

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER ARCADIA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030		
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W0000	<p>This visit was for the Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey completed October 5, 2012.</p> <p>Dates of Survey: November 13, 14, 15, 16, and 19, 2012.</p> <p>Facility number: 000730 Provider number: 15G580 AIM number: 100272190</p> <p>Surveyors: Susan Eakright, Medical Surveyor III-Team Leader Susan Reichert, Medical Surveyor III Tracy Brumbaugh, Medical Surveyor III Claudia Ramirez, Public Health Nurse Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 11/26/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of my proceedings and submit these responses pursuant to our regulatory obligations. Beverly Sayre Cowart Administrator		

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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, the facility failed for 10 of 10 sampled clients (clients #2, #5, #7, #8, #22, #28, #37, #50, #55, and #57) and 47 additional clients (clients #1, #3, #4, #6, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #23, #24, #25, #26, #27, #29, #30, #31, #32, #33, #34, #35, #36, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #51, #52, #53, #54, and #56) to ensure they had access to the dining room closet, broom, and mop bucket (with assistance as needed), and for 6 of 6 clients in facility (clients #2, #5, #23, #28, #38, and #50) who had motion sensors on their bedroom doors, the facility failed to ensure clients' rights were protected in regard to monitoring the clients' movements in their rooms without a plan for the restriction.</p> <p>Findings include:</p> <p>1. On 11/13/12 from 4:30pm until 6:05pm and on 11/14/12 from 5:30am until 7:35am, observations were</p>	W0125	<p>1. The closet containing client's dining room mop and bucket, broom and dust pan was locked on 11-13-2012. This closet was locked as a result of necessary repairs required within the original chemical storage room. The dining room storage closet was used as an alternate storage facility pending repairs within the chemical storage closet. The maintenance supervisor did inform the interdisciplinary Team of the repair and the need to temporarily use the dining room closet as an alternative. However, the necessary items needed for client access were not removed from the closet prior to potential use during dining hours. In the future, if necessary, all items requiring access for dining room purposes will be available to all clients. The lock and subsequent chemicals were immediately removed and access restored for all clients. As a systemic systems change, in the future, closets requiring client access will not be used as temporary storage or locked from client access.</p>	12/19/2012			

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	<p>conducted at the home of 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, and #57. During the above observation periods, the dining room closet containing the broom and mop bucket was locked.</p> <p>On 11/13/12 at 5:15pm, the facility's CDM (Certified Dietary Manager) was interviewed and stated "The closet is always locked." At 5:30pm, the CDM unlocked the closet with a key. There was a dining room broom and a mop bucket inside. In the back of the closet were two five gallon pails of dishwasher chemicals sealed inside each individual container. The CDM indicated the facility stored the chemical in the closet. The CDM stated "no client had access" to the dining room broom and mop bucket.</p> <p>On 11/14/12 at 11:00 a.m. a review of the Human Rights Committee (HRC) minutes for the last year 2012 did not indicate a discussion of the facility restriction of the locked dining room broom and mop bucket.</p> <p>On 11/15/12 at 4:45pm, an interview with</p>		<p>2. Client #38 did have an assessment that addressed elopement behavior. Human Rights Committee and guardian approvals were obtained prior to implementation of motion sensors for client #38's bedroom doorway. As a measure to remove potential restrictions for clients #2, 5, 23, 28, 38, 50, 8 and all other clients residing in bedrooms with those clients needing motion sensors, individual bed monitoring systems will be implemented for those clients assessed. A new elopement assessment has been completed for client #38 and Human Rights Committee was obtained for the use of this individual monitoring system on 11-26-2012. Guardian consent was obtained for the use of this individualized system and the subsequent plan for reduction of use on 12-5-2012. In the future, should a client be assessed for the need for a motion detection system, HRC and guardian approvals and reduction of use plans will be approved and implemented.</p> <p>Further, HRC will review all clients using a motion detection system and their reduction plans at least biannually. Additionally, all full room motion detection systems have been removed. At the present time, there is only one client assessed for the need for individualized motion detection</p>				

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	<p>Qualified Mental Retardation Professional #68 was conducted. QMRP #68 stated "no clients" had an identified need for the mop bucket and broom in the dining room to be locked.</p> <p>2. On 11-14-12 from 5:40 a.m. until 7:20 a.m. an observation in the bedrooms of clients #2, #5, #23, #28, #38, and #50 was conducted. At 6:50 a.m. an alarm chimed 8 times. At 7:00 a.m. a chime noise sounded 26 times.</p> <p>On 11-14-12 at 7:10 a.m. an interview with Qualified Mental Retardation Professional #68 indicated the sound was someone going in and out of the bedroom doors where clients #2, #5, #23, #28, #38, and #50 lived.</p> <p>On 11-14-12 at 1:40 p.m. clients #2, #5, #23, #28, #38, and #50 were observed to have motion sensors at the doorway of their bedrooms which sounded in the hallway each time motion inside the bedrooms was detected.</p> <p>On 11-15-12 at 11:00 a.m. a review of the Human Rights Committee (HRC) dated 2-4-12 indicated "door alarms" for clients' rooms was discussed and the members thought the alarms were "a good idea" for clients with blindness to alert staff so clients wouldn't go into other client's</p>		<p>systems.</p> <p>The QMRP is responsible. The Program Director will monitor.</p>				

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	<p>rooms without permission. No specific clients were mentioned in the restriction.</p> <p>On 11-14-12 at 2:20 p.m. a record review for client #5 was conducted. The Behavior Support Plan (ISP) dated 6-25-12 did not include the need for motion sensors for his bedroom door. Client #5's record indicated he was blind. Client #5's record did not include an identified need for the motion sensors.</p> <p>On 11-14-12 at 3:00 p.m. a record review for client #8 was conducted. The Individualized Support Plan (ISP) dated 7-12-12 did not include the need for motion sensors for his bedroom door. Client #8 did not have a Behavior Support Plan to review.</p> <p>On 11-14-12 at 4:00 p.m. a record review for client #23 was conducted. The Comprehensive Functional Assessment (CFA) dated 11-4-12 did not indicate client #23 was blind or had a need for a motion sensor for his bedroom door. Client #23's record did not indicate behaviors of going into other clients' rooms.</p> <p>On 11-14-12 at 3:15 p.m. a record review for client #38 was conducted. The Behavior Support Plan dated 6-25-12 did not indicate client #38 was blind or had</p>						

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	<p>the need for motion sensors at his bedroom door. Client #38's record did not indicate behaviors of going into other clients' rooms.</p> <p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. The IHP (Individual Habilitation Plan) dated 07/06/12 did not indicate any restrictions to his bedroom. Client #50's record did not indicate identified behaviors of going into other clients' rooms.</p> <p>On 11-15-12 at 12:15 p.m. an interview with Qualified Mental Retardation Professional #68 indicated some clients did have motion sensors above their bedroom doors. She indicated the sensors were turned on when clients went to bed and off when they got up. She indicated there was no protocol to review for the motion sensors and the motion sensors were not included in clients' Behavior Support Plans.</p> <p>On 11-15-12 at 12:15 an interview with the Assistant Director of Nursing indicated the alarms were due to client #38 getting up in the night and the sound was to alert staff he was leaving his room. She stated client #38 "was quick" when he got out of bed during the night.</p> <p>This deficiency was cited on 10/5/2012.</p>						

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-3(a)(1) 3.1-3(c) 3.1-3(d)				

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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview for 1 of 10 sampled clients (client #55) and 6 additional clients (clients #1, #3, #10, #14, #47, and #51), the facility failed to ensure each client had individual outerwear of hats/gloves/coats and for 9 of 10 sampled clients (clients #2, #5, #8, #22, #28, #37, #50, #55, and #57) to ensure age appropriate items were offered during active treatment opportunities.</p> <p>Findings include:</p> <p>1. On 11-14-12 from 5:40 a.m. until 7:20 a.m. an observation at the home of clients #1, #3, #10, #14, #47, #51 and #55 was conducted. At 7:00 a.m. clients #1, #3, #10, #14, #47, #51, and #55 were at the end of the hallway waiting for the school bus. Direct care staff (DCS) #200 opened a coat closet and took down a box of gloves and hats from a shelf and offered clients #1, #3, #10, #14, #47, #51, and #55's gloves and hats from the box. Clients #1, #3, #10, #14, #47, #51, and #55 picked out a hat and gloves from the stock of hats and gloves in the box. DCS</p>	W0137	<p>1. For clients #55, 1, 3, 10, 14, 47, 51, 2, 5, 8, 22, 28, 37, 50, 57 and all other clients, personal hats, gloves and scarves for school clients will be accessed from individualized storage compartments located at the zone exit. These compartments are marked with each client's name and subsequent picture to increase each client's independent access of these items. Any additional outer wear items for school-aged clients will be located in each client's respective rooms. 2. For clients #2, 5, 8, 22, 28, 37, 50, 57 and all clients will continue to be offered promotion of growth and independence through client choices of both age appropriate and client preferred items during training opportunities. Training and client preferred items often become mixed or co-mingled during periods prior to active treatment training and leisure opportunities. Programming training supplies continue to be modified to more closely accommodate individual client ages and training opportunities that promote individual participation. To maintain the integrity of individual client rights,</p>	12/19/2012			

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	<p>#200 put the box back on the shelf in the coat closet.</p> <p>On 11-14-12 at 7:10 a.m. an interview with DCS #200 indicated clients #1, #3, #10, #14, #47, #51, and #55 picked their hat and gloves from a box in the coat closet.</p> <p>On 11-15-12 at 12:15 p.m. an interview with Qualified Mental Retardation Professional #68 stated a box of gloves and hats was kept for the "kids" to choose from when going outside.</p> <p>2. On 11-13-12 from 1:15 p.m. until 5:50 p.m. an observation at the home of clients #5, #8, and #55 was conducted. Program room 6 had children's toys, coloring books, crayons, play doh, nerf guns, little tykes toys, toy cars and trucks, vtech toys, lego blocks, plastic links, and infantino toys for the clients to use.</p> <p>On 11-13-12 at 2:15 p.m. an interview with direct care staff #11 and #25 indicated clients #5, #8, and #55 were all over the age of 18.</p> <p>During observations in program group #1 on 11/13/12 from 1:30 PM until 1:41 PM, from 2:11 PM until 2:28 PM and again from 4:50 PM until 5:40 PM, clients #22,</p>		<p>those items identified as client preferred or client-purchased items that may not be considered age-appropriate will continue to be offered. Appropriate times will be identified as leisure-based opportunities. To better prepare staff to recognize times for transition of items, weekly staff training sessions will be implemented following each shift. Weekly direct care shift meetings will be afforded for more individualized training, fielding questions and providing assistance for staff to better distinguish the difference between training supplies and client preferred items. The Shift Supervisors are responsible for the meeting supervision and training. The QMRP will monitor.</p>				

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	<p>#37 and #57 were presented materials which included a toy alphabet musical interactive bus, toy plastic beads, and children's books while a children's movie channel including a cartoon movie about ants, and a teenaged sitcom played on the TV. Client #22 was assisted to play a card game activity, and at 1:32 PM was asked if she wanted to play again by staff #55. Client #22 did not respond and was not offered other activity. At 1:35 PM, client #57 had a motorcycle magazine, but at 1:40 PM, client #57 was offered a children's glow in the dark bracelet to wear. At 2:18 PM staff #22 read a children's book regarding a pig to client #57. Client #40 repeatedly picked up and dropped the alphabet bus and beads. Staff #22 read a children's book to client #57 regarding a yak and other animals at 2:21 PM. Staff #55 offered a bin of materials including children's flash cards, balloons, foam puppets, and children's books at 2:25 PM to client #52, and read a children's book to her.</p> <p>During observations in group #1 on 11/14/12 from 6:40 AM until 7:35 AM materials available in program group #1 where clients #22, #37 and #57 were present included 2 baby dolls, toy tool box (identified with client #57's initials penned in marker), an infant rattle, a clear infant ball with rotating elephant in the</p>						

