT for evaluation of the client's left shoulder. The form indicated the client had a history of clavicle fracture. The 11/20/12 form indicated "Initial evaluation performed (sic) Pt (patient) demonstrates weakness, decreased ROM. HEP (exercises) provided and explained to pt. transportation present." The form indicated PT would follow-up.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 on 12/20/12 at 3:00 PM indicated the facility did not conduct an investigation in regard to client B's injury of unknown source and/or ensure the re-injury or injury was not due to the PRT done on 11/11 or 11/12/12.</p> <p>2. The facility's reportable incident reports and/or investigations were</p>			

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	<p>reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports indicated the following:</p> <p>-11/9/12 "[Client B] was in her room listening to music and trying to calm herself after a phone call with her father that didn't go well. She was upset and crying. [Client B] spoke at length with her QSP (Qualified Support Professional) and staff to help her regain control of her emotions. When staff went to assist with another client's aggressive behavior. (sic) [Client B] intentionally scratched her arms and legs. [Client B] was seen by the nurse, treated and evaluated. The Doctor gave orders for her to be placed on Level 2 Suicide Precautions...Level 2 Precautions-clients must remain in staff sight at all times...."</p> <p>-11/10/12 "[Client B] was in her room reading, staff checking on her every 15 minutes. At 8:10PM (sic) [client B] told staff to get out of her room. When staff asked her what was the matter they found that [client B] had bent her glasses and removed the lenses. She began crying and would not answer any questions. Staff notice (sic) that [client B's] arms were very red and continued to ask what was wrong and what was bothering her. [Client B] cursed and began using the lenses to scrape her arm. Staff attempted</p>						

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	<p>to remove the lenses but [client B] refused. Staff radioed for the Safety & (and) Security Professional to assist and [client B] began biting herself. Staff continued to engage [client B]. The SSP arrived and spoke with [client B] and helped her made (sic) a good decision and gave the lenses to staff. [Client B] refused to come out of her room so staff sat outside her door for 5 minutes at which time [client B] wanted to speak with staff and stated that she doesn't like to be alone,...[Client B] asked staff to take dangerous object from her room...[Client B] was seen by the nurse, treated and evaluated. The Doctor gave orders for her to be placed on Level 2 Suicide Precautions...Level 2 Suicide Precautions-clients must remain in staff sight at all times. In order to prevent self harm they are only allowed access to their personal items when staff are present but cannot have sharps, belts or any items which can be used to injure themselves. During hours of sleep clients on Level 2 Suicide Precautions will sleep in the observation room on their unit to ensure they do not have access to any objects with which to harm themselves."</p> <p>The facility's 11/16/12 follow-up report indicated "Staff involved in this incident report were not providing appropriate supervision to [client B], who had been</p>				

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	<p>placed on a Level 2 Suicide Precaution per order from psychiatrist on 11/9/12." The facility failed to provide documentation of an investigation in regard to the possible neglect/lack of staff supervision.</p> <p>-11/11/12 "[Client B] was being monitored by staff due to previous self injuring behaviorShe (sic) was in her room and staff discovered she had a fork and was putting it in her mouth trying to harm herself (sic) Staff removed the fork and informed the nurse who evaluated [client B]. [Client B] was taken to the observation room so staff could make sure she was safe...." The 11/11/12 reportable incident report indicated client B "...started clawing at arm to open old wound. Did not respond to redirection and placed in PRT (Primary Restraint Technique). In dining room at 5:04 pm, [client B] had a strange facial expression on her face. When asked if ok, she shook her head no. Placed Hoodie over her head. Continued to monitor client. When asked to remove Hoodie, staff saw she had a spoon in her mouth. Staff able to get spoon from her. Remains on Level 2 Suicide Precautions...."</p> <p>The facility's 11/16/12 follow-up report indicated "Investigation into this incident confirmed that staff was providing</p>						

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	<p>appropriate line of sight supervision for [client B] as she remained on Level 2 Suicide Precaution. [Client B] will smuggle items to use for self-harming purposes inside her clothes and has become very adept at doing this quickly and subtly, even though staff have her in eye sight. She was putting dishes away after a meal and snuck utensils into the sleeves of her shirt. She then used the utensils later to attempt to engage in self harm. The reason she was initially informed she could not stay in her own room is because Level 2 Precaution (which she was still on) states that you cannot have access to your personal items. [Client B's] personal items were still inside her room as she had been sleeping in the observation room...." The facility's 11/16/12 follow-up report and/or reportable incident reports from 10/12 to 12/12 failed to indicate any additional information/interviews and/or documentation of an investigation in regards to how the client acquired silverware 2 different times on the same day while on Level 2 Suicide Precautions.</p> <p>Interview with LPN #1, Transitional Treatment Coordinator (TTC) #1, #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior. LPN #1 indicated client B scratched her arms on 11/9/12. LPN #1</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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	<p>indicated client B stated she was "stressed." QSP #1 indicated client B was on level II suicide precautions on 11/10/12. QSP #1 indicated client B took the lenses out of her glasses on 11/10/12 and attempted to cut herself. QSP #1, LPN #1 and TTC #1 indicated client B was on level II precautions (line of sight) when client B obtained a plastic fork and placed it in her mouth in her bedroom. TTC #1 and QSP also indicated client B was on line of sight (level II precautions) when she obtained a spoon and placed it her mouth in the dining room. QSP #1 indicated facility staff were present in the dining room when client B placed the spoon in her mouth. TTC #1 and QSP #1 did not indicate how client B was able to get hold of a spoon after the client had obtained a fork. TTC #1 indicated the facility did not conduct an investigation in regard to neglect/supervision of client B obtaining a spoon. TTC #1 did not provide a documented investigation in regard to the 11/11/12 fork incident/allegation of possible neglect.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports indicated the following client to client incidents:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
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	-11/22/12 "On 11-22-12 AT (sic) 8:15 pm [client P] returned to her unit from the canteen and set her pop on the table in the dayroom and went to her bedroom. Staff saw the pop and took it to the office so no other peer could take it...[Client P] came out of her room and began yelling at staff, attacking her and attempt (sic) to bite saying that staff took her pop. Staff tried to explain tha (sic) her pop was not taken, but was placed in the office so no one else could get it. [Client P] continue (sic) to be aggressive and would not listen. She spat in staff's face then went to her room for a personal time out. [Client P] returned to the day room and called her peer [client B] a 'b...'. This upset [client B] who yelled back at [client P]. Both were redirected to stop and the environment was rearranged, separating the two clients. [Client P] laughed and returned to her room. [Client P] came back out and was pointing at [client M] making negative comments repeatedly trying to instigate peer, then she hit [client M] on the head with one open handed blow. ([Client M] was not injured. At this time [peer Z] got up and hit [client P]. ([Client P] was not injured). Staff separated them and again [client P] went to her room for personal time out. [Client P] again yelled at staff. She said she wanted her pop. [Client P] then grabbed						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>and pulled peer [client Z's] hair. ([Client Z] was not injured). Staff immediately prompted [client P] to stop pulling [client Z's] hair and let go but [client P] refused. Staff was able to get [client P's] fingers released and [client P] went back to her room then returned immediately yelling, attacking staff before getting up and standing on the table. [Client P] was redirected to come down. [Client P] then hit peer [client A] then went to her room again...."</p> <p>-12/9/12 Client Z was waiting to get her medications. The reportable incident report indicated "...All of a sudden, [client Z] got up and hit one of her peers. Staff intervened and redirected [client Z]...She then went at two additional peers and attempted to hit them as well..." The facility's above mentioned 11/22/12 and 12/9/12 reportable incident reports did not indicate the facility conducted an investigation in regard to the client to client aggression/abuse incidents.</p> <p>Interview with TTC #1 and Qualified Support Professional (QSP) #1 on 12/18/12 at 3:35 PM indicated client to client incidents/aggression were discussed in the facility's daily morning meetings. When asked if the facility conducted investigations in regard to the client to client aggression/abuse, TTC #1 stated "It</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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	<p>depends on severity of incident and injury. We look at video. A deep investigation is done with injury." QSP #1 indicated she would have to check to see if an investigation was conducted for 12/9/12 incident. QSP #1 and/or TTC #1 did not provide any additional documentation of an investigation for the 12/9/12 incident.</p> <p>4. The facility's records were reviewed on 12/18/12 at 11:30 AM. The records indicated on 11/26/12 at 8:57 PM client C was in the dayroom playing cards while another client who was watching the television. Client C asked the other client to turn the television down. When the other client did not respond to client C's request, client C hit the other client.</p> <p>Client C's record was reviewed on 12/19/12 at 3 PM. Client C's Behavioral Incident Reports indicated: __On 11/27/12 at 7:05 PM client C became upset when the client asked for his vending machine money. Staff gave client C the \$2.50 that was in the client's pouch. Client C indicated "there should be more money." The staff showed the pouch to client C to prove that was all of the money in client C's pouch. The LDSP (Lead Support Professional) told client C the LDSP would have to look into what happened to his money.</p>				

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>The facility records did not indicate an investigation was conducted in regards to client C's physical abuse toward another client on 11/26/12 and client C's allegation made about his missing money on 11/27/12.</p> <p>Interview with TTC (Transitional Team Coordinator) #1 on 12/20/12 at 3:00 PM indicated all injuries of unknown origin and allegations of abuse were to be investigated. TTC #1 indicated all investigations had been provided for review.</p> <p>5. The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM. ___ On 11/27/12 at 2:30 PM client D used the telephone at the facility to call 911. The client told the dispatcher he did not feel safe and had been threatened by his peer. The police arrived and the client told the police "he was tired of being threatened and attacked by his peers." After the police left the building client D was asked why he felt he was being threatened and unsafe. "He talked about two of his peers who had been agitated and physically disruptive in the past 24 hours. [Client D] was reminded that he was never the object of their agitation or aggression and that he had not been</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>physically or verbally threatened since admission to [WTS] more than 6 weeks ago." The report indicated this was client D's 3rd time of calling 911 and reporting false alarms. Due to this pattern client D's phone use was to be monitored. The facility records did not indicate client D's allegations of being threatened by his peers had been investigated by the facility.</p> <p>__The 12/3/12 follow up report indicated client D "stated he felt unsafe due to peer's agitated state and physically disruptive behavior which was directed at staff not at clients. Although [client D] was never the focus of his peer's agitation or aggression, [client D] makes all incidents on the unit about him and personalizes all issues his peers are having." The facility records did not indicate client D's continued allegations of being threatened by his peers had been investigated by the facility.</p> <p>Client D's record was reviewed on 12/20/12 at 1:20 PM. Client D's Nursing Progress Notes indicated: __ On 10/3/12 at 4 PM client D reported bruising to both lower knees. The note indicated the nurse notified the physician. __ On 10/4/12 at 11:30 AM client D "showed this nurse (LPN #1) and staff" bruising to both knees and a bruise on the client's left thigh. The note indicated</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>client D stated he "doesn't know how he got them."</p> <p>__ On 10/11/12 at 10:15 AM the nurse was called to assess client D due the client's complaint of bruised and swollen left knee. The note indicated the bruises were noted previously on 10/3/12. The note indicated client D stated, "Nothing happened to my legs." "Now states staff at [name of hospital] threw me against the wall." The note indicated the bruises were not noted on client D's admission to the facility on 9/20/12.</p> <p>__ On 10/13/12 at 9:45 AM the facility doctor assessed client D due to the client being aggressive toward another peer. The note indicated client D had an abrasion to his chin.</p> <p>__ On 10/13/12 at 10 AM (late entry) indicated RN #1 assessed client D post altercation with another client at 9:30 PM on 10/12/12. The note indicated the nurse evaluated client D's chin, right ankle and knee and provided first aid.</p> <p>__ On 11/7/12 at 5:30 AM indicated client D complained at 10 PM "one of his peers [name of peer] had pushed client D with a piece of furniture against him [client D] at right hip and groin area." The note indicated the nurse assessed client D and gave the client something for pain.</p> <p>__ On 11/11/12 at 8 AM indicated client D was complaining of swelling in his left hip. The nurse indicated a bruise on the</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>side of client D's left thigh that was "healing well."</p> <p>The facility records did not indicate client D's injuries of unknown origin reported on 10/3/12, 10/4/12, 10/11/12 and 11/11/12 were investigated. The facility records failed to indicate client D's allegations of abuse on 10/13/12 and 11/7/12 were investigated.</p> <p>Interview with TTC (Transitional Team Coordinator) #1 on 12/20/12 at 3:00 PM indicated all injuries of unknown origin and allegations of abuse were to be investigated. TTC #1 indicated all investigations had been provided for review.</p> <p>6. The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM. ___The BDDS (Bureau of Developmental Disabilities Services) report of 11/22/12 at 12:20 PM indicated the staff noted two bruises on client S's shoulders. Client S made allegations a staff had "hurt him bad" in the hallway. "Prior to reviewing the videotape footage, safety and security and QSP went back to talk to [client S] in an attempt to get more information about the situation. [Client S] then said that the staff had a pocketknife and threatened to kill him with it. [Client S] stated that this</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>took place while he was roommates with a prior peer." The report indicated while questioning one of the staff, the staff indicated client S was "upset one day, he attempted to call 911" and became angry when he was redirected and hit another staff over the head with the phone. Client S was placed in a PRT. The report indicate client S's bruising "appears to be within this week."</p> <p>__The BDDS report of 11/27/12 at 10:25 PM client S became upset with another client and threw a cup of water on the other client. Client S was redirected out of the room.</p> <p>Client S's BIRs (Behavior Incident Reports) were reviewed on 12/20/12 at 11 AM.</p> <p>__On 11/19/12 at 9:07 PM indicated client S entered the day room and approached client T and spit on him. Client T retaliated by slapping client S. The staff separated clients S and T. Client S approached client T. Staff were unable to redirect client S and placed client S in a sitting PRT.</p> <p>__On 11/22/12 at 12:20 PM client S was noted to have a 4 cm yellowish green bruise on client S's right shoulder, a 2 cm yellowish purple bruise on client S's left shoulder, four 1 cm purple bruises on client S's left inner upper arm, two 3 cm scratches with 4 cm bruising around the</p>			
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	<p>scratches on client S's inner left upper arm and a 2 1/2 cm scratch on client S's mid to lower right back.</p> <p>Client S's "Client Report of Illness or Injury" body scans indicated: __11/10/12 at 4:20 PM indicated right side of client S's face noted with reddened area to cheek and ear. Client S indicated he didn't know what happened and couldn't remember if he had put something on his face.</p> <p>The facility failed to provide evidence of a written investigation in regards to client C's injuries of unknown origin and allegations of abuse reported on 11/22/12. The facility failed to provide evidence an investigation had been conducted in regards to client S's client to client abuse reported on 11/19/12 and 11/27/12. The facility failed to provide evidence of an investigation of client S's injury of unknown origin reported on 11/10/12.</p> <p>The facility record did not indicate client D's injury of unknown source reported on 10/3/12, 10/4/12, 10/11/12 and 11/11/12 were investigated. The facility records failed to indicate client D's allegations of abuse on 10/13/12 and 11/7/12 were investigated.</p> <p>Interview with TTC (Transitional Team</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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	<p>Coordinator) #1 on 12/20/12 at 3:00 PM indicated all injuries of unknown origin and allegations of abuse were to be investigated. TTC #1 indicated all investigations had been provided for review.</p> <p>This federal tag relates to complaint #IN00119674.</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review 3 of 3 investigations reviewed, the facility failed to report and/or provide evidence the administrator was notified of the results of the investigations within 5 business days for clients C, D and S.</p> <p>Findings include:</p> <p>The facility's investigative reports were reviewed on 12/18/12 at 11:30 AM. The reports indicated: ___ On 11/15/12 at 8:10 PM LPN #1 found bruises on client S's left side of his chest and left arm. "The 3 bruises are located on [client S's] left inner arm (1 cm, dark purple in color), above left breast (6 cm x 3 cm, purple and yellow in color), and below left breast (10 cm x 3 cm, purple and yellow in color)." ___ On 11/21/12 at 5:45 PM client C called the facility from his home visit for the holiday and requested the staff come get him. Client C alleged his stepfather was arguing with his mother then hit Client C. ___ On 12/14/12 facility investigative report indicated client D "came running out of his room agitated with his</p>	W0156	<p>Facility will to ensure allegations of abuse/neglect, and injuries of unknown source are immediately reported to the Administrator, thorough investigations are conducted, and the results of investigations are reported to the Administrator within 5 working days.</p> <p>Reporting format will be changed to specifically note that the Administrator was notified immediately on report all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying Administrator, date, and time.</p>	02/06/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
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	<p>roommate. [Client D] told the Lead Direct Support Professional that he was moving out of their room. Client D's roommate came after him also agitated and before staff could step between the two the roommate swung at [client D]. Staff immediately stepped between the two and separated them. Both clients quickly calmed in different areas of the unit. [Client D] reported that he had been hit in the eye and was evaluated by the nurse. There was some blood in the eye and for safety it was determined to send him [client D] out to the [name of hospital] for treatment. At the hospital [client D] was told he had hyphema (bleeding in the eye) and needed to be evaluated by an eye specialist at [name of hospital] [Client D] told the emergency room staff that he did not feel safe and he was not going to [name of hospital] until he could press charges against his roommate." The report indicated the actions taken: The IDT (Interdisciplinary Team) evaluated the incident and decided to do a permanent room change for [client D] and his roommate. "They are now on different halls and during the Life Skills day are on a 10 foot restriction from each other."</p> <p>The facility's investigative reports in regards to the incidents of 11/15/12, 11/21/12 and 12/14/12 for clients C, D and S failed to indicate the administrator</p>		<ul style="list-style-type: none"> · Responsible Party: Office Manager · Reporting format to be completed by 1/26/13. · Supervisors will be retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations / TTCs · Completed by 2/6/13. · Transition Team Coordinators (TTC), Qualified Support Professionals, Lead Direct Support Professionals, and Health Services Staff will monitor the appropriate forms to ensure to ensure the proper reporting of reportable incidents and the timely thorough reporting 		

