

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G366	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 58808 ST MARYS LN GOSHEN, IN 46526
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/7, 4/8, 4/9 and 4/17/14</p> <p>Facility Number: 000880 Provider Number: 15G366 AIMS Number: 100235120</p> <p>Surveyors: Amber Bloss, QIDP-TC Paula Chika, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/28/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview, and</p>	W000104	Please see corrections made at W125, W149, W153, W154,	05/09/2014

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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	record review for 2 of 4 sampled clients (#3, #4) and 1 additional client (#8), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the governing body did not neglect clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to report an allegation of abuse to state officials, to conduct thorough investigations, and to ensure a client had a right to due process in regards to the use of a restrictive behavior program which utilized the client's money. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care/nursing needs of the clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored client programs in regards to development and revision, to ensure needed supports were a part of the client's program plan, to ensure the facility owned day program did not utilize a restrictive behavior program, and to ensure a client was placed in an appropriate classroom at the day program.		W159, W227, W240, W257, W318 and W331				

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	<p>Findings include:</p> <p>Please refer to W125. The governing body failed to ensure the client's right to due process in regard to the use of a restricted behavioral program being implemented at the facility's own day program (Client #4).</p> <p>Please refer to W149. The governing body failed to implement its written policies and procedures to prevent neglect of the client in regard to physical and mental decline as related to Dementia (Client #3), failed to prevent neglect of a client in regard to the client's chronic pain due to Osteoarthritis (Client #4), and failed to report an allegation of client to client aggression to state officials and conduct thorough investigations for staff to client abuse and client to client aggression/abuse (clients #4, #8).</p> <p>Please refer to W153. The governing body failed to report an allegation of client to client abuse to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services-APS) (Client #4).</p> <p>Please refer to W154. The governing body failed to thoroughly investigate an allegation of abuse and/or injury of</p>						

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W000125	<p>unknown origin (clients #4, #8).</p> <p>Please refer to W159. The governing body failed to exercise operating direction over the facility QIDP (Qualified Intellectual Disabilities Professional) to ensure coordination of client choice of classroom into day program services, and failed to monitor day program services to prevent use of a restricted behavioral program (Client #4). The governing body failed to exercise operating direction over the facility QIDP to ensure a revision of a BSP (Behavior Support Plan)/ISP (Individual Support Plan) as needed to address nightmares, sleeplessness, and Dementia.</p> <p>9-3-1(a)</p> <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>			
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	<p>Based on interview and record review for 1 of 4 sampled clients (#4), the facility failed to ensure the client's right to due process in regard to the use of a restricted behavioral program being implemented at the facility's own day program.</p> <p>Findings include:</p> <p>Interview with client #4 on 4/8/14 at 9:00 AM indicated she did not carry money on her person to the day program. Client #4 indicated facility staff carried the client's money to the day program and would give it to staff.</p> <p>Interview with day program staff #2 on 4/8/14 at 9:10 AM indicated facility staff would bring client #4's money to the day program and give it to staff. Day program staff #2 indicated client #4's money was part of a reinforcer program. Day program staff stated client #4 would get money to use in a vending machine at the end of the week if the client's "behavior was up to PAR." When asked what behavior up to PAR meant, Day program staff #2 stated "Participation, Attitude and Restroom." Day program staff indicated client #4 would have to have good behavior to get money to use in the vending machine. Day program staff indicated client #4 would choose to</p>	W000125	<p>When the administrator was made aware of the PAR program it was immediately discontinued. All facility staff and day service staff are being trained on the behavior support plan of client #4 as well as all others who reside in the facility. All staff have been trained that only the measures noted in the behavior support plan can be utilized at any time, and that there are no restrictions within any of the plans including client #4. Client #4 as of 5/1/14 will be given a dollar a week to carry in her change purse to spend as she wishes. She will be given a dollar week and if not spent and add up to 5 dollars will be asked to put money back into safe keeping other than one dollar as she is at high risk of financial exploitation. In order to prevent this practice in the future, the QIDP will conduct day service audits and staff interviews three times per week to make sure that the BSP for client #4 and all others are being followed appropriately, and that no restrictive measures that have not been approved by the IDT and Human Rights Committee are being used. Failure to comply will result in disciplinary action. Person Responsible: QIDP</p>	05/09/2014			

