

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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W0000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: January 23, 24, 25, 26, 30, 31, and February 1, 2012</p> <p>Facility Number: 000614 AIMS Number: 100272120 Provider Number: 15G068</p> <p>Surveyors: Susan Eakright, Medical Surveyor III-Team Leader Kathy Craig, Medical Surveyor III Kathy Wanner, Medical Surveyor III Claudia Ramirez, Public Health Nurse Surveyor III, RN</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 2/7/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Gaston desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on March 2, 2012</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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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the facility by ensuring maintenance and repair needs were completed and the facility was odor free for 68 of 68 clients living in the facility (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67 and #68).</p> <p>Findings include:</p> <p>1. Observations of the facility kitchen, where meals are prepared for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67 and #68 were conducted on 1/24/12 at 12:04 P.M.. The metal kitchen shelving in the dry storage area was rusty. The kitchen mop bucket, mops and janitor drain area were located in the dry storage area with no divider or separation between the area and the stored dry foods. The florescent light fixtures in the kitchen had numerous dead bugs laying on the inside cover of the light fixtures.</p>	W0104	<p><u>W104</u></p> <p>It is the policy of the governing body and this facility to ensure that maintenance and repair needs are completed and that the facility is odor free.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>The metal shelves with rust that were noted in the kitchen have been replaced. Divider doors have been installed in the kitchen pantry to separate the janitorial supplies and drain from the stored dried foods. All light fixtures throughout the facility were checked, and those with insects present were removed and cleaned, including the kitchen, main building hallways, and training center areas. The slats in louvered doors in the Training Center that were broken have been repaired and re-stained.</p> <p>Numerous residents who have incontinence reside in the hallway where the surveyor reports detecting the smell of urine. No facility staff or residents complained about the odor, and at the time of the surveyor's observation, facility staff was cleaning bedrooms and bathrooms as incontinent incidents occurred; however some residents with strong odors</p>	03/02/2012			

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	<p>Observations of the main building hallways were conducted on 1/24/12 at 12:41 P.M.. The florescent light fixtures in the hallways had numerous dead bugs laying on the inside cover of the lights fixtures</p> <p>Observations of the training center building were conducted on 1/23/12 at 12:20 P.M.. The florescent light fixtures in the dining area had numerous dead bugs laying on the inside cover of the light fixtures. Two of the three wooden doors to the storage closets had broken slats.</p> <p>There was no maintenance request available for review for these maintenance needs.</p> <p>The facility administrator was interviewed on 1/26/12 at 1:41 P.M.. The administrator indicated he was not aware of the kitchen shelves being rusty, and would need to check about them and the other issues.</p> <p>On 1/25/12 at 3pm, and on 1/26/12 at 1:41pm, no maintenance requests were available for review of facility maintenance needs. On 1/26/12 at 2:35pm, the facility administrator provided a typed document titled and undated "Maintenance Pending Repair" which indicated a list of the above areas. The administrator stated "I typed it up."</p> <p>2. Observations were conducted at the facility on 1/24/12 from 7:15 AM to 9:10 AM. The hallway where rooms 1-13 (client bedrooms) for clients #1, #2, #4, #6, #8, #9, #10, #14, #18, #21, #24, #25,</p>		<p>can cause a lingering odor to be detected at times. While no residents during the survey were noted to have a UTI or inadequate intake of fluids, our staff is aware of the need to encourage fluids and monitor for residents who may have symptoms of a UTI. For all residents who reside in the west corridor, staff responsible for cleaning resident rooms will be in-serviced to change mop water frequently, to utilize disinfectant chemicals with as much frequency as is needed to eliminate the source of any urine odor.</p> <p>In addition nursing staff will be in-serviced regarding the importance of encouraging fluid intake of all residents, including those that live in the area of the facility cited on the 2567.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> All residents have the potential to be affected; however, no resident was identified as being directly affected by these practices.</p> <p>In the future, if the Administrator or any other interdisciplinary team member observes any of these issues, they will address their concern to the department manager(s) involved to make sure that correction ensues. If the</p>	
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	<p>#27, #29, #31, #33, #36, #37, #38, #39, #40, #41, #42, #45, #46, #53, #54, #55, #56, #59, #62, #63, and #64 resided had a strong urine odor. On 1/25/12 at 9:35 AM, an observation was done again for this same hallway. The urine odor was still present. On 1/26/12 at 12:55 PM, an observation was done again for this same hallway. The urine odor was still present.</p> <p>Interview on 1/26/12 at 1:05 PM with staff #8 who was a nurse with the facility was conducted. She stated she didn't "have a good sense of smell." She stated "We've worked here so long maybe we don't notice it."</p> <p>Interview on 1/26/12 at 1:05 PM with staff #12 who was a nurse with the facility was conducted. She indicated she didn't notice an odor but hadn't been down that hallway that day.</p> <p>Interview on 1/26/12 at 1:10 PM with staff #49 was conducted. She stated she hadn't noticed an odor but when someone has an accident it will permeate.</p> <p>3.1-13(r) 3.1-19(bb) 3.1-21(i)(3) 3.1-26(g) 3.1-32(a)</p>		<p>source of the issue is identified as a breakdown in staff performance, the Administrator and/or department manager(s) of the identified staff will re-train them as needed in the facility policy at that time. Progressive disciplinary action will also be rendered for continued noncompliance.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> The Maintenance Director will review the identified environmental areas as part of the facility's preventive maintenance program on a weekly basis. In addition the facility has a maintenance repair requisition which can be initiated by any staff member who observes equipment or physical plan issues that require repair. The Maintenance Supervisor checks for any completed requests for repair during each tour of duty so that he can address the issues as quickly as possible.</p> <p>In regards to the urine odor, all members of the interdisciplinary team will observe for this issue as part of the routine rounds that each one makes throughout each tour of duty.</p> <p>Any concerns that are identified with environmental issues, including needed repairs or urine</p>				

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			<p>odors, will be addressed as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Maintenance Director will review the results of completed and pending repairs, including any written requests for repairs with the Administrator or his designee at morning management meetings which occur at least 5 days a week. The Administrator or Housekeeping Supervisor Will also bring the results of rounds made each day throughout the facility in regards to urine odor to the morning meeting at least 5 days a week.</p> <p>This information will be forwarded to the QA Committee for review and recommendation at the monthly meeting. Any recommendations received will be followed through by the designated management staff and results of those recommendations will be reviewed at the next scheduled QA meeting. This will occur on an ongoing basis.</p> <p>Completion 3/2/12</p>		

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W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation: Client Protections, is not met as the facility failed to implement their policy and procedure to prohibit neglect of client #6 in regard to her refusals to leave her room for three days, to thoroughly report and to take sufficient corrective action for client to client physical aggression, falls, medication administration, and employee theft incidents for 8 of 10 sample clients (clients #2, #3, #4, #6, #7, #8, #9, #10), and for 11 additional clients (clients #15, #20, #33, #34, #40, #54, #64, #66, #68, #69, and #70).</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility neglected to implement their policy and procedure to protect clients #3, #4, #7, #34, #54, #68, and #69 from client #6's identified physically aggressive and stealing behaviors. The facility neglected to take prompt action when client #6 refused to come out of her room for 3 days which led to police intervention. The facility neglected to implement measures to protect clients #9 and #10 from their identified PICA behavior (eating inedible objects)/SIB (Self Injurious Behaviors). The facility neglected to protect clients who were at risk for falls from falling (clients #2, #4, #7, #8, #15, #20, #33, #40, #64, #68 and #70). The facility neglected to follow their medication policy and procedure (for clients #3 and #6), and the facility neglected to protect client's personal property from employee theft (client #66).</p> <p>2. Please refer to W153. The facility failed to thoroughly report all information in the Bureau of</p>	W0122	<p>W122 Condition Client Protections The facility has been diligent in its efforts to protect the welfare and dignity of all residents of the facility. Inherent in the philosophy of the ICFMR regulations residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to residents while still affording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also encouraged residents to have meaningful relationships with the staff. It is the facilities intent to encourage these normalized experiences but to keep safeguards in place that minimize the risk injuries or events that could be viewed as possible violation of their rights. The facility will continue and re-new efforts to protect residents in all manners, but maintains that in protecting a residents right to make choices, that events can occur where residents will risk injury. 1. See response at W149 related to resident aggression between #6 and her peers, related to events surrounding #6's behavior that led to police intervention, related to resident</p>	03/02/2012			

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	<p>Developmental Disabilities Services (BDDS) reports to the administrator and BDDS in accordance with State law through established procedures for 1 of 1 report for client (#6) and to report 1 of 2 incidents of peer to peer aggression to client #5.</p> <p>3. Please refer to W157. The facility failed to implement sufficient corrective action to protect clients #3, #4, #7, #34, #54, #68, and #69 from client #6's identified physically aggressive and stealing behaviors, to implement sufficient corrective action to protect clients who were at risk for falls from falling (clients #2, #4, #7, #8, #15, #20, #33, #40, #64, #68 and #70), and failed to take sufficient corrective action after client #6 stockpiled her medications in her room.</p> <p>3.1-37(a)</p>		<p>#9 and #10's behavior that is self-injurious, related to residents #2,#4, #7, #8, #15, #20, #33 #40, #64, #68 and #70 who experienced falls, related to failure to follow medication policy to protect #3 and #6 and to protect #66 from an employee taking their property off the premises. 2. See response at W153 related to thorough reporting of events to BDDS and the Administrator for resident #5 and #6. 3. See response at W157 related to resident aggression between #6 and her peers, and related to residents #2,#4, #7, #8, #15, #20, #33 #40, #64, #68 and #70 who experienced falls.</p>		

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review, and interview, for 8 of 10 sample clients (clients #2, #3, #4, #6, #7, #8, #9, #10), and for 11 additional clients (clients #15, #20, #33, #34, #40, #54, #64, #66, #68, #69, and #70), the facility neglected to implement their policy and procedure to protect clients #3, #4, #7, #34, #54, #68, and #69 from client #6's identified physically aggressive and stealing behaviors. The facility neglected to take prompt action when client #6 refused to come out of her room for 3 days which led to police intervention. The facility neglected to implement measures to protect clients #9 and #10 from their identified PICA behavior (eating inedible objects)/SIB (Self Injurious Behaviors). The facility neglected to protect clients who were at risk for falls from falling (clients #2, #4, #7, #8, #15, #20, #33, #40, #64, #68 and #70). The facility neglected to follow their medication policy and procedure (for clients #3 and #6), and the facility neglected to protect client's personal property from employee theft (client #66).</p> <p>Findings include:</p> <p>1. On 01/23/12 at 11:30 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following incident for client #6:</p> <p>-A BDDS report dated 7/13/11 for an incident on 7/12/11 at 1:30 P.M. indicated the following: "7/12/11 [name of doctor] contacted to update on resident condition regarding increased aggression towards staff, refusing to leave bedroom or allow anyone to assess, refusing intakes and</p>	W0149	<p>W149.1It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of a client, including prompt handling of severe behaviors, implementing measures to protect clients from PICA and SIB behaviors, implementing measures to protect residents who are at risk for falls, following appropriate medication policy and procedure, and protecting clients' personal property from theft. On page 7 of 59 the 2567 contains a statement that the BDDS report of this incident with Resident #6 did not "indicate what actions the facility staff had taken prior to having client #6 transported to the ER". While the staff actions were not detailed on the BDDS report, they were detailed in the resident's medical record and were available for the surveyor's review during the survey. According to Resident #6's record, in the days leading up to this resident's hospitalization she was noted to participate in programming on 7/8/11. On 7/9/11 progress notes indicate that the nurse was present with her in room on both day shift and afternoon shift that same day and allowed the nurse to take vitals with no complaints. The progress notes then reflect that she was clinically monitored</p>	03/02/2012			

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	<p>medications. Order received to send to [name of hospital] ER (emergency room), if resident becomes injurious to self or others for evaluation. At 1:30 pm resident sent to ER via ambulance with police dept. (department) available for assistance with transport of resident due to increase in aggressive behavior. Resident assessed and admitted to [name of hospital] psych (psychiatric) unit for eval (evaluation) and stabilization." The BDDS report did not indicate what actions the facility staff had taken prior to having client #6 transported to the ER.</p> <p>Client #6's record was reviewed on 1/24/12 at 1:50 P.M.. Client #6's record indicated a quarterly nursing progress note for client #6 the time period between 6/8/11 and 9/7/11 indicated "Walking quickly in hallway in socks and fell, refused assessment, yelling and took G-chair (geriatric chair) into room...was yelling and continued to refuse assessment. Spent 3 (three) days in room and wouldn't allow staff into room and refused to take medications. Unable to contact [name of mental health services], [name of doctor] notified with orders for Haldol (anti-psychotic) and send to ER for evaluation if becomes self-injurious to self or others and continue to contact [name of mental health services]. Police were available and present for assessment and because of aggression to sheriff, he believe (sic) her to be a danger to herself and others and resident was transported to ER via ambulance and police...." The progress note indicated client #6 had gone to the dining area and eaten her dinner the evening of her fall. There was no other documentation available for review to indicate if client #6 ate her meals at the other meal times.</p> <p>-A Qualified Mental Retardation Professional (QMRP) progress note dated 7/13/11 at 1:35 P.M.. indicated "[Client #6] was admitted to the psych</p>		<p>related to a fall 7/8/11. Nursing was assessing her each shift as she would allow and her clinical monitoring was resolved on 7/11/11. Resident #6 did leave her room for meals on 7/10/11 at breakfast and supper consuming 100% of both meals and also consumed 100% of her HS snack. She took in 72 oz of hydration on 7/10/11. Resident #6 also came out of her room for breakfast and lunch on 7/11/11 consuming 100% of each meal and taking in 64 oz. of hydration. She did refuse her supper meal. After she refused breakfast on 7/12/11 her physician was contacted and the nurse advised to contact psych services. A new order was then received to send her to ER if she became self-injurious or posed a threat to others; in addition, the nurses were approved to give 1 time administration of 5mg Haldol IM prior to going to ER for extreme agitation. Contrary to the statement on page 7 of 59 of the 2567, Resident #6 was in and out of her room during the days leading up to the hospitalization and did allow staff in her room at times. She did refuse her medication on the date she admitted to the hospital (7/12/11), but not on the days prior to that. This is confirmed by the documentation on the Medication Administration Record for July 2011, which supports that the nurse did administer her</p>				

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	<p>unit yesterday. She was taken via ambulance by police in handcuffs. She had not taken meds (medications) for an indeterminate time due to refusal and staff having found where she had hidden med's in room. She was aggressive with staff and police prior to transport...."</p> <p>On 1/24/12 at 1:50pm, no documentation was available for review to indicate which medications or the number of medications staff found in client #6's room. Client #6's record indicated she had a room by herself.</p> <p>An interview was conducted with the facility Director of Nursing (DON)/RN on 1/26/12 at 10:48 A.M.. When asked about staff following the medication policy, the DON/RN gestured with her mouth and stated, "Well they (staff administering medications) can do mouth checks, have them (clients) stick their tongue out, but can't ensure they (clients) are not pocketing the meds." The DON indicated no documentation was available for review to determine what kind of pills client #6 had collected, the number of pills at the time of the incident, whether the administrator had knowledge of the medications in client #6's bedroom, and what protective measures were put in place after the incident had occurred.</p> <p>On 1/26/12 at 12:30pm, an interview with the facility administrator was completed. The administrator indicated he was unsure whether he was notified of client #6 stockpiling medications. The administrator indicated no additional information was available for review to determine what kind of pills client #6 had collected, the number of medication pills, or protective measures in place after the incident to protect client #6.</p> <p>2. On 1/23/12 at 11:30am, a record review of the BDDS (Bureau of Developmental Disabilities</p>		<p>medication to her each day prior to 7/12/11. The staff was monitoring Resident #6's behavior and noted an escalation in her aggressiveness when some of her medication was found scattered on the floor of her room, apparently after being cheeked by the resident at some point in time. After the Director of Nursing conferred with the attending physician and the facility's mental health service provider regarding the resident's behavior changes and the discovery of what was assumed to be some of the resident's medication, the decision was made to admit her to the psychiatric unit for her safety and further assessment of her mental health status. <u>1. What corrective action will be done by the facility?</u> The facility will train nurses to document progress notes that accurately reflect the level of a resident's refusal of treatment, including taking their medication. It is anticipated that residents may at times be resistive to treatment. If the resident eventually complies with taking their medication the Medication Administration Record will indicate this and a progress note that reflects a refusal will not be needed. All licensed nurses will be trained to assess if residents are pocketing medications that are taken orally. If medications are found that appear to have been pocketed by the resident, an</p>				