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	<p>center and a toy drawing board. Staff #23 offered a toy stuffed monkey to client #37 who then threw it on the floor, and a Little Tykes miniature toy key board which client #37 did not use.</p> <p>Staff #23 was interviewed on 11/14/12 at 7:30 AM. When asked if the toy keyboard was geared toward adults, he stated, "No," and indicated there were no other options available in the room for a keyboard for clients to use. He indicated staff #73 purchased the supplies for the program rooms.</p> <p>Staff #73 was interviewed on 11/14/12 at 7:45 AM. She indicated she was given a list of specific program materials to purchase by Qualified Mental Retardation Professional (QMRP) #68. She indicated the Little Tykes keyboard was age appropriate.</p> <p>Client #22's record was reviewed on 11/14/12 at 3:21 PM. Client #22's record indicated she was over the age of 21.</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. Client #37's record indicated he was over the age of 40.</p> <p>Client #57's record was reviewed on 11/15/12 at 11:20 AM. Client #57's record indicated he was over the age of</p>				

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	<p>40.</p> <p>QMRP #68 and Assistant Director of Nursing #69 were interviewed on 11/15/12 at 12:15 PM. When asked if the infant toys, children's books and Little Tykes keyboard were age appropriate, QMRP #68 stated, "We're working on it," and indicated clients should be offered a choice of age appropriate materials.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-9(a)</p>						

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review, and interview for 3 of 10 sampled clients (clients #8, #37, and #55), the facility neglected to implement their policy and procedure to thoroughly investigate allegations of abuse, neglect, and/or unknown injuries (client #55), neglected to ensure sufficient corrective action was in place for 2 of 2 clients (clients #37 and #55) who had unknown fractures, and neglected to have client #8's protective order at the facility to provide protection from client #8's convicted sexual abuser.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 11/13/12 at 2:45 P.M.. A review of the BDDS (Bureau of Developmental Disability Services) reports from 9/24/12 to 11/13/12 indicated the following:</p> <p>-A BDDS report on 10/24/12 for an incident on 10/24/12 at 7:20pm, indicated client #55 "had gone to another program room (classroom at the facility)." The report indicated client #55 went into the bathroom alone. "When [client #55] jumped he came down on the sink with</p>	W0149	<p>1. The Program Director, or her designee, will continue to conduct and compile a thorough investigation for all reportable injuries of unknown origin. A thorough investigation may include, but is not limited to, interview of the client if possible, interview of responsible supervisory/direct care staff, medical assessment if warranted, interview of potential witnesses, review of written assessments and written investigations. To ensure that appropriate investigative practices occur, all reportable incidents of unknown origin and/or reportable incidents that require investigation will be reviewed by the facility administrator or her designee. Additionally, a new incident investigation form will be implemented for witness statements that will become part of each investigatory document. The Program Director is responsible. The IDT will monitor.</p> <p>2. Any client that requires or has been issued a protective court order restricting visitation or contact will have supporting documentation placed in their client record. For client #8, court documentation was obtained on 11-21-2012. A summary and supporting court ordered</p>	12/19/2012			

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	<p>his R (right) arm, bumping the skin. He hit the sink hard enough to loosen it from the wall." The report indicated client #55 was later seen at the emergency room and was diagnosed with a fracture above the elbow joint and his arm was put in a cast the following day.</p> <p>Client #55's record was reviewed on 11/14/12 at 2pm. Client #55's 10/24/12 "Accident/Incident Form" indicated "Investigative Findings: [Client #55] was in the bathroom of another group room he was visiting watching himself in the mirror. He began jumping around and acting silly. When [client #55] jumped, he came down on the sink with his R arm, bumping the sink. He hit the sink hard enough to loosen it from the wall. Current Behavior Program 0 (none available). Corrective Action: [Client #55] was reminded to be more careful. Staff were instructed to monitor more closely and to intervene when [client #55] begins acting silly."</p> <p>Client #55's written 10/24/12 investigative notes were reviewed on 11/14/12 at 2pm. Client #55's notes indicated there were no witnesses to the incident and staff reported they responded to the noise heard inside the bathroom. No witness statement from client #55 was available for review.</p>		<p>restrictions were placed in client #8's client record. The original court document will be maintained in the social service office. The secure documentation will be placed in a binder that will include, but is not limited to, relevant information specific to client visitation restrictions via court order and/or parent, guardian, Health Care Representative requests regarding visitation rights. Attachment A has been created and mailed to all client representatives on 12-5-2012 to chronicle visitation requests or restrictions. These forms will become a part of the admission packet and a part of each client's annual habilitation program for review and revision at least annually. The Social Service Designee is responsible. The Administrator or her designee will monitor. 3. For client #37, staff were trained regarding transfer procedures (Att. B). Staff interview revealed that the sling used for client #37 had become stretched and too large for transfer practice for client #37. A pair of smaller slings were purchased on 11-21-2012, inserviced on 11-30-2012 and implemented for use on 12-1-2012. Staff training included the use of the sling for client #37, the purpose behind the need to use the sling and the appropriate technique needed for transferring client #37 with the</p>				

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	<p>On 11/15/12 at 4:45pm, an interview with the Administrator and the Program Director was conducted. Both administrative staff indicated no witness statement was obtained from client #55. Both staff indicated client #55's right arm fracture was unknown and not witnessed by the facility staff.</p> <p>2. A BDDS (Bureau of Developmental Disabilities Services) report, dated 10/19/12 indicated on 10/17/12 at 7:00 PM, client #37 was found with bruising on the top of his right shoulder and assessed with normal range of motion and no signs or symptoms of pain. On 10/19/12, a nursing assessment noted swelling. Client #37 was sent to the hospital by his primary care physician and diagnosed with a displaced fractured right clavicle from unknown cause. A follow up report dated 10/29/12 indicated client #37 was non-ambulatory and after a "thorough investigation" there was no evidence of a fall. The report indicated "since [client #37] has osteoporosis, was are (sic) treating this as pathological (due to underlying disease) until we are</p>		<p>sling. In the future, staff will be trained for use of a sling, if assessed as necessary. Staff training will be documented with staff signatures. Follow-up training/discussion will be provided to direct care staff approximately one week after initial training. This process will be implemented as a measure to ensure training was effective and modifications implemented as identified through subsequent training. The staff trainer will monitor staff transfers and assess equipment monthly. The QMRP will monitor.</p>				

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	<p>informed differently. He is normally a 2 person lift. (One staff bear hugging his top half and the second staff holding his legs.) Since the fracture, we are now transferring him with a sling or 2 bath blankets to prevent any direct handling of his extremities." The report indicated staff had been trained on fall prevention and all transfers. An undated note attached to the report indicated, "Attention Staff [client #37] is to be transferred with a sling or bath blankets. There are no exceptions to this rule. His bones are getting worse so we need to be extra careful when transferring." There was no evidence in the investigation of a determined cause of client #37's fracture. There was no evidence to determine if client #37 was transferred using the correct technique.</p> <p>During observations on 11/13/12 at 4:25 PM, client #37 sat in a recliner without a sling present for transferring him.</p> <p>Staff #22 was interviewed on 11/13/12 at 4:25 PM. She indicated client #37 had a sling for transferring until today and stated, "I guess we're to pick him up," and indicated she had no other training to transfer client #37 other than a two person lift.</p> <p>The Assistant Director of Nursing (ADON) #69 was interviewed on</p>				

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	<p>11/14/12 at 7:11 AM and indicated client #37 was to be transferred using a sling.</p> <p>During observations on 11/14/12 at 7:20 AM, client #37 was transferred from his wheelchair to a table after a sling was placed under him. Staff #53 placed her arms through the sling under client #37's arms and across his chest and staff #56 placed her arms through the sling and around client #37's legs. Staff #53 and #56 lifted client #37 without having him bear his weight on the sling leaving the handles of the sling slack.</p> <p>Staff #56 was interviewed on 11/14/12 at 7:21 AM. When asked about the use of the sling for client #37 and the slack handles, staff #56 stated its use was "Just in case."</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. A letter from client #37's orthopaedic doctor dated 10/25/12 indicated client #37 had a fracture of the right clavicle of "unclear etiology. This could have occurred in transfer or if the patient struck something with his arm." The letter indicated a repeat x-ray would take place in 4 to 5 weeks to check healing of the fracture. A 10/19/12 physician's order indicated "Use sling/2 bath blankets in lifting/transferring pt (patient) until healed, then evaluate." A</p>						

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	<p>Fall/Fracture Risk Plan dated 10/20/12 indicated staff were to use a sling or two bath blankets to transfer or reposition client #37.</p> <p>The ADON #69 was interviewed on 11/15/12 at 12:15 PM and indicated staff should have implemented the use of the sling when transferring client #37 to prevent further injury to his fractured clavicle.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:05 PM and indicated there was no determination of the cause of client #37's fracture. The Program Director indicated no results of the investigation were available for review.</p> <p>The facility's records were reviewed on 11/13/12 at 2pm. A review of the facility's "Abuse and Neglect Policy and Procedure", dated 4/26/11, indicated in part, the following: "Staff will ensure the protection and treatment of all clients by refraining from the use of physical, verbal, sexual, or psychological abuse of any client. The facility shall act proactively to assure that clients are free from serious and immediate threat to their physical and psychological health and safety. The facility will further ensure that all clients are free from neglect.</p>						

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	<p>Neglect will include the failure to provide appropriate care, food, medical care or supervision."</p> <p>3. On 11/14/12 at 10:15am, the facility's records of restrictive measures were reviewed and interview was conducted with QMRP (Qualified Mental Retardation Professional) #68. The list included undated "Court Orders" with client #8's name. QMRP #68 stated client #8's undated "Court Order" was not for a restriction. QMRP #68 stated "The order is to protect [client #8] from a former staff who was convicted of sexual battery against [client #8]" several years ago "at this facility." QMRP #68 indicated at the former staff person's sentencing hearing the court filed a Court Order of protection for client #8 to prohibit access by the convicted sexual abuser/former staff person when the abuser was discharged from prison. QMRP #68 stated "We never got a copy of the court order." QMRP #68 indicated the facility had not obtained a copy of the court order to protect client #8. QMRP #68 indicated client #8 did not recognize danger and could not call for assistance.</p> <p>On 11-14-12 at 3:00 p.m. a record review for client #8 was conducted. The Individualized Support Plan (ISP) dated 7-12-12 did not indicate a court protective</p>						

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	<p>order was in place to ensure client #8 was safe from a previous staff that had assaulted him.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #55), the facility failed to thoroughly investigate an unknown fracture.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 11/13/12 at 2:45 P.M.. A review of the BDDS (Bureau of Developmental Disability Services) reports from 9/24/12 to 11/13/12 indicated the following:</p> <p>-A BDDS report on 10/24/12 for an incident on 10/24/12 at 7:20pm, indicated client #55 "had gone to another program room (classroom at the facility). The report indicated client #55 went into the bathroom alone. "When [client #55] jumped he came down on the sink with his R (right) arm, bumping the skin. He hit the sink hard enough to loosen it from the wall." The report indicated client #55 was later seen at the emergency room and was diagnosed with a fracture above the elbow joint and his arm was put in a cast the following day.</p>	W0154	<p>The Program Director, or her designee, will continue to conduct and compile a thorough investigation for all reportable injuries of unknown origin. A thorough investigation may include, but is not limited to, interview of the client if possible, interview of responsible supervisory/direct care staff, medical assessment if warranted, interview of potential witnesses, review of written assessments and written investigations. To ensure that appropriate investigative practices occur, all reportable incidents of unknown origin and/or reportable incidents that require investigation will be reviewed by the facility administrator or her designee. Additionally, a new incident investigation form will be implemented for witness statements that will become part of each investigatory document (Att C).</p> <p>The Program Director is responsible. The IDT will monitor.</p>	12/19/2012			

