

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  11/14/2012
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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 a post certification revisit (PCR) to the initial certification survey completed on 8/23/12.</p> <p>Survey Dates: 11/7, 11/8 and 11/14/12</p> <p>Facility Number: 12836 Provider Number: 15G809 AIM Number: 101091250</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Claudia Ramirez, Public Health Nurse Surveyor III-RN (11/7 to 11/8/12)</p> <p>Quality Review completed 11/16/12 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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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 record review and interview for 1 of 4 sampled clients (#1), the facility neglected to implement the facility's policy and procedure by neglecting to provide adequate supervision to client #1 while he was in the community.</p> <p>Findings include:</p> <p>On 11/07/12 at 1:30 PM the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 10/23/12 through 11/06/12 and indicated the following:</p> <p>11/06/12: "[Client #1] accompanied two staff and two of his peers to the [name] Government Center to participate in the presidential election. While in line, a poll worker asked staff and clients to step out of line to check their precinct, and confirm their registration cards. Staff and clients approached the table to do so, and then proceeded on to the next room to vote. It was at this point staff discovered that [client #1] was missing. (Later, when discussing the incident with the Transitional Team Coordinator (TTC), [client #1] reported that when staff turned away from him to lead them into the next</p>	W0149	- Note: Client was noted per Logansport State Hospital documentation upon admission in mid-August to be an elopement risk. From admission until the 11-06-12 incident at the polling site, client had been on numerous highly supervised outings to address increased independence in being able to more successfully access the community. He had done remarkably well up until the 11-06-12 incident. Client's BSP was revised to indicate specific / adequate staff supervision required when on a community outing and approved on 11-08-2012. - Behavior Support Plans (BSPs) for the above client and other clients have been revised to indicate specific levels of supervision when determined to be able to attend community outings. - BSPs were approved in HRC on 11-26-12. - Future clients requiring specific supervision while in the community will have these needs addressed in ISPs and/or BSPs with necessary approval by the Human Rights Committee prior to implementation. Overseen by the assigned QSP and Behavioral Specialist.	11/26/2012	

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	<p>room he, 'took off.')</p> <p>One staff searched through the Government Center, inside and out, while the other staff stayed with the two remaining clients and allowed them to vote. One staff got into the company vehicle and drove around the community searching for [client #1], then came back to pick up the rest of the group. At this time Staff called Warner Transitional Services (WTS) to report that [client #1] was missing. Staff on the scene were instructed to call the [name] Police Department, report that [client #1] had eloped, and to give a complete description of what he was wearing. Two minutes later while still searching the neighborhood WTS staff saw [client #1] in the police car. Staff approached and [client #1] got out of the police vehicle. With the officer's permission, staff asked [client #1] to come with them, but [client #1] continued to stare at the police officer. The officer tried to redirect [client #1] to accompany WTS staff but [client #1] became aggressive, punched the officer in the face twice and spat in his mouth. Staff tried to assist and calm [client #1] down. Staff report that the officer was ready to use a Taser to subdue [client #1]. [Client #1] continued to fight, kicking, pinching and was placed in handcuffs by the police officer. The WTS TTC arrived at this point and spoke</p>						

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	<p>with the officer. It was the police officer's determination that if [client #1] was capable of voting he was able to know he was assaulting a police officer and [client #1] was arrested on two felony counts of assaulting an officer. He was taken to [name] County Jail.</p> <p>It was discovered from talking to witnesses at the scene that after [client #1] had left staff sight he had gone to a local home in the neighborhood, knocked on the door and requested a ride to Keystone. The lady who answered the door thought that [client #1] was intoxicated due to his way of speaking and said no. [Client #1] told her he would figure it out. The lady then called the police who picked [client #1] up prior to WTS staff calling to report him missing.</p> <p>After [client #1's] arrest, Staff from WTS took copies of [client #1's] MAR (Medication Administration Record) sheets, and enough of his medications for three full days to the [name] County Jail...".</p> <p>Client #1's record was reviewed on 11/08/12 at 9:35 AM. Client #1's record contained the following dated documents:</p> <p>Historical information prior to admission on 08/20/12:</p>						