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	<p>buy/purchase peanut butter M and Ms when earned. When asked if this restriction/reinforcer was part of the client's behavior plan, day program staff #2 stated, "The manager told us to do this."</p> <p>Client #4's 1/3/13 Behavior Support Plan (BSP) reviewed on 4/8/14 at 9:57 AM indicated client #4 demonstrated the targeted behaviors of verbal aggression, physical aggression and lying. Client #4's BSP indicated client #4 was on a positive reinforcement schedule. The BSP indicated "...Any time that [client #4] cooperates with a staff request, staff should give [client #4] social reinforcers, verbal praise and/or a pat on the back. Staff should also praise [client #4] any time she exhibits appropriate behavior. If [client #4] has a good day, staff should give her five or ten minutes of one on one time. Informal reinforcement schedules may be utilized to encourage the development of adaptive behaviors." Client #4's 1/3/13 BSP did not indicate client #4's money should be restricted and/or indicate the client's money should be used to reinforce the client's behavior. The 1/3/13 BSP also did not indicate the "PAR" program was a part of the client's behavior plan.</p> <p>Client #4's record was reviewed on</p>			

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	<p>4/8/14 at 9:57 AM. Client #4's 10/8/13 Individual Program Plan (IPP) indicated client #4 had a guardian. The 1/3/13 BSP and/or 10/8/13 IPP did not indicate the client's guardian gave consent in regard to restricting the client's money and/or indicate the facility's Human Rights Committee reviewed the restrictive "PAR" program.</p> <p>Interview with administrative staff #1 on 4/8/14 at 4:15 PM and on 4/9/14 at 1:30 PM indicated she had not heard of the "PAR" program used at the day program. Administrative staff #1 indicated the facility did not restrict client #4's money and she was capable of carrying money to the day program if she wanted. Administrative staff #1 indicated she found out the "PAR" program was being utilized at the day program on the direction of a previous manager at the group home. Administrative staff #1 indicated the restrictive behavior plan was not part of the client's BSP and/or IPP. Administrative staff #1 indicated the restrictive program was stopping as of 4/9/14 as it should not have been implemented/used. Administrative staff #1 indicated the Qualified Intellectual Disabilities Professional (QIDP) was not aware of the PAR program being utilized.</p> <p>9-3-2(a)</p>						

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W000149	<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, the facility failed to implement its written policies and procedures to prevent neglect of the client in regard to physical and mental decline as related to Dementia for 1 of 4 sampled clients (Client #3).</p> <p>Based on observation, record review, and interview, the facility failed to implement its written policy and procedures to prevent neglect of client #4 in regard to the client's chronic pain due to Osteoarthritis.</p> <p>Based on record review and interview, the facility failed to implement its written policies and procedures to report an allegation of client to client aggression to state officials and conduct thorough investigations for staff to client abuse and</p>	W000149	<p>It is very difficult to determine what is the deficient practices in the many pages of narrative. I attempted to address the items as I think were intended as deficient practices. If all items are not addressed, this is the reason. Client #3 had a swallow study completed on 4/4/2014. The order is for mechanical soft meat and fruit cut into 1/2" pieces. Staff have been trained on the diet, and with the review of the dietitian to fork smash soft fruits only. Staff has 1:1 supervision of client #3 at meals and she is prompted to take a drink between each bite. On 5/2/14 the nursing staff met with the agency consulting Nurse Practitioner to review new procedures for weight loss, psychotropic medications pain monitoring and dementia assessing. From this meeting, the following procedures are being implemented: Prior to any new psychotropic medication being added to an individuals drug</p>	05/02/2014