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	<p>Client #55's record was reviewed on 11/14/12 at 2pm. Client #55's 10/24/12 "Accident/Incident Form" indicated "Investigative Findings: [Client #55] was in the bathroom of another group room he was visiting watching himself in the mirror. He began jumping around and acting silly. When [client #55] jumped, he came down on the sink with his R arm, bumping the sink. He hit the sink hard enough to loosen it from the wall. Current Behavior Program 0 (none available). Corrective Action: [Client #55] was reminded to be more careful. Staff were instructed to monitor more closely and to intervene when [client #55] begins acting silly."</p> <p>Client #55's written 10/24/12 investigative notes were reviewed on 11/14/12 at 2pm. Client #55's notes indicated there were no eyewitnesses to the incident and staff reported they responded to the noise heard inside the bathroom. No witness statement from client #55 was available for review.</p> <p>On 11/15/12 at 4:45pm, an interview with the Administrator and the Program Director was conducted. Both administrative staff indicated no witness statement was obtained from client #55. Both staff indicated client #55's right arm fracture was unknown and not witnessed</p>						

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	<p>by the facility staff. Both staff indicated the investigation was not thorough.</p> <p>On 11-15-12 at 12:15 p.m. an interview with the Qualified Mental Retardation Professional indicated client #55 could be in the bathroom by himself and could go to other program rooms independently. The QMRP indicated client #55 could not give a clear explanation as to what happened to his arm, and client #55's fracture was not witnessed by any facility staff.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>						

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview for 2 of 10 sampled clients (clients #37 and #55), the facility failed to implement effective corrective action for 2 of 2 clients (clients #37 and #55) with unknown fractures.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 11/13/12 at 2:45 P.M.. A review of the BDDS (Bureau of Developmental Disability Services) reports from 9/24/12 to 11/13/12 indicated the following:</p> <p>-A BDDS report on 10/24/12 for an incident on 10/24/12 at 7:20pm, indicated client #55 "had gone to another program room (classroom at the facility)." The report indicated client #55 went into the bathroom alone. "When [client #55] jumped he came down on the sink with his R (right) arm, bumping the skin. He hit the sink hard enough to loosen it from the wall." The report indicated client #55 was later seen at the emergency room and was diagnosed with a fracture above the elbow joint and his arm was put in a cast the following day. No corrective action was available for review.</p>	W0157	<p>For client #37, staff were trained regarding transfer procedures (Att. B). Staff interview revealed that the sling used for client #37 had become stretched and too large for transfer practice for client #37. A pair of smaller slings were purchased on 11-21-2012, inserviced on 11-30-2012 and implemented for use on 12-1-2012. Staff training included the use of the sling for client #37, the purpose behind the need to use the sling and the appropriate technique needed for transferring client #37 with the sling. In the future, staff will be trained for use of a sling, if assessed as necessary. Staff training will be documented with staff signatures. Follow-up training/discussion will be provided to direct care staff approximately one week after initial training. This process will be implemented as a measure to ensure training was effective and modifications implemented as identified through subsequent training. The staff trainer will monitor staff transfers and assess equipment monthly. The QMRP will monitor.</p> <p>2. For client #55, staff were trained regarding this client's tendency to</p>	12/19/2012			

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	<p>Client #55's record was reviewed on 11/14/12 at 2pm. Client #55's 10/24/12 "Accident/Incident Form" indicated "Investigative Findings: [Client #55] was in the bathroom of another group room he was visiting watching himself in the mirror. He began jumping around and acting silly. When [client #55] jumped, he came down on the sink with his R arm, bumping the sink. He hit the sink hard enough to loosen it from the wall. Current Behavior Program 0 (none available). Corrective Action: [Client #55] was reminded to be more careful. Staff were instructed to monitor more closely and to intervene when [client #55] begins acting silly." No documented staff training and no written corrective action were available for review.</p> <p>On 11/15/12 at 4:45pm, an interview with the Administrator and the Program Director was conducted. Both administrative staff indicated client #55's incident did not have documented corrective action and no staff retraining was available for review.</p> <p>On 11-14-12 at 1:30 p.m. a record review for client #55 was conducted. Client #55's Behavior Support Plan (BSP) dated 10-25-12 indicated staff were to "be aware" he may play around in the bathroom and should check on him. The BSP did not include what level of</p>		<p>be more reckless when acting silly, as any other adolescent would. Information regarding client #55's increased potential for reckless, adolescent behavior has been placed on his client information data sheet. This data sheet will be part of client #55's program book for easy and quick access for staff to refer to for guidance.</p> <p>In the future, should any client require corrective action as a result of documented incidents, their client information sheet will be updated, trained and placed in each client's program book.</p> <p>The QMRP is responsible. The IDT will monitor.</p>				

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	<p>supervision client #55 was to have in the bathroom.</p> <p>2. A BDDS (Bureau of Developmental Disabilities Services) dated 10/19/12 indicated on 10/17/12 at 7:00 PM, client #37 was found with bruising on the top of his right shoulder and assessed with normal range of motion and no signs or symptoms of pain. On 10/19/12, a nursing assessment noted swelling. Client #37 was sent to the hospital by his primary care physician and diagnosed with a displaced fractured right clavicle from unknown cause. A follow up report dated 10/29/12 indicated client #37 was non-ambulatory and after a "thorough investigation" there was no evidence of a fall. The report indicated "since [client #37] has osteoporosis, was are (sic) treating this as pathological (due to underlying disease) until we are informed differently. "He is normally a 2 person lift. (One staff bear hugging his top half and the second staff holding his legs.) Since the fracture, we are now transferring him with a sling or 2 bath blankets to prevent any direct handling of his extremities." The report indicated staff had been trained on fall prevention and all transfers. An undated note attached to the report indicated, "Attention Staff [client #37] is to be transferred with a sling or bath blankets. There are no exceptions to</p>				

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	<p>this rule. His bones are getting worse so we need to be extra careful when transferring." No written review dates and no staff names signifying training for client #37's transfers were available for review.</p> <p>During observations on 11/13/12 at 4:25 PM, client #37 sat in a recliner without a sling present for transferring him.</p> <p>Staff #22 was interviewed on 11/13/12 at 4:25 PM. She indicated client #37 had a sling for transferring until today and stated, "I guess we're to pick him up," and indicated she had no other training to transfer client #37 other than a two person manual lift.</p> <p>The Assistant Director of Nursing (ADON) #69 was interviewed on 11/14/12 at 7:11 AM and indicated client #37 was to be transferred using a sling.</p> <p>During observations on 11/14/12 at 7:20 AM, client #57 was transferred from his wheelchair to a table after a sling was placed under him. Staff #53 placed her arms through the sling under client #37's arms and across his chest and staff #56 placed her arms through the sling and around client #37's legs. Staff #53 and #56 lifted client #37 without having him bear his weight on the sling leaving the</p>				

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	<p>handles of the sling slack.</p> <p>Staff #56 was interviewed on 11/14/12 at 7:21 AM. When asked about the use of the sling for client #37 and the slack handles, staff #56 stated its use was "Just in case."</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. A letter from client #37's orthopaedic doctor dated 10/25/12 indicated client #37 had a fracture of the right clavicle of "unclear etiology. This could have occurred in transfer or if the patient struck something with his arm." The letter indicated a repeat x-ray would take place in 4 to 5 weeks to check healing of the fracture. A 10/19/12 physician's order indicated "Use sling/2 bath blankets in lifting/transferring pt (patient) until healed, then evaluate." A Fall/Fracture Risk Plan dated 10/20/12 indicated staff were to use a sling or two bath blankets to transfer or reposition client #37.</p> <p>The ADON #69 was interviewed on 11/15/12 at 12:15 PM and indicated staff should have implemented the use of the sling when transferring client #37 to prevent further injury to his fractured clavicle. ADON #69 indicated she would look for the staff training for client #37's transfers.</p>						

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	<p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>			

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview, and record review, for 1 of 10 sampled clients (client #55) and 6 additional clients (clients #1, #3, #10, #14, #47, and #51) who attended school daily from the facility, the facility's Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor the development of program implementation and active treatment while the clients were at school.</p> <p>Findings include:</p>	W0159	<p>1. For client #14, the QMRP requested that the facility Speech Language Pathologist to re-evaluate and/or implement a communication program that parallels programs utilized by outside services. Discussion with the Speech Language Pathologist indicated that client #14 has had previous exposure to picture communication programs within the facility that have proven to be ineffective and without progress. The Speech Language Pathologist will reassess client #14's current, in-house communication program and develop a more homogenous program that mirrors the concept for communication programs utilized by outside services. 2. Client #14's QMRP is also an employee of the same outside service source for client #14. The QMRP responsible will continue to receive documentation, through Xerox copies, of resource communication exchanges. Liaison services will continue to be provided through the facility's Social Services person. To further ensure that client #14's QMRP remains involved, informed and active in client #14's and all other client's outside service resources, the Social</p>	12/19/2012	

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	1. During observation on 11/14/12 at 5:30 PM staff #74 stated, "You are NOT dragging me down the hall", when client #14 grabbed her hand. Client #14 was not		Service person will forward all emailed exchanges that occur between outside services and this facility. Additionally, the QMRP will provide her own email/written responses to any communication if deemed appropriate through assessment of data exchange. Should further assessment be required, the Program Director will visit the outside resource to maintain monitoring of active treatment/IEP objective implementation and cohesion. Client #14 and all other clients that receive outside services, progress is consistently monitored. The facility Social Services person makes regular scheduled and unscheduled weekly visits to outside service for all clients who receive those services. Weekly Social Service visits are documented on a School Visit Record sheet following each visit. (see Att. F) Client information obtained from outside service observations are reviewed during weekly IDT meetings. Should observation data reveal that additional observation and client monitoring for progress is assessed as necessary, the QMRP will visit the outside resource. The QMRP will make an initial visit on 12/19/2012. The QMRP is responsible. The Program Director will monitor.		