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	<p>had been notified of the results of the investigations.</p> <p>Interview with TTC (Transitional Team Coordinator) #1 on 12/20/12 at 3:00 PM indicated the results of all investigations were to be reported to the Administrator within 7 days of the date of the incident. The TTC failed to provide evidence the investigations of the incidents of 11/15/12, 11/21/12 and 12/14/12 were reported to the Administrator.</p>		<p>(within 5 working days) the investigative reports are completed and received by Administrator.</p> <p>Initiated by: 2/6/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to ensure all staff, who worked with the client, were retrained in regard to monitoring the client to prevent self harm incidents.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/10/12 reportable incident report indicated "[Client B] was in her room reading, staff checking on her every 15 minutes. At 8:10PM (sic) [client B] told staff to get out of her room. When staff asked her what was the matter they found that [client B] had bent her glasses and removed the lenses. She began crying and would not answer any questions. Staff notice (sic) that [client B's] arms were very red and continued to ask what was wrong and what was bothering her. [Client B] cursed and began using the lenses to scrape her arm. Staff attempted to remove the lenses but [client B] refused. Staff radioed for the Safety &</p>	W0189	<p>The facility will ensure all staff who work with a client are retrained in regard to monitoring the client to prevent self-harm incidents. QSPs/TTCs will assure that all staff working with a client receives training in regard to client monitoring to prevent incidents of self-harm. Date to be Completed: 2/6/13</p>	02/06/2013

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	<p>(and) Security Professional to assist and [client B] began biting herself. Staff continued to engage [client B]. The SSP arrived and spoke with [client B] and helped her made (sic) a good decision and gave the lenses to staff. [Client B] refused to come out of her room so staff sat outside her door for 5 minutes at which time [client B] wanted to speak with staff and stated that she doesn't like to be alone,...[Client B] asked staff to take dangerous object from her room...[Client B] was seen by the nurse, treated and evaluated. The Doctor gave orders for her to be placed on Level 2 Suicide Precautions...Level 2 Suicide Precautions-clients must remain in staff sight at all times. In order to prevent self harm they are only allowed access to their personal items when staff are present but cannot have sharps, belts or any items which can be used to injure themselves. During hours of sleep clients on Level 2 Suicide Precautions will sleep in the observation room on their unit to ensure they do not have access to any objects with which to harm themselves."</p> <p>The facility's 11/16/12 follow-up report indicated "Staff involved in this incident report were not providing appropriate supervision to [client B], who had been placed on a Level 2 Suicide Precaution per order from psychiatrist on 11/9/12."</p>						

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	<p>Client B's record was reviewed on 11/19/12 at 3:09 PM. Client B's 11/7/12 Transitional Behavioral Support Plan (TBSP) indicated client B was admitted to the facility on 11/7/12. Client B's 11/7/12 TBSP indicated client B demonstrated "...Self-Injurious Behavior (SIB): defined as cutting/scratching her arms and legs, biting herself, stabbing herself with multiple household objects (caps to shampoo bottles, broken plastic spoons, CDs, plastic combs, etc.) It was also indicated that [client B] tends to barricade herself in her room so that staff cannot intervene. This is accomplished by pushing heavy pieces of furniture in front of the door." Client B's 11/7/12 TBSP also indicated client B demonstrated "...Suicide attempts: defined as gestures/attempts to take one's life. (Noted history of attempted overdose with anti-coagulants)."</p> <p>The facility's inservice training records were reviewed on 12/20/12 at 4:30 PM. The facility's 11/16/12 Precautions for [Client B] indicated one staff (staff #1) was re-trained on 11/16/12 on monitoring client B due to the 11/10/12 incident. The 11/16/12 sheet indicated the one staff was retrained on Level I Suicide precautions, Level II Suicide Precautions and "Self Harm Observation (Specific to [client</p>						

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	<p>B)]...." The 11/16/12 inservice record indicated "...Additionally, per HRC (Human Rights Committee) approved BSP (Behavior Support Plan) [client B] is to only use metal spoons at meal times and staff must count silverware to ensure she is not bringing these items back to the hall." The 11/16/12 training record indicated the facility failed to retrain all staff, who worked with client B, to ensure client B was supervised/monitored to prevent self harm incidents.</p> <p>Interview with LPN #1, Transitional Treatment Coordinator (TTC) #1, #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior. LPN #1 indicated client B scratched her arms on 11/9/12. LPN #1 indicated client B stated she was "stressed." QSP #1 indicated client B was on level II suicide precautions on 11/10/12. QSP #1 indicated client B took the lenses out of her glasses on 11/10/12 and attempted to cut herself. TTC #1 and QSP #1 indicated two staff were retrained in regard to monitoring client B as it was determined the staff did not monitor client B on 11/11/12 with the incident in regard to the fork. TTC #1 and QSP #1 indicated only the two staff involved were re-trained and all staff, who worked with client B, were not re-trained on monitoring client B.</p>						

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients (A), the client's Treatment Support Plan (TSP) failed to address the client's identified behavioral need.</p> <p>Findings include:</p> <p>During the 12/18/12 observation period between 4:14 PM and 6:40 PM, at the facility, client A wore an orange one piece jumpsuit which zipped in the back.</p> <p>Client A's record was reviewed on 12/20/12 at 1:13 PM. Client A's Progress Notes indicated the following (not all inclusive):</p> <p>-12/10/12 "...At one point [client A] stripped down naked in the day room...."</p> <p>-11/30/12 "...She (client A) went to bathroom and came out to day room. [Client A] started to strip naked. Staff escorted her back to her room. [Client A] took off all her clothes and refused to dress. The Progress note indicated once client A returned to the day room client A</p>	W0227	<p>Client A's TBSP (BSP) has been amended to include using/wearing a "non-tear" jump-suit as a reactive intervention to address the behavior(s) of 'tearing up/off clothing' and 'stripping naked in public areas'. Human Rights Committee (HRC) approval was also obtained.</p> <p>Responsible Party: Behavioral Services Coordinator</p> <p>Completed on: 1/2/13.</p> <p>Behavioral Services Coordinator will regularly review all clients and their plans to assure that any restrictive/intrusive intervention(s) are</p>	02/06/2013	

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	<p>"...started to undress. Staff escorted her back to her room....She refused to put on shoes or keep her clothes on...."</p> <p>-11/28/12 "...[Client A] stripped her clothes off more than twice...."</p> <p>-11/25/12 (8 AM to 4 PM) "...[Client A] stripped off her clothing in the hallway and was redirected to her room to get dressed...."</p> <p>-11/25/12 (12 AM to 8 AM) "...She came out of her room and started taking off her clothes. Staff escorted her back to her room where she stripped naked. [Client A] refused to put back on and became agitated...."</p> <p>-11/23/12 "...[Client A] stripped off all her clothing in Life Skills (classroom area) and was assisted back to the unit @ 11 am...."</p> <p>-11/19/12 (4 PM to 12 AM) "...She then transitioned to the library where she continued yelling and pushing over chairs and throwing small objects. She returned to the unit and began undressing herself and walking around the unit. Staff assisted her in putting on a jumpsuit so she could stay clothed...."</p> <p>-11/19/12 (12 AM to 8 AM) "...[Client A]</p>		<p>properly incorporated into a formal BSP and approved by the Human Rights Committee (HRC) and all staff working with client are trained prior to implementation.</p> <p>Date to be Completed/Implemented: 2/6/13</p> <p>Additionally, for all clients in IDT and ISP meetings, the QSPs and other team members will present for review and consideration any possible restrictive interventions that may be effectively incorporated into a BSP and implemented upon approval of the HRC and staff training.</p> <p>To be Completed / Implemented by 2/6/13.</p>		

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	<p>stripped naked in the dayroom...."</p> <p>Client A's 11/26/12 Transition Behavior Support Plan (TBSP) indicated client A demonstrated "Self Harming Behavior" which was "...defined as biting self, she bites knees and refuses to wear arm guards, rolls around on floor and mattress, rips off clothing and or refuses to dress, hits self and roommate with objects causing bruising.*...." Client A's 11/26/12 TBSP did not specifically address the client's identified behavioral need in regard to stripping as there were no specific interaction guidelines/objective in place which addressed the client's identified behavior of stripping.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and Qualified Support Professional (QSP) #1 on 12/20/12 at 3:00 PM indicated client A wore the jump suit as the client would strip off her clothing and tear her clothes. QSP #1 indicated client A did not have an active treatment plan/objective which specifically addressed the client's stripping behavior.</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the client's Treatment Support Plan (TSP) failed to indicate how facility staff were to monitor the client while in the dining room to prevent the client from obtaining utensils to harm herself. The client's TSP also failed to indicate how facility staff were to specifically monitor the client in her bedroom, when on level II supervision, to prevent incidents of self harm.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's reportable incident reports indicated the following:</p> <p>-11/11/12 "[Client B] was being monitored by staff due to previous self injuring behaviorShe (sic) was in her room and staff discovered she had a fork and was putting it in her mouth trying to harm herself (sic) Staff removed the fork and informed the nurse who evaluated [client B]. [Client B] was taken to the observation room so staff could make sure she was safe...." The 11/11/12</p>	W0240	<p>In order to help provide support, encourage independence and keep all of our clients safe while doing so, the Facility has put into action the following:</p> <ol style="list-style-type: none"> Facility has implemented a silverware tracking form and protocol to be used for all clients, including Client B. *All necessary staff will be trained by 2/6/13. At least one staff member is always assigned to a dining table to assist/monitor our clients, including Client B, while they are eating in dining room. Several clients have been moved throughout the facility to better address their individual needs; Client B was moved to a single room, on 1/22/13. <p>Additionally, Client B's TBSP (BSP) has been amended to specify how the facility staff are to monitor Client B while on level II</p>	02/06/2013	

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	<p>reportable incident report indicated client B "...started clawing at arm to open old wound. Did not respond to redirection and placed in PRT (Primary Restraint Technique). In dining room at 5:04 pm, [client B] had a strange facial expression on her face. When asked if ok, she shook her head no. Placed Hoodie over her head. Continued to monitor client. When asked to remove Hoodie, staff saw she had a spoon in her mouth. Staff able to get spoon from her. Remains on Level 2 Suicide Precautions...."</p> <p>The facility's 11/16/12 follow-up report indicated "Investigation into this incident confirmed that staff was providing appropriate line of sight supervision for [client B] as she remained on Level 2 Suicide Precaution. [Client B] will smuggle items to use for self-harming purposes inside her clothes and has become very adept at doing this quickly and subtly, even though staff have her in eye sight. She was putting dishes away after a meal and snuck utensils into the sleeves of her shirt. She then used the utensils later to attempt to engage in self harm...."</p> <p>Client B's Behavioral Incident Reports (BIR) were reviewed on 12/19/12 at 12:35 PM. Client B's 11/11/12 BIR, at 12:40 PM, indicated "Staff was monitoring</p>		<p>supervision to prevent incidents of harm self; HRC approval obtained and staff working with Client B have been retrained. These interventions/stratagems include:</p> <ul style="list-style-type: none"> ü Specific limitations while on Suicide Precaution Levels. <i>(Please see the attached revised Suicidal Client Management Policy)</i> ü HRC approval for Client B's bedroom door to remain locked while precaution/supervision level continues. ü If Client B enters another peer's room/unsafe area while on precaution, she will be redirected by staff/team member to exit peer's room/unsafe area. If Client B fails to comply with the request, staff will escort Client B out of the area to ensure safety of Client B. ü Furthermore, Client's B BSP has been revised to include the need for a modified PRT due to history of chronic shoulder pain. (Currently, staff working with Client B, have been trained on proper use of 'modified PRT'.) 		