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	<p>03/30/12: Client #1's previous placement's Individualized Interdisciplinary Comprehensive Treatment Plan (ICTP) dated 03-30-12 indicated client #1 was an elopement risk.</p> <p>08/15/12: Facility's Admission Review Form included client #1's ICTP which indicated client #1's behaviors included elopement. The form indicated, "Special Requirements." "[Client #1] is an elopement risk &amp; (and) should be closely monitored when he is outside of [facility] for activities, outings, appointments."</p> <p>08/20/12: Admission to facility.</p> <p>08/20/12: The Transition Behavior Support Plan (TBSP) indicated client #1's behaviors included: physical aggression, inappropriate touching, verbal aggression and history of elopement. The plan included what staff should do if client #1 attempted to elope from the facility. The plan did not include how staff were to monitor him in the community or what to do should he attempt to elope when he was in the community.</p> <p>On 11/07/12 at 12:50 PM, a review of the facility's 08/2012 Policy on Abuse and Neglect indicated, "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be</p>						

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	<p>vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights...". The "Legally Mandated Responsibilities" undated document indicated the following definitions: "Neglect means an act or omission that places a resident in a situation that may endanger the resident's life or health...the facility's failure to provide adequate medical care, personal care...or places an individual's health or safety at substantial risk...".</p> <p>An interview with the QMRP (Qualified Mental Retardation Professional) #1 and Administrative Staff #1 was conducted on 11/08/12 at 3:05 PM. Both the QMRP #1 and AS #1 indicated client #1 had a history of elopement behavior. They indicated client #1 required 24 hour supervision and should not have been allowed to elope from the staff. They indicated staff needed to protect the clients and staff neglected to follow the abuse/neglect policy and procedure. Both the QMRP #1 and AS #1 indicated client #1's TBSP did not contain specific instructions on how staff were to monitor client #1 in the community or what to do should he attempt to elope when he was in the community.</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 1 of 5 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct and/or document a thorough investigation in regard to an allegation of theft/mistreatment of client #5's CDs (compact discs).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/7/12 at 3:02 PM. The facility's 10/23/12 reportable incident report indicated "[Client #5] and her peers were in the small gym dancing and exercising. [Client #5's] and staff left the gym and went to the library (sic). While in the library [client #5] reported to staff that 5 of her CD's (sic) were missing. The only CD that she can recall is her [name of music] CD. Staff assisted [client #5] with filling out a client grievance/allegation report. Safety and Security Professional (SSP) and the Transitional Team Coordinator (TTC) reviewed the footage and it could not be determined if anyone took her CD's (sic). Staff reported all of [client #5's] CD's (sic) stayed in her case and the only CD's (sic) out on the floor</p>			W0154	<p>- Client had the one CD she could recall by title replaced plus 4 additional CDs of her choice were purchased by the facility - completed: 11-16-2012 ; - Facility staff has thoroughly inventoried all client personal items; i.e. items such as CDs have been inventoried by name/title versus number of CDs; 11-15-2012 - Clients who alleged theft of personal items will continue to have their claims properly investigated and documentation of investigations will be properly maintained; - The QSPs and TTC will assure that allegations of theft are thoroughly investigated and properly documented;</p>		11/16/2012

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	<p>was (sic) two of her peers. The two peers that had CD's (sic) in the gym gave the TTC and the SSP permission to go and (sic) through their CD's (sic) with them. None of [client #5's] CD's (sic) was found." The 10/23/12 reportable incident report did not include any additional documentation of an investigation which included interviews, a conclusion and/or recommendations in regard to the allegation.</p> <p>Interview with administrative staff #2 on 11/8/12 at 3:08 PM indicated she could not locate any documentation of an investigation for the above mentioned 10/23/12 allegation of theft/mistreatment made by client #5.</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 3 of 4 sampled clients (#1, #3 and #4), the clients' Individual Support Plans (ISPs) failed to specifically indicate what staff were to do when a client (#4) threatened to harm herself/made suicidal threats, and to specifically indicate how facility staff were to monitor clients, who had a history of elopement, when in the community.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 11/8/12 at 9:51 AM. Client #4's telephone physician's order sheets indicated the following (not all inclusive):</p> <p>-10/9/12 at 11 AM, "Clarification: Client (client #4) placed on Suicide II (level of supervision/precautions) Due to suicidal thoughts...."</p> <p>-10/14/12 "Place client on Level II suicide precautions r/t (related to) suicidal ideation. Staff to check client Q (every) 15 minutes."</p> <p>-10/28/12 "May place res (resident) on Level II suicide precautions x (times 12 (hours) re eval (re-evaluate). Related to</p>	W0240	<p>- Clients #1, #2 and #3's BSPs have been revised for required / adequate staff supervision while on community / off-site outings. Completed: 11-09-12 - Client #4's BSP has been revised to indicate techniques / strategies when client threatens self harm. Completed: 11-09-2012 - Plans for clients who harm themselves/make suicidal threats and those who have a history of elopement in the community have been updated and where indicated have been approved by the Human Rights Committee to indicate specific interventions / protocols for staff to address; Completed: 11-26-2012 - Plans for future clients who harm themselves / make suicidal threats and those who have a history of elopement in the community will have specific interventions / protocols incorporated into their ISPs for staff to address and approved by the Human Rights Committee; - QSPs, Behavioral Specialists and TTCs will monitor high risk client needs to assure for the inclusion of specific interventions / protocols for staff into ISPs / BSPs</p>	11/26/2012	