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	<p>directed to use a communication system or redirected after grabbing staff #74's hand.</p> <p>During observations on 11/13/12 from 3:30pm to 6pm, client #14 was not observed to use a communication book.</p> <p>Observations were completed at the school on 11/14/12 from 11:15 AM until 1:10 PM. Client #14 grabbed the teacher's hand at 12:21 PM. The teacher redirected client #14 to a communication book to direct her to her schedule and to select choices when indicated in the schedule such as taking a walk.</p> <p>Client #14's communication book used at school was reviewed on 11/14/12 at 12:45 PM. The book contained picture cards to represent computer, wheelchair, restroom, tricycle, music, water and bottle and the words work and finished.</p> <p>Client #14's teacher indicated on 11/14/12 at 12:45 PM client #14 was to follow a schedule using the communication book alternating between completing tasks and selecting choices. The teacher indicated she was uncertain if the system was used at client #14's home, but the materials had been provided to her home. She indicated client #14's Qualified Mental Retardation Professional (QMRP) did not visit the</p>			

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	<p>school, but the facility's social worker provided liaison services between client #14's home and the school.</p> <p>Client #14's record was reviewed on 11/14/12 at 3:24 PM. A speech language assessment dated 11/29/11 indicated client #14 was to focus on her ability to respond to "hi" and "bye," and indicated picture symbols for the words would be added to her goal. Client #14's formal goals dated December, 2011 did not include a communication goal. Progress notes dated 4/24/12 for client #14's Individualized Education Program indicated client #14 "is a very clever and inquisitive young lady. She is a quick learner and very persistent...She is very capable of performing most tasks presented if she chooses after one or two demonstrations...[Client #14] is taught in a structured setting with her work options and reward options represented by icons and printed words. [Client #14] sleeps for significant amounts of time and therefore her response to instruction and intervention is not truly representative of what it could be if she were able to participate more of her instructional day. [Client #4] has demonstrated growth in academic and personal management skills as measured by data collected when she is awake...[Client #14] is very agitated most of the time when she is awake...Social</p>						

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	<p>Emotional: "[Client #14] can be very aggressive and combative. She will strike out at staff/peers/classmates when unprovoked. She is very determined to acquire attention from preferred persons and will physically grab and pull them to attempt to have her needs met. [Client #14] is physically resistive to interventions which she does not 'agree' with, often throwing herself to the ground or using escape maneuvers and running from staff... [Client #14] has been sleeping an inordinate amount of time each school day for much of this year. It was recently reported that she is sleeping at night at home as well. Her home receives daily accounts of sleep times each day through the communication notebook which goes home from school to home." For communication: "No changes in communication are observed. Attempts to engage her result in refusal and aggression. She hits, swats, and becomes combative...When awake and cooperative, (16 of 20 opportunities), and when given multiple prompts and assistance, she followed directions and matched pictures 4 of 4 times. She has handed/given an object per request 2 of 3 times." Client #14's Behavior Support Plan dated 9/15/12 did not address her pulling or sleeping behavior and was written by Qualified Mental Retardation Professional (QMRP) #66.</p>				

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	<p>Client #14's QMRP #66 was interviewed on 11/ 14/12 at 4:41 PM and indicated client #14 had a picture communication system to be used in her program area, but the program was recently revised and the communication system had not been implemented. She indicated she did not visit the school to observe clients during the school day.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:36 PM. She indicated client #14's sleeping behavior was tracked and indicated she slept much of the night and pulling others is client #14's way of communication. She indicated the pulling behavior should be formally addressed and did not indicate a cause for client #14's sleeping behavior other than she didn't think client #14 liked school.</p> <p>2. Client #1, #3, #10, #14, #47, #51, and #55's QMRP records were reviewed with QMRP #66 and an interview was conducted on 11/14/12 at 4:41 PM. QMRP #66 indicated she did not visit the school to observe implementation of active treatment programs for clients #1, #3, #10, #14, #47, #51, and #55 during their school day.</p> <p>This deficiency was cited on 10/5/2012.</p>						

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-17(a)				

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W0164	<p>483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on observation, interview, and record review for 1 additional client (client #14), the facility failed to ensure a professional program services clinician (behavioral consultant) was available to work with client #14's identified behavioral needs.</p> <p>Findings include:</p> <p>During observation on 11/14/12 at 5:30 PM staff #74 stated, "You are NOT dragging me down the hall", when client #14 grabbed her hand. Client #14 was not directed to use a communication system or redirected after grabbing staff #74's hand.</p> <p>During observations on 11/15/12 from 5:30am to 7:30am, client #14 was not observed to use a communication book.</p> <p>Observations were completed at the school on 11/15/12 from 11:15 AM until 1:10 PM. Client #14 grabbed the teacher's hand at 12:21 PM. The teacher redirected client #14 to a communication book to direct her to her schedule and to</p>	W0164	<p>1. For client #14, the QMRP requested that the facility Speech Language Pathologist to re-evaluate and/or implement a communication program that parallels programs utilized by outside services. Discussion with the Speech Language Pathologist indicated that client #14 has had previous exposure to picture communication programs within the facility that have proven to be ineffective and without progress. The Speech Language Pathologist will reassess client #14's current, in-house communication program and develop a more homogenous program that mirrors the concept for communication programs utilized by outside services.</p> <p>2. Client #14 will be provided with outside, professional assessment through a behavioral specialist on 12-6-2012. Recommendations from this assessment will be reviewed by the Interdisciplinary Team to better determine the appropriate behavioral intervention/training program to assist client #14 with maladaptive behavioral episodes experienced at home and at outside services. As an additional note,</p>	12/19/2012			

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	<p>select choices when indicated in the schedule such as taking a walk.</p> <p>Client #14's communication book used at school was reviewed on 11/15/12 at 12:45 PM. The book contained picture cards to represent computer, wheelchair, restroom, tricycle, music, water and bottle and the words work and finished.</p> <p>Client #14's teacher indicated client #14 was to follow a schedule using the communication book alternating between completing tasks and selecting choices. The teacher indicated she was uncertain if the system was used at client #14's home, but the materials had been provided to her home. She indicated client #14's Qualified Mental Retardation Professional (QMRP) did not visit the school, but the facility's social worker provided liaison services between client #14's home and the school. Client #14's teacher indicated she was completing steps to have client #14 evaluated by a behavior therapist.</p> <p>Client #14's record was reviewed on 11/14/12 at 3:24 PM. A speech language assessment dated 11/29/11 indicated client #14 was to focus on her ability to respond to "hi" and "bye," and indicated picture symbols for the words would be added to her goal. Client #14's formal</p>		<p>client #14's psychiatrist discontinued her prescribed Staraterra for hyperactivity on 10-30-2012 and client #14 was started on Provera on 10-25-2012 to assist her with beginning her menses. These two medication events increased the observed behavioral episodes during the survey process.</p> <p>In the future, should any client experience behavioral episodes that requires subsequent evaluation by outside professional services will be completed as assessed.</p> <p>The Program Director is responsible. The Behavior Management Committee will monitor.</p>				

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	goals dated December, 2011 did not include a communication goal. Progress notes dated 4/24/12 for client #14's Individualized Education Program indicated client #14 "is a very clever and inquisitive young lady. She is a quick learner and very persistent...She is very capable of performing most tasks presented if she chooses after one or two demonstrations....[Client #14] is taught in a structured setting with her work options and reward options represented by icons and printed words. [Client #14] sleeps for significant amounts of time and therefore he response to instruction and intervention is not truly representative of what it could be if she were able to participate more of her instructional day. [Client #4] has demonstrated growth in academic and personal management skills as measured by data collected when she is awake...[client #14] is 'very agitated' most of the time when she is awake..." Social Emotional: "[Client #14] can be very aggressive and combative. She will strike out at staff/peers/classmates when unprovoked. She is very determined to acquire attention from preferred persons and will physically grab and pull them to attempt to have her needs met. [Client #14] is physically resistive to interventions which she does not 'agree' with, often throwing herself to the ground or using escape maneuvers and running			

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	<p>from staff... [Client #14] has been sleeping an inordinate amount of time each school day for much of this year. It was recently reported that she is sleeping at night at home as well. Her home receives daily accounts of sleep times each day through the communication notebook which goes home from school to home." For communication: "No changes in communication are observed. Attempts to engage her result in refusal and aggression. She hits, swats, and becomes combative...When awake and cooperative, (16 of 20 opportunities), and when given multiple prompts and assistance, she followed directions and matched pictures 4 of 4 times. She has handed/given an object per request 2 of 3 times." Client #14's Behavior Support Plan dated 9/15/12 did not address her pulling or sleeping behavior and was written by Qualified Mental Retardation Professional (QMRP) #66. The plan indicated client #14 had 639 incidents in June, 552 in July and 203 in August (year not specified) of target behaviors of physical aggression defined as of hitting and pulling hair, kicking, pinching, sticking fingers up clients' noses and biting clients and staff. Stripping defined as taking shirt and clothes off in public places and leaving the program room unattended. The incidents were not separated by type.</p>						

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	<p>Client #14's QMRP #66 was interviewed on 11/ 14/12 at 4:41 PM and indicated client #14 had a picture communication system to be used in her program area, but the program was recently revised and the communication system had not been implemented.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:15 PM and indicated QMRP #66 had written the plan and a behavior specialist had not been consulted regarding client #14's behaviors.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:36 PM. She indicated client #14's sleeping behavior was tracked and indicated she slept much of the night and pulling others is client #14's way of communication. She indicated the pulling behavior should be formally addressed and did not indicate a cause for client #14's sleeping behavior other than she didn't think client #14 liked school.</p> <p>3.1-23.(a)(1)</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review, and interview, the facility failed for 5 of 10 sampled clients (clients #2, #22, #28, #37, and #50) and 3 additional clients (#42, #48 and #53) to ensure staff had been sufficiently trained to use a sling (client #37) and to identify clients and communicate specific client information.</p> <p>Findings include:</p>	W0189	<p>1. As a measure to ensure that all staff can communicate basic client information for all clients, client information data forms have been created (Att. D). Client information data sheets will include personal data including, but not limited to, client's pictures, medical information and personal identification information specific to each client. Client information Data sheets will be accessible in each client's identified program book and a binder for staff's immediate access. Additionally, daily staffing sheets will now contain information related to community appointments, where a client is going and why they are going.</p> <p>2. For client #37, staff were trained regarding transfer procedures (Att. B). Staff interview revealed that the sling used for client #37 had become stretched and too large for transfer practice for client #37. A pair of smaller slings were purchased on 11-21-2012, inserviced on 11-30-2012 and implemented for use on 12-1-2012. Staff training</p>	12/19/2012			

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			<p>included the use of the sling for client #37, the purpose behind the need to use the sling and the appropriate technique needed for transferring client #37 with the sling.</p> <p>1. As a measure to ensure that all staff can communicate basic client information for all clients, client information data forms have been created (Att. D). Client information data sheets will include personal data including, but not limited to, client's pictures, medical information and personal identification information specific to each client. Client information Data sheets will be accessible in each client's identified program book and a binder for staff's immediate access. Additionally, daily staffing sheets will now contain information related to community appointments, where a client is going and why they are going.</p> <p>2. For client #37, staff were trained regarding transfer procedures (Att. B). Staff interview revealed that the sling used for client #37 had become stretched and too large for transfer practice for client #37. A pair of smaller slings were purchased on 11-21-2012, inserviced on 11-30-2012 and implemented for use on 12-1-2012. Staff training included the use of the sling for client #37, the purpose behind the need to use the sling and the appropriate technique needed for transferring</p>		

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			<p>client #37 with the sling.</p> <p>In the future, staff will be trained for use of a sling, if assessed as necessary. Staff training will be documented with staff signatures. Follow-up training/discussion will be provided to direct care staff approximately one week after initial training. This process will be implemented as a measure to ensure training was effective and modifications implemented as identified through subsequent training.</p> <p>The staff trainer will monitor staff transfers and assess equipment monthly. The QMRP will monitor.</p> <p>In the future, staff will be trained for use of a sling, if assessed as necessary. Staff training will be documented with staff signatures. Follow-up training/discussion will be provided to direct care staff approximately one week after initial training. This process will be implemented as a measure to ensure training was effective and modifications implemented as identified through subsequent training.</p>		

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	<p>1. The facility's records were reviewed on 11/13/12 at 2:45 P.M.. A review of the BDDS (Bureau of Developmental Disability Services) reports from 9/24/12 to 11/13/12 indicated on 10/19/12, a nursing assessment noted swelling, client #37 was sent to the hospital by his primary care physician and diagnosed with a displaced fractured right clavicle from unknown cause. The report indicated "since [client #37] has osteoporosis, was are (sic) treating this as pathological (due to underlying disease) until we are informed differently. "He is normally a 2 person lift. (One staff bear hugging his top half and the second staff holding his legs.) Since the fracture, we are now transferring him with a sling or 2 bath blankets to prevent any direct handling of his extremities." The report indicated staff had been trained on fall prevention and all transfers. An undated note attached to the report indicated, "Attention Staff [client #37] is to be transferred with a sling or bath blankets. There are no exceptions to this rule. His bones are getting worse so we need to be extra careful when transferring."</p> <p>During observations on 11/13/12 at 4:25 PM in program #1, client #37 sat in a recliner without a sling present for transferring him.</p>			