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	<p>[client B] for self harm because of previous incident of self harm. She was in her room laying down. Staff discovered she had a plastic fork in her mouth trying to commit suicide. The fork was removed from her mouth and the nurse was notified. [Client B] was informed that she would need to move to the observation room to monitor for any further suicidal attempts but she refused...."</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's 11/11/12 Progress Notes for 8 AM to 4 PM indicated client B went to her bedroom and tried to self harm with a plastic fork. The progress note indicated client B tried to cut herself and was placed in a PRT. Client B's 11/11/12 Progress Note for 4 PM to 12 AM indicated "...By 5:05 pm [client B] attempted to harm herself, later calmed down after staff redirected her...."</p> <p>Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/11/12 at 12:50 PM, "Called to res (resident) room (sic) res (sic) had been scratching her arms @ (at) wrists (sic) res (sic) also reported to have stuck a fork plastic in her mouth trying to cut it...placed on Level II suicide precaution. Staff aware."</p>		<ul style="list-style-type: none"> · Responsible Parties: Behavioral Service Coordinator / Treatment Team Coordinator / and Qualified Support Professional · Date Completed and Implemented: 2/6/13 · For all clients, the Interdisciplinary Team will indicate in their individual BSPs how they are to be monitored per his/her needs and situation. · Approval will be obtained from the HRC and staff working with client(s) will be trained on the specifics of required monitoring before being implemented by the facility and facility staff. · Responsible Parties: Behavioral Services Coordinator / Treatment Team Coordinator Date to be Implemented for all clients: 2/6/13 		

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	<p>-11/11/12 at 1:05 PM, "Res placed in PRT @12:53 related to self harm et. able (sic) to process out by 1 pm...moved to OBS (observation) room."</p> <p>-11/11/12 at 7:21 PM, "Res monitor closely by staff. Will place her hands inside her shirt asked per staff to take her hands out (sic). Res also had a spoon in her hoodie pocket from dinner taken per writer."</p> <p>Client B's 11/7/12 Transitional Behavioral Support Plan (TBSP) indicated client B was admitted to the facility on 11/7/12. Client B's 11/7/12 TBSP indicated client B demonstrated "...Self-Injurious Behavior (SIB): defined as cutting/scratching her arms and legs, biting herself, stabbing herself with multiple household objects (caps to shampoo bottles, broken plastic spoons, CDs, plastic combs, etc.) It was also indicated that [client B] tends to barricade herself in her room so that staff cannot intervene. This is accomplished by pushing heavy pieces of furniture in front of the door." Client B's 11/7/12 TBSP also indicated client B demonstrated "...Suicide attempts: defined as gestures/attempts to take one's life. (Noted history of attempted overdose with anti-coagulants)." Client B's 11/7/12</p>						

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	<p>TBSP indicated "...Since [client B] has a history of cutting herself with sharp objects it is recommended that sharps not be easily accessible for [client B] and that staff count sharp items before and after [client B] uses them and supervises her at all times when she's using a sharp item. Again, because of her extensive history of using silverware as an instrument for self-harm, [client B] should only use metal spoons at meal times. [Client B] should never be allowed to use knives. Silverware should be counted before and after meals to ensure that [client B] taking any utensils with her (sic)...." Client B's record and/or TSP did not indicate how facility staff were to monitor client B when the client was in the dining room to prevent taking utensils. The client's TBSP and/or 12/7/12 TSP did not specifically indicate how facility staff were to monitor client B in her bedroom when on Level II supervision to prevent self harm incidents.</p> <p>Interview with LPN #1, Transitional Treatment Coordinator (TTC) #1, #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior. LPN #1 indicated client B scratched her arms on 11/9/12. LPN #1 indicated client B stated she was "stressed." QSP #1 indicated client B was on level II suicide precautions (line of</p>						

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	<p>sight) on 11/10/12. QSP #1 indicated client B took the lenses out of her glasses on 11/10/12 and attempted to cut herself. QSP #1, LPN #1 and TTC #1 indicated client B was on level II precautions when client B obtained a plastic fork and placed it in her mouth in her bedroom. TTC #1 and QSP also indicated client B was on line of sight (level II precautions) when she obtained a spoon and placed it her mouth in the dining room. QSP #1 indicated facility staff were present in the dining room when client B placed the spoon in her mouth. QSP #1 indicated facility staff were to count the silverware before and after the client was in the dining room. QSP #1 indicated there was one staff person at each table. QSP #1 and TTC #1 indicated the client's IDT did not review client B's TBSP in regard to how staff were to monitor the client in the dining room and/or in her bedroom, when on suicide precautions, to prevent the client from harming herself.</p> <p>This federal tag relates to complaint #IN00119674.</p>			

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W0266	<p>483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.</p> <p>Based on observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Behavior and Facility Practices for 3 of 4 sampled clients (A, B and D) and for 2 additional clients (J and S). The facility failed to ensure clients B, D, J and S were not injured as a result of physical restraints, and/or failed to ensure sufficient safeguards were out in place to prevent potential injury. The facility failed to ensure its behavior management policy included restraint techniques which allowed clients' arms to be extended and/or hyperextended. The facility failed to ensure the use of a jumpsuit to prevent client A from stripping was part of the client's behavior plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility failed to ensure specific restraint methods/techniques utilized by the facility were included in the facility's behavior management policy for clients B, J and S. Please see W276. The facility failed to review and/or look at its restraint techniques to ensure 	W0266	<p>(a) The facility will exercise general policy and operating direction over the facility to ensure policy and procedures include restraint techniques of not hyper-extending arms and to ensure the facility included the restrictive interventions of a 'non-tear' jumpsuit in a client's Behavior Support Plan (BSP).</p> <p>Please see response to tag W 227 for specifics regarding the inclusion of 'non-tear' jumpsuit as approved restrictive intervention for Client A.</p> <p>Facility staff will receive retraining on the Handle With Care®</p>	02/06/2013

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	<p>its implementation did not cause injuries/potential injuries to clients. The facility failed to ensure safeguards were put in place to ensure the protection of the clients to prevent injuries due to the clients' current injuries and/or health risks regarding physical restraints for clients B, D and J. Please see W285.</p> <p>3. The facility failed to ensure the use of a jumpsuit, to prevent the client from stripping, was part of the client's behavior plan for client A. Please see W289.</p>		<p>Primary Restraint Technique (PRT), specifically with respect to the proper positioning of client arms to not be hyper-extended during a restraint procedure.</p> <ul style="list-style-type: none"> · Responsible Parties: Treatment Team Coordinators · Completed by 2/6/13. · National trainer (New York) from Handle With Care® will complete annual "train the trainer" on 2/4 – 2/7/13 with focus being given to de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques. · Responsible Party: Human Resources Coordinator · Additionally modified 		

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			<p>PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition.</p> <ul style="list-style-type: none"> Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised be a PRT; Behavioral Services Coordinator to address via BSPs / Human Rights Committee approvals & QSPs for staff training and implementation. Completed by: 2/4/13. (b) Facility will exercise general policy and operating direction to prevent neglect and/or abuse of clients in regard to possible injuries from restraint and/or injuries of unknown source. 		

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			<p>A nurse will provide face-to-face client assessment within two hours following any physical restraint with minimum of one follow-up within a 24 hour period with additional follow-up/ recommendations for further intervention as indicated.</p> <p>Responsible Party: Health Services Coordinator (DON).</p> <p>Completed/Implemented by: 1/26/13.</p>		

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W0276	<p>483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. Based on record review and interview for 1 of 4 sampled clients (B) and for 2 additional clients (J and S), the facility failed to ensure specific restraint methods/techniques utilized by the facility were included in the facility's behavior management policy.</p> <p>Findings include:</p> <p>1. During the 12/19/12 observation period between 10:30 AM and 11:40 AM, at the facility, client J sat in the day room and complained of pain in her left shoulder. Client J was guarding her left arm/shoulder as the client refused to use it.</p> <p>Interview with client J on 12/19/12 at 11:24 AM stated the client started having pain in her left shoulder/arm after staff utilized "a PRT" (Primary Restraint Technique) on the client. Client J demonstrated (with her good arm) and stated "They hold my arm back behind me." Client J demonstrated her arm being held backwards in a hyperextended</p>	W0276	<p>· The facility will ensure specific restraint methods/techniques utilized are included in the facility's behavior management policy.</p> <p>· Facility behavior management policy will be revised to note specific restraint methods to be utilized to accommodate the physical and/or other needs presented by clients. · Responsible Party: Quality Assurance Director to revise policy · Date to be Completed: 2/6/13</p> <p>Additionally for clients noted in citation: · Additionally modified PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition. · Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised in a regular PRT; Behavioral Services Coordinator to address via BSPs / Human Rights Committee approvals & QSPs for staff training and</p>	02/06/2013	

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	<p>position. Client J indicated she had told staff about her arm/shoulder pain. Client J indicated her shoulder was hurt on 12/17/12. Client J indicated the nurse was aware of her injury. Client J stated "I have been telling them since that night. It is swollen. I can't move it." Client J indicated 2 staff were initially involved in the PRT but there were other staff around. Client J indicated she was admitted to the facility on 11/5/12 and had been restrained 2 times using the PRT restraint. Client J indicated this was the first time her shoulder/arm was hurt. Client J indicated she got upset and threw items in her room and hit staff.</p> <p>Interview with LPN #2 on 12/19/12 at 11:40 AM indicated client J had been complaining of arm pain. When asked what happened to client J's arm, LPN #2 stated "Put in PRT and has complained of pain every since. I need to call and get X-ray."</p> <p>Client J's Behavioral Incident Reports (BIRS) were reviewed on 12/19/12 at 12:35 PM. Client J's 12/17/12 BIR indicated at 10:00 PM client J was placed in a PRT escort and a PRT standing restraint. The BIR indicated client J "Ran up on staff and pulled her hair...Tried to attack peer (client B) and Pull another staff's hair." The 12/17/12 BIR indicated</p>		<p>implementation. Completed by: 2/6/13.</p>				

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	<p>client J was redirected to her room to calm down, and began to throw things when she went to her bedroom. The BIR indicated when staff went into the client's bedroom, the client picked up her TV and threw it at the door causing it to break. The BIR indicated client J was asked to go to a "calm space" to calm down but the client refused. The BIR indicated client J was then escorted by 2 staff. The 12/17/12 BIR indicated a standing PRT was done from 10:22 PM to 10:30 PM. The BIR debriefing section indicated 4 staff were involved in the "Level III Intervention." The BIR section indicated "Face to Face: Assessment of Client Following Level II Intervention (To be completed within one hour of Level III Intervention by the nurse, LDSP, QSP (Qualified Support Professional), SSP (Safety & Security Professional) or a designated supervisor other than the person(s) implementing the restraint). Physical: (Check all that apply and provide brief description)." The BIR indicated "No Complaints" was checked.</p> <p>Client J's record was reviewed on 12/19/12 at 11:45 AM. Client J's Progress Notes indicated the following (not all inclusive):</p> <p>-12/17/12 (4 PM to 12 AM) "...[Client J] upset over Bingo prizes and got</p>						

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	<p>physically aggressive with staff & (and) peer. [Client J] threw and broke several items in her room including throwing her t.v...."</p> <p>-12/18/12 (8 AM to 4 PM) "[Client J] was in bed refusing to get up when staff arrived on the unit at 8 am. [Client J] refused breakfast but took her 8 am meds. [Client J] got up at 9:00 am complaining of shoulder pain in her left shoulder. When asked why it was hurting she stated she did not know:..at 12:15pm [client J] ate 100% of her meal and returned to the unit to lay down due to discomfort in her left shoulder. She talked with LDSP (Lead Direct Support Professional) again about shoulder pain after receiving Ibuprofen (pain) & a heating pad from nursing. At 1:33pm [client J] explain to LDSP it was this time she felt her left shoulder pain could be a result of being placed in a PRT the night before...."</p> <p>Client J's 11/13/12 Transition Behavioral Support Plan (TBSP) indicated "Level III Intervention" (physical restraint) could be used with client J when she became aggressive, demonstrated property destruction and/or self-injurious behavior. Client J's 11/13/12 TBSP indicated a Standing PRT Escort, Standing PRT and/or a Sitting PRT could be utilized. Client J's 11/13/12 TBSP indicated</p>				