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	<p>verbalizations of suicidal thoughts states 'I'm having thoughts of doing something to my self (sic)...."</p> <p>Client #4's Reinforcement Tracking Sheet for 10/29/12 to 11/4/12 indicated client #4 was on suicide precautions on 10/29, 10/30 and 10/31/12.</p> <p>Client #4's 10/23/12 Behavioral Support Plan (BSP) indicated client #4's diagnoses included, but were not limited to, Major Depressive Disorder, Recurrent and Post-Traumatic Stress Disorder. Client #4's 10/23/12 BSP indicated client #4 demonstrated self-abusive behavior with no suicidal intent noted. The client's BSP indicated the client's self-abusive behavior was defined as "Bangs head on walls...[Client #4] engages in this behavior 'softly' when she wants attention/staff to intervene. However, when she is 'really upset' she will bang her head 'much harder' and may cause significant self-harm. Banging fists/hands on doors and walls." Client #4's 10/23/12 BSP did not specifically indicate what staff were to do when the client made suicidal threats/gestures.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/8/12 at 3:08 PM indicated client #4 had been placed on suicide watch 3 times</p>						

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	<p>since the client was admitted 9/27/12. QMRP #1 stated client #4 made suicidal threats for "attention." QMRP #1 indicated the client's BSP addressed self harm which should include suicidal threats. QMRP #1 indicated client #4's BSP did not specifically indicate/include what staff were to do when the client made verbal suicidal threats.</p> <p>2. Client #3's record was reviewed on 11/8/12 at 11:46 AM. Client #3's 10/23/12 BSP indicated client #3 demonstrated elopement behavior (trying to run away from the facility and/or staff). Client #3's 10/23/12 BSP indicated "...1. If [client #3] attempts to elope from the WTS (Warner Transitional Services) facility, and is in the building (unauthorized area) or on the property; staff will keep her in sight at all times and attempt to facilitate apprehension. 2. If [client #3] goes beyond the WTS property lines, or eludes/evades WTS direct support staff on and off-ground activity; staff or safety/security professional will immediately alert the local law enforcement agency ([name of local police department]). WTS will provide and/all necessary identifying information to law enforcement and cooperate completely to expedite the safe return of the client..." Client #3's 10/23/12 BSP did not specifically indicate how facility</p>				

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	<p>staff were to monitor/supervise client #3 when in the community for activities to prevent elopement.</p> <p>Interview with QMRP #2 on 11/8/12 at 3:15 PM indicated 2 staff should be present when the client went out into a community with a group. QMRP #2 stated client #3 had "behavior issues" when children were around the client. QMRP #2 indicated client #3's BSP did not specifically indicate how staff should monitor/supervise client #3 when she was in the community to prevent elopement.</p> <p>3. Client #1's record was reviewed on 11/08/12 at 9:35 PM. Client #1's record contained the following dated documents:</p> <p>Historical information prior to admission on 08/20/12:</p> <p>03/30/12: Client #1's previous placement's Individualized Interdisciplinary Comprehensive Treatment Plan (ICTP) dated 03-30-12 indicated client #1 was an elopement risk.</p> <p>08/15/12: Facility's Admission Review Form included client #1's ICTP which indicated client #1's behaviors included elopement. The form indicated, "Special Requirements." "[Client #1] is an elopement risk &amp; (and) should be closely</p>						