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	<p>Staff #22 was interviewed on 11/13/12 at 4:25 PM. She indicated client #37 had a sling for transferring until today and stated, "I guess we're to pick him up," and indicated she had no other training to transfer client #37 other than a two person lift.</p> <p>Staff #27 was interviewed on 11/13/12 at 5:20 PM. He indicated he had been working at the facility for a week, was unaware client #37 had a G-tube, and had not been trained on behavior support plans or individual support plans. When asked when his training would take place, he stated, "I have no idea."</p> <p>The Assistant Director of Nursing (ADON) #69 was interviewed on 11/14/12 at 7:11 AM and indicated client #37 was to be transferred using a sling.</p> <p>The ADON #69 and Qualified Mental Retardation Professional (QMRP) #68 were interviewed on 11/15/12 at 12:15 PM and indicated staff should be trained on client plans and aware of client needs.</p> <p>2. Observations were conducted at the facility in Program Room 4 on 11/13/12 from 1:15 PM until 2:30 PM. During the observation staff #26 and #27 were in the room with clients #28, #2, #42, #50, #53 and #48. At 1:18 PM, Staff #26 indicated</p>						

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	<p>she had been working at the facility for four days. Staff #26 was not able to identify clients #2, #28, #42, #50, #53 and #48 by name and indicated she did not know specifically how to provide service to the individuals or what their individual needs were. At 1:18 PM, Staff #27 indicated he had worked at the facility for one week. He indicated he did not know specifically how to provide service to the individuals or what their individual needs were. Client #53 indicated he was hungry and staff #27 indicated he had returned from a Dr.'s appointment but did not know why he had gone to the Dr. or if he had eaten lunch. At 1:40 PM client #53 was taken from the room to go to the dining room to get his lunch.</p> <p>QMRP #68 was interviewed on 11/15/12 at 12:15 PM. The QMRP indicated staff should know client needs, communicate their information regarding Dr. appointments and should know whether or not they had eaten lunch.</p> <p>3.1-13(b)(1)</p>						

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W0214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on observation, interview, and record review for 2 additional clients (clients #14 and #38) living in the facility, the facility failed to assess client #14's behavior of pulling on others, and client #38 for excessive drinking of fluids.</p> <p>Findings include:</p> <p>1. During observation on 11/14/12 at 5:30 PM staff #74 stated, "You are NOT dragging me down the hall", when client #14 grabbed her hand. Client #14 was not redirected after grabbing staff #74's hand.</p> <p>Observations were completed at the school on 11/14/12 from 11:15 AM until 1:10 PM. Client #14 grabbed the teacher's hand at 12:21 PM. The teacher redirected client #14 to a communication book to direct her to her schedule and to select choices when indicated in the schedule.</p> <p>During interview with client #14's teacher on 11/14/12 at 12:45 PM, she indicated client #14 was to be redirected to her communication book when she pulled on</p>	W0214	<p>1. . Client #14 will be provided with outside, professional assessment through a behavioral specialist on 12-6-2012. Recommendations from this assessment will be reviewed by the Interdisciplinary Team to better determine the appropriate behavioral intervention/training program to assist client #14 with maladaptive behavioral episodes experienced at home and at outside services. As an additional note, client #14's psychiatrist discontinued her prescribed Staraterra for hyperactivity on 10-30-2012 and client #14 was started on Provera on 10-25-2012 to assist her with beginning her menses. These two medication events increased the observed behavioral episodes during the survey process. In the future, should any client experience behavioral episodes that requires subsequent evaluation by outside professional services will be completed as assessed. 2. Client #38's comprehensive functional assessment has been modified to include additional assessment of increased thirst. Consultation with client #38's primary care physician indicated that increased thirst may be a side effect of his</p>	12/19/2012	

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	<p>staff.</p> <p>Client #14's record was reviewed on 11/14/12 at 3:24 PM. Client #14's formal goals dated December, 2011 did not address client #14's pulling on staff behavior. Progress notes dated 4/24/12 for client #14's Individualized Education Program indicated client #14 "is a very clever and inquisitive young lady. She is a quick learner and very persistent...She is very capable of performing most tasks presented if she chooses after one or two demonstrations...[Client #14] is taught in a structured setting with her work options and reward options represented by icons and printed words...[Client #4] has demonstrated growth in academic and personal management skills as measured by data collected when she is awake... [Client #14] is "very agitated most of the time when she is awake...." Client #14's Behavior Support Plan dated 9/15/12 did not address her pulling on others.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:36 PM. She indicated client #14's pulling on others is client #14's way of communication. She indicated the pulling behavior should be formally addressed. She indicated client #14's behaviors had not been assessed by a behavior specialist.</p> <p>2. On 11-13-12 from 1:15 p.m. until 5:50</p>		<p>currently prescribed psychotropic medication and/or related to medication prescribed for EPS. As a result, to assist client #38 with increased thirst, his prescription for Cogentin was discontinued on 11-19-2012 and Biotene was prescribed on 11-21-2012. Staff were trained concerning the effects of increased thirst for the prescription medication and the newly introduced Biotene, Staff was provided with information regarding revisions in client #38's medications. Additionally, staff were retrained regarding client #38's BMP, issues regarding increased thirst and facility Catch and Release behavioral intervention techniques for client #38 and all other clients. The QMRP is responsible The Behavior Management Committee will Monitor.</p>				

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	<p>p.m. an observation at the home of client #38 was conducted. Client #38 went into the bathroom in program room 6 and direct care staff (DCS) #11 indicated to client #38 that he had already had some water and couldn't have any more. DCS #11 placed his arms under client #38's armpits and removed him from the bathroom by pulling him out. Client #38 went into program room #6 bathroom and DCS #11 placed his arms under client #38's armpits and pulled him out of the bathroom and assisted him to sit in a chair. Client #38 banged his head, slapped his face, and grabbed at DCS #25's shirt. DCS #25 told client #38 he was sorry but he couldn't give him any more water. Client #38 hit his face 3 times. Client #38 hit his face 2 times. Client #38 banged his head on the wall and grabbed DCS #11's shirt. DCS #25 indicated client #38 was mad because he couldn't have any more water. DCS #25 asked DCS #59 if he could give client #38 more water and she indicated client #38 could have some more.</p> <p>On 11-14-12 at 6:00 a.m. client #38 was observed during breakfast. Client #38's breakfast card did not indicate he had a liquid restriction. Client #38 immediately drank his milk, juice and breakfast shake. Client #38 ate his breakfast with no more drink offered. DCS #201 brought client</p>				

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	<p>#38 another prepared drink after his meal was completed. Client #38 hit himself in the head 3 times. DCS #50 attempted to put client #38's helmet on his head but he tried to pull the helmet off. DCS #201 held client #38's hands down into his lap so DCS #50 could get the helmet on. Client #38 did not comply with wearing the helmet.</p> <p>On 11-14-12 at 3:15 p.m. a record review for client #38 was conducted. The Behavior Support Plan (BSP) dated 6-25-12 did not address client #38's behaviors due to wanting more to drink and did not indicate he had a liquid restriction. Client #38's BSP did not indicate staff could hold him under his arms and pull him around, and the plan did not indicate DCS could hold client #38's hands in his lap as another DCS attempted to put on his helmet. The plan did indicate to guide his hands to his lap and then release. No assessment was available for review for client #38's liquid restriction and holding his arms down behaviors.</p> <p>On 11-13-12 at 5:00 p.m. an interview with DCS #11 and #25 indicated client #38 was not on a liquid restriction but they were told client #38 was allowed to have only 1 to 2 four ounce drinks during their shift.</p>			

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	<p>On 11-15-12 at 12:15 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) #68 indicated client #38 did not have a liquid restriction and the behaviors due to not getting a drink were not addressed in his plan.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-31(a) 3.1-31(d)</p>				

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W0224	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.</p> <p>Based on record review and interview for 10 of 10 sampled clients (clients #2, #5, #7, #8, #22, #28, #37, #50, #55, and #57), the facility failed to ensure housekeeping, laundry, and cooking assessments were completed.</p> <p>Findings include:</p> <p>1. On 11-14-12 at 3:00 p.m. a record review for client #8 was conducted. The Comprehensive Functional Assessment 10-29-12 did not indicate housekeeping, laundry, and cooking skills had been assessed.</p> <p>On 11-14-12 at 2:20 p.m. a record review for client #5 was conducted. The Comprehensive Functional Assessment dated 10-29-12 did not indicate housekeeping, laundry, and cooking skills had been assessed.</p> <p>On 11-14-12 at 1:30 p.m. a record review for client #55 was conducted. The Comprehensive Functional Assessment dated 10-29-12 did not indicate</p>	W0224	<p>For all clients, the comprehensive functional assessment has been modified to include assessment that addresses each client's independent living skills. Specifically, the comprehensive functional assessment has been updated to include domestic and mealtime sections (Att. E). Although mealtime and domestic skills were addressed in the recommendation portion of the assessment, additional sections were developed. Information gathered from these additional life skills sections will be integrated in each client's daily active treatment program as either formal or informal training opportunities. The QMRP is responsible. The Program Director will</p>	12/19/2012			

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	<p>housekeeping, laundry, and cooking skills had been assessed.</p> <p>2. Client #7's records were reviewed on 11/14/12 at 11:30 AM. The CFA and IHP dated 06/27/12 failed to assess independent living skills of cooking, housekeeping, laundry, and adult daily living skills. Client #7's 10/27/12 "Adaptive Skills Assessment" did not indicate client #7's housekeeping and laundry skills had been assessed.</p> <p>On 11/14/12 at 1pm, QMRP (Qualified Mental Retardation Professional) #68 indicated client #7's housekeeping and laundry skills had not been assessed. QMRP #68 stated "We just ran out of time."</p> <p>3. Client #2's records were reviewed on 11/14/12 at 3:05 PM. The CFA and IHP dated 03/13/12 and the Adaptive Skills Assessment dated 11/03/12 failed to assess independent living skills of cooking, housekeeping and laundry.</p> <p>Client #28's records were reviewed on 11/14/12 at 1:30 PM. The CFA and IHP dated 12/15/11 and the Adaptive Skills Assessment dated 11/04/12 failed to assess independent living skills of cooking, housekeeping and laundry.</p>						

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	<p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. The CFA and IHP dated 07/06/12 and the Adaptive Skills Assessment dated 11/03/12 failed to assess independent living skills of cooking, housekeeping and laundry.</p> <p>QMRP #68 was interviewed on 11/15/12 at 12:15 PM. The QMRP indicated there were no assessments regarding independent living skills of cooking, housekeeping and laundry.</p> <p>4. Client #22's record was reviewed on 11/14/12 at 3:21 PM. Client #22's record did not include assessments of cooking, laundry and housekeeping skills.</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. Client #37's did not include assessments of cooking, laundry and housekeeping skills.</p> <p>Client #57's record was reviewed on 11/15/12 at 11:20 AM. Client #57's record did not include assessments of cooking, laundry and housekeeping skills.</p> <p>QMRP #68 was interviewed on 11/15/12 at 12:15 PM. The QMRP indicated there were no assessments regarding independent living skills of cooking, housekeeping and laundry.</p>						