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	<p>Services) reports was conducted and included the following for client #6:</p> <p>-On 12/9/11 a BDDS report for an incident on 12/8/11 at 7:45am, indicated client #6 had "sugar packets laying on the table in front of her for her use and [client #3] took them." The report indicated client #6 scratched client #3 on the face, neck, and behind right ear.</p> <p>-On 12/4/11 a BDDS report for an incident on 12/3/11 at 7am, indicated client #69 "attempted to steal coffee from [client #6] during breakfast and she scratched him on the side of the face." Client #69 had "4 small scratches to left side of his face."</p> <p>-On 9/16/11 a BDDS report for an incident on 9/15/11 at 2:50pm, indicated client #7 "went up to [client #6] and hit her. [Client #6] then scratched him in return." The report indicated client #6 had 2 small reddish/purple discolorations noted to left forearm. Client #7 had "small scratches noted to face."</p> <p>-On 5/19/11 a BDDS report for an incident on 5/18/11 at 2:15pm, indicated client #68 "tried to take [client #6's] drink and [client #6] became angry." The report indicated client #6 "hit [client #68] causing a 0.3cm (centimeter) discoloration on his left eyelid."</p> <p>-On 4/19/11 a BDDS report for an incident on 4/18/11 at 3:15pm, indicated client #34 "stole [client #6's] juice, she took her juice back, she then grabbed [client #34's] face." The report indicated client #34 had "4 (four) small scratches to [client #34's] face."</p> <p>On 1/24/12 from 6:30am until 8:10am, client #6 was observed in the dining room at the main facility with four (4) facility staff. At 6:30am,</p>		<p>attempt will be made to identify the specific medications, depending on the condition of the actual pill/capsule itself. The success or lack of success in identifying the number and type of medications will be documented in the resident's record. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u>All residents have the potential to be affected; however, no other residents were identified as being affected by this practice at this time. In the future, if staff notices that a resident is experiencing more severe behaviors, including refusal of care and/or medications for longer than is normal for that individual, the nurse will assess the situation and detail her findings in the resident's clinical record. She will notify the DON immediately of her observations, so that the attending physician and mental health worker (if applicable) can be notified of the resident's change and behavior to make sure that interventions are put into place as soon as possible. Once the resident is cared for, if the DON finds that the resident's condition change has been going on without appropriate notification for a longer period of time than is acceptable or that the documentation of the condition change is not as complete and detailed as required, she will</p>				

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	<p>client #6 retrieved a brown cup of fluid from a drink cart and was given eight (8) packets of pink sugar substitute by a facility staff person. At 6:52am, client #6 sat at her table in the dining room, independently got up from her chair, poured an additional cup of brown fluid, and five facility staff were present in the dining room. Client #6 walked to client #4 and #54's table across the dining room in front of four (4) facility staff and took four (4) packets of pink sugar substitute from client #4 and #54's meal trays. No redirection was observed. At 7:10am, client #6 got up from her dining room chair, walked to the fluid cart, poured an additional cup of brown fluid, and walked from table to table taking pink sugar substitute packets from other clients' meal trays without redirection by the eight (8) facility staff in the dining room. At 7:15am, a dietary employee entered the dining room with a pre-set tray of individual sugar packet holders for each table in the dining room.</p> <p>On 1/24/12 at 1:50pm, client #6's record was reviewed. Client #6's 10/6/11 ISP (Individual Support Plan) and 5/5/2010 BSP (Behavior Support Plan) indicated identified behaviors of hoarding food/drink and stealing items from others. Client #6's BSP indicated staff were to return the stolen item to the client to whom it belonged before client #6's behavior resulted in physical aggression. Client #6's BSP indicated client #6's stealing behavior was a precursor for her physical aggression. Client #6's ISP and BSP both indicated staff were to redirect her behavior each time the behavior occurred and staff were to be near her while in the dining room or around other clients. Client #6 had a bedroom alone because of her behaviors.</p> <p>On 1/26/12 at 11am, an interview with QMRP (Qualified Mental Retardation Professional) #67 was completed. QMRP #67 indicated facility staff</p>		<p>re-train the staff involved in the facility's standard of care and services regarding condition changes. She will also render disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Director of Nursing (DON) will observe medication administration with each nurse in the next 30 days. When she has observed every nurse, she will continue random observations, ensuring that each nurse is reviewed at least one more time in the next 90 days. The DON will review residents on focused clinical charting at least 5 days a week during each tour of duty to ascertain if there are any resident condition changes and refusals of medication. If there are any refusals documented, she will also review the MAR (medication administration record) to make sure that follow up to any identified issues has been completed and documented. If she identifies any concerns, she will follow up as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will report any resident changes in condition and medication refusals at the next scheduled morning management meeting which occurs at least 5 days a week. In addition the DON will report the results of her</p>				

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	<p>should have redirected client #6 from hoarding coffee and redirected her stealing behavior of taking other clients' pink sugar substitute in the dining room. QMRP #67 indicated client #6 had a history of physical aggression while dining or participating in hydration opportunities. QMRP #67 indicated client #6 was physically aggressive with other clients.</p> <p>3. On 1/24/11 at 6:37am, client #10 was observed alone in bed inside room #14 in the main building and a yellow crayon and a piece of paper were within his arms reach from the bed on the floor. At 6:40am, ATF (Active Treatment Facilitator) #25 entered the room and assisted another client inside the shared bedroom. At 6:40am, ATF #25 was asked about the objects on the floor of room #14. ATF #25 stated client #10 "had PICA (eating inedibles), should not have small objects on the floor like crayons." ATF #25 picked up the crayon and the piece of paper and left the room.</p> <p>On 1/24/12 from 7:52am until 8:20am, client #10 was observed in Program room A with ATF #21 and ATF #58 with nine clients. Inside the program room were one inch by one inch puzzle pieces, papers, crayons, pencils, pens, checkers, cards, and plastic blocks out on the tables. At 7:52am, ATF #21 indicated he knew client #10 paced, laid down on the floor, and indicated he knew of no other behaviors. ATF #21 indicated client #10's ISP and BSP were not available for him to refer to and stated "He's waiting to go to the dining room, he isn't usually in here except in the mornings." From 7:52am until 8:20am, client #10 walked independently from table to table, corner to corner, and picked up objects then sat them back down in program room A without staff observing or redirecting him. Throughout the observation period ATF #21 and #58 prompted the other nine clients in the program room for</p>		<p>medication administration observations and focus charting reviews to the monthly QA Committee for review and recommendations for improvement. Any recommendations will be followed up by the DON and the results of those recommendations will be brought back and reported to the next scheduled QA Committee. This will continue on an ongoing basis. <u>W149.2 1. What corrective action will be done by the facility?</u> Client #6 has a Behavior Program for Physical Aggression and Stealing. The other residents who were involved in aggressive incidents with #6; #3, #69, #7, #68 and #34 also have behavior plans related to the behavior of physical aggression or stealing. Staff was present on all five occasions described in this report that involved resident #6. When the mal-adaptive behavior was displayed, staff immediately intervened. While the facility does not want any injury to occur, the intervention was completed as written and only superficial injuries occurred. With this population behavior management plans are developed to address the behavior as it is anticipated that behaviors will occur. The staff will be in-serviced to implement the behavior plans as written and to record any instance of resident to resident aggression. The specific behavior plans for these residents</p>				

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	<p>activity and at times had their backs turned to client #10.</p> <p>Client #10's record was reviewed on 1/25/12 at 9:25am. Client #10's 7/7/11 ISP and 5/19/11 BSP indicated the identified behavior of "PICA /Coprphagia (the) eating inedible items including Bowel Movement, Grass, Staples, Classroom Activities, ETC...." Client #10's ISP/BSP indicated client #10 was to have eye sight supervision "while awake" or "will have staff supervision whenever he is out of bed."</p> <p>On 1/26/12 at 10:25am, an interview with QMRP #68 was completed. QMRP #68 stated client #10 was to have eye sight supervision "at all times while awake or out of bed." QMRP #68 indicated client #10 had a history of eating items such as crayons and paper. QMRP #68 stated client #10 "should not have puzzle pieces or crayons without one on one supervision."</p> <p>4. On 1/24/11 at 7:32am, client #9 was observed to sit upright on her bed dressed in room #8 and a staff's red and black open backpack sat across from client #9 on top of the bed side table. At 7:32am, client #9 looked at the back pack. Inside the unzipped back pack the following items were observed in view: alcohol wipes, brush, and comb. From 7:32am until 7:50am, the unclaimed open back pack sat inside client #9's shared bedroom. At 7:50am, ATF #24 entered room #8 and indicated it was his back pack. At 7:50am, ATF #24 walked with client #9 to Program room A, left client #9 inside the program room, and walked away. Client #9 was inside Program room A with ATF #21 and ATF #58 with nine clients. Inside the program room were one inch by one inch puzzle pieces, papers, crayons, pencils, pens, checkers, cards, and plastic blocks out on the tables. At 7:52am, ATF #21 indicated he did not</p>		<p>will be reviewed with staff, including the need for them to follow the plans as written, including redirecting the residents when needed or indicated. Small containers will be placed at each table containing sweetener packets and creamer to make items more readily accessible to residents to reduce the potential of one resident "stealing" the packets from another. <u>2. How will facility identify other residents having the potential to be affected by the same practice?</u> The recording of each instance of resident to resident aggression will identify other residents having the potential to be affected by the same practice. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management plans, they will be prompted at that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put into place. Once the resident's behavior has moderated, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not occur?</u> Management will conduct</p>				

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	<p>know client #9's needs or behaviors. ATF #21 indicated client #9's ISP and BSP were not available for him to refer to. From 7:52am until 8:20am, client #9 sat at a table with one inch by one inch puzzle pieces and two inch by two inch puzzle pieces in front of her on the table. Client #9 mouthed the puzzle pieces without redirection by ATF #21 or ATF #58. Throughout the observation period ATF #21 and #58 prompted the other nine clients in program room A for activity and at times had their backs to client #9 so that the client was not in eye sight supervision.</p> <p>Client #9's record was reviewed on 1/25/12 at 8am. Client #9's 10/11/11 ISP and 7/31/2009 BSP indicated the behavior of "SIB (Self Injurious behavior) inserting foreign objects into orifices on her body especially (her) nose." Client #9's BSP indicated "staff will stay at the table with [client #9] to oversee her performance with the activity." Client #9's BSP indicated "staff will accompany [client #9] whenever she is out of the (special supervision) classroom." Client #9's ISP and BSP indicated client #9 had "Antecedent Condition: tactile stimulation" and staff should redirect and offer "something edible instead."</p> <p>On 1/26/12 at 10:25am, an interview with QMRP #68 was completed. QMRP #68 stated client #9 was to have eye sight supervision "at all times while awake or out of bed." QMRP #68 indicated client #9 had a history of mouthing objects and putting items into her body cavities. QMRP #68 stated client #9 "should not have puzzle pieces without one on one supervision." QMRP #68 indicated client #9 required staff supervision when out of the special classroom. QMRP #68 indicated client #9 should not have been alone with the open staff back pack inside her bedroom.</p>		<p>observations at least 5 days a week at various times of day to assess if staff are implementing behavior plans and intervening appropriately when residents steal food or drink items from others. The IDT will review results of the management observations and response to identified concerns/issues will be done as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The QA Committee will review results from the daily management rounds at least every thirty days and will offer recommendations for process improvement as needed. The Administrator and/or department managers will follow through on the recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. W149.3 W149.4 #4 1. <u>What corrective action will be done by the facility?</u> It should be noted that the back pack left un-attended was never in a location where resident #9 was present. Resident #9 does not attempt to independently ambulate so she always has staff present when she is out of bed. All staff has been re-trained not to leave their back-packs un-attended. Staff that works with resident #9 has been in-serviced on her behavior</p>				

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			intervention plan; (BIP) related to her self injurious behavior; (SIB) and a copy of her BIP will be maintained in all classrooms she participates in. Staff has been retrained to keep resident #9 in "eyesight" during the time she is in the classroom. The classroom will be swept prior to the class convening for the day to ensure there are no small items left on the floor. The items in the classroom for resident activities during the early morning class will be identified as specifically appropriate for that group. The closet will be rearranged in such a way that those activities will be appropriate and readily available and accessible to resident #9 in the classroom. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of which residents present the behavior presented by Resident #9. Behavioral assessments are completed upon admission to the facility and monthly thereafter. If other residents presented this behavior, the documentation and review would identify those residents. Currently, there is not another resident who presents this particular behavior at this facility. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management plans, they will be prompted at	

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			<p>that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put into place. Once the resident's behavior has moderated and/or the resident is deemed to be in a safe situation, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Staff training will be conducted concerning the need to ensure the safety of residents who present PICA behavior. Management staff will complete Administrative Rounds at least 5 days a week at various times to ensure that residents with PICA behavior are being monitored according to plan and that staff have the BIP available to them related to residents PICA behavior. Any identified concerns will be addressed as outlined in question #2. <u>W149.5 #5 1.What corrective action was done by the facility?</u> For resident #8, #40, #20, #15, #33, #70, #7, and all other residents, staff will be in-serviced on strategies to minimize the risk for falls including the use of appropriate adaptive devices. Each resident will continue to be assessed using a Fall Risk Assessment to</p>	

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			<p>determine the likeliness of falls and intervention strategies to reduce the risk of falls. Residents at risk for falls will be part of the updated Falling Leaf program. Staff has been in-serviced on falls and fall prevention at various times during the year. All staff received this training in December 2011. Since the conclusion of the survey staff has received further instruction on specific resident risk plans for falls. Staff will be in-serviced again on the fall risk plans for each resident who has had a fall with injury in the past year. <u>2.</u> <u>How will the facility identify other residents having the potential to be affected by the same practice?</u></p> <p>The facility has assessed all residents for fall risk and thus, is able to identify all residents with the potential to be affected by this practice. In the future if the Administrator or any IDT members observe staff not following and intervening as indicated in the residents' fall risk plans, they will be prompted at that time to intervene to prevent a fall from occurring. The observer will assist as needed to make sure that the appropriate intervention is put into place. Once the resident is safe, the department manager or Administrator will re-train the staff involved regarding the facility's policy for following the fall risk plans as written. In addition progressive disciplinary action will</p>	

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			<p>be rendered for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Efforts will be made to keep the environment clear of any obstacles that may increase the likeliness of falls. The facility management staff will complete Administrative Rounds at least five days a week at various times to assess if the environment is free of congestion, that there are pathways for open egress, that staff monitoring is in place and that adaptive devices are being used in accordance with resident risk plans. The results of the Administrative Rounds will be reviewed at the next scheduled morning management meeting for identification of any unsolved issues and to make sure that correction is put into place as quickly as possible. The Administrator and/or department managers will address concerns as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next</p>	

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			<p>scheduled QA meeting. This will continue on an ongoing basis.</p> <p>W149.6 <u>1. What corrective action will be done by the facility?</u> Each resident will continue to be assessed using a Fall Risk Assessment to determine the likeliness of falls and intervention strategies to reduce the risk of falls. Residents at risk for falls will be part of the updated Falling Leaf program. Staff has been in-serviced on falls and fall prevention at various times during the year. All staff received this training in December 2011. Since the conclusion of the survey staff has received further instruction on specific resident risk plans for falls. Staff will be in-serviced on the fall risk plan for each resident who has had a fall with injury in the past year. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility has assessed all residents for fall risk and thus, is able to identify all residents with the potential to be affected by this practice. In the future if the Administrator or any IDT members observe staff not following and intervening as indicated in the residents' fall risk plans, they will be prompted at that time to intervene to prevent a fall from occurring. The observer will assist as needed to make sure that the appropriate intervention is put into place. Once the resident is safe, the department manager or</p>	

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			<p>Administrator will re-train the staff involved regarding the facility's policy for following the fall risk plans as written. In addition progressive disciplinary action will be rendered for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u>Efforts will be made to keep the environment clear of any obstacles that may increase the likeliness of falls. The facility management staff will complete Administrative Rounds at least five days a week at various times to assess if the environment is free of congestion, that there are pathways for open egress, that staff monitoring is in place and that adaptive devices are being used in accordance with resident risk plans. The results of the Administrative Rounds will be reviewed at the next scheduled morning management meeting for identification of any unsolved issues and to make sure that correction is put into place as quickly as possible. The Administrator and/or department managers will address concerns as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The</p>	

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			<p>Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. The facility wishes to state that the regulation for W149 states that "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client". We believe that this facility met this requirement by having clear written policies in place that prohibit mistreatment, abuse, neglect, and misappropriation of resident property. See Attachment W149-1. The employee in question was properly screened prior to his hire, and there is written documentation that he received proper orientation and training regarding the facility's abuse policies, including misappropriation of resident property. See Attachment W149-2.</p> <p>The Federal Regulation for W149 does not state that the facility will "ensure" that misappropriation of property does not occur. It does state that the facility must develop policies and procedure that "prohibit" misappropriation of property. The current edition of the Merriam-Webster Dictionary defines "prohibit" as "to forbid by authority". Based on the</p>	