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	<p>monitored when he is outside of [facility] for activities, outings, appointments."</p> <p>08/20/12: Admission to facility.</p> <p>08/20/12: The Transition Behavior Support Plan (TBSP) indicated client #1's behaviors included: physical aggression, inappropriate touching, verbal aggression and history of elopement. The plan included what staff should do if client #1 attempted to elope from the facility. The plan did not include how staff were to monitor him in the community or what to do should he attempt to elope when he was in the community.</p> <p>An interview with the QMRP (Qualified Mental Retardation Professional) #1 and Administrative Staff #1 was conducted on 11/08/12 at 3:05 PM. Both the QMRP #1 and AS #1 indicated client #1 had a history of elopement behavior. They indicated client #1's TBSP did not contain specific instructions on how staff were to monitor client #1 in the community or what to do should he attempt to elope when he was in the community.</p> <p>This deficiency was cited on 08/23/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</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  11/14/2012	
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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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) and 3 additional clients (clients #6, #7 and #13) by not ensuring clients received nursing services according to their medical needs, by not ensuring Physician Orders were carried out correctly for clients #6 and #13 and by not ensuring nursing services accurately transcribed Physician's Orders (client #7).</p> <p>Findings include:</p> <p>1. On 11/07/12 at 1:30 PM the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 10/23/12 through 11/06/12 and indicated the following:</p> <p>10/25/12: "[Client #7] was admitted to WTS (Warner Transitional Services) on Monday, October 22, 2012. While at his previous provider he was administered Prolixin (antipsychotic) 25mg (milligram) IM (intramuscularly) every 2 weeks at 8am. When [client #7] was admitted to WTS his transition paperwork from his previous provider stated Prolixin 1.0 mg IM every 2 wks (weeks) at 8am. WTS nurse transcribed the order and sent the order to [name] pharmacy. [Name]</p>	W0331	<p>- Currently in the absence of a Director of Nursing/Health Care Coordinator at this point in time the lead nurse for the Spectrum ESN Homes has provided assistance in the direction and implementation of health services for client care. - Nurses now have specific client assignments as well as daily assignments to focus on areas, such as new client admissions; 1) To assure accurate transcription of physician's orders at time of admission one nurse is assigned to transcribe orders onto the MAR only from the current working MAR from previous facility, which will be audited by a second nurse prior to MAR implementation; 12-07-2012 2) On new client admission and for routine medications of current clients for medications not delivered timely by pharmacy, the nurse on duty will pull appropriate medication from the EDK, if available. If not available, the nurse will immediately contact the pharmacy for STAT delivery; 12-03-2012 3) For all new admissions immediately upon arrival, the nurse will be provided the current working MAR from referring facility to assure that medication times are adhered to; 12-07-2012 4) Client #1 – high risk plan for choking was updated</p>	12/12/2012			

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	<p>pharmacy delivered Prolixin 10 mg IM every 2 wks at 8am. On Thursday, October 25, 2012 at 8am [client #7] was administered Prolixin 10mg IM...".</p> <p>Client #7's records were reviewed on 11/08/12 at 2:00 PM. Client #7's previous provider records indicated he was on Prolixin 25 mg IM. The admission physician orders written by the nurse indicated client #7 was on Prolixin 1.0 mg IM.</p> <p>On 11/08/12 at 3:05 PM an interview with the Administrative Staff (AS) #2 was conducted. The AS #2 indicated it was the responsibility of nursing services to transcribe the orders correctly.</p> <p>2. On 11/07/12 at 1:30 PM the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 10/23/12 through 11/06/12 and indicated the following:</p> <p>10/25/12: "[Client #13] was admitted to WTS on Thursday, October 25, 2012. Her referring provider [name] sent all of her current medications except...Clonazepam (behaviors) 1mg BID. The WTS nurse ordered the medication from pharmacy...[Client #13's] Clonazepam was not delivered by the pharmacy either. She missed her dose</p>		<p>on 11/29/12 to include what measures staff will implement in the event of choking; 11-29-2012</p> <ul style="list-style-type: none"> <li>- For future/all residents the charge nurse will assure high risk plans are in place that specifically include plans to direct staff/facility in the event of an adverse occurrence; 12-12-12</li> </ul> <p>5) This facility has now gone to "blister" packing on a 28 day cycle rotation for medications versus the bottle fill format. This easily identifies when / if medication was administered. Additionally, all nurses have been instructed to immediately document on MAR when medications are administered prior to administering medications to the next client or responding to another task. 11-27-2012</p>	