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	<p>client to client aggression/abuse for 1 of 4 sampled clients (#4) and 1 additional client (#8).</p> <p>Findings include:</p> <p>1) On 4/7/14 at 2:51 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/7/13 to 4/7/14 were reviewed. A BDDS report dated 3/3/14 indicated Client #3 "was eating some apple slices and began choking on a piece of apple. Staff began back blows and she was able to clear the apple. She did not lose consciousness at any time. She reported being fine after the incident but was taken to [Hospital] ER (emergency room) for eval (evaluation). Chest X-ray was negative. She was discharged back to SGL (supported group living) home with no new orders...". The BDDS report indicated Client #3 had a diet order for "regular/cut food into bite size pieces (size of a one inch cube) using example: size of a sugar cube." The BDDS report indicated Client #3 "has no history of swallowing/chewing difficulties but had a choking incident 1/17/2013 d/t (due to) putting too big of bite into her mouth at once, so staff will now monitor during meal times to ensure [Client #3]'s safety." The BDDS report indicated Client #3 "had oral surgery removing 8 teeth on</p>		<p>regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baseline assessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications. QIDP's were trained on this practice on 5/2/14. Weight loss and nutrition tracking. The facility nurses met with the agency Nurse Practitioner and dietitian and devised the following nutrition tracking program: All individuals including client #3 will be weighed one to two times per month. If there is a weight gain or loss of 5 lbs a reweigh will be completed. The nurse will be notified of any person with a 5lb weight gain or loss. If there is a weight loss, a food consumption log will be put into place and the client will be seen by the dietitian on the next</p>	

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	<p>12/6/2013. New diet order after surgery was for liquid diet/soft foods for 10 days slowly increasing to solid foods and resuming to bit (sic) size pieces."</p> <p>-The follow up BDDS (Bureau of Developmental Disabilities Services) report dated 3/5/14 indicated Client #3's "choking/swallowing plan has been updated stating: Staff are to ensure that [Client #3] has soft fruit only for meals and snacks until further notice...". The report indicated Client #3 "eats too fast, pockets food and often talks or screams while eating." The report indicated "a swallow study was not recommended. We are contacting her PCP (primary care physician) asking for a new referral for a swallow study."</p> <p>During the 4/7/14 observation period between 4:55 PM and 5:20 PM (group home went on an outing) and on 4/8/14 between 6:30 AM and 7:30 AM, at the group home, Client #3 walked with a shuffle. Client #3 dragged her feet as she walked. Client #3 had a flat affect. Specifically, during the 4/8/14 observation period, Client #3 demonstrated slowed/delayed movement when reaching to get a hair brush from staff.</p> <p>On 4/8/14 at 3:09 PM, record review</p>		<p>visit and monthly until their weight is stable. The clients physician will be notified about the weight loss and dietitian recommendations. If there is a 5 lb weight gain interventions will include portion monitoring, increased physical activity if applicable, monitoring possible effects of medications. Weekly weights until weight is stable. Physician and dietitian will be notified of continued weight increase. Dementia assessment and monitoring: If Dementia is suspected the following should be completed:</p> <ul style="list-style-type: none"> · Ask physician for an evaluation order · Baseline exhibiting behaviors to show the day of the evaluation <p>If a diagnosis of Dementia is confirmed, the following must be completed</p> <ul style="list-style-type: none"> · The team will meet and complete the Dementia Comprehensive Risk/Benefit Assessment Tool to identify risk factors that need to be addressed. · The nurse will put "high risk" plans into place for anything that triggers a high or medium risk · The nurse will put "at risk" plans into place for anything that triggers a low risk · Symptoms such as aggression, BM tracking, Wandering, SIB, depression symptoms, labile mood, insomnia will be tracked on care tracker 				