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			<p>documentation of this employee's orientation, he was informed of and given the Hickory Creek at Gaston written policy prohibiting abuse of any kind. He was clearly informed that Hickory Creek at Gaston does not allow, and indeed "forbids" the abuse or misappropriation of resident property. His signature on the attached documents <i>W-149-2</i> indicates that he understood this facility policy. His decision to misappropriate Resident #66's property was made without the knowledge and consent of Hickory Creek at Gaston. When he took those items, he violated the well known and longstanding written policy and practice of this facility that residents are to be free of abuse and neglect, including misappropriation of property. Based on this information, we request that #7 of W149 be deleted from the 2567.</p> <p>- 7.</p> <p><u>1. What corrective action will be done by the facility?</u> The facility immediately intervened when it received knowledge that the employee had taken items from the resident to their home. The BDDS report reflected that the police were called, the items returned, and the socks replaced. In addition staff was in-serviced to not take personal possessions off the premises, and the guardian was notified. The employee was</p>		

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			<p>suspended immediately and when contact was made with him, he was asked to make a statement. He chose not to do so and resigned effective immediately. When the surveyor questioned the administrator about the incident the Administrator answered her questions, but was unaware that she needed more information. Staff will again be in-serviced on the facility abuse policy, including the prohibition of misappropriation of any residents' property for any reason.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> All residents that reside in the facility have personal possessions. Thus, the facility is able to identify that all residents can be affected by an employee taking their possessions.</p> <p>As with this situation, when the Administrator becomes aware of an allegation of abuse, neglect, or misappropriation of property, he will suspend the employee immediately and begin a thorough investigation. He will notify all appropriate agencies and will report the occurrence, as well as the final results of the investigation and whatever action is being taken regarding the employee's employment as well</p>		

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			<p>as any other necessary follow up. Abuse of any kind, including misappropriation of property, is not allowed in this facility and is not tolerated for any reason.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> All staff will be trained on the abuse policies once again, including misappropriation of property by 3/2/12. As with this facility's current practice, new employees will continue to receive this training as part of their initial orientation to the facility. The Administrator and all management staff will make frequent rounds throughout each one's tour of duty to observe staff interaction with residents and to be available to receive any allegation of abuse, neglect, or misappropriation of property. Any identified concerns will be addressed immediately as indicated in question #2.</p> <p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> - The Administrator will bring the results of the Administrative rounds and any other allegations of abuse to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on</p>		

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	<p>5. On 01/23/12 at 11:30 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following incidents:</p> <p>-On 03/28/11: A BDDS report submitted 03/29/11 for an incident on 03/28/11 at 7:30 PM indicated the following regarding client #8: "[Client #8] was in his wheelchair in his room. The CNA caring for him was getting him ready for a shower and removed his laptray. She momentarily went to get a towel and returned to find him on the floor. He was bleeding from his nose...he was taken by ambulance to ER (emergency room)...[Client #8] has been assessed as a high risk for falling...."</p> <p>-On 04/05/11: A BDDS follow-up report indicated, "[Client #8] is to have his lap-tray in place when up in his wheelchair."</p> <p>Client #8's records were reviewed on 01/25/12 at 9:50 AM. Client #8's Physical Therapy Evaluation dated 04/07/11 indicated client #8 was prescribed a wheelchair with a lap tray. Client #8's Physician Orders dated 01/2012 indicated client #8's laptray should be in place when he was in the wheelchair.</p> <p>-On 05/15/11: A BDDS report submitted 05/16/11 for an incident on 05/15/11 at 11:50 AM indicated the following regarding client #40: "[Client #40] was in his classroom and stood up</p>		<p>any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p> <p>- Administrator responsible Completion date: 3/2/2012</p>				

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	<p>from his chair. He took a step and lost his balance. He fell against the wall of the classroom causing an abrasion on his back measuring 20cm by 3cm (sic). He was also rubbing his head... [client #40] uses a wheelchair for mobility due to weakness in his legs causing poor balance and control."</p> <p>Client #40's records were reviewed on 01/25/12 at 2:30 PM. Client #40's record contained a "Fall Risk Assessment" which indicated he was at risk for falls. The assessment form contained eight clinical condition parameters, one of which was a, "history of falls (past 3 months)" and used a scoring system. The scoring for, "1-2 falls in the past 3 months" was a score of "2." The form was to be completed on a quarterly basis and in addition with every fall. The 02/09/11 assessment indicated client #40 was given a score of "2" which indicated he had fallen 1-2 times in the past 3 months.</p> <p>-On 05/16/11: A BDDS report submitted 05/16/11 for an incident on 05/16/11 at 4:45 AM indicated the following regarding client #20: "[Client #20] got up out of the Geri-chair...Nursing assessed a 6cm (sic) laceration to the back of his head...[client #20] was sent to the ER for evaluation. He returned to the facility with 8 staples to the back of his head." The report did not indicate whether or not staff had assisted him up from the chair to walk with assistance as ordered.</p> <p>Client #20's records were reviewed on 01/25/12 at 3:00 PM. Client #20's record contained a Nursing Care Plan dated 04/27/11 which included a "Risk Plan" which indicated, "[Client #20] has a history of numerous falls and has a diagnosis of Osteopenia (bone mineral density is lower than normal)." Client #20's Physician Orders dated</p>				

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	<p>01/2012 indicated client #20 was to have, "1-2 staff assist walk with belt."</p> <p>-On 08/07/11: A BDDS report submitted 08/08/11 for an incident on 08/07/11 at 8:00 PM indicated the following regarding client #15: "[Client #15] was sitting in a Gerrchair (sic) in an upright position. He was trying to reposition himself using the hand rests. He fell forward on the floor...noted a superficial 2 cm laceration across the bridge of his nose and a nosebleed." The report did not indicate whether or not staff assisted client #15 to reposition himself.</p> <p>Client #15's records were reviewed on 01/25/12 at 3:30 PM. Client #15's record contained a "Comprehensive Functional Assessment" dated 02/02/11 which indicated he was at risk for falls. Client #15's "Episodic Care Plan Weight Loss," dated 05/01/11, indicated he had lost 9.6 pounds since 04/23/11 due to decreased appetite, emesis (vomiting) and refusing to eat. The "Episodic Care Plan Falls" dated 04/03/11 indicated, "Risk for falls." The "Episodic Care Plan Falls" dated 08/07/11 indicated, "fell forward d/t (due to) trying to reposition self. Risk for additional falls. R/T overall gen (general) health deterioration d/t disease process."</p> <p>-On 08/11/11: A BDDS report submitted 08/11/11 for an incident on 08/10/11 at 10:45 AM indicated the following regarding client #33: "Staff report resident was ambulating to dining room without difficulty and use of roller walker with assisted (sic) by one staff for cue direction due to blindness when resident went to floor in Dining room prior to being seated and hitting head on table resulting in an 1.5 cm open area...sent to ER for evaluation...returned to facility with area to head closed via glue."</p>						

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	<p>Client #33's records were reviewed on 01/25/12 at 3:45 PM. Client #33's record contained a "Episodic Care Plan Falls" dated 04/03/11 which indicated, "Risk for falls. R/T: Assessed as a high risk for falling." The plan indicated staff were to "guide walker (R/T resident blind)" and "touch chair before sitting." Client #33's chronology of the "Needs Oriented Progress Notes" indicated she had a history of falls dating back to 2006 and indicated, "[Client #33] is blind and staff are to be responsible to direct her around obstacles." Client #33's ISP dated 01/03/11 indicated staff were to, "reinforce safety awareness, touch chair before sitting" and provide verbal cues for client to follow.</p> <p>-On 11/15/11: A BDDS report submitted 11/16/11 for an incident on 11/15/11 at 8:55 AM indicated the following regarding client #70: "[Client #70] was in the living room area in a wheelchair after breakfast. It was reported ...that [client #70] leaned forward and fell from her wheelchair falling to the floor. As a result of the fall, [client #70] hit her nose on the floor and bleeding was noted...there is a 1.5cm x 1.5cm (sic) red discoloration to her left nostril and 1cm (sic) x 1.5cm (sic) purple discoloration to bridge of her nose." The report did not document whether or not client #70 was safely secured in her wheelchair.</p> <p>Client #70's records were reviewed on 01/25/12 at 4:00 PM. Client #70's record contained an ISP dated 10/04/11 which indicated client #70 was at risk for falls. The Psychological Services document dated 10/04/11 indicated client #70 has maladaptive behaviors and "becomes impatient." The physician orders dated 01/2012 indicated an order which originated on 01/28/11 for: "May use pelvic stabilizer in wheelchair if needed."</p>				

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	<p>-On 12/15/11: A BDDS report submitted 12/16/11 for an incident on 12/15/11 at 7:00 PM indicated the following regarding client #7: "Staff reported resident was seated on the commode with staff present. Reported they turned to ask for assistance and when turned back resident was seated on the floor...assessed immediately and noted a small open area 0.2cm to forehead."</p> <p>Client #7's records were reviewed on 01/25/12 at 4:30 PM. Client #7's ISP dated 09/06/11 indicated client #7 was at risk for falls. An "Episodic Care Plan Falls" dated 04/13/11 indicated client #7 was, "Risk for falls. R/T: Assessed as at high risk for falling." The plan indicated staff were to: "Stay with when on toilet. Monitor for fatigue, unsteadiness."</p> <p>On 01/26/12 at 1:00 PM an interview with the Director of Nursing was conducted. The DON indicated staff should be paying attention to the clients and directly monitoring them and it was the agency's responsibility to ensure the safety of the residents.</p> <p>6. On 01/23/12 at 11:30 AM a record review of the BDDS reports was conducted and included the following incidents related to clients "found" on the floor:</p> <p>-On 05/02/11: A BDDS report submitted 05/02/11 for an incident on 05/02/11 at 2:20 AM indicated the following regarding client #2: "Staff found [client #2] sitting on the floor in her bathroom...There was a superficial laceration to the back of [client #2's] head, 0.2 cm by 1.2 cm...Nursing previously assessed [client #2] as a fall risk. The Fall Care Plan states that the Interdisciplinary Team recognizes that due to her desire for independence and her current condition, [client #2] will fall. The goal is to prevent injury."</p>						

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	<p>-On 11/14/11: A BDDS report submitted 11/15/11 for an incident on 11/14/11 at 7:15 PM indicated the following regarding client #2: "[Client #2] was found by staff on the floor on left side near a neighboring bed. She stated that she didn't hit her head. Resident was confused before and after the fall...Discolorations on left shoulder 2cm x 2cm and 1.5cm x 1.5cm."</p> <p>Client #2's records were reviewed on 01/25/12 at 1:45 PM. Client #2's ISP dated 06/09/11 indicated client #2 had a history of and was at risk for falls. Client #2's record contained a "Fall Risk Assessment" which indicated she was at risk for falls. The assessment form contained eight clinical condition parameters, one of which was a, "history of falls (past 3 months)" and used a scoring system. The scoring for, "3-4 falls in the past 3 months" was a score of "4." The form was to be completed on a quarterly basis and in addition with every fall. The 05/05/11 assessment indicated client #2 was given a score of "4" which indicated she had fallen 3 or more times in the past 3 months. There were 4 "Episodic Care Plan Falls" documents dated, 04/03/11, 06/22/11, 07/10/11 and 07/22/11. Each form indicated client #2 had fallen.</p> <p>-On 08/03/11: A BDDS report submitted 08/04/11 for an incident on 08/03/11 at 9:45 PM indicated the following regarding client #4: "Staff reported resident was on the floor next to bed...superficial abrasions to the top of her left hand measuring 1cm x 1cm and to the left side of her left hand measuring 1cm x 1cm."</p> <p>Client #4's records were reviewed on 01/25/12 at 11:30 AM. Client #4's ISP dated 07/27/11 indicated client #4 was at risk for falls related to paralysis. Client #4's record contained a "Fall</p>			
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	<p>Risk Assessment" which indicated she was at risk for falls. The assessment form contained eight clinical condition parameters, one of which was a, "history of falls (past 3 months)" and used a scoring system. The scoring for, "1-2 falls in the past 3 months" was a score of "2." The form was to be completed on a quarterly basis and in addition with every fall. The 07/27/11 assessment indicated client #4 was given a score of "2" which indicated she had fallen 1-2 times in the past 3 months.</p> <p>-On 05/10/11: A BDDS report submitted 05/11/11 for an incident on 05/10/11 at 12:30 PM indicated the following regarding client #64: "[Client #64] was noted to be lying on the floor in his bedroom. [Client #64] stated that he had fallen...small abraded area to right elbow."</p> <p>-On 08/30/11: A BDDS report submitted 08/30/11 for an incident on 08/30/11 at 12:55 PM indicated the following regarding client #64: "Resident was found sitting up on the floor between his bed and another resident's bed...found a 5.5cm x 1.5cm abrasion to back of left thigh. He was alert and stated, 'I fell.'"</p> <p>Client #64's records were reviewed on 01/25/12 at 12:00 PM. Client #64's ISP dated 01/03/11 indicated client #64 was at risk for falls. Client #64's "Episodic Care Plan Falls," dated 04/03/11 and indicated client #64 was, "assessed as at high risk for falling." An OT (Occupational Therapy) note dated 01/07/10 indicated, "Pt (patient) has been discovered on floor (possible falling) a couple of times." An addendum to the 01/07/11 OT note indicated, "12-31-10 fall in classroom on floor next to table."</p> <p>-On 11/09/11: A BDDS report submitted 11/10/11 for an incident on 11/09/11 at 7:30 AM</p>						

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	<p>indicated the following regarding client #68: "[Client #68] was found by staff to be sitting on the floor beside his bed at 7:30 am. He had a small abrasion to his right knee with a small amount of blood on the floor...He usually uses a wheelchair for transportation due to poor balance issues."</p> <p>-On 11/19/11: A BDDS report submitted 11/20/11 for an incident on 11/19/11 at 8:50 PM indicated the following regarding client #68: "[Staff reported finding [client #68] on his knees facing the wall in the east hallway...small open bleeding area to right knee."</p> <p>Client #68's records were reviewed on 01/25/12 at 12:30 PM. Client #68's record contained a "Fall Risk Assessment" which indicated he was at risk for falls. The assessment form contained eight clinical condition parameters, one of which was a, "history of falls (past 3 months)" and used a scoring system. The scoring for, "1-2 falls in the past 3 months" was a score of "2." The form was to be completed on a quarterly basis and in addition with every fall. The 05/18/11 assessment indicated client #68 was given a score of "2" which indicated he had fallen 1-2 times in the past 3 months.</p> <p>On 01/26/12 at 1:00 PM an interview with the Director of Nursing was conducted. The DON indicated it was the agency's responsibility to ensure the safety of the residents.</p> <p>7. On 01/23/12 at 11:30 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following incident for client #66. A 1/11/12 BDDS report for an incident on 1/10/12 at 5pm, indicated QMRP (Qualified Mental Retardation Professional) #66 was "approached by a lady from</p>						

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	<p>[name of city] in the parking lot of the facility she identified herself as the wife of (an employee)...She handed [QMRP #66] two DVD's with the name of [client #66]. The [employee] wife indicated that [the employee] had brought them home with him. [The wife] told [QMRP #66] that they were getting a divorce so she did not care if [the employee] got in trouble...[The report indicated the wife brought client #66's socks to the police station]. [The employee] when questioned claimed he had borrowed the socks when a pair he was wearing got wet...." The report indicated the employee resigned.</p> <p>On 1/26/12 at 12:30pm, an interview with the administrator was completed. The administrator indicated QMRP #66 immediately reported the allegation and the employee was suspended, later resigned, and no additional information was available for review.</p> <p>On 1/26/12 at 10:30am, a review of the facility's "Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property," dated 5/2010, indicated "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse...Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents. Neglect occurs when a facility fails to provide necessary care for residents...."</p> <p>3.1-27(a) 3.1-28(a)</p>			

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W0153	<p>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.</p> <p>Based on record review and interview, the facility failed to thoroughly report incidents in the Bureau of Developmental Disabilities Services (BDDS) reports for 1 of 1 report (client #6) and to report 1 of 2 incidents of peer to peer aggression (client #5) to the administrator and BDDS in accordance with State law.</p> <p>Findings include:</p> <p>Facility records were reviewed on 1/23/12 at 11:30am, including the BDDS reports for the time period between 1/23/11 and 1/23/12. The BDDS reports indicated the following:</p> <p>1. For client #6: A BDDS report dated 7/13/11 for an incident on 7/12/11 at 1:30 P.M. indicated the following: "7/12/11 [name of doctor] contacted to update on resident condition regarding increased aggression towards staff, refusing to leave bedroom or allow anyone to assess, refusing intakes and medications. Order received to send to [name of hospital] ER (emergency room), if resident becomes injurious to self or others for evaluation. At 1:30 pm resident sent to ER via ambulance with police dept. (department) available for assistance with transport of resident due to increase in aggressive behavior. Resident assessed and admitted to [name of hospital] psych (psychiatric) unit for eval (evaluation) and stabilization." The front of the BDDS report indicated "Handcuffs: (yes was checked)."</p>	W0153	<p>W153.1 It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of a client, including prompt handling of severe behaviors, implementing measures to protect clients from PICA and SIB behaviors, implementing measures to protect residents who are at risk for falls, following appropriate medication policy and procedure, and protecting clients' personal property from theft. On page 7 of 59 the 2567 contains a statement that the BDDS report of this incident with Resident #6 did not "indicate what actions the facility staff had taken prior to having client #6 transported to the ER". While the staff actions were not detailed on the BDDS report, they were detailed in the resident's medical record and were available for the surveyor's review during the survey. According to Resident #6's record, in the days leading up to this resident's hospitalization she was noted to participate in programming on 7/8/11. On 7/9/11 progress notes indicate that the nurse was present with her in room on both day shift and afternoon shift that same day and</p>	03/02/2012	