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	<p>"...staff may immediately utilize a different physical restraint in an attempt to avert the crisis by using a Standing PRT or Sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others involved.) [Client J] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by 'Handle With Care'...."</p> <p>Interview with LPN #1, QSP #2 and TTC #1 and #2 on 12/20/12 at 3:00 PM indicated client J was restrained on 12/17/12 due to aggressive behaviors toward others and property destruction.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/16/12 reportable incident report indicated "[Client B] complained of pain in her left shoulder to nurse at 12:00 PM on 11/15/2012. Nurse then</p>				

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	<p>contacted [client B's] primary care physician and he ordered an x-ray to be completed on her left shoulder...."</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/11/12 at 1:05 PM, "Res (resident) placed in PRT @ (at) 1253 related to self harm et. (and) able to process out by 1pm 0 (zero) distress. Res moved to OBS (observation) room."</p> <p>-11/12/12 at 5:30 PM, "Placed in PRT due to self injurious bx (behavior). Reopened areas to Lt (left) arm & leg. Areas cleansed. Per [name of doctor] moved Suicide I."</p> <p>-11/13/12 at 12 AM, "...Remains on Level I suicide precautions (with) staff in reach. Will monitor Tylenol given effectively for c/o pain in shoulder at 9:25 pm. Reports hx (history) of collar bone fx (fracture) in past and having chronic pain."</p> <p>-11/15/12 at 12 PM, "New order per [name of doctor]. X-ray Lt shoulder c/o disc (complaints of discomfort). S1 (Slight) edema to the front of the shoulder. Client stating difficulty (with) ROM (range of motion). Also stated she</p>			

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	<p>has fx'ed (fractured) before. [Name of xray company] notified."</p> <p>-11/16/12 at 5:30 AM, "Complaints pf pain (L) (left) shoulder, x-ray done this shift, results came back positive, res has a fx, results faxed to MD (Medical Doctor), to await new orders, res given tylenol prn (as needed) for pain."</p> <p>-11/16/12 at 12 PM, "[Name of doctor] called r/t (related to) Xray results et. recommended dedicated clavicle series. [Name of xray company] called...."</p> <p>-11/16/12 at 7:40 PM, "[Name of xray company] here to complete clavicle (L) arm."</p> <p>-11/16/12 at 11:30 PM, "Received X-ray results showing 0 fracture/dislocation seen in (L) arm. Will continue to monitor and medicate for pain."</p> <p>Client B's 11/7/12 Transition Behavioral Support Plan (TBSP) Level II section indicated "In certain instances, a client may exhibit maladaptive behaviors that are dangerous to the client or others. In theses situations, to be referred to as 'crisis situation', it may be necessary for staff to intercede in the treatment process by implementing physical restraint, environmental restraint, or a PRN</p>			

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	<p>psychotropic intervention...." Client B's TBSP indicated facility staff could utilize a Standing PRT Escort, Standing PRT, Sitting PRT when client B demonstrated self-harm behavior and/or physical aggression. Client B's 11/7/12 TBSP indicated "[Client B] has no known condition that would prohibit the use if any of the physical restraint techniques utilized by 'Handle With Care' and WTS. (Please see WTS Physical Restraint policy for an explanation of each technique and its proper implementation)...."</p> <p>Interview with LPN #1, TTC #1 and #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior where PRT had been used with the client. When asked if the facility had identified any clients who had physical limitations where the PRT could not be used, LPN #1, TTC #1, QSP #1 and #2 stated "No at this point and time." TTC #1 indicated the facility did not hyperextend clients' arms, but the clients arms would be held back if the client tried to pinch and hit others and themselves. TTC #1 indicated additional staff could assist to hold the client's legs, head and/or etc as needed. TTC #1 indicated the PRT was designed for 2 staff to implement.</p> <p>Interview with Behavior Specialist (BS)</p>			

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	<p>#1 and TTC #1 on 12/20/12 at 5:15 PM indicated the PRT was part of the Handle With Care physical intervention techniques. TTC #1 and BS #1 indicated the Sitting PRT and Standing PRT were part of the facility's behavioral management policy. When asked if hyperextending the clients' arms was a part of the technique/policy, TTC #1 and BS #1 indicated they thought it was part of the program and policy. When the TTC #1 and BS #1 went to review the Handle With Care program book and behavior management policy, TTC #1 and BS #1 indicated they were not able to locate where the clients' arms should be extended/hyperextended. TTC #1 indicated the policy did say other staff could be used.</p> <p>3. During the 12/18/12 observation period between 4:14 PM and 6:40 PM, at the facility, the following was observed: __5:13 PM client S began yelling and hitting th hallway coming from the dining room. Client S calculator, breaking it and began swinging at th to spit on them. Client S was physically restrain and forced down to the floor in a sitting positior (Qualified Support Professional) #3, was on his behind client S with his arms over and under cli and interlocked at client S's shoulder blades beh TTC (Transitional Team Coordinator) #1 was o behind QSP #3, holding client S's hands tightly. arms were being extended backwards, behind hi</p>			

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	<p>hyperextended upward position. Client S's hand red in color indicating decreased circulation. Client S's body was slightly bent forward with 2 staff laying on client S's legs and feet. Another staff held client S's head and chin as the client was trying to bite and spit holding him. LPN (Licensed Practical Nurse) #1 was holding and watching the restraint. LPN #1 would speak to client S and try to calm the client. Client S was fighting and trying to get out of the hold, at one point client S said "Let go of my neck."</p> <p>At 5:25 PM, LPN #1 asked client S to count to 10 to see if the client was calm. Client S counted to 10 and the staff removed their hands from client S's head. Client S was asked to count to 10 again and the client began struggling trying to get out of his restraint and trying to bite the staff. The staff grabbed client S's head as the staff struggled to regain control. The staff tightened their holds on the client to maintain the original restraint position as the client was struggling to get free. The client yelled, "I don't want her here!" referring to TTC #1.</p> <p>At 5:30 PM the staff then changed positions to continue the sitting restraint with client S. Client S continued to have his arms hyperextended behind him with one staff person remaining at the client's back with their arms over and under the client's arms and the staff's arms interlocked behind client S. The TTC #1 was rubbing client S's hands and wrists. The client stated, "I don't want her here!"</p>			

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	<p>Both of client S's hands and wrists were bluish red in color. Client S stated, "My arms hurt." The client requested to be able to rock. The restraint was maintained with 5 staff and LPN #1 monitoring.</p> <p>__At 5:35 PM, client S complained his right arm was hurting. Client S stated "My arm hurt. My arm hurt." Client S's arms remained hyperextended behind him with the client's upper body slightly bent forward. A staff continued to be at client S's back with the staff's arms under and over the client's and interlocked behind client S. The staff continued to try to have client S count with them but the client continued to struggle. Client S attempted to bite his knee.</p> <p>__At 5:40 PM the Administrator arrived on site. Client S stated to the Administrator, "They put my arms behind me," and "They were holding me too tight." The staff continued to maintain their hold on client S with the client's arms hyperextended behind his back.</p> <p>__At 5:45 LPN #1 checked the client and TTC #1 started rubbing the client's right hand. The client was asked to count to 10 and the hyperextension of his arms were released as the client was allowed to bring his arms down to his side. The client again complained of arm pain.</p> <p>__At 5:47 PM client S began hitting himself, fighting the staff and trying to bite the staff and himself. The</p>						

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	<p>Administrator and another staff immediately lay across client S's legs as the client continued to struggle to stay free from being restrained again. The client grabbed at his clothes and managed to pull his shirt off while laying down on the floor. The staff were able to reestablish their hold and pulled client S back up to a sitting position. Client S's arms were again hyperextended behind him with a staff kneeling behind client S with the staff's arms over and under the client's arms at shoulder area and the staff's arms interlocked behind the client. The client stated, "I want my mommy." The Administrator prompted the client to count to try to calm himself.</p> <p>__At 5:48 PM LPN #1 left to call the doctor. The staff asked client S, "Are you not going to bite?" and "Are you going to be good?" The staff noted client S's left wrist was bleeding as another staff ran to get the first aid kit. The staff indicated client S had bitten himself. Client S's arms were brought forward as the staff continued to restrain the client from movement. Client S was observed to have a large reddened area across his neck and shoulders from the struggle/restraint.</p> <p>__At 6:01 PM LPN #1 returned and tried to place a gauze dressing over client S's wound on his left wrist. Client S struggled as LPN #1 managed to place a large band-aid over the wound. Client S was</p>						

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	<p>observed to have several small yellowish brown bruises up and down his inner left arm. The client continued to struggle with the staff as the Administrator and another staff lay across client S's legs and a staff remained behind client S with their arms under and over client S's arms. LPN #1 indicated she had called the doctor and client S could have Benadryl.</p> <p>__At 6:06 PM LPN #1 gave client S an IM (Intra-muscular) medication/shot of Benydryl to calm him. Client S was crying, "I want my mommy."</p> <p>__At 6:09 PM client S began to calm and all staff removed their restraint on the client. Client S refused to get up and continued to lie on the floor. The Administrator and 3 staff remain with client S as he lay on the floor in the hallway. One of the staff placed a pillow under his head.</p> <p>__At 6:15 PM client S continued to lay calmly on the floor as the staff prompted the client to go to bed.</p> <p>Client S's record was reviewed on 12/19/12 at 12 PM. Client S's BSP (Behavior Support Plan) of 12/4/12 indicated "in certain instances, a client may exhibit maladaptive behaviors that are dangerous to the client or others. In these situation, to be referred to as crisis situations, it may be necessary for staff to intercede in the treatment process by</p>						

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	<p>implementing physical restraint, environmental restraint, or a PRN (as needed) psychotropic intervention. At no times should these treatment techniques be implemented longer than necessary for the client to gain self-control and focus on appropriate alternatives to the behavior(s). Interventions written under level three should only be utilized in a crisis situation and with prior approval and thoroughly documented on an Incident Report." Sometimes with a client in a crisis situation, a standing PRT escort isn't feasible, as it becomes more dangerous to try to move the client from the original place of escalation. If [client S] refuses to comply with the request in step 2 and remains a danger to himself or escalates while in the 'calm space' (isolation), staff may immediately utilize a different physical restraint technique (see below) or enter the 'calm space' isolation and employ a physical restraint in an attempt to avert the crisis by using a standing PRT or sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting</p>						

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	<p>PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others in (sic) involved). [Client S] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by "Handle With Care." The BSP indicated "Physical restraint CANNOT exceed 30 minutes." And, "if a client is unable to regain self-control within ten (10) minutes of the expiration of the approved timeframe.... a licensed nurse will be notified to authorize a time extension."</p> <p>Interview with Behavior Specialist (BS) #1 and TTC #1 on 12/20/12 at 5:15 PM indicated the PRT was part of the Handle With Care physical intervention techniques. TTC #1 and BS #1 indicated the Sitting PRT and Standing PRT were part of the facility's behavioral management policy. When asked if hyperextending the clients' arms was a part of the technique/policy, TTC #1 and BS #1 indicated they thought it was part of the program and policy. When the TTC #1 and BS #1 went to review the Handle With Care program book and behavior management policy, TTC #1 and BS #1 indicated they were not able to locate where the clients' arms should be extended/hyperextended. TTC #1 indicated the policy did say other staff could be used.</p>				

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	<p>The facility's policy and procedures were reviewed on 12/18/12 at 12:15 PM and 12/19/12 at 11:58 AM. The facility's revised 10/12 Physical Restraint Policy indicated the facility utilized the Active Physical Restraint of PRT which was part of the Handle With Care Behavior Management System. The 10/12 policy defined and described the following restraints used by the facility:</p> <p>"1. PRT Escort-used for escorting a client when he or she is a danger to his/herself (sic) or others for the purpose of removing the client from the milieu and getting the client to the Calm Space where he or she can calm down. A PRT Escort may also be used when a client is refusing to move on his own in an emergency evacuation. One person- staff is located behind the client with arms over client's arms and hands interlocked between the client's shoulder blades. Two person - staff are behind the client on each side of the client. The outside arm of each staff is located over the client's arm with the hand over the client's shoulder blade; the inside arm of each staff member is holding the client's wrist. 2. Sitting PRT - used when the client is a danger to his/herself or others, when a client drops his or her weight during a PRT Escort, when a client refuses to walk in a PRT</p>			
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	<p>Escort, or when a client is too aggressive to be moved using the PRT Escort. The Primary staff member who initiates the restraint is behind the client with arms over client's arms and hands interlocked between the client's shoulder blades; this staff member takes a deep step back and brings the client gently to the floor. The Secondary staff secures the client's legs by laying his or her torso (face down) across the client's legs; the Secondary staff will bend his or her knee closest to the client's feet bringing it toward the torso for additional support and stability. Other staff may be required to assist the Primary and Secondary staff to keep the client from injuring his/herself (sic) or others. 3. Standing PRT- This is a transitional restraint technique to be used for a short period of time when a client is a danger to self or others. A standing PRT may be implemented for a short period of time until another staff arrives to fulfill the role of Secondary staff in a Sitting PRT. Staff is located behind the client with arms over client's arms and hands interlocked between the client's shoulder blades; a wall is used to assist with containing the client until the client can be transitioned to a Sitting PRT. Whenever possible cushion will immediately be placed between the client and the wall...." The 10/12 policy did not indicate clients' arms should be extended</p>						

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	backwards and/or hyperextended.			