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	<p>indicated Client #3 had a MRI (magnetic resonance imaging) on 9/24/12 due to "new onset of confusion and disorientation." The report indicated Client #3 had "no trauma" to explain the confusion and disorientation. Client #3's MRI report indicated "no acute pathology. No findings to explain provided symptoms." The report indicated Client #3 was "referred in evaluation of seizure disorder. There have been no witnessed convulsive seizures, just behavioral disturbance and anger outbursts."</p> <p>Record review indicated Client #3 had a "psychological evaluation" dated "June 3 through June 17, 2013." The evaluation indicated "apparently there has been a tremendous decline in her functioning in the last two years or so, and especially since about September of 2012. Staff have noticed that her body is very rigid, that she does a lot of lip puckering, and that she has lost at least 75 percent of her hand functioning. Additionally, her cognitive functioning seems to be deteriorating rapidly and no one seems to know why." The evaluation indicated "one suggestion that the neurologist made was that it might be somewhat due to her medication, and the neurologist suggested that the Lorazepam (generic for Ativan, anti-anxiety) be given as</p>		<p>Pain and nutritional intake will be monitored on separate flow sheets If there is a noted increase in symptoms or behaviors relating to the Dementia The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. A Dementia plan has been implemented and trained for client #3 A food consumption log has been put into place for client #3. If her weight remains stable for 30 days, the log will be discontinued and monitored per our procedure. On 5/2/14 the QIDP's were trained on the requirement to update the IPP when there is a significant change. Client #3's lpp was updated as needed. Client #4 has a pain plan in place that has been trained with staff. A new procedure has been developed and the nurse will monitor the frequency of PRN meds used with prescribed routine pain meds. Client #4's pain management physician reviewed her current regimen on 4/28/14 and does not feel he ought to change the meds. He is concerned that if he increases her medication she will be at high risk for fall. She is scheduled to see him on 5/9/14. The team agreed to have client #4 be seen by her PCP in order to determine the course of action to take with</p>				

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	<p>needed instead of on a regular basis." The evaluation indicated "staff members indicated that [Client #3]'s speech has declined. She used to talk in sentences but no longer does. She also has lost so much of hand functioning that she can no longer turn doorknobs. She gets very frustrated with things she cannot do. There are significant changes in coordination and she often bumps or walks into things." The report indicated Client #3's "medications have been decreased and discontinued because it has been thought that some of them may have been contributing to her problems. Abilify (anti-depressant) seemed to make her worse, chlorpromazine (Thorazine, antipsychotic) seems to have led to more symptoms of tardive dyskinesia, which she is displaying with the lip puckering and rigidity. She was on Seroquel about two years ago and has been lip puckering at least that long, which is probably a symptom of tardive dyskinesia." The report indicated Client #3 "was still fairly high functioning until about two years ago. Her records indicate that she has a history of Bipolar Disorder and Impulse Control Disorder. She has been on lithium (mood stabilizer) a lot in the past, also Zyprexa (antipsychotic) off and on over the years. The Exelon patch (Rivastigmine Transdermal System, used for the treatment of dementia) was started</p>		<p>her knee. The team will recommend a second opinion for knee replacement. A d/c order was given for ice and heat. The pain doctor prescribed aspercreme in its place. Client #4 has a wheelchair at her disposal at all times for use as she chooses. The hoyer for client #4 has been D/C for nonuse. Client #4 does not want to use it. Client #4 continues with her PT exercises. See correction at W153 See correction at W154 Failure to complete and comply with any of these corrections will result in disciplinary action. Person Responsible: QIDP, Nurse</p>		

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	<p>in 2012 and increased and then discontinued because it seemed to be making her worse. She was started on Abilify (anti-depressant) in January (2013) but made her worse. She has lost a lot of weight, but eats even more than before at the present time." The report indicated Client #3's "sleep patterns have improved, however. The September, 2012 neurologist reports mention that she was exhibiting hypersomnolence (excessive sleepiness), sleeping much of the time." The report indicated "during the winter months of 2012-2013, she was up screaming at night, according to staff reports." The report indicated "January and February of 2013 were the worst in terms of symptoms, staff reports, but December 2013 (sic, 2012) was also very bad. She has still not recovered her full functioning from that time." The evaluation indicated "[Client #3]'s Visual Working memory Index (VWMI) was predicted to be at a score of about 63 from her cognitive ability, and instead was at a standard score of 40. This 23 standard score difference is statistically significant, and indicated significant cognitive decline in this area. Her Immediate Memory (IM) score of 40 is significantly below the score of 64 which would be predicted from her cognitive level, and her Delayed Memory (DM) score of 40 is significantly below the</p>			