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	<p>Client #6's record was reviewed on 1/24/12 at 1:50 P.M.. Client #6's record indicated the following:</p> <p>-A quarterly nursing progress note for client #6 for the time period between 6/8/11 and 9/7/11 indicated "Walking quickly in hallway in socks and fell, refused assessment, yelling and took G-chair (geriatric chair) into room...was yelling and continued to refuse assessment. Spent 3 (three) days in room and wouldn't allow staff into room and refused to take medications. Unable to contact [name of mental health services], [name of doctor] notified with orders for Haldol (anti-psychotic) and send to ER for evaluation if becomes self-injurious to self (sic) or others and continue to contact [name of mental health services]. Police were available and present for assessment and because of aggression to sheriff, he believe (sic) her to be a danger to herself and others and resident was transported to ER via ambulance and police...."</p> <p>-A Qualified Mental Retardation Professional (QMRP) progress note dated 7/13/11 at 1:35 P.M.. indicated "[Client #6] was admitted to the psych unit yesterday. She was taken via ambulance by police in handcuffs. She had not taken meds (medication) for an indeterminate time due to refusal and staff having found where she had hidden meds in room. She was aggressive with staff and police prior to transport...."</p> <p>The facility administrator was interviewed on 1/26/12 at 12:30pm. The administrator stated client #6's BDDS report indicated what had occurred and did not include "all" information about the incident. The administrator indicated no further information was available for review regarding the report made to BDDS on 7/13/11 which did not include client #6 being administered Haldol (for behaviors), a narrative regarding client</p>		<p>allowed the nurse to take vitals with no complaints. The progress notes then reflect that she was clinically monitored related to a fall 7/8/11. Nursing was assessing her each shift as she would allow and her clinical monitoring was resolved on 7/11/11. Resident #6 did leave her room for meals on 7/10/11 at breakfast and supper consuming 100% of both meals and also consumed 100% of her HS snack. She took in 72 oz of hydration on 7/10/11. Resident #6 also came out of her room for breakfast and lunch on 7/11/11 consuming 100% of each meal and taking in 64 oz. of hydration. She did refuse her supper meal. After she refused breakfast on 7/12/11 her physician was contacted and the nurse advised to contact psych services. A new order was then received to send her to ER if she became self-injurious or posed a threat to others; in addition, the nurses were approved to give 1 time administration of 5mg Haldol IM prior to going to ER for extreme agitation. Contrary to the statement on page 7 of 59 of the 2567, Resident #6 was in and out of her room during the days leading up to the hospitalization and did allow staff in her room at times. She did refuse her medication on the date she admitted to the hospital (7/12/11), but not on the days prior to that. This is confirmed by the</p>				

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	<p>#6 being handcuffed, client #6 having hidden medications in her room, what the medications were, what they were for, how many medications were found, or how the facility planned to resolve the issue of client #6 hiding medications.</p> <p>2. For client #5: Client #5's record was reviewed on 1/25/12 at 12:05 P.M.. Client #5's record indicated the following: -A nursing note for client #5 dated 11/30/11 at 6:45 P.M. indicated the following: "Was hit on the head by Res. #276 (unidentified) with a book backpack. States head hurts/eyes hurt...neuro (neurological) checks initiated..." -A nursing note for client #5 dated 11/30/11 at 7:00 P.M. "Tylenol (pain) given for complaints of headache." -A nursing note for client #5 dated 11/30/11 at 7:00 P.M. "Ice pack applied to head." -A nursing note for client #5 dated 12/1/11 at 8:45 A.M. "Complaints of headache." On 1/23/12 at 11:30am, the facility BDDS reports were reviewed and no BDDS report was available for review regarding client #5 being hit in the head with a book backpack. The facility administrator was interviewed on 1/26/12 at 12:30pm. The administrator indicated no BDDS report was completed for client #5 getting hit in the head with a back pack. The administrator indicated Resident #276 was client #6.</p> <p>3.1-28</p>		<p>documentation on the Medication Administration Record for July 2011, which supports that the nurse did administer her medication to her each day prior to 7/12/11. The staff was monitoring Resident #6's behavior and noted an escalation in her aggressiveness when some of her medication was found scattered on the floor of her room, apparently after being cheeked by the resident at some point in time. After the Director of Nursing conferred with the attending physician and the facility's mental health service provider regarding the resident's behavior changes and the discovery of what was assumed to be some of the resident's medication, the decision was made to admit her to the psychiatric unit for her safety and further assessment of her mental health status. <u>1. What corrective action will be done by the facility?</u> The facility will train nurses to document progress notes that accurately reflect the level of a resident's refusal of treatment, including taking their medication. It is anticipated that residents may at times be resistive to treatment. If the resident eventually complies with taking their medication the Medication Administration Record will indicate this and a progress note that reflects a refusal will not be needed. All licensed nurses will be trained to assess if</p>				

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			<p>residents are pocketing medications that are taken orally. If medications are found that appear to have been pocketed by the resident, an attempt will be made to identify the specific medications, depending on the condition of the actual pill/capsule itself. The success or lack of success in identifying the number and type of medications will be documented in the resident's record. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> All residents have the potential to be affected; however, no other residents were identified as being affected by this practice at this time. In the future, if staff notices that a resident is experiencing more severe behaviors, including refusal of care and/or medications for longer than is normal for that individual, the nurse will assess the situation and detail her findings in the resident's clinical record. She will notify the DON immediately of her observations, so that the attending physician and mental health worker (if applicable) can be notified of the resident's change and behavior to make sure that interventions are put into place as soon as possible. Once the resident is cared for, if the DON finds that the resident's condition change has been going on without appropriate notification for a longer period of time than is</p>	

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			<p>acceptable or that the documentation of the condition change is not as complete and detailed as required, she will re-train the staff involved in the facility's standard of care and services regarding condition changes. She will also render disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Director of Nursing (DON) will observe medication administration with each nurse in the next 30 days. When she has observed every nurse, she will continue random observations, ensuring that each nurse is reviewed at least one more time in the next 90 days. The DON will review residents on focused clinical charting at least 5 days a week during each tour of duty to ascertain if there are any resident condition changes and refusals of medication. If there are any refusals documented, she will also review the MAR (medication administration record) to make sure that follow up to any identified issues has been completed and documented. If she identifies any concerns, she will follow up as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will report any resident changes in condition and medication refusals</p>	

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			<p>at the next scheduled morning management meeting which occurs at least 5 days a week. In addition the DON will report the results of her medication administration observations and focus charting reviews to the monthly QA Committee for review and recommendations for improvement. Any recommendations will be followed up by the DON and the results of those recommendations will be brought back and reported to the next scheduled QA Committee. This will continue on an ongoing basis. W153.2 <u>1. What corrective action will be done by the facility?</u> Staff will be in-serviced to report all resident to resident aggression to the charge nurse. Licensed nurses will be in-serviced on facility and BDDS guidelines related to reporting on resident to resident aggression. The current BDDS policy indicates that resident to resident aggression which results in serious injury is to be reported. While this incident resulted in a headache for resident #5, that is not considered a "serious" injury. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> All residents in the facility share living areas that allow unlimited access areas of the home. Thus, all residents of the facility are identified with the potential to be affected. In the future if the Administrator or any</p>		

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			<p>IDT members observe staff not reporting instances of resident to resident aggression, the Administrator will make sure that the appropriate report to BDDS is completed and filed with that agency. Once that is done, the department manager or Administrator will re-train the staff involved regarding the facility's policy for reporting of aggressive behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Management staff will conduct Administrative Rounds to review resident-to-resident aggression as well as daily incident reports at least 5 days weekly during each one's tour of duty. The results of those incidents will be brought to the next scheduled morning IDT management meeting for review and discussion. Any identified concerns with staff response to resident to resident aggression will be addressed as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department</p>		

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			managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.		

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W0157	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, for 6 of 10 sample clients (clients #2, #3, #4, #6, #7, and #8), and for 10 additional clients (clients #15, #20, #33, #34, #40, #54, #64, #68, #69, and #70), the facility failed to implement sufficient corrective action to protect clients #3, #4, #7, #34, #54, #68, and #69 from client #6's identified physically aggressive and stealing behaviors, to implement sufficient corrective action to protect clients who were at risk for falls from falling (clients #2, #4, #7, #8, #15, #20, #33, #40, #64, #68 and #70), and failed to take sufficient corrective action after client #6 stockpiled her medications.</p> <p>Findings include:</p> <p>1. On 01/23/12 at 11:30 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following incident for client #6:</p> <p>-A BDDS report dated 7/13/11 for an incident on 7/12/11 at 1:30 P.M. indicated the following: "7/12/11 [name of doctor] contacted to update on resident condition regarding increased aggression towards staff, refusing to leave bedroom or allow anyone to assess, refusing intakes and medications. Order received to send to [name of hospital] ER (emergency room), if resident becomes injurious to self or others for evaluation. At 1:30 pm resident sent to ER via ambulance with police dept. (department) available for assistance with transport of resident due to increase in aggressive behavior. Resident assessed and admitted to [name of hospital] psych (psychiatric) unit for eval (evaluation) and stabilization."</p>	W0157	<p><u>W157.1</u> It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of a client, including prompt handling of severe behaviors, implementing measures to protect clients from PICA and SIB behaviors, implementing measures to protect residents who are at risk for falls, following appropriate medication policy and procedure, and protecting clients' personal property from theft. On page 7 of 59 the 2567 contains a statement that the BDDS report of this incident with Resident #6 did not "indicate what actions the facility staff had taken prior to having client #6 transported to the ER". While the staff actions were not detailed on the BDDS report, they were detailed in the resident's medical record and were available for the surveyor's review during the survey. According to Resident #6's record, in the days leading up to this resident's hospitalization she was noted to participate in programming on 7/8/11. On 7/9/11 progress notes indicate that the nurse was present with her in room on both day shift and afternoon shift that same day and allowed the nurse to take vitals with no complaints. The progress notes then reflect that she was clinically monitored related to a</p>	03/02/2012			

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	<p>Client #6's record was reviewed on 1/24/12 at 1:50 P.M.. Client #6's record indicated a quarterly nursing progress note for client #6 the time period between 6/8/11 and 9/7/11 indicated "Walking quickly in hallway in socks and fell, refused assessment, yelling and took G-chair (geriatric chair) into room...was yelling and continued to refuse assessment. Spent 3 (three) days in room and wouldn't allow staff into room and refused to take medications. Unable to contact [name of mental health services], [name of doctor] notified with orders for Haldol (anti-psychotic) and send to ER for evaluation if becomes self-injurious to self or others and continue to contact [name of mental health services]. Police were available and present for assessment and because of aggression to sheriff, he believe (sic) her to be a danger to herself and others and resident was transported to ER via ambulance and police...."</p> <p>-A Qualified Mental Retardation Professional (QMRP) progress note dated 7/13/11 at 1:35 P.M.. indicated "[Client #6] was admitted to the psych unit yesterday. She was taken via ambulance by police in handcuffs. She had not taken meds (medication) for an indeterminate time due to refusal and staff having found where she had hidden meds in room. She was aggressive with staff and police prior to transport...."</p> <p>On 1/24/12 at 1:50pm, no documentation was available for review to indicate what medications and how many medications staff had found in client #6's room. Client #6's record indicated she had a room by herself.</p> <p>An interview was conducted with the facility Director of Nursing (DON)/RN on 1/26/12 at 10:48 A.M.. When asked about staff following the medication policy, the DON/RN gestured with her</p>		<p>fall 7/8/11. Nursing was assessing her each shift as she would allow and her clinical monitoring was resolved on 7/11/11. Resident #6 did leave her room for meals on 7/10/11 at breakfast and supper consuming 100% of both meals and also consumed 100% of her HS snack. She took in 72 oz of hydration on 7/10/11. Resident #6 also came out of her room for breakfast and lunch on 7/11/11 consuming 100% of each meal and taking in 64 oz. of hydration. She did refuse her supper meal. After she refused breakfast on 7/12/11 her physician was contacted and the nurse advised to contact psych services. A new order was then received to send her to ER if she became self-injurious or posed a threat to others; in addition, the nurses were approved to give 1 time administration of 5mg Haldol IM prior to going to ER for extreme agitation. Contrary to the statement on page 7 of 59 of the 2567, Resident #6 was in and out of her room during the days leading up to the hospitalization and did allow staff in her room at times. She did refuse her medication on the date she admitted to the hospital (7/12/11), but not on the days prior to that. This is confirmed by the documentation on the Medication Administration Record for July 2011, which supports that the nurse did administer her</p>				

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	<p>mouth and stated, "Well they (staff administering medications) can do mouth checks, have them (clients) stick their tongue out, but can't ensure they (clients) are not pocketing the meds." The DON indicated no documentation was available for review to determine what kind of pills client #6 had collected, the number of medication pills at the time of the incident, whether the administrator had knowledge of the medications in client #6's bedroom, and what protective measures were put in place after the incident had occurred.</p> <p>On 1/26/12 at 12:30pm, an interview with the facility administrator was completed. The administrator indicated he was unsure whether he was notified of client #6 stockpiling medications. The administrator indicated no additional information was available for review to determine what kind of pills client #6 had collected, the number of medication pills, or protective measures in place after the incident to protect client #6. The administrator indicated the corrective action was recorded on each BDDS report and no further information was available for review.</p> <p>2. On 1/23/12 at 11:30am, a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following for client #6. Each report indicated client #6 had a program for physical aggression and stealing behaviors and failed to indicate sufficient corrective action was taken after each incident.</p> <p>-On 12/9/11 a BDDS report for an incident on 12/8/11 at 7:45am, indicated client #6 had "sugar packets laying on the table in front of her for her use and [client #3] took them." The report indicated client #6 scratched client #3 on the face, neck, and behind right ear.</p>		<p>medication to her each day prior to 7/12/11. The staff was monitoring Resident #6's behavior and noted an escalation in her aggressiveness when some of her medication was found scattered on the floor of her room, apparently after being cheeked by the resident at some point in time. After the Director of Nursing conferred with the attending physician and the facility's mental health service provider regarding the resident's behavior changes and the discovery of what was assumed to be some of the resident's medication, the decision was made to admit her to the psychiatric unit for her safety and further assessment of her mental health status. <u>1. What corrective action will be done by the facility?</u> The facility will train nurses to document progress notes that accurately reflect the level of a resident's refusal of treatment, including taking their medication. It is anticipated that residents may at times be resistive to treatment. If the resident eventually complies with taking their medication the Medication Administration Record will indicate this and a progress note that reflects a refusal will not be needed. All licensed nurses will be trained to assess if residents are pocketing medications that are taken orally. If medications are found that appear to have been pocketed by</p>				

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	<p>-On 12/4/11 a BDDS report for an incident on 12/3/11 at 7am, indicated client #69 "attempted to steal coffee from [client #6] during breakfast and she scratched him on the side of the face." Client #69 had "4 small scratches to left side of his face."</p> <p>-On 9/16/11 a BDDS report for an incident on 9/15/11 at 2:50pm, indicated client #7 "went up to [client #6] and hit her. [Client #6] then scratched him in return." The report indicated client #6 had 2 small reddish/purple discolorations noted to left forearm. Client #7 had "small scratches noted to face."</p> <p>-On 5/19/11 a BDDS report for an incident on 5/18/11 at 2:15pm, indicated client #68 "tried to take [client #6's] drink and [client #6] became angry." The report indicated client #6 "hit [client #68] causing a 0.3cm (centimeter) discoloration on his left eyelid."</p> <p>-On 4/19/11 a BDDS report for an incident on 4/18/11 at 3:15pm, indicated client #34 "stole [client #6's] juice, she took her juice back, she then grabbed [client #34's] face." The report indicated client #34 had "4 (four) small scratches to [client #34's] face."</p> <p>On 1/24/12 from 6:30am until 8:10am, client #6 was observed in the dining room at the main facility. At 6:30am, client #6 retrieved a brown cup of fluid from a drink cart and was given eight (8) packets of pink sugar substitute. At 6:52am, client #6 sat at her table in the dining room, independently got up from her chair, and poured an additional cup of brown fluid. Client #6 walked to client #4 and #54's table across the dining room in front of four (4) facility staff and took four (4) packets of pink sugar substitute from client #4 and #54's meal trays. No redirection was observed. At 7:10am, client #6 got up from her</p>		<p>the resident, an attempt will be made to identify the specific medications, depending on the condition of the actual pill/capsule itself. The success or lack of success in identifying the number and type of medications will be documented in the resident's record. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> All residents have the potential to be affected; however, no other residents were identified as being affected by this practice at this time. In the future, if staff notices that a resident is experiencing more severe behaviors, including refusal of care and/or medications for longer than is normal for that individual, the nurse will assess the situation and detail her findings in the resident's clinical record. She will notify the DON immediately of her observations, so that the attending physician and mental health worker (if applicable) can be notified of the resident's change and behavior to make sure that interventions are put into place as soon as possible. Once the resident is cared for, if the DON finds that the resident's condition change has been going on without appropriate notification for a longer period of time than is acceptable or that the documentation of the condition change is not as complete and detailed as required, she will</p>				