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W0285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on observation, interview and record review for 2 of 4 sampled clients (B and D) and for 1 additional clients (J), the facility failed to review and/or look at its restraint techniques to ensure its implementation did not cause injuries/potential injuries to clients. The facility failed to ensure safeguards were put in place to ensure the protection of the clients to prevent further injuries due to the clients' current injuries and/or health risks regarding physical restraints.</p> <p>Findings include:</p> <p>1. During the 12/19/12 observation period between 10:30 AM and 11:40 AM, at the facility, client J sat in the day room and complained of pain in her left shoulder. Client J was guarding her left arm/shoulder as the client refused to use it.</p> <p>Interview with client J on 12/19/12 at 11:24 AM stated the client started having pain in her left shoulder/arm after staff utilized "a PRT" (Primary Restraint</p>	W0285	<ul style="list-style-type: none"> · Facility will ensure safeguards are put in place to ensure the protection of the clients to prevent further injuries due to the clients' current injuries and/or health risks regarding physical restraints. · Modified PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to current injuries and/or health risks regarding physical restraints. · Responsible Parties: Health Services Coordinator (DON) to assess clients who may be compromised in a 	02/06/2013

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	<p>Technique) on the client. Client J demonstrated (with her good arm) and stated "They hold my arm back behind me." Client J demonstrated her arm being held backwards in a hyperextended position. Client J indicated she had told staff about her arm/shoulder pain. Client J indicated her shoulder was hurt on 12/17/12. Client J indicated the nurse was aware of her injury. Client J stated "I have been telling them since that night. It is swollen. I can't move it." Client J indicated 2 staff were initially involved in the PRT but there were other staff around. Client J indicated she was admitted to the facility on 11/5/12 and had been restrained 2 times using the PRT restraint. Client J indicated this was the first time her shoulder/arm was hurt. Client J indicated she got upset and threw items in her room and hit staff.</p> <p>Interview with LPN #2 on 12/19/12 at 11:40 AM indicated client J had been complaining of arm pain. When asked what happened to client J's arm, LPN #2 stated "Put in PRT and has complained of pain every since. I need to call and get X-ray."</p> <p>Client J's Behavioral Incident Reports (BIRS) were reviewed on 12/19/12 at 12:35 PM. Client J's 12/17/12 BIR indicated at 10:00 PM client J was placed</p>		<p>regular PRT; Behavioral Services Coordinator to address via BSPs / Human Rights Committee (HRC) approvals & QSPs for staff training and implementation.</p> <p>Completed by: 2/6/13</p> <p>Additionally for clients noted in citation:</p> <p>Clients B, D and J will have restraint techniques in BSP reviewed and modified as warranted to address physical/medical conditions or to mitigate health risks.</p> <p>BSP modifications will be approved by HRC prior to implementation.</p> <p>Responsible Parties: Health Services Coordinator (DON) for review of health risks;</p>				

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	<p>in a PRT escort and a PRT standing restraint. The BIR indicated client J "Ran up on staff and pulled her hair...Tried to attack peer (client B) and Pull another staff's hair." The 12/17/12 BIR indicated client J was redirected to her room to calm down, and began to throw things when she went to her bedroom. The BIR indicated when staff went into the client's bedroom, the client picked up her TV and threw it at the door causing it to break. The BIR indicated client J was asked to go to a "calm space" to calm down but the client refused. The BIR indicated client J was then escorted by 2 staff. The 12/17/12 BIR indicated a standing PRT was done from 10:22 PM to 10:30 PM. The BIR debriefing section indicated 4 staff were involved in the "Level III Intervention." The BIR section indicated "Face to Face: Assessment of Client Following Level II Intervention (To be completed within one hour of Level III Intervention by the nurse, LDSP, QSP (Qualified Support Professional), SSP (Safety & Security Professional) or a designated supervisor other than the person(s) implementing the restraint). Physical: (Check all that apply and provide brief description)." The BIR indicated "No Complaints" was checked. The BIR did not indicate an actual physical assessment was completed.</p>		<p>Behavioral Services Coordinator and QSP to develop restraint modifications and presentation to HRC for approval prior to implementation;</p> <p>Date to be Completed: 2/6/13</p>		

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	<p>Client J's record was reviewed on 12/19/12 at 11:45 AM. Client J's Progress Notes indicated the following (not all inclusive):</p> <p>-12/17/12 (4 PM to 12 AM) "...[Client J] upset over Bingo prizes and got physically aggressive with staff & (and) peer. [Client J] threw and broke several items in her room including throwing her t.v...."</p> <p>-12/18/12 (8 AM to 4 PM) "[Client J] was in bed refusing to get up when staff arrived on the unit at 8 am. [Client J] refused breakfast but took her 8 am meds. [Client J] got up at 9:00 am complaining of shoulder pain in her left shoulder. When asked why it was hurting she stated she did not know...at 12:15pm [client J] ate 100% of her meal and returned to the unit to lay down due to discomfort in her left shoulder. She talked with LDSP (Lead Direct Support Professional) again about shoulder pain after receiving Ibuprofen (pain) & a heating pad from nursing. At 1:33pm [client J] explain to LDSP it was this time she felt her left shoulder pain could be a result of being placed in a PRT the night before. LDSP assisted [client J] with filling out a grievance form. [Client J] remained in bed the remainder of the shift being checked on by staff to ensure safety and</p>						

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	<p>comfort."</p> <p>Client J's 12/18/12 Nursing Progress Note, at 9 AM, indicated "C/O Lt (left) shoulder Disc. (discomfort). ROM (range of motion) Refused. No edema 0 (zero) redness bruising noted by report. Client threw TV last evening. Will monitor Heat Applied." Client J's record neglected to indicate any additional documentation and/or monitoring of the client's shoulder as there was no additional nursing documentation in the client's record as of 12/19/12 at 11:45 AM.</p> <p>Client J's 11/13/12 Transitional Behavioral Support Plan (TBSP) indicated "Level III Intervention" (physical restraint) could be used with client J when she became aggressive, demonstrated property destruction and/or self-injurious behavior. Client J's 11/13/12 TBSP indicated a Standing PRT Escort, Standing PRT and/or a Sitting PRT could be utilized. Client J's 11/13/12 TBSP indicated "...staff may immediately utilize a different physical restraint in an attempt to avert the crisis by using a Standing PRT or Sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management</p>				

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	<p>System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others involved.) [Client J] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by 'Handle With Care'...."</p> <p>Client J's 11/13/12 Transition Support Plan (TSP) failed to indicate the facility and/or the client's interdisciplinary team reviewed the incident/allegation of possible abuse/injury from restraint.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and #2 on 12/19/12 at 2:45 PM indicated the facility's nurse had ordered an X-ray for client J's shoulder. TTC #1 indicated she was not aware of the allegation of possible abuse/injury in restraint with client J until 12/19/12. TTC #1 indicated TTC #1 indicated client J's QSP was made aware of the grievance/allegation on 12/18/12. TTC #1 indicated client J's grievance was not seen as an allegation of possible abuse, and/or as injury from restraint as the client had thrown her TV that night.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
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	<p>Interview with RN #1 on 12/20/12 at 10:30 AM indicated client J had an X-ray done on 12/19/12. RN #1 indicated the results of the X-ray were negative for a fracture or dislocation. RN #1 indicated client J was instructed to move her arm but the client would state "It hurts."</p> <p>Interview with LPN #1, QSP #2 and TTC #1 and #2 on 12/20/12 at 3:00 PM indicated client J was restrained on 12/17/12 due to aggressive behaviors toward others and property destruction. TTC #1 indicated the facility's Security and Safety Professional did the assessment of the client after the incident on 12/17/12. TTC #1 stated no "Client Injury Report" was completed. TTC #1 indicated client J did not have any complaints after she was restrained on 12/17/12. When asked if a physical assessment had been completed, TTC #1 stated "No Complaints checked." TTC #1 indicated the facility did not do an actual physical assessment of the client. LPN #1 indicated client J complained of the injury to her left shoulder on 12/18/12. LPN #1 stated "Nurse came right away" and heating pad was applied. TTC #1 and QSP #2 indicated the client's IDT had not reviewed the incident to ensure protective measures were put in place until the facility determined if the injury was a result from the PRT.</p>						

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/16/12 reportable incident report indicated "[Client B] complained of pain in her left shoulder to nurse at 12:00 PM on 11/15/2012. Nurse then contacted [client B's] primary care physician and he ordered an x-ray to be completed on her left shoulder. Mobile x-ray technician came to the facility and performed an x-ray at 2:07 AM on 11/12.2012 (sic). Results from the x-ray state: 'There is a suggestion of a fracture of the distal third of the clavicle with no displacement of the left shoulder. The acromioclavicular and coracoclavicular joints are normal.' Conclusion from the radiologist performing the examination stated: 'Questionable clavicle fracture as described above. Dedicated clavicle series recommended.' [Client B's] primary care physician was faxed the report from the radiologist at 3am on 11/16/2012. Primary care physician ordered a dedicated clavicle series to be performed. Nurse contacted the mobile x-ray company and they are scheduled to come to the facility to perform this examination as soon as possible...Additionally, [client B] will be seen and evaluated by primary care physician on 11/17/2012...."</p>			

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	<p>The facility's 11/21/12 follow-up report indicated "Results of the dedicated clavicle series state: '2 views of the left clavicle demonstrate no fracture, dislocation or bony reaction. Acromioclavicular articulation is normal.' The conclusion from the radiology report states: 'No fracture or dislocation in clavicle.'" [Client B] notified staff that she has had issues with injuring her shoulder in the past. Physical therapy appointment was scheduled by WTS to further provide support for [client B's] symptoms. The initial evaluation by the therapist was completed on 11/20/2012 and states 'demonstrates weakness and decreased range of motion.' [Client B] was given four exercises by the physical therapist to do at WTS, three times a day, using a rolled up towel. Staff will assist [client B] in completing these exercises...."</p> <p>Client B's record was reviewed on 12/19/12 at 3:09 PM. Client B's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-11/11/12 at 1:05 PM, "Res (resident) placed in PRT @ (at) 1253 related to self harm et. (and) able to process out by 1pm 0 (zero) distress. Res moved to OBS (observation) room."</p>						

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	<p>-11/12/12 at 5:30 PM, "Placed in PRT due to self injurious bx (behavior). Reopened areas to Lt (left) arm & leg. Areas cleansed. Per [name of doctor] moved Suicide I."</p> <p>-11/13/12 at 12 AM, "...Remains on Level I suicide precautions (with) staff in reach. Will monitor Tylenol given effectively for c/o pain in shoulder at 9:25 pm. Reports hx (history) of collar bone fx (fracture) in past and having chronic pain."</p> <p>-11/15/12 at 12 PM, "New order per [name of doctor]. X-ray Lt shoulder c/o disc (complaints of discomfort). S1 (Slight) edema to the front of the shoulder. Client stating difficulty (with) ROM (range of motion). Also stated she has fx'ed (fractured) before. [Name of xray company] notified."</p> <p>-11/16/12 at 5:30 AM, "Complaints of pain (L) (left) shoulder, x-ray done this shift, results came back positive, res has a fx, results faxed to MD (Medical Doctor), to await new orders, res given tylenol prn (as needed) for pain."</p> <p>-11/16/12 at 12 PM, "[Name of doctor] called r/t (related to) Xray results et. recommended dedicated clavicle series. [Name of xray company] called...."</p>						

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	<p>-11/16/12 at 7:40 PM, "[Name of xray company] here to complete clavicle (L) arm."</p> <p>-11/16/12 at 11:30 PM, "Received X-ray results showing 0 fracture/dislocation seen in (L) arm. Will continue to monitor and medicate for pain."</p> <p>-11/19/12 at 10 AM, "Spoke with [name of doctor]. No new orders related to X-ray results."</p> <p>-11/19/12 at 5:00 PM, "New Order per [name of doctor]. PT (Physical Therapy) eval (evaluation) related to Lt shoulder."</p> <p>-11/19/12 at 5:05 PM, "Scheduled PT 11-20-12 at [name of company]."</p> <p>-11/25/12 at 3:00 AM, client B complained of pain in the side of her left shoulder. The note indicated Tylenol was given to client B for pain.</p> <p>Client B's physician's orders and/or faxed orders indicated the following (not all inclusive):</p> <p>-11/15/12 "X-ray LT Shoulder C/O Disc. Sl edema to the front of the shoulder difficulty with ROM"</p>				

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	<p>-11/16/12 "X-Ray (clavicle series) related to recommendation"</p> <p>-11/19/12 "PT Eval Due to Hx (history) of Fx to Lt Shoulder C/O Disc"</p> <p>Client B's 11/17/12 Medical Visit Summary form indicated client B saw her primary care doctor as the client continued to complain of pain and the X-ray showed no fracture. Client B's medical visit form indicated "Will allow for normal healing and allow patient to take Non-Narcotic pain medication for now in view of No Fracture noted on X-ray."</p> <p>Client B's 11/20/12 Medical Visit Summary form indicated seen a PT for evaluation of the client's left shoulder. The form indicated the client had a history of clavicle fracture. The 11/20/12 form indicated "Initial evaluation performed (sic) Pt (patient) demonstrates weakness, decreased ROM. HEP (exercises) provided and explained to pt. transportation present." The form indicated PT would follow-up.</p> <p>Client B's 11/7/12 Transition Behavioral Support Plan (TBSP) Level II section indicated "In certain instances, a client may exhibit maladaptive behaviors that are dangerous to the client or others. In</p>						

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	<p>theses situations, to be referred to as 'crisis situation', it may be necessary for staff to intercede in the treatment process by implementing physical restraint, environmental restraint, or a PRN psychotropic intervention...." Client B's TBSP indicated facility staff could utilize a Standing PRT Escort, Standing PRT, Sitting PRT when client B demonstrated self-harm behavior and/or physical aggression. Client B's 11/7/12 TBSP indicated "[Client B] has no known condition that would prohibit the use if any of the physical restraint techniques utilized by 'Handle With Care' and WTS. (Please see WTS Physical Restraint policy for an explanation of each technique and its proper implementation)...Staff debriefing should be done following each occurrence of restraint and/or emergency intervention. Debriefing with [client B] should be done following her release from restraint/emergency intervention...."</p> <p>Client B's BIRs were reviewed on 12/19/12 at 12:35 PM. Client B's BIRs indicated the following (not all inclusive):</p> <p>-11/11/12 Client B tried to cut herself with a fork. The 11/11/12 BIR indicated facility staff utilized PRT Escort, Standing PRT and Sitting PRT with the client. The 11/11/12 Face to Face</p>				