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	<p>of Clonazepam 1mg on 10/25/12 at 8pm and 10/26/12 at 8am...".</p> <p>Client #13's record was reviewed on 11/08/12 at 2:25 PM. Client #13's October 2012 Physician Orders indicated client #13 was ordered Clonazepam 1 mg BID.</p> <p>On 11/08/12 at 3:05 PM an interview with the Administrative Staff (AS) #2 was conducted. The AS #2 indicated it was the responsibility of nursing services to ensure medications were received timely from pharmacy and if there was a problem they should assist to resolve it so the clients received their medicines as ordered.</p> <p>3. 10/25/12: "[Client #6] and one of his peers were admitted to WTS on Thursday, October 25, 2012 from [name]. Client #6 arrived to WTS around 10:20 AM. The [name] staff did not leave WTS until 2:40 PM...All of his medicine and medical paperwork was (sic) provided to the nurse on duty. The nurse began noon medication administration for all of the other clients residing at WTS. The nurse was not informed of [client #6] needing a 12pm medication administered. After the nurse was finished passing 12pm medication to all of the other clients she returned to the wellness clinic. The nurse</p>						

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	<p>began reviewing and organizing [client #6's] medical paperwork and medications. The nurse determined [client #6] had a 12pm medication (Propranolol 20 mg) (high blood pressure) that was not administered. [Client #6] received his next scheduled dose as prescribed...".</p> <p>Client #6's record was reviewed on 11/08/12 at 2:45 PM. Client #6's October 2012 Physician Orders indicated client #7 was ordered Propranolol 20 mg TID (three times daily).</p> <p>On 11/08/12 at 3:05 PM an interview with the Administrative Staff (AS) #2 was conducted. The AS #2 indicated it was the responsibility of nursing services to ensure medications were given as prescribed and the nurse should have looked at the new admission orders to ensure client #6 receive his medications as ordered.</p> <p>4. 10/25/12: "[Client #1] was eating dinner in the dining room which consist (sic) of pepper steak, rice pilaf, string beans and bread. It was reported that [client #1] choked on a piece of meat...He started to pound on the table, and began showing signs of choking, and pushed his chair from the table. Staff immediately intervened by standing him up and administering 5 upward thrusts. After</p>						

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	<p>these interventions [client #1] was able to respond and started coughing...".</p> <p>Client #1's record was reviewed on 11/08/12 at 9:35 AM. Client #1's ISP (Individualized Support Plan) dated 09/10/12 indicated client #1 was at risk for choking and he needed to be supervised at meals. Client #1's ISP/risk plan did not indicate what the nurse/facility would do if the client choked to monitor the client to prevent complications and/or aspiration.</p> <p>On 11/08/12 at 3:05 PM an interview with the QMRP (Qualified Mental Retardation Professional) #1 was conducted. The QMRP #1 indicated client #1 was at risk for choking and he did not have a specific plan to address how the client would be monitored if he choked.</p> <p>5. 10/27/12: "[Client #13] was administered her Synthroid (for thyroid) 50 mcg (microgram) as ordered at 6:50 am. The nurse did not sign the MAR indicating the medication was administered. The oncoming nurse was passing the 8am medication and noticed there was no documentation of [client #13] receiving her Synthroid 50 mcg. Around 9:30 am the nurse that passed the second dose of Synthroid contacted the</p>						

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	<p>nurse on duty. The nurse informed the other nurse that she administered [client #13's] Synthroid due to her not administering the medication because it was not documented. The nurse told her that she administered the medication but did not document...The nurse on duty then audited [client #13's] medication to determine the count. It was determined [client #13] received Synthroid to mcg twice on 10/27/12...".</p> <p>Client #13's record was reviewed on 11/08/12 at 2:25 PM. Client #13's October 2012 Physician Orders indicated client #13 was ordered Synthroid 50 mcg daily in the AM.</p> <p>On 11/08/12 at 3:05 PM an interview with the Administrative Staff (AS) #2 was conducted. The AS #2 indicated it was the responsibility of nursing services to ensure medications were administered as ordered and nurses were to document after they gave them.</p> <p>This deficiency was cited on 08/23/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				