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	<p>dining room chair, walked to the fluid cart, poured an additional cup of brown fluid, walked from table to table taking pink sugar substitute packets from other clients' meal trays in the dining room without redirection by the eight (8) facility staff in the dining room. At 7:15am, a dietary employee entered the dining room with a pre set tray of individual sugar packet holders for each table in the dining room.</p> <p>On 1/24/12 at 1:50pm, client #6's record was reviewed. Client #6's 10/6/11 ISP and 5/5/2010 BSP indicated identified behaviors of hoarding food/drink and stealing items from others. Client #6's BSP indicated staff were to return the stolen item to the client in which it belonged before client #6's behavior resulted in physical aggression. Client #6's BSP indicated client #6's stealing behavior was a precursor for her physical aggression. Client #6's ISP and BSP both indicated staff were to redirect her behavior each time the behavior occurred and staff were to be near her while in the dining room or around other clients. Client #6 had a bedroom alone because of her behaviors.</p> <p>On 1/26/12 at 11am, an interview with QMRP (Qualified Mental Retardation Professional) #67 was completed. QMRP #67 indicated facility staff should have redirected client #6 from hoarding coffee and redirected her stealing behavior of taking other clients pink sugar substitute in the dining room. QMRP #67 indicated client #6 had a history of physical aggression while dining or participating in hydration opportunities. QMRP #67 indicated client #6 was physically aggressive with other clients. QMRP #67 indicated client #6's BSP was reviewed yearly.</p> <p>3. On 01/23/12 at 11:30 AM a record review of the BDDS reports was conducted and included the</p>		<p>re-train the staff involved in the facility's standard of care and services regarding condition changes. She will also render disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Director of Nursing (DON) will observe medication administration with each nurse in the next 30 days. When she has observed every nurse, she will continue random observations, ensuring that each nurse is reviewed at least one more time in the next 90 days. The DON will review residents on focused clinical charting at least 5 days a week during each tour of duty to ascertain if there are any resident condition changes and refusals of medication. If there are any refusals documented, she will also review the MAR (medication administration record) to make sure that follow up to any identified issues has been completed and documented. If she identifies any concerns, she will follow up as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will report any resident changes in condition and medication refusals at the next scheduled morning management meeting which occurs at least 5 days a week. In addition the DON will report the</p>				

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	<p>following incidents related to clients "found" on the floor:</p> <p>-On 05/02/11: A BDDS report submitted 05/02/11 for an incident on 05/02/11 at 2:20 AM indicated the following regarding client #2: "Staff found [client #2] sitting on the floor in her bathroom...There was a superficial laceration to the back of [client #2's] head, 02 cm (sic) by 1.2 cm...Nursing previously assessed [client #2] as a fall risk. The Fall Care Plan states that the Interdisciplinary Team recognizes that due to her desire for independence and her current condition, [client #2] will fall. The goal is to prevent injury."</p> <p>-On 11/14/11: A BDDS report submitted 11/15/11 for an incident on 11/14/11 at 7:15 PM indicated the following regarding client #2: "[Client #2] was found by staff on the floor on left side near a neighboring bed. She stated that she didn't hit her head. Resident was confused before and after the fall...Discolorations on left shoulder (2cm x 2cm and 1.5cm x 1.5cm)."</p> <p>Client #2's records were reviewed on 01/25/12 at 1:45 PM. Client #2's ISP dated 06/09/11 indicated client #2 had a history of and was at risk for falls. Client #2's record contained a "Fall Risk Assessment" which indicated she was at risk for falls. The assessment form was to document be completed on a quarterly basis and with every fall. The form indicated she was a high risk for falls as per the assessments completed on 05/03/11, 06/11/11, 06/22/11, 07/09/11 and 01/15/12.</p> <p>-On 05/10/11: A BDDS report submitted 05/11/11 for an incident on 05/10/11 at 12:30 PM indicated the following regarding client #64: "[Client #64] was noted to be lying on the floor in his bedroom. [Client #64] stated that he had fallen...small abraded area to right elbow."</p>		<p>results of her medication administration observations and focus charting reviews to the monthly QA Committee for review and recommendations for improvement. Any recommendations will be followed up by the DON and the results of those recommendations will be brought back and reported to the next scheduled QA Committee. This will continue on an ongoing basis. <b>W157.2 1. What corrective action will be done by the facility?</b> Client #6 has a Behavior Program for Physical Aggression and Stealing. The other residents who were involved in aggressive incidents with #6; #3, #69, #7, #68 and #34 also have behavior plans related to the behavior of physical aggression or stealing. Staff was present on all five occasions described in this report that involved resident #6. When the mal-adaptive behavior was displayed, staff immediately intervened. While the facility does not want any injury to occur, the intervention was completed as written and only superficial injuries occurred. With this population behavior management plans are developed to address the behavior as it is anticipated that behaviors will occur. The staff will be in-serviced to implement the behavior plans as written and to record any instance of resident to resident aggression. The specific behavior plans for these residents</p>				

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	<p>-On 08/30/11: A BDDS report submitted 08/30/11 for an incident on 08/30/11 at 12:55 PM indicated the following regarding client #64: "Resident was found sitting up on the floor between his bed and another resident's bed...found a 5.5cm (sic) x 1.5cm (sic) abrasion to back of left thigh. He was alert and stated, 'I fell.'"</p> <p>Client #64's records were reviewed on 01/25/12 at 12:00 PM. Client #64's ISP dated 01/03/11 indicated client #64 was at risk for falls. Client #64's "Episodic Care Plan Falls," indicated client #64 was, "assessed as at high risk for falling."</p> <p>-On 11/09/11: A BDDS report submitted 08/30/11 for an incident on 08/30/11 at 12:55 PM indicated the following regarding client #68: "[Client #68] was found by staff to be sitting on the floor beside his bed at 7:30 am. He had a small abrasion to his right knee with a small amount of blood on the floor...He usually uses a wheelchair for transportation due to poor balance issues."</p> <p>-On 11/19/11: A BDDS report submitted 11/20/11 for an incident on 11/19/11 at 8:50 PM indicated the following regarding client #68: "[Staff reported finding [client #68] on his knees facing the wall in the east hallway...small open bleeding area to right knee."</p> <p>Client #68's records were reviewed on 01/25/12 at 12:30 PM. Client #68's record contained a "Fall Risk Assessment" which indicated he was at risk for falls. The assessment form was to document be completed on a quarterly basis and with every fall. The form indicated he was a high risk for falls as per the assessments completed on 02/16/11, 03/18/11, 05/18/11, 09/30/11, 11/09/11, 11/16/11 and 12/27/11.</p>		<p>will be reviewed with staff, including the need for them to follow the plans as written, including redirecting the residents when needed or indicated. Small containers will be placed at each table containing sweetener packets and creamer to make items more readily accessible to residents to reduce the potential of one resident "stealing" the packets from another. <u>2. How will facility identify other residents having the potential to be affected by the same practice?</u> The recording of each instance of resident to resident aggression will identify other residents having the potential to be affected by the same practice. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management plans, they will be prompted at that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put into place. Once the resident's behavior has moderated, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not occur?</u> Management will conduct</p>				

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	<p>On 01/26/12 at 1:00 PM an interview with the facility Director of Nursing was conducted. The DON indicated it was the agency's responsibility to ensure the safety of the residents. The DON indicated no further information was available for review to determine sufficient corrective action taken by the facility. The DON indicated the only information available was the information on each BDDS report.</p> <p>On 1/26/12 at 12:30pm, an interview with the facility administrator was completed. The administrator indicated the corrective action was recorded on each BDDS report and no further information was available for review. The administrator indicated the facility did not want clients to fall or be found on the floor and stated "clients of this population will fall."</p> <p>3.1-28(e)</p>		<p>observations at least 5 days a week at various times of day to assess if staff are implementing behavior plans and intervening appropriately when residents steal food or drink items from others. The IDT will review results of the management observations and response to identified concerns/issues will be done as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The QA Committee will review results from the daily management rounds at least every thirty days and will offer recommendations for process improvement as needed. The Administrator and/or department managers will follow through on the recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p> <p>W157.3 <u>1.What corrective action will be done by the facility?</u></p> <p>_ Each resident will continue to be assessed using a Fall Risk Assessment to determine the likeliness of falls and intervention strategies to reduce the risk of falls. Residents at risk for falls will be part of the updated Falling Leaf program. Staff has been in-serviced on falls and fall prevention at various times during the year. All staff received this training in December 2011. Since the conclusion of the survey staff</p>				

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			has received further instruction on specific resident risk plans for falls. Staff will be in-serviced on the fall risk plan for each resident who has had a fall with injury in the past year. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility has assessed all residents for fall risk and thus, is able to identify all residents with the potential to be affected by this practice. In the future if the Administrator or any IDT members observe staff not following and intervening as indicated in the residents' fall risk plans, they will be prompted at that time to intervene to prevent a fall from occurring. The observer will assist as needed to make sure that the appropriate intervention is put into place. Once the resident is safe, the department manager or Administrator will re-train the staff involved regarding the facility's policy for following the fall risk plans as written. In addition progressive disciplinary action will be rendered for continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Efforts will be made to keep the environment clear of any obstacles that may increase the likeliness of falls. The facility management staff will complete Administrative Rounds at least five days a week at various times		

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			to assess if the environment is free of congestion, that there are pathways for open egress, that staff monitoring is in place and that adaptive devices are being used in accordance with resident risk plans. The results of the Administrative Rounds will be reviewed at the next scheduled morning management meeting for identification of any unsolved issues and to make sure that correction is put into place as quickly as possible. The Administrator and/or department managers will address concerns as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis	

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W0209	<p>Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to ensure participation in the ISP (Individual Support Plan) by the parent/health care representative/guardian for 2 of 10 sampled clients (#4 and #6).</p> <p>Findings include:</p> <p>Client #6's record was reviewed on 1/24/12 at 1:50 P.M.. Client #6's record indicated she had a guardian who assisted her with decisions. Client #6's record indicated she had an Individual Support Plan (ISP) dated 10/6/11. There was no indication client #6's guardian had participated in the development of client #6's ISP.</p> <p>Client #4's record was reviewed on 1/25/12 at 12:05 P.M.. Client #4's record indicated he had a guardian who assisted him with decisions. Client #4's record indicated he had a Behavior Support Plan (BSP) dated 9/13/11. There was no indication client #4's guardian had participated in the development of client #4's BSP.</p> <p>The Qualified Mental Retardation Professional (QMRP) for client #6 was</p>	W0209	<p>W209</p> <p>Addendum to POC</p> <p>How does the facility try to coordinate IDT meetings with the guardian to determine if the guardian could attend at more convenient times for the guardian? For those guardians who are un-able to attend the meetings, how does the facility get their input prior to the meeting rather than just seeking consents for plans after the meeting?</p> <p>The facility sends the guardian a letter a month prior to the ISP meeting expressing the facilities desire for the guardian to participate in the development of the ISP. <i>See Attachment W209-1</i> The letter also clearly states that if the date is inconvenient for the guardian to contact us with an alternative date and we will re-schedule the meeting. Follow-up phone calls are made by social services if the guardian does not respond to the letter in order to aggressively encourage the guardian participation. In the case of resident #6, her guardian was involved in helping her parents re-locate out of state during and around the time of her</p>	03/02/2012			

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	<p>interviewed on 1/16/12 at 11:10 A.M.. When asked if the QMRP had documentation to show if client #6's guardian had been encouraged to participate in the development of her ISP, the QMRP stated, "I sent it to them, they said they mailed it back to me yesterday."</p> <p>The QMRP for client #4 was interviewed on 1/26/12 at 10:40 A.M.. When asked about guardian participation for client #4's BSP, the QMRP indicated client #4's BSP did not have any restrictive interventions included. There was no documentation of guardian participation available for review.</p> <p>3.1-35(a)</p>		<p>ISP and despite our efforts to encourage her participation, she was not able to attend the meeting. The plan was developed to remain in compliance with timeliness prior to the guardian participation due to the guardian's personal circumstances that did not allow her to attend at the time. The guardian did review the plan as soon as her schedule allowed and did verbally consent to the plan. The ISP plan mailed to the guardian was accompanied by a letter which specifically encourages the guardian to be actively involved in making changes to the ISP of #6. See <i>attachment W209-2</i>. The letter advises the guardian to express if they agree with the plan as it relates to 6 different categories of the plan. The guardian did acknowledge by telephone that she had reviewed the plan and was in agreement with the plan. She indicated she thought she had sent the letter back to the facility but had lost our pre-stamped return address envelope and may have written the wrong address. The written approval for resident #6 was acquired at guardians last visit and does acknowledge her participation and approval of the ISP. See <i>attachment W209-3</i>.</p> <p>In the case of resident #4 her guardian has been actively involved in the development of all</p>		

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			<p>program plans. The guardian was present at the ISP meeting where the QMRP discussed issues with the guardian related to the behavior plan she just had not signed off on the plan until after it was completed. The surveyor stated that they were not questioning guardian participation and approval, just that written approval could not be confirmed. This was corrected prior to the end of the survey and the written approval was showed to the surveyor who chose not to share in her narrative on the 2567 that she was shown the written approval by #4's guardian.</p> <p>In the future the IDT will send a letter to the guardian encouraging their active participation in the development of the annual ISP. The letter will express to the guardian that if the identified date for the meeting is not convenient that an alternative date or time will be arranged. If there is still a barrier, the IDT will work with the guardian to utilize a phone conference to ensure that the guardian is involved in the development of the plan. Once the input of the guardian and other IDT members is utilized to develop a plan, the team will complete the ISP and a copy of the plan will be forwarded to the guardian who can they review the plan and again will have the opportunity to request changes, additions or adjustment to the</p>		

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			<p>ISP. The ISP will become final after the guardian has signed off on the plan and indicated in writing they have had an opportunity to participate in the development and review of the plan and they are in agreement with the ISP. If circumstances do not allow the guardian to participate in the plan development and review prior to the 365 day time period from the date of the previous ISP, the facility will clearly document this in the resident record and the ISP will be completed. As soon as the guardian is able to complete their review, their input will be shared with the IDT and an addendum will be made at that time.</p> <p>W 209 <u>1. What corrective action will be done by the facility?</u> For resident #6, the guardian declined to attend the Individual Support Plan Meeting for this resident and did not make herself available for phone conference. The written Plan was mailed to the guardian and approval and signature received since the survey exit. For resident #4, a faxed form indicating guardian participation in resident #4's Behavior Intervention Plan was submitted to the surveyor during the QMRP interview. In the future, if Guardians fail to attend ISP's or to return signed consent after giving verbal consent in a timely manner, a follow-up request will be mailed and the additional effort</p>	

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			<p>to obtain the guardian signature will be documented. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of residents at this facility who have guardians or health care representatives. The annual ISP always reviews the status of resident guardianship to ensure those residents with the potential to be affected are identified. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Guardians and health care representatives for all residents will be informed of Program development and Individual Program Plans that have restrictive measures with signatures obtained prior to implementation of plans. Documentation of good faith efforts to include the guardian or Health Care Representative will be submitted when a guardian does not participate in program or plan development. The IDT will review any issues regarding obtaining guardian participation in program or plan development at least 5 days per week. This information will be recorded as part of the Administrative Rounds (AR). <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or designated IDT member will bring the results of the Administrative</p>	

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			rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.		