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	<p>score of 68 which would be predicted from her cognitive level." The report indicated "these results suggest that there has been significant cognitive decline in memory functioning even relative to her very low General Ability Index, or in other words IQ (intelligence quotient), which at this point is 45 according to this testing. This is consistent with some type of dementia process." In the "Summary & Recommendations" of the psychological evaluation, the report indicated "some of her difficulties may have been due to overmedication, and there seemed to be opinions to support this idea. However, there also appear to be unknown dementing factors at work, since she continues to decline even when many of her medications have been discontinued. She is showing signs of what appears to be tardive dyskinesia in the repetitive lip puckering and rigidity of muscle tone. She has seen two neurologists and apparently no one has been able to determine what is wrong. However, there clearly is a dementia process at work, and it will be necessary to pursue further neurological assessment to see what might be an effective level of treatment."</p> <p>Record review indicated the facility failed to document Client #3 had further neurological assessment following the recommendations of the psychological</p>			

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	<p>evaluation.</p> <p>Progress notes from 1/1/2013 to 2/24/14 were reviewed. The progress notes indicated the following:</p> <p>1/01/13 - Client #3 "saw [psychiatrist]. Med (medication) changes were made. Return in 1-2 months."</p> <p>1/17/13 - Client #3 "went to [hospital] ER (emergency room) after a choking incident at day program to make sure no aspiration had occurred."</p> <p>1/24/13 - Client #3 "put her pm (evening) pills in her mouth, and refused to drink water to swallow them with. Instead, she held them in her mouth for @ (sic) a few seconds, then spit them on the floor. Staff punched new pills/flushed the ones that were on the floor, and she took the new pills in a spoonful of pudding."</p> <p>2/7/13 - Client #3 "saw [psychiatrist]. Labs ordered. Med (medication) changes made."</p> <p>2/7/13 - "5:30pm accident illness filled out due to client digging into her behind, pulling out feces and dropping it into the tub. Staff then noticed that client had some blood on her fingers...."</p>						

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	<p>2/10/13 - Client #3 "is requiring an EXTREME amount of redirection/attention. She has spent this entire evening walking around the house, SCREAMING and being disruptive to everyone else in the home. Redirection has been unsuccessful by all staff. She is refusing to have pants on outside of her bedroom, excessive crying and screaming (no words, just screaming)."</p> <p>2/17/13 - "Client was being disruptive during lunch. Client was asked to leave the table, and then started punching staff in the back of the head. Client was redirected to another room."</p> <p>2/19/13 - Client #3 "saw the dietician. No changes to current plan."</p> <p>2/19/13 - "Client slipped in the shower. She fell and hit her lower back on the back on the tub and then slid down onto her bottom...."</p> <p>2/25/13 - Client #3 "laid in her bed from 11pm until 11:45pm screaming. Staff went into her room several times she did not answer any questions, nor did she open her eyes."</p> <p>2/26/13 - "3:45 am - [Client #3] was walking on the living room floor back to her bedroom. The floor had just been</p>				

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	<p>mopped and was wet. [Direct Support Professional] helped her back to her room but she slipped and fell onto her bottom."</p> <p>2/26/13 - Client #3 "had a Doctors appointment today with [primary care physician]. She went in to get checked for hemorrhoids. [Primary care physician] and her nurse noticed that [Client #3] was very unstable and confused, more than she's ever seen her. [Primary care physician] sent orders for a CT (x-ray computed tomography) to be done STAT (immediately) and labs to be done before the scan."</p> <p>2/26/13 - Client #3 "saw [neurologist] to go over her CT scan results. The CT Scan came back normal. Labs were ordered and completed today. A lumbar puncture with sedation was scheduled for 3/7/13 at noon. [Neurologist] thinks that [Client #3]'s stiffness is due to psych (psychiatric) medication side effects."</p> <p>3/01/13 - Client #3 "has been constantly walking around in circles today repeating each request in (sic) with one word, over and over without stopping even after staff assists her with what she is wanting."</p> <p>3/7/13 - Client #3 "went to [psychiatrist]. No changes were made at this time. Return in 2-3 months."</p>			