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>Assessment indicated client B had no complaints. No actual physical assessment was documented for client B. The 11/11/12 BIR indicated 3 staff were involved in the Standing PRT and with a monitor and a two staff and a monitor were involved in the PRT escort and Sitting PRT.</p> <p>-11/12/12 Client B was scratching her legs and arms attempting to self harm. The BIR indicated a Sitting PRT was utilized by 3 staff and a monitor. The BIR indicated a "Face to Face" assessment was completed and there was no complaints. The 11/12/12 BIR indicated an Illness and Injury Report was also completed. The BIR indicated client B's arms and legs were assessed and the areas were cleansed.</p> <p>-11/27/12 Client B threw shoes at staff and hit the TV 2 times in the day room. The BIR indicated client B did not respond to verbal redirection. The BIR indicated 2 staff utilized a PRT Escort with a monitor and 3 staff utilized a Sitting PRT with a monitor. The 11/27/12 BIR indicated a "Change in breathing" was checked. The BIR indicated "Breathing hard" in the section entitled "Signs of tension in the client." The BIR indicated "No complaints" was checked in the Face to Face Assessment.</p>						

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	<p>The 11/27/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/27/12 BIR did not indicate the PRT was modified.</p> <p>-11/29/12 Client B "charged staff swinging her fist" and hit staff in their upper torso. The BIR indicated 3 staff placed the client in a Sitting PRT with a monitor. The BIR indicated "No complaints" was checked in the Face to Face assessment. The 11/29/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/29/12 BIR did not indicate the PRT was modified.</p> <p>-11/30/12 Client B refused to leave her bedroom door open to be monitored. The client attempted to barricade the door and yelled at staff to get out of her room. Client B threw shoes at the staff when they attempted to keep the door open. The BIR indicated client B was placed in a Standing PRT and an PRT Escort by 2 staff with a monitor. The BIR indicated "No complaints" was checked in the Face to Face assessment. The 11/30/12 BIR did not indicate a physical assessment was completed after the restraint. The 11/30/12 did not indicate the PRT was modified.</p> <p>Client B's 12/7/12 Transitional Support</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>Plan (TSP) indicated client B's interdisciplinary team (IDT) did not meet to review the client's behavioral incidents and/or restraints. The above mentioned BIRs indicated the facility restrained client B on 11/27, 11/29 and 11/30/12 after the client was found to have a shoulder injury on 11/16/12 and saw a PT for evaluation/treatment on 11/20/12. The facility and/or the client's IDT failed to review the use of the PRTs with client B to ensure sufficient safeguards were put in place to protect the client from injury and/or re-injury.</p> <p>Interview with LPN #1, TTC #1 and #2, QSP #1 and #2 on 12/20/12 at 3:00 PM indicated client B demonstrated self harm behavior where PRT had been used with the client. LPN #1 indicated client B received PT for her shoulder. LPN #1 stated client B received "Strengthening exercises of shoulder due to weakening of muscles." LPN #1 and QSP #1 indicated client B had a history of clavicle fractures as reported by the client. TTC #1 indicated the facility did not conduct an investigation in regard to client B's injury of unknown source, and/or to ensure the re-injury or injury was not due to the PRT done on 11/11 or 11/12/12. When asked if client B's IDT reviewed/looked at the use of the PRT with client B, TTC #1 and QSP #1 stated "No." LPN #1 stated client</p>						

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	<p>B's IDT "Should have looked at." LPN #1 indicated the PRT should probably not be done with client B due to the client's shoulder injury. When asked if client B had been restrained since 11/16/12, QSP #1 stated "She (client B) has had 5 incidents where she was restrained. Not sure." When asked if the client's IDT had modified the PRT to ensure client B's protection, QSP #1 and TTC #1 stated "No." When asked if the facility had identified any clients who had physical limitations where the PRT could not be used, LPN #1, TTC #1, QSP #1 and #2 stated "No at this point and time." TTC #1 indicated the facility did not hyperextend clients' arms, but the clients' arms would be held back if the client tried to pinch and hit others and themselves. TTC #1 indicated additional staff could assist to hold the client's legs, head and/or etc as needed. TTC #1 indicated the PRT was designed for 2 staff to implement.</p> <p>Interview with Behavior Specialist (BS) #1 and TTC #1 on 12/20/12 at 5:15 PM indicated the PRT was part of the Handle With Care physical intervention techniques. TTC #1 and BS #1 indicated the Sitting PRT and Standing PRT were part of the facility's behavioral management policy. When asked if hyperextending the clients' arms was a part of the technique/policy, TTC #1 and</p>						

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	<p>BS #1 indicated they thought it was part of the program and policy. When TTC #1 and BS #1 went to review the Handle With Care program book and behavior management policy, TTC #1 and BS #1 indicated they were not able to locate where the clients' arms should be extended/hyperextended. TTC #1 indicated the policy did say other staff could be used. When asked if the facility's behavior management policy addressed how the facility handled injuries in restraint, TTC #1 stated "Should be in policy." When TTC #1 reviewed its policy, TCC#1 was not able to find how the facility would address injuries from the use of restraints.</p> <p>3. The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM. _ On 11/16/12 at 4:50 PM client D was in the dining room and walked over to a female client's table. The staff redirected client D and client D became angry with the staff, began cursing, yelling and "hitting staff." The report indicated client D was placed in a sitting PRT (Primary Restraint Technique). The report indicated the client was in this hold for 16 minutes.</p> <p>Client D's record was reviewed on 12/20/12 at 1:30 PM.</p>				

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	<p>__ Client D's Medical Visit Summary of 11/17/12 indicated the client saw his doctor due to "c/o (complaint of) right wrist pain to shoulder R/t (related to) PRT (Primary Restraint Technique)." The record indicated the client was to have an x-ray of his right hand and shoulder.</p> <p>__ Client D's Radiology Report of 11/17/12 indicated the results of the x-ray of client D's right shoulder were "Modest degenerative joint disease of the right shoulder, otherwise, no fracture or dislocation seen." The result of the x-ray of client D's right hand was "Modest degenerative joint disease, otherwise, no fracture seen."</p> <p>__ Client D's BSP (Behavior Support Plan) of 12/14/12 indicated a crisis situation defined as any situation where client D continued to behave dangerously and prevention techniques, de-escalation procedures, replacement behaviors and response suppression procedures have been attempted and failed to avert the dangerous behavior, restrictive behavioral controls may be utilized by staff." The BSP indicated: Level Three step one indicated the client was to be asked to go to a "Calm Space (Isolation)." Step two indicated if client D refused to go on his own to a calm space, the staff were to accompany client D. Step three indicated if client D refused to comply with steps one and two, the staff were to use a</p>				

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	<p>Standing PRT Escort. Step four indicated if the staff were unable to escort the client safely then a Standing PRT, Sitting PRT, or Modified PRT were to be used. The BSP indicated client D "has no known condition that would prohibit the use of any of the physical restraint techniques utilized by Handle With Care ."</p> <p>Client D's Nursing Progress Notes indicated: __ On 10/29/12 at 12:30 PM LPN (Licensed Practical Nurse) #1 indicated the client was placed in PRT due to verbal aggression leading to physical aggression of the staff. The note indicated client D had redness to his left side of his neck that was fading and a small scratch to the left side of his face and one on his left hand. __ On 11/17/12 at 1 PM indicated client D's physician was notified of client D's complaints of right wrist pain radiating to the client's shoulder. The note indicated the physician ordered for the client to have x-rays to rule out a fracture. The note indicated client D was using his right hand. __ On 11/1/12 at 2:48 AM indicated nursing had received the results of client D's x-rays of his hand and shoulder. "Results of (R) right hand showed modest Osteoarthritis but no fracture/dislocation seen. View of right shoulder demonstrate</p>						

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	<p>no fracture, dislocation or bony reaction. Conclusion shows modest degenerative joint disease of the right shoulder. Also (R) wrist demonstrates no fracture, dislocation or bony reaction as well. Will fax (client D's physician) all results and await response."</p> <p>Client D's record did not indicate the IDT (Interdisciplinary Team) had reviewed client D's BSP in regards to the use of restraints and how client D was to be restrained if needed due to client D's recent diagnosed health issues in regards to client D's right hand, right shoulder, left eye and complaints of back and hip pain.</p> <p>Interview with LPN #1 on 12/20/12 at 3:00 PM indicated she was not aware of the results of client D's x-rays. When asked if client D should be put in PRT for behavior management given the results of his x-rays, LPN #1 stated, "No." LPN #1 indicated client D's BSP needed to be reviewed and revised to include client D's medical issues.</p>				

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the use of a jumpsuit, to prevent the client from stripping, was part of the client's behavior plan.</p> <p>Findings include:</p> <p>During the 12/18/12 observation period between 4:14 PM and 6:40 PM, at the facility, client A wore an orange one piece jumpsuit which zipped in the back.</p> <p>Client A's record was reviewed on 12/20/12 at 1:13 PM. Client A's 11/19/12 Progress Note indicated "...She (client A) then transitioned to the library where she continued yelling and pushing over chairs and throwing small objects. She returned to the unit and began undressing herself and walking around the unit. Staff assisted her in putting on a jumpsuit so she could stay clothed...."</p> <p>Client A's 11/26/12 Transition Behavior Support Plan (TBSP) indicated client A</p>	W0289	<p>- Client A's BSP has been amended to include the use/wearing of a 'non-tear' jumpsuit as an approved intervention to address stripping behavior.</p> <p>- Responsible Party: Behavioral Services Coordinator</p> <p>- Completed on: 1/2/13.</p> <p>- Behavioral Services Coordinator & QSPs will regularly review all clients to assure that any restrictive/intrusive intervention(s) are properly incorporated into a formal BSP and approved by the Human Rights Committee (HRC)</p>	02/06/2013

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	<p>demonstrated "Self Harming Behavior" which was "...defined as biting self, she bites knees and refuses to wear arm guards, rolls around on floor and mattress, rips off clothing and or refuses to dress, hits self and roommate with objects causing bruising *...." Client A's 11/26/12 TBSP did not indicate a jumpsuit, which zipped in the back, was to be used to keep the client clothed.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and Qualified Support Professional (QSP) #1 on 12/20/12 at 3:00 PM indicated client A wore the jump suit as the client would strip off her clothing and tear her clothes. QSP #1 indicated client A's 11/26/12 TBSP did not include/incorporate using a jumpsuit to keep the client clothed.</p>		<p>prior to implementation.</p> <ul style="list-style-type: none"> · On-going. · Additionally, in IDT meetings, QSPs and other team members will present for review and consideration any possible restrictive interventions that may be effectively incorporated into a BSP and implemented after approval of the HRC. · On-going. 		

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation interview and record review for 1 of 4 sampled clients (C) and for 2 additional clients (J and S), the facility's nursing services failed to meet the nursing needs of the clients. The nursing services failed to monitor/follow-up with client J's shoulder complaints, to contact a client's doctor in regard to a client's shoulder complaint and/or to obtain an X-ray timely. The facility's nursing services failed to accurately document follow-ups and/or assessments as no late entry dates were indicated in client J's record. The facility's nursing services failed to conduct physical assessments of client S when physically restrained, and/or failed to complete recommended daily body checks/assessments of the client with known injuries due to behavior and/or injuries of unknown source. The facility's nursing services failed to monitor/assess client C, with known medical issues, after being restrained to ensure placement of Urinary Stimulator Probe.</p> <p>Findings include:</p> <p>1. During the 12/19/12 observation period between 10:30 AM and 11:40 AM, at the facility, client J sat in the day room</p>	W0331	<p>Facility's nursing services will conduct physical assessments of client's within 2 hours of being physically restrained, and complete daily body checks/assessments of clients with known injuries due to behavior and/or injuries of unknown source until issue is resolved / no longer requiring medical oversight per nursing protocols.</p> <p>Facility's policy will be modified to reflect that a nurse will conduct assessment of clients within two hours of all physical restraints with follow-up within 24 hours and thereafter as indicated & any physical complaint following a physical restraint will be assessed by a nurse immediately with</p>	02/06/2013	

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	<p>and complained of pain in her left shoulder. Client J was guarding her left arm/shoulder as the client refused to use it.</p> <p>Interview with client J on 12/19/12 at 11:24 AM stated the client started having pain in her left shoulder/arm after staff utilized "a PRT" (Primary Restraint Technique) on the client. Client J demonstrated (with her good arm) and stated "They hold my arm back behind me." Client J demonstrated her arm being held backwards in a hyperextended position. Client J indicated she had told staff about her arm/shoulder pain. Client J indicated her shoulder was hurt on 12/17/12. Client J indicated the nurse was aware of her injury. Client J stated "I have been telling them since that night. It is swollen. I can't move it." Client J indicated 2 staff were initially involved in the PRT but there were other staff around. Client J indicated she was admitted to the facility on 11/5/12 and had been restrained 2 times using the PRT restraint. Client J indicated this was the first time her shoulder/arm was hurt. Client J indicated she got upset and threw items in her room and hit staff.</p> <p>Interview with LPN #2 on 12/19/12 at 11:40 AM indicated client J had been complaining of arm pain. When asked</p>		<p>follow-up as indicated.</p> <ul style="list-style-type: none"> · Nursing initial assessment and follow-ups on restraints and injuries of unknown source will be properly documented on revised "client injury report". · Nurse will immediately assess clients with known medical conditions/medical devices, including implants, immediately upon conclusion of a physical restraint. · Responsible Parties: <ul style="list-style-type: none"> o Quality Assurance Director to revise the "Physical Restraint Policy" by 2/6/13; o Health Services Coordinator & Office Manager to revise "Client Illness Report" to include additional information and provide space for initial assessment and 				