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W0210	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, for 2 of 2 sample clients (clients #4 and #5) who were new admissions to the facility, the facility failed to perform a comprehensive functional assessment which included audio and vision assessments within 30 days of their admission.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 1/25/12 at 10:07 A.M.. Client #4's record indicated she was admitted to the facility on 7/27/11. Client #4's record indicated she had a hearing/audio assessment on 11/3/11. Client #4's record indicated the hearing/audio assessment was not completed within 30 days of her admission to the facility.</p> <p>Client #5's record was reviewed on 1/25/12 at 12:05 P.M.. Client #5's record indicated he was admitted to the facility on 7/27/11. Client #5's record indicated he had a hearing/audio assessment on 11/3/11. Client #5's record indicated he had a vision assessment on 9/9/11. Client #5's record indicated the hearing/audio</p>	W0210	<p>W210 It is the policy of this facility to perform a comprehensive functional assessment which includes audio and vision assessments within 30 days of each resident's admission to the facility. <u>1. What corrective action will be completed by the facility?</u> Audio and vision within 30 days of admission will be added to the admission checklist form that nursing fills out with every new admission. The nurses will be in-serviced on this requirement, so that each new resident receives the required assessments on a timely basis. Resident #4 and #5 audio and vision assessments have been completed. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of all new admissions, therefore the facility is able to identify all residents who may be affected by this. The admission checklist will identify residents with the potential to be affected by this practice. If, however, the Administrator finds that audio or vision assessments have not been performed for any newly admitted resident as required, he will address it immediately with the involved staff to make sure that</p>	03/02/2012			

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	<p>assessment and the vision assessment were not completed within 30 days of his admission to the facility.</p> <p>An interview with the facility Director Of Nursing (DON)/RN was conducted on 1/26/12 at 10:31 A.M.. The DON/RN indicated the audio and vision assessments for clients #4 and #5 had not been completed within 30 days of their admission to the facility.</p> <p>3.1-31(a) 3.1-31(d)</p>		<p>assessments are scheduled. Once that is done, he or a designee will re-train the staff on the facility policy regarding audio and vision assessments for new residents. Progressive disciplinary action will be rendered for instances of continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Staff will review the admission checklist during admission meetings which occur on the day of the admission to ensure that audio and vision assessments will be completed within 30 days of every new admission. In addition, monitoring for completion of those assessments will be indicated on the Administrative Rounds form. If any concerns or noncompliance are identified, they will be addressed as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p>		

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W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview for 3 of 10 sample clients (clients #6, #9, and #10), the facility failed to implement ISP/BSP (Individual Support Plan/Behavior Support Plan) objectives/goals when opportunities existed.</p> <p>Findings include:</p> <p>1. On 1/24/12 from 6:30am until 8:10am, client #6 was observed in the dining room at the main facility. At 6:30am, client #6 retrieved a brown cup of fluid from a drink cart and was given eight (8) packets of pink sugar substitute. At 6:52am, client #6 sat at her table in the dining room, independently got up from her chair, and poured an additional cup of brown fluid. Client #6 walked to client #4 and #54's table across the dining room in front of four (4) facility staff and took four (4) packets of pink sugar substitute from client #4 and #54's meal trays. No redirection was observed. At 7:10am, client #6 got up from her dining room</p>	W0249	<p><b>W249.1</b> 1. <u>What corrective action will be done by the facility?</u> Client #6 has a Behavior Program for Physical Aggression and Stealing. The other residents who were involved in aggressive incidents with #6; #3, #69, #7, #68 and #34 also have behavior plans related to the behavior of physical aggression or stealing. Staff was present on all five occasions described in this report that involved resident #6. When the mal-adaptive behavior was displayed, staff immediately intervened. While the facility does not want any injury to occur, the intervention was completed as written and only superficial injuries occurred. With this population behavior management plans are developed to address the behavior as it is anticipated that behaviors will occur. The staff will be in-serviced to implement the behavior plans as written and to record any instance of resident to resident aggression. The specific behavior plans for these residents will be reviewed with staff, including the need for them to follow the plans as written, including redirecting the residents</p>	03/02/2012			

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	<p>chair, walked to the fluid cart, poured an additional cup of brown fluid, walked from table to table taking pink sugar substitute packets from other clients' meal trays without redirection by the eight (8) facility staff in the dining room. At 7:15am, a dietary employee entered the dining room with a pre set tray of individual sugar packet holders for each table in the dining room.</p> <p>On 1/24/12 at 1:50pm, client #6's record was reviewed. Client #6's 10/6/11 ISP and 5/5/2010 BSP indicated behaviors of hoarding food/drink and stealing items from others. Client #6's BSP indicated staff were to return the stolen item to the client in which it belonged before client #6's behavior resulted in physical aggression. Client #6's ISP and BSP both indicated staff were to redirect her behavior each time the behavior occurred.</p> <p>On 1/26/12 at 11am, an interview with QMRP (Qualified Mental Retardation Professional) #67 was completed. QMRP #67 indicated facility staff should have redirected client #6 from hoarding coffee and redirected her stealing behavior of taking other clients' pink sugar substitute in the dining room. QMRP #67 indicated client #6 had a history of physical aggression while dining or participating in hydration opportunities.</p>		<p>when needed or indicated. Small containers will be placed at each table containing sweetener packets and creamer to make items more readily accessible to residents to reduce the potential of one resident "stealing" the packets from another. <u>2. How will facility identify other residents having the potential to be affected by the same practice?</u> The recording of each instance of resident to resident aggression will identify other residents having the potential to be affected by the same practice. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management plans, they will be prompted at that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put into place. Once the resident's behavior has moderated, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not occur?</u> Management will conduct observations at least 5 days a week at various times of day to assess if staff are implementing behavior plans and intervening</p>				

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	<p>2. On 1/24/11 at 6:37am, client #10 was observed alone in bed inside room #14 in the main building and a yellow crayon and a piece of paper were observed within his arms reach by client #10 from the bed on the floor. At 6:40am, ATF (Active Treatment Facilitator) #25 entered the room and assisted another client inside the shared bedroom. At 6:40am, ATF #25 was asked about the objects on the floor of room #14. ATF #25 stated client #10 "had PICA (eating inedibles), should not have small objects on the floor like crayons." ATF #25 picked up the crayon and the piece of paper and left the room.</p> <p>On 1/24/12 from 7:52am until 8:20am, client #10 was observed in Program room A with ATF #21 and ATF #58 with nine clients. Inside the program room were one inch by one inch puzzle pieces, papers, crayons, pencils, pens, checkers, cards, and plastic blocks out on the tables. At 7:52am, ATF #21 indicated he knew client #10 paced, lay down on the floor, and ATF #21 indicated he did not know of client #10's other behaviors. ATF #21 indicated client #10's ISP and BSP were not available for him to refer to and stated "he's waiting to go to the dining room, he isn't usually in here except in the mornings." From 7:52am until 8:20am, client #10 walked independently from</p>		<p>appropriately when residents steal food or drink items from others. The IDT will review results of the management observations and response to identified concerns/issues will be done as indicated in question #2. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The QA Committee will review results from the daily management rounds at least every thirty days and will offer recommendations for process improvement as needed. The Administrator and/or department managers will follow through on the recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. W249.3 #4 1. What corrective action will be done by the facility? It should be noted that the back pack left un-attended was never in a location where resident #9 was present. Resident #9 does not attempt to independently ambulate so she always has staff present when she is out of bed. All staff has been re-trained not to leave their back-packs un-attended. Staff that works with resident #9 has been in-serviced on her behavior intervention plan; (BIP) related to her self injurious behavior; (SIB) and a copy of her BIP will be maintained in all classrooms she</p>				

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	<p>table to table, corner to corner, and picked up objects then sat them back down in program room A without staff observing him or redirecting client #10. Throughout the observation period ATF #21 and #58 prompted the other nine clients in program room A for activity and at times had their backs turned to client #10.</p> <p>Client #10's record was reviewed on 1/25/12 at 9:25am. Client #10's 7/7/11 ISP and 5/19/11 BSP indicated the identified behavior of "PICA /Coprphagia (the) eating inedible items including Bowel Movement, Grass, Staples, Classroom Activities, ETC...." Client #10's ISP/BSP indicated client #10 was to have eye sight supervision "while awake" or "will have staff supervision whenever he is out of bed."</p> <p>On 1/26/12 at 10:25am, an interview with QMRP #68 was completed. QMRP #68 stated client #10 was to have eye sight supervision "at all times while awake or out of bed." QMRP #68 indicated client #10 had a history of eating items such as crayons and paper. QMRP #68 stated client #10 "should not have puzzle pieces or crayons without one on one supervision."</p> <p>3. On 1/24/11 at 7:32am, client #9 was observed to sit upright on her bed dressed</p>		<p>participates in. Staff has been retrained to keep resident #9 in "eyesight" during the time she is in the classroom. The classroom will be swept prior to the class convening for the day to ensure there are no small items left on the floor. The items in the classroom for resident activities during the early morning class will be identified as specifically appropriate for that group. The closet will be rearranged in such a way that those activities will be appropriate and readily available and accessible to resident #9 in the classroom. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of which residents present the behavior presented by Resident #9. Behavioral assessments are completed upon admission to the facility and monthly thereafter. If other residents presented this behavior, the documentation and review would identify those residents. Currently, there is not another resident who presents this particular behavior at this facility. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management plans, they will be prompted at that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put</p>				

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	<p>in room #8 and a staff's red and black open backpack sat across from client #9 on top of the bed side table. At 7:32am, client #9 looked at the back pack. Inside the unzipped back pack the following items were observed in view: alcohol wipes, brush, and comb. From 7:32am until 7:50am, the unclaimed open back pack sat inside client #9's shared bedroom. At 7:50am, ATF #24 entered room #8 and indicated it was his back pack. At 7:50am, ATF #24 walked with client #9 to Program room A, left client #9 inside the program room, and walked away. Client #9 was inside Program room A with ATF #21 and ATF #58 with nine clients. Inside the program room were one inch by one inch puzzle pieces, papers, crayons, pencils, pens, checkers, cards, and plastic blocks out on the tables. At 7:52am, ATF #21 indicated he did not know client #9's needs or behaviors. ATF #21 indicated client #9's ISP and BSP were not available for him to refer to. From 7:52am until 8:20am, client #9 sat at a table with one inch by one inch puzzle pieces and two inch by two inch puzzle pieces in front of her on the table. Client #9 mouthed the puzzle pieces without redirection by ATF #21 or ATF #58. Throughout the observation period ATF #21 and #58 prompted the other nine clients inside program room A for activity and at times had their backs turned to</p>		<p>into place. Once the resident's behavior has moderated and/or the resident is deemed to be in a safe situation, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Staff training will be conducted concerning the need to ensure the safety of residents who present PICA behavior. Management staff will complete Administrative Rounds at least 5 days a week at various times to ensure that residents with PICA behavior are being monitored according to plan and that staff have the BIP available to them related to residents PICA behavior. Any identified concerns will be addressed as outlined in question #2.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>It should be noted that at no time during the survey was #10 ever observed to display PICA behavior and that staff were present with this individual at all times. The staff that works with resident #10 has implemented his behavior plan related to his PICA behavior effectively and this is reflected in the fact that the surveyors never observed him engage in an attempt of PICA.</p>				

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	<p>client #9.</p> <p>Client #9's record was reviewed on 1/25/12 at 8am. Client #9's 10/11/11 ISP and 7/31/2009 BSP indicated the identified behavior of "SIB (Self Injurious behavior) inserting foreign objects into orifices on her body especially (her) nose." Client #9's BSP indicated "staff will stay at the table with [client #9] to oversee her performance with the activity." Client #9's BSP indicated "staff will accompany [client #9] whenever she is out of the (special supervision) classroom." Client #9's ISP and BSP indicated client #9 had "Antecedent Condition: tactile stimulation" and staff should redirect and offer "something edible instead."</p> <p>On 1/26/12 at 10:25am, an interview with QMRP #68 was completed. QMRP #68 stated client #9 was to have eye sight supervision "at all times while awake or out of bed." QMRP #68 indicated client #9 had a history of mouthing objects and putting items into her body cavities. QMRP #68 stated client #9 "should not have puzzle pieces without one on one supervision." QMRP #68 indicated client #9 required staff supervision when out of the special classroom. QMRP #68 indicated client #9 should not have been alone with the open staff back pack inside</p>		<p>The staff that works with resident #10 has been retrained to visually monitor him when he is out of bed. Resident #10's behavior intervention plan has been placed in Program room A so that staff who work with him in the classroom will have access to his behavior intervention plan; (BIP) and staff has been re-trained on the implementation of his BIP for PICA. The items in the classroom for resident activities during the early morning class will be identified specifically for that group. The closet will be rearranged in such a way that those activities will be readily available and accessible to resident #10 in the classroom. The classroom will be swept daily before the class convenes for the day to ensure there are no small items left on the floor.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u></p> <p>The facility is aware of which residents would be adversely affected by having inappropriate items in their immediate environment. A formal assessment has been completed for each individual resident at the facility regarding this behavior. In the future if the Administrator or any IDT members observe staff not following and intervening when behaviors occur as directed in the behavior management</p>				

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	her bedroom.  3.1-23(a) 3.1-32(a) 3.1-33(a) 3.1-37(a)		plans, they will be prompted at that time to intervene as needed, and the observer will assist as needed to make sure that the appropriate intervention was put into place. Once the resident's behavior has moderated, the department manager or Administrator will re-train the staff involved regarding the facility's policy for managing behaviors. In addition progressive disciplinary action will be rendered for continued noncompliance.  <u>3. What measures will be put into place to ensure this practice does not recur?</u> Staff training will be conducted concerning the need to ensure the safety of residents who present PICA behavior. Management staff will complete Administrative Rounds at least 5 days a week at various times to ensure that residents with PICA behavior are being monitored according to plan and that staff have the BIP available to them related to residents PICA behavior. Any identified concerns will be addressed as outlined in question #2.  - <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review		

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			and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.	
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W0263	<p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to insure the Human Rights Committee (HRC) approved the implementation of Behavior Support Plans (BSP) for 3 of 9 sampled clients who had BSPs with restrictive interventions (#3, #4, and #6) only after the written informed consent of the clients' guardians had been obtained.</p> <p>Findings include:</p> <p>1. Review on 1/25/12 at 10:50 AM of client #3's records was conducted. Client #3's Behavior Intervention Plan dated 12/9/10 indicated she had diagnoses of obsessive-compulsive disorder and anxiety disorder and she was on the following behavior medications for her disorders: Navan, Depakote, Paxil, Abilify, and Klonopin. The Human Rights Committee (HRC) gave written approval for client #3's plan on 7/19/11 before the guardian gave written consent which was dated 7/22/11.</p> <p>2. Client #4's record was reviewed on 1/25/12 at 10:07 A.M.. Client #4's record indicated she had a BSP dated 12/20/11 which included the restrictive intervention of the psychotropic medications Zoloft (anti-depressant) and Depakote Sprinkles (mood stabilizer). Client #4's record indicated the HRC approved the implementation of the BSP on 12/19/11 and the guardian approval on 12/20/11. Client #4's record indicated the HRC had given approval for the implementation of client #4's BSP prior to her guardian giving consent.</p> <p>Client #4's Qualified Mental Retardation Professional (QMRP) was interviewed on 1/26/12</p>	W0263	<p>W263 It is the policy of this facility to approve implementation of BSP only after written informed consent is received from the residents' guardians. <u>1. What corrective action will be done by the facility?</u> The Human Rights Committee (HRC) had approved the restrictive programs cited for resident #3, #4 and #6 and was aware that guardian had given verbal consent to the program. For all residents of the facility, any restrictive behavior program change or medication increase for the control of resident behavior will be submitted to the guardian for review and written consent. The Human Rights Committee, as the oversight entity, will review and confirm that the guardian written consent has been obtained for the proposed program or medication change. All QMRPs and Social Service staff will be in-serviced on the new protocol for achieving appropriate HRC approval of restrictive measures, including review that the guardian has given written approval. . In emergency situations if verbal consent is received from the guardian, the HRC will review and approve the program prior to implementation, and again after written guardian consent is received. <u>2. How will the facility</u></p>	03/02/2012			

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	<p>at 10:25 P.M.. When asked about the HRC approving the plan prior to the guardian, the QMRP stated. "We get all the consents and then put the plan in effect." The QMRP indicated the HRC had approved client #4's plan prior to her guardian giving consent. The QMRP indicated the facility implemented plans after the HRC had consented to the plan.</p> <p>3. Client #6's record was reviewed on 1/24/12 at 1:50 P.M.. Client #6's record indicated she had a BSP dated 7/22/11 which included the restrictive interventions of the psychotropic medications Invega (anti-psychotic) and Lexapro (anti-depressant); and the use of Bear Hug and Baskethold restraints. Client #6's record did not indicate what date the HRC and Guardian had signed for approval of the BSP implementation.</p> <p>Client #6's QMRP was interviewed on 1/26/12 at 11:10 A.M.. When asked about the HRC giving approval prior to the guardian, the QMRP stated, "I don't know, probably HRC signed before the guardian, I always pass it on to the HRC right away."</p> <p>3.1-3(n)(2)</p>		<p><u>identify other residents having the potential to be affected by the same practice?</u> The facility will review all new behavior management programs with restrictive measures at daily meetings which occur at least 5 days a week to identify other residents who may be affected.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> The facility's notification form to indicate that the guardian and Human Rights Committee have been informed and have given consent will be revised to specify in what order approvals and signatures are to be obtained. The guardian approval and signature will be first, the IDT signatures will be obtained at a point in time prior to HRC review, and the Human Rights Committee will review last as the oversight entity that reviews and confirms that the guardian consent has been obtained for the proposed change. The IDT will review all new intrusive programs at daily meetings that occur at least 5 days a week and document the review on the Administrative Rounds document. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and</p>				

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			recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.		