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	<p>3/13/13 - Client #3 "went to the ER (emergency room) to see about her left arm and why she was not using it. ER doctor took and (sic) x-ray of her wrist and hand which came back as normal. Doctor found some swelling around her wrist due to her past physical aggression. [Client #3's] wrist is wrapped in an ace bandage and is to be worn day and night."</p> <p>3/17/13 - Client #3 "was screaming at another housemate "GOOOOO (sic) TO BED!!!!!" several times, redirection successful for a short period of time in each situation."</p> <p>4/18/13 - Client #3 "saw [psychiatrist]. D/C (discontinue) all psych (psychiatric) meds for two weeks. Return in two weeks."</p> <p>5/2/14 - "Saw [psychiatrist], no changes at this time."</p> <p>5/17/13 - "Went into [Client #3]'s room, she had a small BM (bowel movement) in her toilet along with blood, blood/bm smeared all over her toilet, sink, floor, and walls, all over [Client #3] and her hands...."</p> <p>6/03/13 - Client #3 "started her dementia testing with [psychologist]...."</p>			

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	<p>6/5/13 - Client #3 "was seen by [psychiatrist] for a psych (psychiatric) med review. Staff state that [Client #3] is very stiff in her arms and staff still have to help feed her. No changes were made."</p> <p>9/4/13 - Client #3 "saw [psychiatrist] today. She said that she seems to be doing well. She would like her Luthium (sic) levels checked and is going to start her on Aricept (used in treatment of dementia) 5 mg (milligrams) for 1 month then increase to 10mg. Will see her back in 3 months."</p> <p>12/5/13 - Client #3 "saw [psychiatrist] for her psychotropic medication review. She will be getting Zyprexa (antipsychotic) 5mg (milligrams) at am and at HS (evening)."</p> <p>12/6/13 - "Notified [psychiatrist] of [Client #3]'s family concern with new order for Zyprexa and that she does not want [Client #3] taking that medication."</p> <p>12/6/13 - "Due to the family not wanting [Client #3] to be on the Zyprexa, [psychiatrist] discontinued it."</p> <p>1/9/14 - Client #3 "saw [psychiatrist] today for a Psyche (sic) (psychotropic)</p>			

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	<p>med review. Her temper tantrums have increased, so she will start taking Saphris 5mg., Trazodone 200mg and she will get an extra 150mg of Lithium in the evening."</p> <p>2/6/14 - Client #3 "saw [psychiatrist] today for a psych med review. She is going to start taking Trilafon (antipsychotic) and increase her Trazodone due to not sleeping and an increase in bowel and bladder control."</p> <p>The "Psychiatric Progress Notes" from 3/6/13 to 4/2/14 were reviewed. A psychiatric progress note dated 3/6/13 indicated "Lately, I am having a difficult time with this patient. She had regressed significantly and was a puzzle to me, so a lot of things were done. I had ordered lab work, including CMP (comprehensive metabolic profile), CBC (complete blood count) with differential (white blood cell differential which counts the number of each type of white blood cell) and TSH (thyroid stimulating hormone). I had also, out of desperation, started her on chlorpromazine (antipsychotic). She was also started on Exelon (used in the treatment of Dementia) patch because she was so confused and forgetful. She used to be on Zyprexa and lithium for a long time and was fairly stable." The note indicated Client #3 had seen a neurologist</p>						

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	<p>and the neurologist sent a report to the psychiatrist which indicated "the patient had tardive dyskinesia (a movement disorder caused by long term use of antipsychotics), which is totally wrong." The note indicated "the family is saying to see if I can decrease and discontinue her Exelon patch, which I did, and she had done well. Apparently her confusion at that time was maybe with the increase in Exelon patch, which is very surprising. The patient is scheduled to have lumbar puncture (collection of cerebrospinal fluid for diagnostic testing and/or to treat elevated intracradial pressure) as suggested by her neurologist, and we do not see that there is a need for that." The note indicated the psychiatrist "suggested the staff to call [neurologist]'s office to tell that the patient had already improved and, in my opinion and staff's opinion, she does not need lumbar puncture. I doubt the neurologist is going to agree to that..." The note indicated the psychiatrist indicated "my plan is to gradually wean her off of Exelon patch. She is taking 4.6mg currently, and then it will be discontinued." The note indicated "she will stay on chlorpromazine (antipsychotic) 50 mg (milligram) q (each) a.m. and 200 mg q (each) HS (evening)." The note indicated "In the MAR (medication administration record), it says she is on lithium (mood</p>			