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	<p>what happened to client J's arm, LPN #2 stated "Put in PRT and has complained of pain ever since. I need to call and get X-ray." LPN #2 stated when she came in, "Night nurse gave report. She (client J) needed x-ray done." When asked if LPN #2 had called to obtain an x-ray, LPN #2 stated "Not yet. I need to call and get X-ray." LPN #2 could not explain why she had not called the doctor and/or obtained an X-ray as of 11:40 AM on 12/19/12.</p> <p>Client J's Behavioral Incident Reports (BIRS) were reviewed on 12/19/12 at 12:35 PM. Client J's 12/17/12 BIR indicated at 10:00 PM client J was placed in a PRT escort and a PRT standing restraint. The BIR indicated client J "Ran up on staff and pulled her hair...Tried to attack peer (client B) and Pull another staff's hair." The 12/17/12 BIR indicated client J was redirected to her room to calm down, and began to throw things when she went to her bedroom. The BIR indicated when staff went into the client's bedroom, the client picked up her TV and threw it at the door causing it to break. The BIR indicated client J was asked to go to a "calm space" to calm down but the client refused. The BIR indicated client J was then escorted by 2 staff. The 12/17/12 BIR indicated a standing PRT was done from 10:22 PM to 10:30 PM.</p>		<p>follow-up by 2/6/13;</p> <ul style="list-style-type: none"> o Health Services Coord. to train nurses on proper documentation / completing the revised "Client Injury Report" with follow-up by 2/6/13; o Health Seervices Coord. to train nurses on revised "Physical Restraint Policy", to include focus on immediately assessing those clients with known medical conditions / medical devices by 2/6/13 				

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	<p>The BIR debriefing section indicated 4 staff were involved in the "Level III Intervention." The BIR section indicated "Face to Face: Assessment of Client Following Level II Intervention (To be completed within one hour of Level III Intervention by the nurse, LDSP, QSP (Qualified Support Professional), SSP (Safety & Security Professional) or a designated supervisor other than the person(s) implementing the restraint). Physical: (Check all that apply and provide brief description)." The BIR indicated "No Complaints" was checked. The BIR did not indicate nursing services completed an actual physical assessment.</p> <p>Client J's record was reviewed on 12/19/12 at 11:45 AM. Client J's Progress Notes indicated the following (not all inclusive):</p> <p>-12/17/12 (4 PM to 12 AM) "...[Client J] upset over Bingo prizes and got physically aggressive with staff & (and) peer. [Client J] threw and broke several items in her room including throwing her t.v...."</p> <p>-12/18/12 (8 AM to 4 PM) "[Client J] was in bed refusing to get up when staff arrived on the unit at 8 am. [Client J] refused breakfast but took her 8 am meds. [Client J] got up at 9:00 am complaining</p>			

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>of shoulder pain in her left shoulder. When asked why it was hurting she stated she did not know...at 12:15pm [client J] ate 100% of her meal and returned to the unit to lay down due to discomfort in her left shoulder. She talked with LDSP (Lead Direct Support Professional) again about shoulder pain after receiving Ibuprofen (pain) & a heating pad from nursing. At 1:33pm [client J] explain to LDSP it was this time she felt her left shoulder pain could be a result of being placed in a PRT the night before. LDSP assisted [client J] with filling out a grievance form. [Client J] remained in bed the remainder of the shift being checked on by staff to ensure safety and comfort."</p> <p>Client J's Nursing Progress Notes indicated the following:</p> <p>-12/16/12 (6 PM) "Reported nose bleed @ (at) 10 AM. Monitored thru the day for further bleeding. No C/O (complaints) pain or discomfort. Non further bleeding."</p> <p>-12/18/12 (9 AM) "C/O Lt (left) shoulder Disc. (discomfort). ROM (range of motion) Refused. No edema 0 (zero) redness bruising noted by report. Client threw TV last evening. Will monitor Heat Applied." Client J's record</p>						

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	<p>neglected to indicate any additional documentation and/or monitoring of the client's shoulder as there was no additional nursing documentation in the client's record as of 12/19/12 at 11:45 AM. Client J's faxed physician orders from 11/12 to 12/12 and the client's nursing notes indicated the facility failed to inform client J's doctor of the client's shoulder complaints, and/or failed to obtain an x-ray of the client's shoulder as of 12/19/12 at 11:45 AM. Client J's nursing notes neglected to indicate any additional monitoring and/or documentation in regard to the client's shoulder pain/discomfort as of 12/19/12 at 11:45 AM as there were no additional nurse notes to review. On 12/20/12 at 10:30 AM, client J's nurse notes were reviewed to see if the X-ray had been obtained. The nurse notes indicated documentation for 12/18/12 that was not present on 12/19/12. The nurse notes did not contain any late entry dates.</p> <p>Client J's 11/13/12 Transition Behavioral Support Plan (TBSP) indicated "Level III Intervention" (physical restraint) could be used with client J when she became aggressive, demonstrated property destruction and/or self-injurious behavior. Client J's 11/13/12 TBSP indicated a Standing PRT Escort, Standing PRT and/or a Sitting PRT could be utilized.</p>			

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	<p>Client J's 11/13/12 TBSP indicated "...staff may immediately utilize a different physical restraint in an attempt to avert the crisis by using a Standing PRT or Sitting PRT. A PRT, Primary Restraint Technique, is an approved interactive treatment technique outlined in the Handle With Care (HWC) Behavior Management System with specific methods and ways to implement those. These can be done with one or more staff if deemed necessary to avert a 'crisis situation' and keep the individual safe from self-harm. (Please note, a Sitting PRT ALWAYS requires more than one staff member to ensure the safety of the client and any others involved.) [Client J] has no known condition that would prohibit the use of any of the physical restraint techniques utilized by 'Handle With Care'...."</p> <p>Interview with Treatment Team Coordinator (TTC) #1 and #2 on 12/19/12 at 2:45 PM indicated the facility's nurse had ordered an X-ray for client J's shoulder. TCC #1 and #2 did not know why the X-ray had not been ordered prior to 12/19/12 when questioned by the surveyor. TTC #1 and #2 did not know why there was no additional monitoring or follow-up documented by nursing staff as of 12/19/12.</p>						

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	<p>Interview with RN #1 on 12/20/12 at 10:30 AM indicated client J had an X-ray done on 12/19/12. RN #1 indicated the results of the X-ray was negative for a fracture or dislocation. RN #1 indicated client J was instructed to move her arm but the client would state "It hurts."</p> <p>Interview with LPN #1, QSP #2 and TTC #1 and #2 on 12/20/12 at 3:00 PM indicated client J was restrained on 12/17/12 due to aggressive behaviors toward others and property destruction. TTC #1 indicated the facility's Security and Safety Professional did the assessment of the client after the incident on 12/17/12. TTC #1 stated no "Client Injury Report" was completed. TTC #1 indicated client J did not have any complaints after she was restrained on 12/17/12. When asked if a physical assessment had been completed, TTC #1 stated "No Complaints checked." TTC #1 indicated the facility did not do an actual physical assessment of the client. LPN #1 indicated client J complained of the injury to her left shoulder on 12/18/12. LPN #1 stated "Nurse came right away" and a heating pad was applied.</p> <p>2. During the 12/18/12 observation period between 4:14 PM and 6:40 PM, at the facility, the following was observed: __5:13 PM client S began yelling and hitting th</p>				

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	<p>hallway coming from the dining room. Client S calculator, breaking it and began swinging at th to spit on them. Client S was physically restrain and forced down to the floor in a sitting positior (Qualified Support Professional) #3, was on his behind client S with his arms over and under cli and interlocked at client S's shoulder blades beh TTC (Transitional Team Coordinator) #1 was o behind QSP #3, holding client S's hands tightly. arms were being extended backwards, behind hi hyperextended upward position. Client S's hand red in color indicating decreased circulation. Cl body was slightly bent forward with 2 staff layi client S's legs and feet. Another staff held client and chin as the client was trying to bite and spit holding him. LPN (Licensed Practical Nurse) # and watching the restraint. LPN #1 would speak client to try and calm the client. Client S was fig and trying to get out of the hold, at one point cli "Let go of my neck."</p> <p>__At 5:25 PM, LPN #1 asked client S to count to 10 to see if the client was calm. Client S counted to 10 and the staff removed their hands from client S's head. Client S was asked to count to 10 again and the client began struggling trying to get out of his restraint and trying to bite the staff. The staff grabbed client S's head as the staff struggled to regain control. The staff tightened their holds on the client to maintain the original restraint position as the client was struggling to get free. The client yelled, "I don't want her here!" referring to TTC #1.</p>			

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	<p>__At 5:30 PM the staff then changed positions to continue the sitting restraint with client S. Client S continued to have his arms hyperextended behind him with one staff person remaining at the client's back with their arms over and under the client's arms and the staff's arms interlocked behind client client S. The TTC #1 was rubbing client S's hands and wrists. The client stated, "I don't want her here!" Both of client S's hands and wrists were bluish red in color. Client S moaned, "My arms hurt." The client requested to be able to rock. The restraint was maintained with 5 staff and LPN #1 monitoring.</p> <p>__At 5:35 PM, client S complained his right arm was hurting. Client S stated "My arm hurt. My arm hurt." Client S's arms remained hyperextended behind him with the client's upper body slightly bent forward. A staff continued to be at client S's back with the staff's arms under and over the client's and interlocked behind client S. The staff continued to try to have client S count with them but the client continued to struggle. Client S attempted to bite his knee.</p> <p>__At 5:40 PM the Administrator arrived on site. Client S stated to the Administrator, "They put my arms behind me." and "They were holding me too tight." The staff continued to maintain their hold on client S with the client's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
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	<p>arms hyperextended behind his back.</p> <p>__At 5:45 LPN #1 checked the client and TTC #1 started rubbing the client's right hand. The client was asked to count to 10 and the hyperextension of his arms were released as the client was allowed to bring his arms down to his side. The client again complained of arm pain.</p> <p>__At 5:47 PM client S began hitting himself, fighting the staff and trying to bite the staff and himself. The Administrator and another staff immediately lay across client S's legs as the client continued to struggle to stay free from being restrained again. The client grabbed at his clothes and managed to pull his shirt off while laying down on the floor. The staff were able to reestablish their hold and pulled client S back up to a sitting position. Client S's arms were again hyperextended behind him with a staff kneeling behind client S with the staff's arms over and under the clients arms at shoulder area and the staffs arms interlocked behind the client. The client moaned, "I want my mommy." The Administrator prompted the client to count to try to calm himself.</p> <p>__At 5:48 PM LPN #1 left to call the doctor. The staff asked client S, "Are you not going to bite?" and "Are you going to be good?" The staff noted client S's left wrist was bleeding as another staff ran to get the first aid kit. The staff indicated</p>						

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	<p>client S had bitten himself. Client S's arms were brought forward as the staff continued to restrain the client from movement. Client S was observed to have a large reddened area across his neck and shoulders from the struggle/restraint.</p> <p>__At 6:01 PM LPN #1 returned and tried to place a gauze dressing over client S's wound on his left wrist. Client S struggled as LPN #1 managed to place a large band-aid over the wound. Client S was observed to have several small yellowish brown bruises up and down his inner left arm. The client continued to struggle with the staff as the Administrator and another staff lay across client S's legs and a staff remained behind client S with their arms under and over client S's arms. LPN #1 indicated she had called the doctor and client S could have Benadryl.</p> <p>__At 6:06 PM LPN #1 gave client S an IM (Intra-muscular) medication/shot of Benadryl to calm him. Client S was crying, "I want my mommy."</p> <p>__At 6:09 PM client S began to calm and all staff removed their restraint on the client. Client S refused to get up and continued to lie on the floor. The Administrator and 3 staff remain with client S as he lay on the floor in the hallway. One of the staff placed a pillow under his head.</p> <p>__At 6:15 PM client S continued to lay calmly on the floor as the staff prompted</p>			

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	<p>the client to go to bed.</p> <p>The facility's reportable incident reports and investigative reports were reviewed on 12/18/12 at 12 PM. Client S's BIRs (Behavior Incident Reports) were reviewed on 12/20/12 at 11 AM.</p> <p>The reports indicated: ___The BDDS (Bureau of Developmental Disabilities Services) report of 11/15/12 at 8:10 PM indicated the nurse found bruises on client S's left side of his chest and left arm. "The 3 bruises are located on [client S's] left inner arm (1 cm, dark purple in color), above left breast (6 cm x 3 cm, purple and yellow in color), and below left breast (10 cm x 3 cm, purple and yellow in color)." The report indicated client S first indicated his roommate had injured him then said it was not his roommate. The report indicated the client was assessed by LPN #1 and QSP #3. QSP #3 indicated "the bruising did not look as if it was inflicted by a "fist or hand. The bruises appeared to be linear as if they were caused by an object possibly resulting from a fall." The report indicated the results of the investigation reflect "that there is still no known cause from the bruising. Daily body checks will be implemented at night to check for any bruising that may have occurred for the next 30 days. [Client S] will be monitored for complaints of pain</p>				

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	<p>and proper healing."</p> <p>__The BDDS report of 11/16/12 at 4:54 PM indicated client S went out of bounds from the dining hall during dinner. When staff followed him, client S began swinging at the staff and attempting to hit, kick and bite staff. Client S was placed in a sitting PRT. Then at 5:35 PM client S walked out of bounds from the hall and staff followed him. Client S began cursing the staff and went to the fire extinguisher by the door to the small gym and started punching it, punching the wall, and biting himself. Client S then started pulling at the door of the fire extinguisher. When directed to stop, client S became more agitated and got in the staff's face, throwing punches and trying to bite the staff. Client S calmed for a short period then punched the staff that was trying to calm him. The report indicated client S was placed in a sitting PRT for 1 minute, released and then again placed in a sitting PRT for another 15 minutes.</p> <p>__The BIR of 11/16/12 indicated the face to face assessment was conducted by SSP (Safety and Security Professional) #3 at 11/16/12 at 7:15 PM. The assessment indicated client S had no complaints.</p> <p>__The BDDS report of 11/17/12 at 4 PM indicated the nurse noted swelling and bruising to client S's right hand. The nurse notified the physician and the client was sent to the Emergency Room for</p>						