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	This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-31(c)(10)				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon observation, record review and interview for 6 of 10 sampled clients (clients #2, #22, #28, #37, #50 and #57) and 1 additional client (client #38), the facility failed to ensure clients' objectives were implemented and failed to ensure active treatment was provided during formal and informal opportunities.</p> <p>Findings included:</p> <p>1. Observations were conducted at the facility in Program Room 4 on 11/13/12 from 1:15 PM until 2:30 PM. During the observation staff #26 and #27 were in the room with 6 clients. Client #2 had the following activities during the observation: walked around the class room.</p> <p>During the observation periods on 11/13/12 from 4:00 PM until 5:25 PM, client #2 was in the recreation room for supper. Staff #55, #59 and #28 were present in the room. Napkins were placed</p>	W0249	<p>For clients #2, 22, 28, 37, 50, 57, 38, and all other clients, staff will continue to be trained in the appropriate techniques to facilitate client participation during mealtime and active treatment opportunities. Small group and individual training in these areas of objective training and issue of custodial care will continue to be conducted. Topic areas that will be covered may include, but is not limited to, training materials appropriate to client's chronological age, teaching strategies, review of newly behavior management plans, providing client choice and active participation to mesh active treatment with everyday activities. Previous training interventions required additional time to reinforce staff retention of designed training. Continued training efforts in the topic areas listed are necessary to ensure that staff possesses the ability to recognize areas that promotes client participation and inclusion of their identified needs, interests and active treatment</p>	12/19/2012			

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	<p>on the table by staff #55. Client #2's plate was filled for him, carried to the table by staff #59 and his pre-filled glasses of liquids were taken to him by staff #59. Client #2 had the following activities during the observation: fed himself.</p> <p>During the observation periods on 11/14/12 from 6:00 AM until 7:30 AM, client #2 was in the recreation room after finishing breakfast. Staff #42 and #58 were present in the room. Client #2 had the following activities during the observation: walked around the recreation room.</p> <p>During the observation periods on 11/14/12 from 10:45 AM until 12:30 PM, client #2 was in the recreation room for lunch. Staff #42 and #58 were present in the room. There were no napkins on the table during the meal. Client #2's plate was filled for him, carried to the table by staff #58 and his pre-filled glasses of liquids were taken to him by staff #58. Client #2 had the following activities during the observation: walked with the nurse to the medication room, had his blood sugar checked, was given his insulin, returned to the recreation room and fed himself.</p> <p>Client #2's records were reviewed on 11/14/12 at 3:05 PM. Client #2's</p>		<p>programs. The Staff Trainer is responsible. The QMRP will monitor.</p>		

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	<p>Individual Habilitation Plan (IHP) was dated 03/13/12 and contained but was not limited to the following goals: will screw lids on 3 specimen cups; will fold his own underwear; will participate in an informal activity with staff for 1 minute; will ID (identify) a quarter by pointing when presented with dissimilar coins; will complete a 10-piece puzzle; will place his napkin on his lap before meals and will get insulin syringe from container prior to insulin administration.</p> <p>On 11/15/12 at 12:15 PM an interview was conducted with the QMRP #68. The QMRP indicated client #2's goals should have been implemented and indicated staff should have been prompting the clients every 15 minutes and given them a choice of activities.</p> <p>2. Observations were conducted at the facility in Program Room 4 on 11/13/12 from 1:15 PM until 2:30 PM. During the observation staff #26 and #27 were in the room with 6 clients. Client #28 had the following activities during the observation: sat in a recliner.</p> <p>During the observation periods on 11/13/12 from 4:00 PM until 5:25 PM, client #28 was in the recreation room for supper. Staff #55, #59 and #28 were present in the room. Napkins were placed</p>						

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	<p>on the table by staff #55. Client #28's plate was filled for him, carried to the table by staff #59 and his pre-filled glasses of liquids were taken to him by staff #59. Client #28 had the following activities during the observation: fed himself, took his dishes to the sink and wiped the table.</p> <p>During the observation periods on 11/14/12 from 6:00 AM until 7:30 AM, client #28 was in the recreation room after finishing breakfast. Staff #42 and #58 were present in the room. Client #28 had the following activities during the observation: sat in a rocking chair, went to see the nurse, returned to the rocking chair, colored for 3 minutes, walked around the recreation room.</p> <p>Client #28's records were reviewed on 11/14/12 at 1:30 PM. Client #28's Individual Habilitation Plan (IHP) was dated 12/15/11 and contained but was not limited to the following goals: will come to cart (med) when name is called; will chew food in mouth before taking another bite; will point to a named letter (A, B, C, D) when asked; will ID a coin when presented with dissimilar items; will attend to a selected leisure activity for 10 minutes; will participate in an informal activity with 1-2 peers for 3 minutes.</p>						

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	<p>On 11/15/12 at 12:15 PM an interview was conducted with the QMRP #68. The QMRP indicated client #28's goals should have been implemented and indicated staff should have been prompting the clients every 15 minutes and given them a choice of activities.</p> <p>Observations were conducted at the facility in Program Room 4 on 11/13/12 from 1:15 PM until 2:30 PM. During the observation staff #26 and #27 were in the room with 6 clients. Client #50 had the following activities during the observation: sat in a recliner.</p> <p>During the observation periods on 11/13/12 from 4:00 PM until 5:25 PM, client #50 was in the recreation room for supper. Staff #55, #59 and #28 were present in the room. Napkins were placed on the table by staff #55. Client #50's plate was filled for him, carried to the table by staff #59 and his pre-filled glasses of liquids were taken to him by staff #59. Client #50 had the following activities during the observation: fed himself, carried his dishes to the sink and wiped the table. Client #50 was not prompted to wipe his mouth.</p> <p>During the observation periods on 11/14/12 from 6:00 AM until 7:30 AM, client #50 was in the recreation room after</p>						

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	<p>finishing breakfast. Staff #42 and #58 were present in the room. Client #50 had the following activities during the observation: rocked in a rocking chair and tossed a ball three times.</p> <p>During the observation periods on 11/14/12 from 10:45 AM until 12:30 PM, client #50 was in the recreation room for lunch. Staff #42 and #58 were present in the room. There were no napkins on the table during the meal. Client #50's plate was filled for him, carried to the table by staff #58 and his pre-filled glasses of liquids were taken to him by staff #58. Client #50 had the following activities during the observation: fed himself and carried his dishes to the sink.</p> <p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. Client #50's IHP was dated 07/06/12 and contained but was not limited to the following goals: will wipe face clean as needed; will place 6 shapes into a shape sorter; will place 10 small items into an empty container; will select a leisure item/activity given a choice of 2; will participate in an informal group activity with 1-2 peers and 1 staff for 5 minutes.</p> <p>On 11/15/12 at 12:15 PM an interview was conducted with the QMRP #68. The QMRP indicated client #50's goals should</p>				

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	<p>have been implemented and indicated staff should have been prompting the clients every 15 minutes and given them a choice of activities.</p> <p>3. During observations on 11/13/12 from 1:30 PM until 1:41 PM, from 2:11 PM until 2:28 PM and again from 4:50 until 5:40 PM, clients #22, #37 and #57 were present in program group #1. The materials in the room included a toy alphabet musical interactive bus, toy plastic beads, and children's books while a children's movie channel including a cartoon movie about ants, and a teenaged sitcom played on the TV. Client #22 was assisted to play a card game activity, and at 1:32 PM was asked if she wanted to play again by staff #55. Client #22 did not respond and was not offered other activity. At 1:35 PM, client #57 had a motorcycle magazine, but at 1:40 PM, client #57 was offered a children's glow in the dark bracelet to wear. At 2:18 PM staff #22 read a children's book regarding a pig to client #57. Staff #22 read a children's book to client #37 regarding a yak and other animals at 2:21 PM. Client #37 attempted to hit staff #22 and bite staff #55 during the observations. Client #25 chewed on her shirt without redirection during the observations. Staff #55 placed a new towel around client</p>			

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	<p>#25's neck at 2:18 PM, but did not redirect her from chewing it after client #25 picked up a piece of the towel with her tongue and chewed it.</p> <p>During observations in group #1 on 11/14/12 from 6:40 AM until 7:35 AM materials available in program group #1 where clients #22, #37 and #57 were present included included 2 baby dolls, toy tool box (identified with client #57's initials penned in marker), an infant rattle, a clear infant ball with rotating elephant in the center and a toy drawing board. Staff #23 offered a toy stuffed monkey to client #37 who then threw it on the floor, and a Little Tykes miniature toy key board to which client #37 did not grasp, then a slipper and hairbrush by staff #34. Client #37 attempted to bite staff #4 after being offered the objects. Client #25 chewed a towel without direction during the observation. Clients #22, #57 slept and were not prompted to participate in activities during the observation.</p> <p>Client #22's record was reviewed on 11/14/12 at 3:21 PM. Client #22's Individual Habilitation Plan (IHP) dated 5/29/12 included objectives to verbally respond when asked if she needs changed, extend both arms through her shirt, tolerate by keeping her mouth open for brushing strokes, maintain grasp of</p>						

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	<p>selected items for 5 seconds, verbally identify a solid item by stating y/n (yes/no) when placed in her hand, tolerate toothbrushing by allowing the touch of staff for 15 seconds, appropriately state y/n if she is happy or mad when asked. Client #22's 1/17/12 Behavior Management Plan indicated she was blind and "Once every 30 minutes, staff should verbally interact with [client #22]. Staff should speak with her every 30 minutes for at least 1 minute."</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. Client #37's 5/31/12 IHP indicated objectives to assist with changing, pull shirt down over his head, throw used toothette in the trash, remove both socks from his feet, tolerate grasping an item, allow touch of staff's hand by not moving away for 5 seconds, push self forward for 10 feet.</p> <p>Client #57's record was reviewed on 11/15/12 at 11:20 AM. Client #57's 2/2/12 IHP indicated objectives to select appropriate coin, extend both of his arms forward, turn one page of a magazine, push one of his feet down into his shoe, verbally answer 5 questions of a tv/book or magazine, bring towel to his face, pull shirt over his head, fasten one tab of his brief, release his toothbrush into the container, remove clothing protector from</p>						

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	<p>around his neck prior to bedrest.</p> <p>Client #25's record was reviewed on 11/15/12 at 12:00 PM and indicated December, 2012 objectives to take presented item from staff when presented with her view, turn one page of a desired magazine, respond to textured item rubbed to her hand using facial expression, maintain her attention to TV program for 45 seconds, respond to a sucker placed on her tongue.</p> <p>QMRP #68 and Assistant Director of Nursing #69 were interviewed on 11/15/12 at 12:15 PM and indicated clients' objectives should be implemented at formal and informal opportunities, and client #25 should be redirected from chewing her shirt or a towel and offered a sucker to address her chewing behavior.</p> <p>4. On 11-14-12 from 10:45 a.m. until 1:45 p.m. an observation at the home of client #5 was conducted. Client #5 was assisted by direct care staff (DCS) #64 as he walked down the hall with her holding him under his arms as he went to lunch. At 12:10 p.m. client #5 was assisted by DCS #64 as he walked by holding him from behind under his arms. Client #5 did not use a gait trainer for walking to and from meals.</p>						