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W0318	<p>The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide timely health care, by failing to initiate CPR timely, for 1 of 3 client deaths (client #71), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client #3) with identified choking risks and one additional client (client #47) to ensure they were safe from choking.</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed to provide nursing services to initiate CPR timely, for 1 of 3 client deaths (client #71), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client #3) with identified choking risks and one additional client (client #47) to ensure they were safe from choking.</p> <p>3.1-17(a)</p>	W0318	<p>W 318 Condition of Health Care Services The facility has been diligent in its efforts to provide quality health services to the residents of the facility. When resident # 71 became non-responsive on 2/25/11 the nurse did initiate CPR immediately upon confirming code status. Staff performing CPR continued to perform CPR until advised to stop by EMT's. Further, the facility wishes to express that staff intervened appropriately when resident #3 choked. Resident #3 was identified as having choking risk and the facility care planned aggressively to minimize her risk. This included appropriately trained staff being present that intervened effectively when she choked. Aggressive follow-up and monitoring occurred after the incident with assessment by qualified professional, the development of updated strategies for her dining risk plan that staff was trained in and monitoring by management to ensure the strategies was implemented by staff. The facility cannot guarantee that residents with choking risk will never choke. However, the facility believes that it did provide quality health care services when the incident occurred that resulted in there being no negative outcomes. The facility</p>	03/02/2012	

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			respectfully requests that this citation be deleted from the survey findings. Even though we disagree with this citation, we are submitting a plan of correction as required. See response at W331, part one related to providing nursing services with CPR being administered to resident #71 in a timely manner. See response at W331, part two, related to incidents of choking with resident #3. See response at W331, part 3, related to resident #47 coughing with a struggle when taking her medication on 1/23/12.		

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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to provide timely nursing services and health care, by failing to initiate CPR timely, for 1 of 3 client deaths (client #71), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client #3) with identified choking risks and one additional client (client #47) to ensure they were safe from choking.</p> <p>Findings include:</p> <p>1. On 01/26/12 at 8:00 AM, a record review, of the Mortality Review Packet, was conducted and included the following dated documents:</p> <p>02/25/11: A BDDS (Bureau of Developmental Disabilities Services) report submitted 02/25/11 for an incident on 02/25/11 at 1:50 AM indicated the following regarding client #71: "Staff noted [client #71] sitting on bed at 10:30 pm. She was encouraged to go to the bathroom and to go to bed. She was later seen by charge nurse (staff #9) at approximately 12:00am in bed, no apparent distress. At 12:55 am resident observed to be non-responsive, in bed by CNA (staff #15). Licensed nurse</p>	W0331	<p>Addendum W331.</p> <p>W331 The facility already has those with eating habits that put them at risk for choking identified so staff can provide interventions to re-direct un-safe eating habits. Resident #3 who is the only resident to choke recently has a staff that is at her table during all meals to provide cues when she begins to use an un-safe eating habit. Staff will continually be trained as any new residents are identified that may be at risk of choking and management staff are conducting rounds to identify if staff interventions are in place and appropriate.</p> <p><u>W331</u> It is the policy of this facility that CPR is initiated timely for residents who need emergency medical interventions. The progress note dated 2/25/11 (<i>Attachment W331-1</i>) clearly indicates that CPR was started as soon as the code status was confirmed. This fact was included in the Internal Investigation into the death of resident #71 which was made available to the surveyor upon request during the survey. The three staff identified in the survey as #9, #15 and #19 all confirmed that C.P.R. was initiated as soon as the resuscitation status was confirmed and continued until the Emergency Personnel told them</p>	03/02/2012			

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	<p>summoned. Assessed resident to be non-responsive. Confirmed code status...."</p> <p>02/25/11: Written statement by staff #15 indicated, "I stopped at [client #71's] bed and asked her to get up and use the bathroom - I thought she was awake because her eyes were half open. She didn't respond so I touched her arm - it was cold and her lips were blue. I asked [staff #19] to get [staff #9] - after she looked at her we began CPR."</p> <p>02/25/11: Written statement by staff #19 indicated, "I started T'S (Toilet Schedule) residents in Room 14 when I heard [staff #15] trying to get [client #71] up to use the bathroom. She was saying her name over and over. I walked in there (client #71's room) turned on the overhead light looked at [client #71] called her by name and then her lips was (sic) purple, face was close to pail (sic). She wouldn't move or make any movements. So I ran down to get [staff #9] the nurse to come down there."</p> <p>02/25/11: Nursing note at 12:55 AM indicated, "Staff called this nurse to resident's room. Resident not responsive. Upon assessment resident appeared pink, cool to touch did not respond. Absence of respirations and pulse were noted.</p>		<p>to stop. The staff who responded worked with sincere effort to perform CPR in accordance with the law. We acknowledge that the Pre-Hospital Care Report from the Delaware County EMS states that the First Responders told them that no one was doing CPR when they arrived at the facility. Later on this same report it indicates that there is redness over the center of her chest which they assumed was from the CPR. (Attachment 331-2) We have attempted to get the run report from the First Responders in Gaston for review; however, we have not been successful in obtaining it. Please review the signed statements of the three employees (Attachment W331-3) that verify they performed CPR until told to stop by the EMS personnel. We would also like to address another comment on the Delaware County EMS report, where they quote the LPN on duty as saying that "she does not know what to do". To clarify, the LPN was talking about her uncertainty regarding whether or not she should wait for the coroner to visit before releasing the body. Her uncertainty had nothing to do with whether or not she should be performing CPR – she had already made that decision and had been performing CPR up to that point, as described in her progress notes. Based on this information, the facility respectfully requests</p>		

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	<p>Code status confirmed."</p> <p>02/25/11: EMS Pre-hospital care report indicated, "Per the [town] first responders when they arrived with the PT (patient) no one was doing CPR...The LPN [staff #9] on duty was advised we believe this to be a (sic) in facility death and the coroner is not required. The LPN [staff #9] states 'she does not know what to do'."</p> <p>11/03/10: Resuscitation Status Form signed by physician to resuscitate.</p> <p>On 01/26/12 at 8:30 AM a review of the 08/2007 facility, "Cardio-Pulmonary Resuscitation (CPR) for Adults" Policy and Procedure was conducted. The policy indicated, "CPR will be performed by trained personnel only. CPR will be performed on all residents, unless the physician has ordered otherwise. Begin CPR immediately if resident/patient has: a) no pulse; b) no respiration; c) unresponsiveness; d) no physician's order for 'DNR' (Do Not Resuscitate)."</p> <p>On 01/26/12 at 10:00 AM a review of staff #9, #15 and #19's CPR status was conducted. Staff #94 provided copies of CPR cards which indicated staff #9, #15 and #19 had been trained and were current in CPR.</p>		<p>that this citation be deleted from the survey findings. Even though we disagree with this citation, we are submitting a plan of correction as required. <u>1. What corrective action will be done by the facility?</u> All facility staff will be re-trained on facility policy to initiate CPR immediately upon confirmation that an unresponsive resident has no pulse, no respiration, and does not have a DNR order. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility exercises an advanced directive on each resident to identify other residents that could be affected by this same practice. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The IDT completed an audit of all charts to ensure that advanced directives are present and medical records clearly marked to identify if a resident has a DNR order or not. During Administrative Rounds staff will conduct interviews with staff members to confirm knowledge of how to respond to a situation when CPR is indicated. If the staff is not able to articulate the appropriate response re-training will occur. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or DON will bring the results of</p>				

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	<p>On 01/26/12 at 1:00 PM an interview with the facility Director of Nursing was conducted. The DON indicated all staff were trained in CPR and when a resident has no pulse, respirations, is unresponsive and does not have a DNR order, then CPR should be started immediately by the staff.</p> <p>2. On 01/23/12 at 11:30 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was conducted and included the following incidents related to choking:</p> <p>1. 07/28/11: A BDDS report submitted 07/29/11 for an incident on 07/28/11 at 11:30 AM indicated the following regarding client #3: "While [client #3] was in dining room...she engaged in an unsafe eating behavior. [Client #3] has the ability to use dining utensils, but chose to use her mouth to suck a small amount of mechanicalized (sic) roast beef...from her plate into her mouth and in doing so causing her to be unable to cough or breathe...The Heimlich was performed...and a small amount of chopped beef with broth and gravy was dislodged with success and breathing resumed."</p> <p>8/19/11: A follow-up BDDS report indicated client #3's "dining risk plan has</p>		<p>the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator or DON will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. <u>W331.2 - 1.What corrective action will be done by the facility?</u></p> <p>The BDDS report clearly stated in the instance where resident #3 choked on 7/28/11 that her meal was prepared as ordered by the physician, that staff were present who were trained in CPR, and that they performed the Heimlich successfully. The report also reflects that she was assessed by a licensed nurse, that her physician was notified, and that a chest x-ray was done with no negative outcomes. The BDDS report also reflects that she was clinically monitored by licensed nursing staff for 7 days checking her vital signs including O2 stats and lung sounds following the occurrence. The nurses monitored at the next meal to determine if feeding strategies were being followed. The BDDS follow-up report (8/5/11) also reflects that resident #3 was assessed by a Speech Therapist, that staff was trained to implement her dining risk plan with additional cues to minimize her risk of choking. Management staff monitored the</p>				

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	<p>been updated to direct staff to be present at the table where [client #3] is eating."</p> <p>12/28/11: A BDDS report submitted 12/29/11 for an incident on 12/28/11 at 5:20 AM indicated the following regarding client #3: "Resident was in dining room consuming prepared diet...when she began to cough with a struggle...struggle quickly increased and resident was unable to cough and (sic) performed abdominal thrust were successfully performed and successfully dislodged potatoes and normal breathing resumed." The BDDS report did not indicate whether or not staff were present at the client's table.</p> <p>Client #3's records were reviewed on 01/25/12 at 1:00 PM. Client #3's record contained a Nutritional Assessment dated 09/28/11 which indicated client #3 was at risk for gulping and sucking of her foods and fluids. Client #3's Physician Orders dated 01/2012 indicated client #3's diagnosis included Dysphasia (difficulty swallowing).</p> <p>On 01/26/12 at 1:00 PM an interview with the facility Director of Nursing was conducted. The DON indicated client #3 engaged in unsafe eating habits and it was the agency's responsibility to ensure the safety of the residents. The DON</p>		<p>implementation of the new dining risk plan to see that staff was correctly implementing the plan. The BDDS report submitted on 12/29/11 clearly stated in the instance where resident #3 choked on 12/28/11 that her meal was prepared as per physicians order with mechanical soft with pureed meat. That a registered nurse was present, noted a struggle and immediately assessed the situation. That the Heimlich maneuver was successfully performed and normal breathing resumed. The BDDS report also reflects that her doctor was notified, that her diet was down-graded to a pureed diet, a chest x-ray was ordered which revealed no negative outcome. Resident #3 was closely clinically monitored for 7 days by licensed nurses for signs and symptoms of aspiration. In addition, a meal monitor was assigned to remain at the side of resident #3 for 7 days. The follow-up BDDS report completed on 1/5/12 reflected that she had remained stable, that her chest x-ray was clear, that she was screened by a licensed Speech Therapist on 12/30/11 who agreed to down-grade the diet to pureed and that we should continue with current dining strategies. The facility has continued to monitor resident #3 with staff present at her side providing re-direction and verbal cues to encourage her to eat in a</p>		

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	<p>indicated clients with choking plans should be closely monitored to ensure they did not eat in an unsafe manner.</p> <p>2. Observations were conducted at the facility on 01/23/12 from 4:30 PM until 6:40 PM. The observation included medication administration by staff #8. At 5:10 PM staff #8 punched out client #47's oral medications into a plastic medication cup and squirted applesauce onto the pills. Client #47's medications included: Colace (for constipation), Ditropan XL (for hypersalivation), Megace (for weight loss) and Prenatal Tab Plus (for dietary supplement). The Prenatal vitamin was noted to be approximately one inch long and 1/4 inch thick. At 5:15 PM staff #8 attempted to administer client #47's medication to her. Client #47 refused to take the medications from the spoon. At 5:18 PM staff #8 enlisted the assistance of staff #13 to administer the pills to client #47. At 5:21 PM client #47 was coughing after the administration of the Prenatal Tab Plus. She continued to cough until 5:27 PM when she was taken from the dining room into the nurses station for further examination.</p> <p>Client #47's records were reviewed on 01/25/12 at 1:30 PM. Client #47's record contained an ISP dated 03/31/11 which contained a, "Medication Alteration</p>		<p>safe manner. For resident #3 and other residents with dysphasia the facility staff was in-serviced on dysphasia. Staff was made aware of each resident with a diagnosis of dysphasia and identified risk factors that affected individual residents related to choking. The in-service also reviewed the Coughing Choking policy to include definition of choking, component and common causes, subjective and objective findings and intervention procedure. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> Each resident is identified by physician diagnosis. The facility staff training to report signs of symptoms (also known as triggers) to nursing staff will identify others who may be affected by the same practice. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Licensed nurses are present during dining times to monitor residents with dysphasia. In addition management staff will conduct Administrative Rounds in the dining area to assure that staff is monitoring residents at risk of choking, that staff are following dining risk plans, that diets are prepared as ordered by physicians and that verbal cues are given as needed to minimize the risk of choking. <u>4. How will corrective action be monitored to ensure the deficient practice does</u></p>				

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	<p>Assessment Form" dated 03/06/11. The form indicated client #47, "was edentureless (sic) , unable to chew and on a pureed diet related to high risk for aspiration." Client #47's Physician Orders dated 01/2012 indicated client #47 was on a pureed diet and, "May crush meds if pharmaceutically acceptable and place in food."</p> <p>On 01/26/12 at 1:00 PM an interview with the facility Director of Nursing was conducted. The DON indicated client #47 was on a pureed diet and the Prenatal pill was a large pill. She indicated that large of a pill could cause choking. She further indicated there was an order to crush client #47's meds. She indicated it was the agency's responsibility to ensure the safety of the residents.</p> <p>3.1-17(a)</p>		<p><u>not recur and what QA will be put into place?</u> The Administrator or DON will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator or DON will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p> <p><u>W331.3 1. What corrective action will be done by the facility?</u></p> <p>Medication that was being administered to resident #47 was immediately stopped and resident assessed by nurse. Vital signs obtained, and noted to be WNL with o2 sats 95 % on room air with congestion noted in upper lobes. Dr. Reilly was notified upon completion of assessment and orders to monitor and if condition shows no improvement may sent to E.R for further evaluation. Resident was evaluated in ER and returned to facility with no new orders and to follow up with primary physician. Client #47 was closely clinically monitored by licensed nursing staff for seven days. Vital signs remained stable and lung sounds clear. The nurse monitored at next meal/medication administration and noted no issues and resident tolerated meal/medications well. Speech therapy evaluation was completed on 1/25/12 and recommended added diagnosis</p>		

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			<p>of dysphasia and updated dining strategies and staff informed regarding recommendations and dining strategies reflect change. For resident #47 and other residents with dysphasia the facility staff was in-serviced on dysphasia. Staff was made aware of each resident with a diagnosis of dysphasia and identified risk factors that affected individual residents related to choking. The in-service also reviewed the Coughing Choking policy to include definition of choking, component and common causes, subjective and objective findings and intervention procedure. Further, nursing staff was in-serviced on residents identified with dysphasia diagnosis and those with orders to "May crush Medications", medication administration policy and procedure including medication crushing guidelines and to include a visual symbol to indicate "may crush medication" orders attached to MAR. The coughing /choking policy and procedure to include definition, components and common causes, subjective and objective findings and nursing staff intervention procedure was reviewed with nurses. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> Chart audit completed and residents identified with dysphasia diagnosis and those</p>	

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			with orders to "May crush Medications has identified other residents who may be affected by this practice. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Director of Nursing (DON) will observe medication administration with each nurse in the next 30 days. When she has observed every nurse, she will continue random observations, ensuring that each nurse is reviewed at least one more time in the next 90 days. The DON will review residents on focused clinical charting at least 5 days a week during each tour of duty to ascertain if there are any resident condition changes. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will report any resident changes in condition and medication refusals at the next scheduled morning management meeting which occurs at least 5 days a week. In addition, the DON will report the results of her medication administration observations and focus charting reviews to the QA Committee for review and recommendations for improvement. Any recommendations will be followed up by the DON and the results of those recommendations will be brought back and reported to the next scheduled QA Committee. This will continue on an ongoing		