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	<p>assessment. The client was diagnosed with a contusion on his right hand. The report indicated if client S's hand was not better in 9 days he was to seen by a doctor specializing in hands.</p> <p>__The BIR of 11/18/12 at 5:59 PM indicated client S was found in the hall banging his head into the fire extinguisher case. Staff attempted to redirect client S. Client S stopped and entered his room where the staff found client S stabbing himself in the arm with an ink pen. Staff intervened and placed client S in a PRT (Primary Restraint Technique) escort. Client S tried to kick the staff and was "dropped to the floor in a sitting PRT." Once out of PRT client S returned to the hallway and proceeded to hit the window in the biohazard room door. The report indicated the face to face assessment was conducted by LPN #3 at 11/18/12 at 6:30 PM. The assessment indicated client S was complaining of his right hand hurting. The staff gave client S an ice pack.</p> <p>__The BIR of 11/19/12 at 9:07 PM indicated client S entered the day room and approached client T and spit on him. Client T retaliated by slapping client S. The staff separated clients S and T. Client S approached client T. Staff were unable to redirect client S and placed client S in a sitting PRT. Client S's "positioning didn't allow proper coverage on his legs and he</p>						

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	<p>was able to bite each of his legs above the knees." Client S was returned to a standing PRT against the wall. The report indicated only 2 staff participated and monitored the use of the PRT. The report indicated RN (Registered Nurse) #2 conducted a face to face assessment on 11/19/12 at 11:45 PM. RN #2 indicated client S had 2 bite marks on knees with minor cuts. RN #2 indicated the areas were cleansed and would be monitored for signs and symptoms of infection.</p> <p>__The BDDS report of 11/21/12 at 10:45 AM indicated client S wanted to take a walk in the community, when the staff denied his request, client S walked to the steel exit door and started kicking the door. The staff got in front of the door and client S began kicking and biting the staff. The client was placed in a sitting PRT for 10 minutes. A face to face assessment was conducted by client S's LDSP (Lead Support Professional). The report indicated client S had no injuries.</p> <p>__The BDDS 11/22/12 follow up report indicated the facility "has implemented daily body checks to be preformed by the nurse to monitor this situation and to ensure that [client S] is free from abuse/neglect or making future false allegations."</p> <p>__The BDDS report of 11/26/12 at 1:30 PM indicated client S had soiled his clothing and was excused from his</p>						

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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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	<p>activity to return to his unit to shower. Client S became angry and "punched" the shower wall and fell. The report indicated client S was seen by a nurse. Client S became angry again after being asked to help clean up his mess from soiling his clothes and closed his bedroom door and began punching the door. The client calmed and opened the door. While the staff was cleaning the bathroom, client S found the back to a battery supply and cut his arm with it. The client indicated he was going to kill himself. The staff verbally redirected client S to listen to music as a calming/coping technique. While listening to music, client S began punching items and re-injured his hand and throwing chairs. One of the chairs caused "two six inch cuts on his left arm as it scraped his arm while attempting to launch it." The staff immediately intervened and client S began scratching, biting and head butting the staff. The client was placed in a standing PRT and then a sitting PRT for "approximately 5 minutes." The report indicated the client was seen by the nurse for bruising on his hand.</p> <p>__The BIR of 11/26/12 at 2:30 PM indicated BS (Behavior Specialist) #1 conducted a face to face assessment of client S. The BS #1 indicated client S was complaining of pain in his right hand and client S had scrapes and bruises to his</p>						

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	<p>right hand and left arm elbow area scratches." The report indicated the nurse was notified to provide first aid.</p> <p>__The BDDS report of 11/27/12 at 7:10 PM indicated client S became upset when he was denied going to the vending machine because of being on Level II Suicide Precautions. Client S began kicking and hitting, attempting to hit staff with a wooden door from a cabinet. Client S was placed in a sitting PRT for 4 minutes. The report indicated SSP #2 conducted a face to face assessment and noted client S was alert and had no complaints but was agitated, sad and irritated. Later at 10:25 PM client S became upset with another client and threw a cup of water on the other client. Client S was redirected out of the room and as the client was walking down the hallway, he attempted to pull the fire extinguisher from the box on the wall. The staff redirected client S to stop pulling on the fire extinguisher and client S turned and began pushing and fighting with the staff. Client S was placed in a standing PRT for 4 minutes, PRT escort for 2 minutes and then to a sitting PRT for 7 minutes before calming. The report indicated SSP #2 again conducted a face to face assessment with client S and noted client S complained of a headache and dizziness, but was alert, cooperative and had appropriate thought processes. The</p>				

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	<p>report did not indicate the client was physically assessed for bodily injuries or seen by a nurse after complaint of pain.</p> <p>__The BDDS report of 11/29/12 at 7:30 PM indicated client S became upset that he had no money to use in the vending machine. Client S began hitting the staff. Client S was placed in a sitting PRT for "approximately" 10 minutes. The report indicated SSP #2 conducted a face to face assessment with client S and noted client S had no complaints, was alert, but was still a little irritated and sad. The report did not indicate the client was physically assessed for bodily injuries.</p> <p>__The BIR of 11/29/12 at 2:30 PM indicated SSP #2 conducted the face to face assessment at 9:30 PM.</p> <p>__The BDDS report of 11/30/12 at 4:45 PM indicated client S had sat down in the hallway to the dining room and refused to go to the dining room. Client S stood up and threw his slippers at the staff "in a very aggressive manner" and walked toward the dining room. He entered the dining room and sat at another table that was not assigned to him. Client S began biting himself and would not stop with verbal redirection. Client S picked up a chair to try to harm staff. Client S was placed in a sitting PRT for 5 minutes.</p> <p>__The BIR of 11/30/12 at 4:35 PM indicated LDSP conducted a face to face assessment. The report indicated client S</p>						

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	<p>complained "arms hurt" and client S had a cut under his nose. The report did not indicate nursing had assessed client S's injuries.</p> <p>__The BIR of 12/10/12 at 8:15 PM indicated client S became upset and pacing up and down the halls, kicking objects in the hall. Client S entered the storage room and began "tossing his peers belongings." Client S sat on the floor and began kicking the staff. Client S got up and proceeded to the dayroom. Client S continued to be aggressive toward staff. Client S was placed in PRT for 8 minutes. The report indicated a face to face assessment was conducted by SSP #2 at 10:20 PM. The report indicated no physical complaints.</p> <p>__The BIR of 12/10/12 at 8:31 PM indicated client S began digging at a wound on his knee. The report indicated the staff attempted to redirect without success and the client was placed in a standing PRT for 3 minutes then to a sitting PRT for 13 minutes. The report indicated a face to face assessment was conducted by SSP #2 at 10:22 PM. The report indicated no physical complaints.</p> <p>Client S's "Client Report of Illness or Injury" body scans indicated: __11/10/12 at 4:20 PM indicated right side of client S's face noted with reddened area to cheek and ear. The report</p>						

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	<p>indicated client S didn't know what happened and couldn't remember if he had put something on his face.</p> <p>__ 11/11/12 at 6:48 PM indicated client S had scratches on his left wrist from self injurious behavior.</p> <p>__ 11/16/12 at 6:10 PM indicated client S had a scratch on his face, 3 scratches up and down his left inner forearm, 2 scratches on his right hand, 1 scratch to client S's right buttocks and an old bruise on client S's left chest. The report indicated client S did not know how he was injured.</p> <p>__ 11/17/12 at 4:38 PM indicated "hand appeared injured." The report indicated the client complained of pain while making a fist. Client S's right middle finger was not straight, blue discoloration to knuckles and slight swelling. The report indicated the client's physician was notified and an order for the client to have his hand x-rayed.</p> <p>__ 11/18/12 at 6:10 PM client S had stabbed his left inner forearm with a pen three times. The report also indicated an injury to client S's right hand. Client S was placed on Level II Suicide precautions.</p> <p>__ 11/19/12 at 9:10 PM indicated client S had bite marks on both knees with cuts. The report indicated the injury was self inflicted.</p> <p>__ On 11/22/12 at 12:20 PM client S was</p>			

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	<p>noted to have a 4 cm yellowish green bruise on client S's right shoulder, a 2 cm yellowish purple bruise on client S's left shoulder, four 1 cm purple bruises on client S's left inner upper arm, two 3 cm scratches with 4 cm bruising around the scratches on client S's inner left upper arm and a 2 1/2 cm scratch on client S's mid to lower right back. The report did not indicate how client S obtained these injuries.</p> <p>__12/10/12 at 8:21 PM client S bit himself on the left knee "during PRT."</p> <p>Client S's Nursing Progress Notes indicated:</p> <p>__11/10/12 at 4:30 PM indicated client S had a reddened area of irritation to his right cheek and ear. The note indicated client S stated "I don't know what happened." The note indicated client S didn't remember if he had applied something to his face.</p> <p>__11/15/12 at 8:10 AM indicated client S was observed to have a 1 cm bruise on left upper inner arm, a 6 cm by 3 cm bruise above left breast, a 10 cm by 3 cm bruise below left breast.</p> <p>__11/16/12 at 2 PM indicated client S continued to complain of pain to his left breast area.</p> <p>__11/16/12 at 11:30 PM indicated chest x-ray results returned with no rib fracture. The note indicated client S had not</p>				

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	<p>complained of any pain "this shift, but staff reported seeing bruises." __ 11/17/12 at 6 PM indicated client S's right hand was swollen and discolored. The client's right middle finger was curved. __ 11/17/12 at 9:30 PM indicated client S returned from the hospital with a diagnosis of hand contusion. Ice applied to the affected area. __ 11/21/12 at 11 AM indicated client S reported no suicidal thoughts. Physician assessed and discontinued suicide precautions. __ 11/22/12 at 3 PM indicated client S had multiple bruises across both shoulders, back side, right arm and small bruises to left arm with small bruise center of back. __ 11/26/12 Level II Precautions in place due to self injurious behaviors. __ 12/18/12 at 5:10 PM indicated client S was "placed in PRT due to severe agitation, aggression SIB, multi intervention non effective. Client (S) emotional, crying. Requesting certain staff at different times. Would be effective for a short period of time. Attempted to release but would restart with kicking and attempting to bite." The note indicated the nurse called the physician to get an order for a PRN and to extend the restraint over 30 minutes. The note indicated the client had a bite to left wrist, area was cleansed and covered.</p>			

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	<p>__12/18/12 at 6 PM indicated client S was in route to bedroom "calm." The nursing progress notes failed to indicate a physical assessment of client S for injuries after the witnessed PRT of 12/18/12.</p> <p>Client S's physician order of 11/16/12 indicated an order for the client to have a chest x-ray of his left chest "related to bruising and pain."</p> <p>Client S's record failed to indicate nursing services was assessing and monitoring client S's injuries due to self injurious behaviors, aggression and physical restraint. The client's record neglected to indicate nursing services was performing daily body checks as indicated on the 11/15/12 BDDS report and on the follow up BDDS report of 11/22/12.</p> <p>Interview with LPN #1 and TTC #1 on 12/20/12 at 3:00 PM indicated nursing staff did not always do the face to face assessments. TTC #1 stated several staff were qualified to do the face to face assessments, "It doesn't have to be a nurse." LPN #1 indicated if the client did not voice any complaints after a PRT, then their would be no need to do a hands on full body assessment for injury. LPN #1 indicated only areas of the clients' bodies were assessed if the client voiced a</p>						

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	<p>complaint of pain. LPN #1 indicated if a physical assessment was conducted it would be documented in the nursing progress notes. LPN #1 indicated she did not do a full body assessment of client S after being placed in a PRT on 12/18/12 at 5:10 PM. When LPN #1 was asked if she had assessed client S's back due to the redness noted across client S's shoulders and neck, LPN #1 stated, "No."</p> <p>3. Client C's record was reviewed on 12/19/12 at 3 PM. Client C's BSP (Behavior Support Plan) of 12/7/12 indicated the staff could utilize a standing PRT or Sitting PRT. The BSP indicated client C has an internal bladder stimulator due to loss of a kidney as a result of a car accident. "Restraints involving sitting or laying down should be done carefully so that the stimulator is not dislodged." The BSP indicated nursing staff was to be notified as soon as possible for assessment due to possible dislodging of urinary stimulator/probe.</p> <p>Client C's Behavioral Incident Reports indicated: __ On 11/27/12 at 7:05 PM client C became upset when the client asked for his vending machine money. Client C began throwing chairs and overturning tables. Client C exited into the hallway and approached the fire exit and began</p>						

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	<p>striking it with his hand. Client C turned around and began kicking the glass, after 3 strikes breaking it. Client C was placed in a PRT.</p> <p>__ On 12/3/12 at 6:35 PM client C went into the day room with a piece of metal and threatened to cut himself with it. The staff took the item and placed client C in a standing PRT for 1 minute then escorted client C to the quiet room where he calmed immediately.</p> <p>__ On 12/3/12 at 9:17 PM client C became verbally and physically aggressive toward the staff. Client C was placed in a standing PRT and was escorted to a calm area.</p> <p>Client C's Nursing Progress Notes indicated:</p> <p>__ On 12/3/12 at 6:30 PM indicated client C was upset due to being confronted with stealing a peer's money. "Multi staff involved in intervention. Client (C) at one point had keys and electric razor in hand - Threats and action made to throw at this nurse. Client (C) placed in PRT but immediately released." Client C's nursing progress notes did not indicate nursing had completed a physical assessment to ascertain the placement of client C's urinary stimulator/probe post PRC on 12/3/12 at 6:35 PM and 9:17 PM and on 11/27/12.</p>						

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	Interview with LPN #1 on 12/20/12 at 3:00 PM indicated she was not aware if client C had been assessed by a nurse after the client was placed in PRT. The facility nurse indicated if a nurse did evaluate client C it would be documented in his nursing progress notes.			