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	<p>On 11-14-12 at 2:20 p.m. a record review for client #5 was conducted. The Individualized Support Plan (ISP) dated 2-14-12 indicated client #5 had an objective to walk to and from the dining room in his gait trainer for meals.</p> <p>On 11-13-12 from 1:15 p.m. until 5:50 p.m. an observation at the home of client #38 was conducted. Client #38 went into the bathroom in program room 6 and direct care staff (DCS) #11 indicated to client #38 that he had already had some water and couldn't have any more. DCS #11 placed his arms under client #38's armpits and removed him from the bathroom by pulling him out. Client #38 went into program room #6 bathroom and DCS #11 placed his arms under client #38's armpits and pulled him out of the bathroom and assisted him to sit in a chair. Client #38 banged his head, slapped his face, and grabbed at DCS #25's shirt. DCS #25 told client #38 he was sorry but he couldn't give him anymore water. Client #38 hit his own face 3 times. Client #38 hit his face 2 times. Client #38 banged his head on the wall and grabbed DCS #11's shirt. DCS #25 indicated client #38 was mad because he couldn't have any more water. DCS #25 asked DCS #59 if he could give client #38 more water and she indicated client</p>						

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	<p>#38 could have some more.</p> <p>On 11-14-12 at 6:00 a.m. client #38 was observed during his breakfast. Client #38 hit himself in the head 3 times. DCS #50 attempted to put client #38's helmet on his head but he was trying to pull the helmet off. DCS #201 held client #38's hands down into his lap so DCS #50 could get the helmet on. Client #38 did not comply with wearing the helmet.</p> <p>On 11-14-12 at 3:15 p.m. a record review for client #38 was conducted. The Behavior Support Plan dated 6-25-12 did not indicate staff could hold him under his arms, and the plan did not indicate DCS could hold client #38's hands in his lap as another DCS attempted to put on his helmet. The plan did indicate to guide his hands to his lap and then release.</p> <p>On 11-15-12 at 12:15 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) #68 indicated DCS should follow the Behavior Support Plan as it was written.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-23(a)</p>						

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility failed for 4 of 10 sampled clients (clients #2, #5, #28, and #50) and 2 additional clients (clients #23 and #38) to ensure the HRC (Human Rights Committee) reviewed and monitored the need for motion sensors on the bedroom doors.</p> <p>Findings include:</p> <p>1. On 11-14-12 from 5:40 a.m. until 7:20 a.m. an observation of client #38, #5, #2, #28, #23, and #50's bedrooms was conducted. At 6:50 a.m. an alarm chimed 8 times. At 7:00 a.m. a chime noise sounded 26 times.</p> <p>On 11-14-12 at 7:10 a.m. an interview with the Qualified Mental Retardation Professional #68 indicated the sound was someone going in and coming out of each motion sensed bedroom doors.</p>	W0264	Client #38 did have an assessment that addressed elopement behavior. Human Rights Committee and guardian approvals were obtained prior to implementation of motion sensors for client #14's bedroom doorway. As a measure to remove potential restrictions for other clients residing in bedrooms with clients needing motion sensors, individual bed monitoring systems will be implemented for those clients assessed. A new elopement assessment has been completed for client #38 and Human Rights Committee was obtained for the use of this individual monitoring system on 11-26-2012. Guardian consent was obtained for the use of this individualized system and the subsequent plan for reduction of use on 12-5-2012. In the future, should a client be assessed for the need for a motion detection system, HRC and guardian approvals and reduction of use plans will be approved and implemented. Further, HRC will review all	12/19/2012			

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	<p>On 11-14-12 at 1:40 p.m. clients #38, #5, #2, #28, #23, and #50 were observed to have motion sensors at the doorway of their bedrooms.</p> <p>On 11-15-12 at 11:00 a.m. a review of the Human Rights Committee (HRC) minutes dated 2-4-12 indicated "door alarms" for clients rooms was discussed and the members thought the alarms were "a good idea" for clients with blindness to alert staff so clients wouldn't go into other client's rooms without permission. No specific clients were mentioned in the restriction.</p> <p>On 11-14-12 at 3:15 p.m. a record review for client #38 was conducted. The Behavior Support Plan dated 6-25-12 did not indicate client #38 had the need for motion sensors at his bedroom door.</p> <p>On 11-14-12 at 4:00 p.m. a record review for client #23 was conducted. The Comprehensive Functional Assessment (CFA) dated 11-4-12 did not indicate client #23 had a need for a motion sensor for his bedroom door.</p> <p>On 11-14-12 at 2:20 p.m. a record review for client #5 was conducted. The Behavior Support Plan dated 6-25-12 did not include the need for motion sensors for his bedroom door.</p>		<p>clients using a motion detection system and their reduction plans at least biannually. Additionally, all full room motion detection systems have been removed. At the present time, there is only one client assessed for the need for individualized motion detection systems. The QMRP is responsible. The HRC will monitor.</p>				

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	<p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. The IHP (Individual Habilitation Plan) dated 07/06/12 did not indicate a need for an alarm on his bedroom door.</p> <p>On 11-15-12 at 12:15 p.m. an interview with Qualified Mental Retardation Professional #68 indicated some clients did have motion sensors above their bedroom doors. She indicated the sensors were turned on when clients went to bed and off when they got up. She indicated there was no protocol to review for the motion sensors and the motion sensors were not included in clients' Behavior Support Plans.</p> <p>On 11-15-12 at 12:15 an interview with the Assistant Director of Nursing indicated the alarms were due to client #38 getting up in the night and the sound was to alert staff he was leaving his room. She stated client #38 "was quick."</p> <p>On 11/15/12 at 4:45pm, an interview with the facility Administrator, QMRP #68, and the Program Director was completed. The three staff indicated the HRC had not reviewed the motion sensors on the clients' bedroom doors.</p> <p>This deficiency was cited on 10/5/2012.</p>						

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-31(d)(2)				

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W0331	A. For client #37 and all other clients the facility will continue to implement and in-service on risk plans as new conditions arise. On 10/20/12 staff was in-serviced on client #37's fall risk plan and transferring with a sling was demonstrated by the Human Resource/staff trainer. This in-service record was provided during the survey. The staff was rein-serviced on the need of the use of the sling for client #37's transfers and a demonstration was given on how to use the sling for transfers on 11/30/12 by the ADON. The Human Resource/staff trainer will in-service all new employees at the time of hire of the importance and proper use of a sling for transfers. The Human Resource/staff trainer will make monthly audits of sling transfers to ensure proper use of the sling during transfers and rein-service as needed. B. For client #37 and all other clients the Nurses will continue to assess for pain with the nursing assessment. The Nurses will continue to assess for pain and administer pain medication if indicated when informed by direct care staff of possible pain. Each client has a new Client Information Data Sheet with their personal information provided to assist with	12/19/2012	

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			<p>care. The Client Information Data Sheet will list the individual's key pain indicators to assist the direct care staff to recognize signs and symptoms of pain for that individual client and inform the nurse for the need of a pain assessment. Each individual's Client Information Data Sheet will be placed in the program book located in their program room. A copy of the Client Information Data Sheet will also be placed in a binder in the Nurse's office to assist with indicators of pain for each individual client. Pain indicators will also be listed on the Risk Plan if indicated to assist with proper pain assessments. The staff will be in-serviced on the Client Information Data Sheets and the information provided on them. The staff will be in-serviced on where to find the Client Information Data Sheets. The staff will also be in-serviced on the importance of recognizing pain to ensure proper assessment by the nurse and pain management is obtained</p> <p>C. For client #14 will be provided with outside, professional assessment through a behavioral specialist on 12/6/12. Recommendations from this assessment will be reviewed by the Interdisciplinary Team to better determine the appropriate behavioral interventions/training program to assist client #14 with maladaptive behavioral episodes experienced at home and at</p>	

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			<p>outside services. As an additional note, client #14's psychiatrist discontinued her prescribed Strattera for hyperactivity on 10/30/12 and client #14 was started on Provera on 10/25/12 to assist her with beginning her menses. These two medication events increased the observed behavioral episodes during the survey process. Interviews conducted by the ADON with direct care staff who work directly with client #14 on a daily basis revealed that client #14 continues to have no issues with excessive sleeping during the day when client #14 is at home on weekends or during summer vacation. The direct care staff that rides the school bus with client #14 every morning reports that some mornings she falls asleep on the bus and other mornings she stays awake for the entire ride to school. In the future, should any client experience behavioral episodes that requires subsequent evaluation by outside professional services will be completed as assessed. D. For client's #9, 46 and all other clients the nursing staff will ensure that all labeling and printed orders from the pharmacy are printed correctly and match the physician's order. The pharmacy was contacted by the ADON and all Fosamax orders were corrected to read as originally ordered. The nursing staff will be in-serviced on</p>		

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	Based on observation, record review and interview, the facility failed for 4 additional clients (clients #9, #14, #37, and #46) to provide nursing services according to each client's identified need by failing to implement client #37's fall risk plan to address a fracture, failed to		the correct way for checking orders every month when printed MAR's are received from the pharmacy. The nursing staff will be in-serviced on how to clarify orders with the physician prior to administration. The nursing staff will conduct monthly chart audits and review orders to ensure they are printed correctly and give the completed chart audit form to the DON or her designee to review. The DON or her designee will review the physician order sheets and MAR'S to ensure the nursing staff has ensured orders are printed correctly. The DON or her designee will also review the completed chart audit forms to ensure orders were reviewed and corrections made. The Human Resource/staff trainer will in-service all new employees at the time of hire of the importance and proper use of a sling for transfers. The Human Resource/staff trainer will make monthly audits of sling transfers to ensure proper use of the sling during transfers and rein-service as needed. The QMRP will monitor.	

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	<p>include assessment of client #37's pain in a plan to address his fracture, failed to assess client #14's excessive sleeping and failed to ensure medication labels and medication administration record matched physician's orders for clients #9 and #46.</p> <p>Findings included:</p> <p>1. The facility's records were reviewed on 11/13/12 at 2:45 P.M.. A review of the BDDS (Bureau of Developmental Disability Services) reports from 9/24/12 to 11/13/12 indicated the following for client #37:</p> <p>A BDDS report dated 10/19/12 indicated on 10/17/12 at 7:00 PM, client #37 was found with bruising on the top of his right shoulder and assessed with normal range of motion and no signs or symptoms of pain. On 10/19/12, a nursing assessment noted swelling. Client #37 was sent to the hospital by his primary care physician and diagnosed with a displaced fractured right clavicle from unknown cause. A follow up report dated 10/29/12 indicated client #37 was non-ambulatory and after a "thorough investigation" there was no evidence of a fall. The report indicated "since [client #37] has osteoporosis, was are (sic) treating this as pathological (due to underlying disease) until we are informed differently. He is normally a 2</p>				

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	<p>person lift. (One staff bear hugging his top half and the second staff holding his legs.) Since the fracture, we are now transferring him with a sling or 2 bath blankets to prevent any direct handling of his extremities." The report indicated staff had been trained on fall prevention and all transfers. A note attached to the report indicated, "Attention Staff [client #37] is to be transferred with a sling or bath blankets. There are no exceptions to this rule. His bones are getting worse so we need to be extra careful when transferring."</p> <p>During observations on 11/13/12 at 4:25 PM, client #37 sat in a recliner without a sling present for transferring him.</p> <p>Staff #22 was interviewed on 11/13/12 at 4:25 PM. She indicated client #37 had a sling for transferring until today and stated, "I guess we're to pick him up," and indicated she had no other training to transfer client #37 other than a two person lift.</p> <p>The Assistant Director of Nursing (ADON) #69 was interviewed on 11/14/12 at 7:11 AM and indicated client #37 was to be transferred using a sling.</p> <p>During observations in group #1 on 11/14/12 from 6:40 AM until 7:35 AM</p>						