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W0351	<p>Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission).</p> <p>Based on record review and interview, the facility failed to obtain a dental assessment which included a complete extraoral and intraoral dental examination for 2 of 2 sampled clients reviewed who were new admits to the facility (#4 and #5) within 30 days of their admission.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 1/25/12 at 10:07 A.M.. Client #4's record indicated she was admitted to the facility on 7/27/11. Client #4's record indicated she had an initial dental examination on 9/1/11. Client #4's record indicated the dental examination was not completed within 30 days of her admission to the facility.</p> <p>Client #5's record was reviewed on 1/25/12 at 12:05 P.M.. Client #5's record indicated he was admitted to the facility on 7/27/11. Client #5's record indicated he had an initial dental examination on 9/1/11. Client #5's record indicated the</p>	W0351	<p><u>W351</u> It is the policy of this facility to obtain a dental assessment, including a complete extraoral and intraoral dental examination within one month of admission to the facility. <u>1. What corrective action will be done by the facility?</u> Dental evaluations within 30 days of admission will be added the admission checklist form that nursing fills out with every new admission. The nurses will be in-serviced on this requirement, so that each new resident receives the required assessments on a timely basis. Resident #4 and #5 dental assessments have been completed. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of all new admissions, therefore the facility is able to identify all residents who may be affected by this. The admission checklist will identify residents with the potential to affected by this practice. If, however, the Administrator finds that dental assessments have not been performed for any newly admitted resident as required, he will make address it immediately with the</p>	03/02/2012
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	<p>dental examination was not completed within 30 days of his admission to the facility.</p> <p>An interview with the facility Director of Nursing (DON)/RN was conducted on 1/26/12 at 10:31 A.M.. The DON/RN indicated the dental examinations for clients #4 and #5 had not been completed within 30 days of their admission to the facility.</p> <p>3.1-24(a)</p>		<p>involved staff to make sure that assessments are scheduled. Once that is done, he or a designee will re-train the staff on the facility policy regarding dental assessments for new residents. Progressive disciplinary action will be rendered for instances of continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> Staff will review the admission checklist during admission meetings which will occur on the date the resident is admitted to ensure that dental evaluations will be completed within 30 days of every new admission. In addition, monitoring for completion of those assessments will be indicated on the Administrative Rounds form. If any concerns or noncompliance are identified, they will be addressed as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p>		

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W0434	<p>The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions.</p> <p>Based on observation and interview, the facility failed to ensure the floor coverings in the facility kitchen promoted sanitary conditions for 68 of 68 clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67 and #68) who lived in the facility.</p> <p>Findings include:</p> <p>Observations of the facility kitchen were conducted on 1/24/12 at 12:04 P.M.. The vinyl tile flooring was discolored, and had numerous rips and small areas where the vinyl was missing. The flooring had a dark substance around and along all the edges of the walls, cabinets, and fixtures.</p> <p>The facility administrator was interviewed on 1/26/12 at 1:41 P.M.. The administrator stated, "I replaced part of the kitchen flooring earlier." The facility administrator indicated he had not</p>	W0434	<p>W434 Floors <u>1. What corrective action will be done by the facility?</u> The floors tile in the kitchen has been assessed for replacement since an appropriate floor tile that matches the color and thickness of current floor tile could not be obtained. Bids are being accepted from reputable vendors and upon receipt of the bids an agreement will be signed. The materials will be ordered after contractor bids are received. The maintenance and dietary department along with the Administrator will meet with the contractor prior to the beginning of the work to orchestrate the timing of removal of current tile, temporary re-location of equipment, and installation of new flooring material. The complete installation of the flooring will occur on different nights after the kitchen closes to minimize any disruption to the operation of the kitchen. The bids will be reviewed and accepted by 3/2/12 and the installation completed as soon as feasible after material become available. Until the renovation can be completed, the floor surface will be deep cleaned including scrubbing of the floor edges where discoloration is noted. <u>2. How will the facility identify other residents having the potential to be affected by the</u></p>	03/02/2012			

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	replaced the entire vinyl floor.  3.1-19 3.1-21(h)		<u>same practice?</u> All residents that reside in the facility have meals prepared in the kitchen. Thus, the facility is able to identify that all resident were exposed to workers walking on the floor surface of the kitchen. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The Dietary service Manager will assess the floor weekly to ensure that this practice does not recur. Once the new floor tile is installed all pitted areas will be eliminated and the floor will be put on a regular cleaning schedule as recommended by the manufacturer of the flooring which will be installed. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will review with the QA Committee in 30 days the progress on the replacement of floor tile and the results of deep cleaning to eliminate discoloration noted along the edges of the floor. The QA Committee will recommend changes in the frequency of observations based on progress noted.		

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W0436	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed for 4 of 10 sampled (clients #1 #7, #8, and #10) by not ensuring their adaptive equipment was in good repair and not ensuring client #10 was taught and encouraged to wear his eyeglasses.</p> <p>Findings include:</p> <p>1. Observations were conducted at the facility's trailer on 1/23/12 from: 12:15 PM to 1:05 PM; 2:20 PM to 3:35 PM and again at 4:30 PM to 6:00 PM. Client #1 wore a helmet with a face shield. His chin strap on the helmet was torn. Client #7 sat in a wheelchair and had one anti-tipper underneath it.</p> <p>Review on 1/25/12 at 9:55 AM of client #1's records indicated he had multiple seizures each time client #1 experienced seizures and was to wear a helmet.</p> <p>Review on 1/25/12 at 12:00 PM of client #7's records indicated he was a fall risk and used a wheelchair.</p>	W0436	<p>W436.1.2.3 It is the policy of this facility that adaptive equipment is in good repair and that clients are taught and encouraged to use their adaptive equipment. <u>1. What corrective action will be done by the facility?</u> For resident #1, #7, #8 and all other residents, staff will be in-serviced on how to fill out the adaptive equipment repair forms and the need to fill these out when they notice a piece of adaptive equipment that is in need of repair. For client #1 the facility had another chin strap immediately available and it was replaced on 1/26/12 directly following QMRP #65's interview. The chin strap that was replaced was still in place and functioning appropriately but did have cracks in the foam chin strap. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility identifies needed adaptive devices at ISP meetings for each resident; therefore the facility is able to identify all residents who may be affected by this practice. If the Administrator or other IDT manager finds that adaptive devices and equipment are not being used as planned, or are in need of repair, he/she will</p>	03/02/2012			

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	<p>Interview on 1/26/12 at 10:45 AM with staff #65, who was client #1's QMRP (Qualified Mental Retardation Professional) was conducted. Staff #65 did not know client #1's chin strap was torn but she indicated a requisition would be sent out for the chin strap to be fixed.</p> <p>Interview on 1/26/12 at 10:50 AM with staff #67, who was client #7's QMRP was conducted. Staff #67 indicated she did not know one of client #7's anti-tippers was missing from his wheelchair.</p>		<p>follow up with the appropriate staff to make sure that the devices are applied, repaired, or obtained as needed. Once that is done the Administrator or designee will retrain the staff involved regarding the facility policy for the use and maintenance of adaptive devices and render progressive discipline for continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The facility will conduct Administrative Rounds at least 5 days weekly at various times to monitor for the use and condition of adaptive equipment. The IDT will review results from the Administrative Rounds at the next scheduled morning meeting for further recommendations regarding the devices. Any identified concerns or issues will be handled as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p>		

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			<p>W436.4 It is the policy of this facility that adaptive equipment is in good repair and that clients are taught and encouraged to use their adaptive equipment. <u>1. What corrective action will be completed by the facility?</u> Resident #10 will be offered his glasses at least one time per shift per his goal in an effort to train him to wear his glasses. They will be available to him at all times. The length of time and frequency for offering them will be slowly increased to help desensitize Resident #10 to wearing his glasses. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of which residents have a prescription for eyeglasses. Those residents who do not willingly wear their glasses as prescribed will have formal objectives or behavior program intervention as appropriate to train them to wear them. If the Administrator or other IDT manager finds that adaptive devices and equipment, such as eyeglasses are not being used as planned, he/she will follow up with the appropriate staff to make sure that the glasses are applied as needed. Once that is done the Administrator or designee will retrain the staff involved regarding the facility policy for the use and maintenance of adaptive devices and render progressive discipline for continued</p>	

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	2. On 01/23/12 from 4:30 PM until 6:40 PM observations at the facility were conducted. At 4:30 PM client #8 was		noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Staff will be trained to ensure that residents who are prescribed glasses have the glasses available to them and are wearing them or have had them offered. Also, staff will be trained to implement the goals of residents who have goals to learn to wear their glasses. The Administrative Rounds checklist will include a daily check to make sure the glasses are available and in use. The Administrative Rounds will be done at least 5 days per week by professional staff. Identified concerns or issues will be handled as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Administrative rounds to the QA Committee at the monthly meeting for review and recommendations. The Administrator and/or department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.		

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	<p>observed sitting in a wheelchair with a lap tray. The lap tray on the right inner corner near client #8's elbow area was absent of the covering of the lap tray and the wood exposed in an area of approximately 3 inches by 5 inches.</p> <p>Client #8's records were reviewed on 01/25/12 at 9:50 AM. Client #8's Physical Therapy Evaluation dated 04/07/11 indicated client #8 was prescribed a wheelchair with a lap tray.</p> <p>On 01/26/12 at 1:00 PM an interview with the Director of Nursing was conducted. The DON indicated adaptive equipment should be maintained.</p> <p>On 01/24/12 at 1:00 PM, 01/25/12 at 2:54 PM and 01/26/12 at 10:10 AM a list of preventative maintenance of equipment was requested to the Administrator. There were no additional documents available for review.</p> <p>On 01/26/12 at 1:00 PM an interview with the facility Director of Nursing was conducted. The DON indicated adaptive equipment should be maintained.</p> <p>3. Observations were conducted in the main building on 1/24/12 at 11:50 A.M. until 12:10 P.M. including an observation</p>						

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	<p>of staff assisting client #8 walking with two staff and his walker from his wheelchair into the dining room. Client #8's wheelchair was observed to have an asterisk shaped torn area on the back cushion with the largest torn areas measuring 6" (four inches) in length.</p> <p>Qualified Mental Retardation Professional (QMRP) #67 was interviewed on 1/24/12 at 12:01 P.M.. When asked about client #8's wheelchair cushion being torn, QMRP #67 indicated it was torn, but she was not aware of how long it had been torn.</p> <p>4. On 1/23/12 from 2:10pm until 5:45pm, client #10 was observed in the special program room to lay on the floor, walk independently, and in the dining room to eat supper. No prescribed eyeglasses were offered or encouraged by the facility staff.</p> <p>On 1/24/12 from 7:52am until 8:20am, client #10 was observed in Program room A with ATF #21 and ATF #58 and client #10 was not offered or encouraged to wear his prescribed eyeglasses.</p> <p>Client #10's record was reviewed on 1/25/12 at 9:25am. Client #10's 7/7/11 ISP indicated an objective/goal to wear his prescribed eyeglasses.</p>				

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	<p>On 1/26/12 at 10:25am, an interview with QMRP #68 was completed. QMRP #68 stated client #10 should be offered each shift to wear his prescribed eyeglasses.</p> <p>3.1-21(h) 3.1-39(a)</p>			
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W0441	<p>The facility must hold evacuation drills under varied conditions.</p> <p>Based on record review and interview, the facility failed to have staff and individuals practice evacuating from each of the facility buildings using different escape routes, in various types of weather and under varied conditions for 6 of 10 sampled clients (#1, #3, #4, #5, #6 and #7) and 27 additional clients (#11, #12, #13, #16, #23, #24, #26, #28, #32, #34, #35, #41, #45, #50, #52, #55, #56, #57, #58, #59, #60, #61, #62, #63, #65, #67, and #68) who attended the training center.</p> <p>Findings include:</p> <p>Facility evacuation records for clients #1, #3, #4, #5, #6, #7, #11, #12, #13, #16, #23, #24, #26, #28, #32, #34, #35, #41, #45, #50, #52, #55, #56, #57, #58, #59, #60, #61, #62, #63, #65, #67, and #68 were reviewed on 1/23/12 at 1:25 P.M.. The evacuation records indicated an evacuation drill was conducted on each shift for each quarter of the past year for the main building of the facility. The evacuation records did not include any drills from the training center building at the facility, a non-sprinkled double wide trailer consisting of three classrooms, dining area, restrooms, office, storage areas, and medication room.</p>	W0441	<p>W441 It is the policy of this facility to have evacuation drills from the training center, as well as from the main building. <u>1. What corrective action will be done by the facility?</u> Effective January 2012, the facility initiated documented evacuation drills from the Training Center to be completed each month at varied times and under varied conditions. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility assigns the residents who utilize this building and therefore is able to recognize all residents with the potential to be affected by this practice. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The Maintenance Director will set up his book of evacuation drills with scheduled times for the drills in the Training Center each month in advance. This will work as a tickler system to prompt him to conduct the drill in accordance with this regulation so the practice does not recur. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Administrator will meet with Maintenance Director monthly to review completed drills. The Administrator will bring the results of the evacuation drills to the QA Committee at the</p>	03/02/2012			

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	The facility administrator was interviewed on 1/23/12 at 5:55 P.M.. When asked about evacuation training from the training center the facility administrator stated, "We do evacuations from the training center, we just don't document the drills."  3.1-19(a)		monthly meeting for review and recommendations. The Administrator and/or Maintenance Director will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.		

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W0455	<p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to practice proper hygiene habits for 4 of 5 sampled clients (clients #3, #4, #5, and #6) and 6 additional clients (clients #13, #28, #55, #56, #58, and #59).</p> <p>Findings include:</p> <p>1. Observations were conducted on 1/24/12 from 1:10 P.M. until 1:35 P.M.. including observation of client #5's bedroom. Client #5 was alone in his bedroom which he shares with two other male peers. Client #5 was resting in his bed. There was a shower chair in client #5's bedroom which had a smeared brown substance on the seat of the chair.</p> <p>An interview was conducted with Active Treatment Facilitator (ATF) #25 on 1/24/12 at 1:20 P.M.. When asked if the shower chair in client #5's bedroom had feces on it, ATF #25 stated, "Yes."</p> <p>An interview was conducted with the facility administrator on 1/26/12 at 1:41 P.M. He indicated the shower chair was to be cleaned after each use, and should not have been left in client #5's bedroom</p>	W0455	<p>W455 1. <u>Corrective action:</u> All staff will be in-serviced on how to disinfect and/or clean shower chairs. All staff receive this training in orientation prior to working on the floor and will be re-inserviced. <u>How will the facility identify other residents having the potential to be affected by the same practice?</u> The facility is aware of the residents who use a shower chair, therefore the facility is able to identify all residents who may be affected by the deficient practice. <u>What measures will be put into place to ensure this practice does not recur?</u> The facility will conduct Administrative rounds 5 days weekly to assess if shower chairs are disinfected between each use. If shower chairs are noted to be dirty, staff responsible to disinfect and/or clean the shower chair will be re-trained. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> QA Committee will review results from Administrative Rounds to ensure ongoing compliance in 30 days. Based on noted progress the QA Committee will determine the ongoing frequency of observations. W455.2 It is the policy of this facility to have an active infection control program, including practicing proper</p>	03/02/2012			

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	<p>with feces on it.</p> <p>2. Observations were conducted at the facility trailer on 1/23/12 from 4:30 PM to 6:00 PM. Clients #3, #6, #28, #55, and #58 were prompted to wash their hands and then they sat down at one of two dining tables. Staff #67 handed these clients magazines to look at while they waited on their dinner. They were not instructed to re-wash their hands after handling the magazines before getting their own silverware from the silverware bin that was passed around, and before they ate dinner. Staff passed around a silverware bin and instructed clients #3, #28, #55, #58, #6, #4, #13, #59, #6, #5, and #6 to get out their own silverware and then the bin was passed to the next client. The clients touched the other silverware in the bin as they were getting their own silverware out. There was no prompting by the staff to not touch the other silverware.</p> <p>Interview on 1/26/12 at 10:50 AM with staff #67 was conducted. She indicated she handed the clients the magazines to provide active treatment while they were waiting to eat but they probably should have washed their hands after handling the magazines. She also indicated sometimes client slip when getting their own silverware out and touch the other</p>		<p>hygiene habits for the residents.</p> <p><u>1. What corrective action will be completed by the facility?</u> If residents wish to handle activities prior to eating, they will be given the opportunity to wash their hands after handling those objects and immediately prior to eating. Resident silverware will be wrapped in saddle bags so as they pick up their silverware they touch only their own silverware. Staff will be in-serviced to direct residents to wash their hands again if they handle items at meal-time after they have washed their hands. <u>2. How will the facility identify other residents having the potential to be affected by the same practice?</u> Assessments of residents determine those residents who are involved in family style dining, thus identifying other residents having the potential to be affected by this practice. <u>3. What measures will be put into place to ensure this practice does not recur?</u> Management staff will complete Administrative Rounds 5 days a week to observe that staff re-direct residents to re-wash their hands if they touch magazines or other items that could be contaminated. Results will be reviewed with the IDT at daily meetings. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrative Rounds document will be</p>				

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	silverware.  3.1-18(b)(1)		reviewed at least 5 days per week by the Interdisciplinary Team and then monthly with the QA Committee for further recommendations for process improvement. This will occur on an ongoing basis until the QA Committee indicates otherwise based on success of staff and resident performance.		