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	<p>stabilizer), but my notes indicate that I have discontinued that. I think this must be a mistake by staff."</p> <p>A psychiatric progress note dated 4/18/13 indicated "after discussing the case with staff, it is the impression that I should wean her off of all her medications to see how she does and start all over again...."</p> <p>A psychiatric progress note dated 1/17/14 indicated "the patient is having significant problems and it had been very difficult to stabilize her during the last visit. I started her back on Zyprexa (antipsychotic) because of her aggressive behavior, difficulty with sleeping." The note indicated Client #3's "family did not want her to be on that medication...."</p> <p>The progress note indicated "I have very limited choices to treat this patient because of limitations. Either it does not work for her or she has some side effect to certain medication. Staff indicates she does not sleep at night because of her mind is racing and she is talking to herself." The progress note indicated "she is hyper. She has temper tantrums and acts out rather quickly with no provocation even for simple requests by the staff." The progress note indicated "the patient had lost a lot of weight being off zyprexa, I believe. Her appetite is fair." The note indicated the psychiatrist</p>						

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	<p>was to order an increase in Client #3's lithium (mood stabilizer) to "450mg (milligrams) q (each) a.m. and 450mg plus 150mg q (each) supper...." The note indicated the psychiatrist "will try her Trazodone (antidepressant) 200mg q (each) hs (evening)." The note indicated the psychiatrist "will try her on Saphris (antipsychotic) 5mg b.i.d. (twice daily) sublingual (dissolves under the tongue) tablet." The note indicated Client #3 "was on Aricept (used in treating dementia) but did not work for her, so I am not going to start that back."</p> <p>The "Psychiatric Progress Note" dated 2/6/14 indicated Client #3's "speech is rambling and unable to be followed. Her mood and affect are labile and irritable. Thought process is disorganized. Thought associations loose. Thought content is difficult to assess. Her insight and judgement are very poor. Her attention and concentration are poor. Her memory is poor. For orientation, she does not know today's day, month, year." The psychiatrist noted "I have been trying to stabilize her for the last many months but it has been difficult." The note indicated "Currently she is on lithium and I have just started her on Saphris 5mg (milligrams) b.i.d. (twice daily) last time, which was last month and trazodone 200mg q (each) hs (evening). Staff has</p>			

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	<p>not seen any improvement in her behaviors with Saphris. Trazodone worked for a couple of days but now she is not sleeping at all, maybe hardly a couple of hours. She is aggressive, she is calling staff names. She goes to bed and for a couple of hours she is out and just paces around or does things she should not be doing. I do not even think she knows what she is doing, she is so confused. They have noticed she has bowel and bladder accidents all over the house as well, which is a major issue." The note indicated the psychiatrist discontinued the Saphris "because it did not do much for her, not at all. Try Trilafon (antipsychotic) 2 mg b.i.d. (twice daily) and 4 mg q (each) hs (evening) for psychotic behavior and racing thoughts." The note indicated the lithium was continued at the current dose (450mg q (each)am and 450mg plus 150mg q supper) and Trazodone (antidepressant) was increased to 300mg each evening.</p> <p>The "Psychiatric Progress Note" dated 3/3/14 indicated Client #3 "had lost weight and she was casually dressed. She looks disheveled. Her mood is very labile (unstable) and somewhat hypomanic (persistent and pervasive elevated (euphoric) or irritable mood). Her speech is repetitious. Her thought</p>			

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	<p>process is disorganized...." The psychiatrist indicated "I have discussed the case with staff with and have asked them to look into her medications from six months to see whether she has been tried on Depakote (anticonvulsant) so that I can try that. She (Client #3) is already taking enough of lithium. I do not want to see her getting toxic." The note indicated the psychiatrist "will discontinue saphris (already discontinued on 2/6/14) because it is not doing much. Increase Trilafon (antipsychotic) to 4 mg (milligrams) q (each) a.m. and 1 p.m. and 8 mg q (each) hs (evening) hoping to improve her sleep as well as her thinking." The note indicated the psychiatrist was continuing Client #3's Lithium for 450mg each morning and 600mg each supper time. The note indicated the psychiatrist "will try Depakote ER (extended release) 500mg q (each) supper for one week, then increase to 750mg q supper. Depakote level to be done in one week after that dosage." The note indicated the psychiatrist was continuing Client #3's Trazodone 300mg in PM. The note indicated "the patient did not show any benefit from Aricept or Exelon (both used in the treatment of Dementia), instead she had some problems with them, so she is not on any one of those medications. I do not remember about Namenda (used in the</p>			