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	<p>client #37 attempted to bite staff #4 after being offered the objects to hold. During the observation, client #37 was transferred from his wheelchair to a table after a sling was placed under him. Staff #53 placed her arms through the sling under client #37's arms and across his chest and staff #56 placed her arms through the sling and around client #37's legs. Staff #53 and #56 lifted client #37 without having him bear his weight on the sling leaving the handles of the sling slack.</p> <p>Staff #56 was interviewed on 11/14/12 at 7:21 AM. When asked about the use of the sling for client #37 and the slack handles, staff #56 stated its use was "Just in case." She indicated client #37 did not like it when staff used the sling and client #37 would sometimes bite staff when it was used.</p> <p>Client #37's record was reviewed on 11/14/12 at 4:30 PM. A letter from client #37's orthopaedic doctor dated 10/25/12 indicated client #37 had a fracture of the right clavicle of "unclear etiology. This could have occurred in transfer or if the patient struck something with his arm." The letter indicated a repeat x-ray would take place in 4 to 5 weeks to check healing of the fracture. A 10/19/12 physician's order indicated "Use sling/2</p>						

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	<p>bath blankets in lifting/transferring pt (patient) until healed, then evaluate." A Fall/Fracture Risk Plan dated 10/20/12 indicated staff were to use a sling or two bath blankets to transfer or reposition client #37. There was no evidence of of a system to assess client #37's pain from his healing fracture as part of client #37's plan. A behavior assessment dated 5/31/12 indicated "He has also begun trying to bite staff. This is usually indicative of pain or discomfort."</p> <p>The ADON #69 was interviewed on 11/15/12 at 12:15 PM and indicated staff should have implemented the use of the sling when transferring client #37 to prevent further injury to his fractured clavicle. They indicated they were unaware of client #37's biting behavior and indicated staff should have informed them so any issues with pain could be addressed. The ADON indicated client #37 was assessed for pain during nursing assessments.</p> <p>2. During interview with client #14's teacher on 11/14/12 at 12:45 PM, she indicated client #14 slept until noon at school.</p> <p>Client #14's record was reviewed on 11/14/12 at 3:24 PM. Client #14's formal goals dated December, 2011 did not</p>						

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	<p>address client #14's sleeping behavior. Progress notes dated 4/24/12 for client #14's Individualized Education Program indicated client #14 " is very capable of performing most tasks presented if she chooses after one or two demonstrations... [Client #14] sleeps for significant amounts of time and therefore he response to instruction and intervention is not truly representative of what it could be if she were able to participate more of her instructional day. [Client #4] has demonstrated growth in academic and personal management skills as measured by data collected when she is awake... [Client #14] is 'very agitated' most of the time when she is awake..." [Client #14] has been sleeping an inordinate amount of time each school day for much of this year. It was recently reported that she is sleeping at night at home as well. Her home receives daily accounts of sleep times each day through the communication notebook which goes home from school to home." Client #14's Behavior Support Plan dated 9/15/12 did not address her sleeping behavior. There was no evidence in client #14's record the cause of client #14's excessive sleeping had been evaluated.</p> <p>The Program Director #67 was interviewed on 11/15/12 at 1:36 PM. She indicated client #14's sleeping behavior</p>			

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	<p>was tracked and indicated she slept much of the night. She did not indicate a cause for client #14's sleeping behavior during the day other than she didn't think client #14 liked school.</p> <p>3. During the 2:00 PM medication administration period on 11/14/12 at 1:51 PM, RN (registered nurse) #300 gave client #46 Fosamax 70 mg (milligrams). The label and the November, 2012 medication administration record (MAR) indicated, client #46 was to receive the medication "30 minutes before 1st food/beverage/medication weekly."</p> <p>Client #46's physician's orders were reviewed on 11/14/12 at 3:30 PM. Client #46's physician's order dated 1/14/09 indicated client #46 was to take 1 tab mid day with no food intake or reclining 30 minutes after the medication.</p> <p>The ADON #66 was interviewed on 11/14/12 at 1:53 PM and indicated client #46's physician had changed the time of client #46's administration of Fosamax and the pharmacy sometimes mislabels the medication. The ADON stated the medication label and the 11/2012 MAR did not match client #46's physician order.</p> <p>RN #300 was interviewed on 11/14/12 at 2:24 PM and indicated medication labels</p>				

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	<p>should match the MAR and physicians orders.</p> <p>4. Client #9's Fosamax medication was given at 3:01 PM. Client #9's Fosamax label and the November, 2012 label indicated she was to receive the medication before 1st food/beverage/milk.</p> <p>Client #9 physician's orders were reviewed on 11/14/12 at 3:30 PM. A physician's order for client #9 dated 8/28/09 indicated she was to take Fosamax 1 tab each Wednesday for bone mass-may take mid day-no intake or reclining for 30 min (minutes) after.</p> <p>The ADON #66 was interviewed on 11/14/12 at 1:53 PM and indicated client #46's physician had changed the time of client #46's administration of Fosamax and the pharmacy sometimes mislabels the medication. The ADON stated the medication label and the 11/2012 MAR did not match client #46's physician order.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-17(a)</p>						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2012	
NAME OF PROVIDER OR SUPPLIER ARCADIA DEVELOPMENTAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030			
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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT 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 upon observation, record review, and interview for 4 of 10 sampled clients (clients #2, #8, #28, and #50) and 6 additional clients (clients #23, #31, #38, #42, #48 and #53), the facility failed to ensure clients were encouraged to use adaptive equipment.</p> <p>Findings include:</p> <p>During the observation periods on 11/13/12 from 4:00 PM until 5:25 PM, clients #2, #28, #42, #48, #50 and #53 were in the recreation room for supper. All clients used an orange plastic plate to eat from. There were no adaptive plates on the table.</p> <p>Client #2's records were reviewed on 11/14/12 at 3:05 PM. Client #2's undated dining card indicated he was to use a high-sided divided flex plate.</p> <p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. Client #50's undated dining card indicated he was to</p>	W0436	<p>For clients #2, 8, 28, 50, 23, 31, 38, 42, 48, 53 and all clients will be afforded promotion of growth and independence to use adaptive equipment as ordered. Adaptive equipment may include, but is not limited to, use of prescribed and assessed adaptive equipment necessary to complete their meals. Staff have been trained as to the informational access of current dietary cards and newly developed client data information sheets to better recognize and implement necessary use of prescribed adaptive equipment. Weekly direct care shift meetings will be afforded for more individualized training, fielding questions and providing assistance for staff to better distinguish the difference between training supplies and client preferred items. The Staff Trainer will be responsible. The QMRP will monitor.</p>	12/19/2012			

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	<p>use a high-sided divided plate.</p> <p>Client #42's records were reviewed on 11/14/12 at 2:30 PM. Client #42's undated dining card indicated he was to use a high-sided divided plate.</p> <p>Client #48's records were reviewed on 11/14/12 at 2:40 PM. Client #48's undated dining card indicated he was to use a high-sided divided plate.</p> <p>Client #53's records were reviewed on 11/14/12 at 2:50 PM. Client #53's undated dining card indicated he was to use a high-sided divided plate.</p> <p>QMRP #68 was interviewed on 11/15/12 at 12:15 PM. The QMRP indicated adaptive equipment should be used at all times.</p> <p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-21(h) 3.1-39(a)</p>				

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed for 5 of 10 sampled clients (clients #2, #5, #8, #28 and #50) and 8 additional clients (#20, #23, #31, #35, #38, #42, #48 and #53) by not ensuring the clients prepared their food as independently as possible.</p> <p>Findings include:</p> <p>1. During the observation periods on 11/13/12 from 4:00 PM until 5:25 PM, clients #2, #28, #35, #42, #48, #50 and #53 were in the recreation room for supper. The table at the front of the room contained a tray with glasses of liquids. There were no pitchers of liquids on the table. Staff #55, #59 and #28 assisted all of the clients to scoop food onto their plates and all staff carried the filled plates to the table and placed it in front of the clients. Staff #55, #59 and #28 carried the pre-filled glasses of liquids to the clients and sat the drinks on the table in front of them. All of the clients were ambulatory and were observed to eat and drink independently.</p> <p>Client #2's records were reviewed on</p>	W0488	<p>Staff have been re-trained in the appropriate techniques to facilitate client's independent participation and self-management during the dining process, choice and attainment of desired snacks/fluids and participation in meal preparation either formally or informally as assessed. Staff will be provided with client information specific to assessed skills as related to meal preparation, clean-up, and service of their own meals. The QMRP is responsible. The Program Director is responsible.</p>	12/19/2012			

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	<p>11/14/12 at 3:05 PM. The IHP (Individual Habilitation Plan) dated 03/13/12 indicated client #2 was able to carry items, assist with serving and pouring drinks with assistance.</p> <p>Client #35's records were reviewed on 11/14/12 at 3:40 PM. The IHP dated 07/12/12 indicated client #35 was able to carry items, assist with serving and pouring drinks with assistance</p> <p>Client #42's records were reviewed on 11/14/12 at 2:30 PM. The IHP dated 12/27/11 indicated client #42 was able to carry items, assist with serving and pouring drinks with assistance.</p> <p>Client #48's records were reviewed on 11/14/12 at 2:40 PM. The IHP dated 02/07/12 indicated client #48 was able to carry items, assist with serving and pouring drinks with assistance.</p> <p>Client #50's records were reviewed on 11/14/12 at 2:19 PM. The IHP dated 07/06/12 indicated client #50 was able to carry items, assist with serving and pouring drinks with assistance.</p> <p>Client #53's records were reviewed on 11/14/12 at 2:50 PM. The IHP dated 04/05/12 indicated client #53 was able to carry items, assist with serving and</p>				

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	<p>pouring drinks with assistance.</p> <p>QMRP #68 was interviewed on 11/15/12 at 12:15 PM. The QMRP indicated staff should have assisted all the clients to prepare and carry their own food as independently as they could.</p> <p>2. During observations in the dining room on 11/14/12 at 5:50 PM, client #20 was given prepared food and beverages for his meal.</p> <p>During observations in the dining room on 11/15/12 at 5:50 AM, client #20 was given prepared food and beverages for his meal.</p> <p>Staff #77 and #79 were interviewed on 11/14/12 at 6:06 AM and indicated none of the clients had prepared food for the morning meal.</p> <p>3. On 11-13-12 from 1:15 p.m. until 5:50 p.m. an observation at the home of clients #5, #8, #23, #31, #38 and #55 was conducted. At 4:30pm, DCS #76 and #80 indicated no clients helped prepare the supper meal. Clients #5, #8, #23, #38, and #55 were served prepared drinks and food for their supper meal. DCS #70 served client #38 another prepared drink. DCS #84 wiped off the tables, salt and pepper shakers, and swept the dining room floor for clients #5, #8, #23, #31,</p>						

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	<p>#38, and #55. No pitchers of drinks were on the tables. DCS #70 cleared the dirty dishes from the table for client #38.</p> <p>On 11-14-12 from 5:40 a.m. until 7:20 p.m. an observation at the home for clients #5, #8, #23, #38, and #55 was conducted. Clients #5, #8, #23, #38, and #55 were served a prepared breakfast and prepared drinks. Clients #5, #8, #23, #38, and #55 did not assist with meal preparation for their breakfast meal.</p> <p>On 11-14-12 from 10:45 a.m. until 1:45 p.m. an observation at the home of clients #5, #8, #23, #31, and #38 was conducted. Clients #5, #8, #23, #31, and #38 were served a prepared lunch. DCS #50 poured the salad dressing on client #23's prepared salad for him. DCS #64 poured salad dressing on client #38's prepared salad for him. DCS #76 and #82 indicated no clients at the facility helped prepare the lunch time meal.</p> <p>On 11-15-12 at 12:15 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) #68 indicated clients should assist with meal preparation and drink preparation. The QMRP #68 indicated pitchers were not kept on the tables because the drinks were all ready poured into individual cups for clients.</p>						

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	<p>This deficiency was cited on 10/5/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-20(a)</p>				