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	<p>treatment of Dementia). If she has not been tried on that when I come next time I may try that medication."</p> <p>Review of a "telephone order" dated 3/18/14 indicated Client #3's [psychiatrist] ordered "discontinue Depakote (anticonvulsant) ER (extended release) 500mg (milligrams) q (each) supper. Continue Depakote ER 250mg q (each) supper."</p> <p>Record review indicated a nurse quarterly assessment dated 3/2014 which indicated Client #3 had a "Choking/Swallowing Management Plan" dated 9/17/2013. Client #3's choking plan indicated Client #3's diet order "Regular/Cut food into bite size pieces (size of a one inch cube) using example: size of sugar cube. Soft fruit only until further notice - Updated 3/04/2014." Client #3's choking plan indicated "[Client #3] has no history of swallowing/chewing difficulties but had a choking incident on 1/17/13 d/t (due to) putting too big of bite into her mouth at once, so staff will now monitor during meal times to ensure [Client #3]'s safety."</p> <p>Review of Client #3's nurses quarterly dated 3/2014 indicated Client #3 had careplans and/or monitoring of the following: choking/swallowing, allergies, "eyes, ears, nose, throat and upper respiratory", TMJ</p>			

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	<p>(Temporomandibular joint disorder)/jaw pain, nutritional/diet, history of falls, and bowel movements. Client #3's "Nutritional/Diet" plan indicated the following interventions:</p> <p>"a. Regular/Cut food into bite size pieces (1/4 to 1 inch cube size) Updated 6/2013. b. Monitor and record weight monthly (frequency). c. At risk for obesity/labs done and monitored as ordered by PCP (primary care physician). d. Monitor amount of fluid intake. e. Staff to monitor at all meal times. Updated 1/17/2013. f. Staff to ensure that [Client #3] eats slowly and take (sic) smalls bites. Updated 1/17/2013." Review of Client #3's monthly weights from December 2012 to April 2014 indicated the following weights:</p> <p>December 2012 - 183 lbs. (pounds) January 2013 - 179 lbs. February 2013 - 170 lbs. March 2013 - 166 lbs. April 2013 - 164 lbs. May 2013 - 162 lbs. June 2013 - 159 lbs. July 2013 - 154 lbs. August 2013 - 151 lbs. September 2013 - 147 lbs. October 2013 - 144.2 lbs.</p>			

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	<p>November 2013 - 143 lbs. December 2013 - 136 lbs. January 2014 - 134 lbs. February 2014 - 136 lbs. March 2014 - 141 lbs. April 2014 - 141 lbs.</p> <p>Client #3's "Nutritional Assessments" were reviewed from 3/2/13 to 3/18/14. On Client #3's 3/20/13 nutritional assessment, the dietician noted Client #3 weighed "200.8# (pounds)", she was on a "Regular/regular diet", and was able to feed "self". The assessment indicated Client #3's BMI (body mass index, measure of body fat based on height and weight) was 34.4 (less than 18.5 BMI is considered underweight, between 18.5 to 24.9 BMI is average, between 25 and 29.9 BMI is overweight, and over 30 BMI is obese, source National Heart, Lung, and Blood Institute).</p> <p>-Client #3's nutritional assessment on 2/19/13 indicated she weighed "170#" which was down "30# p (past) year". The assessment indicated Client #3's BMI was 29.1. The assessment indicated Client #3 required "one on one @ (at) meals" and ate a "reg. (regular) cut food into bite sized pieces" diet. The dietician noted "Res (resident) had wt (weight) decline over p (past) year r/t (related to) change in condition; possible dementia."</p>			

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	<p>-Client #3's nutritional assessment dated 3/19/13 indicated Client #3 weighed 168.4 lbs., BMI 28.9, ate a regular diet with bite size pieces and required one on one at meals for "pockets food (holds in mouth without swallowing)." The dietician noted Client #3 had a swallow study which resulted in "0 (no) prob. (problem) w/ (with) swallow." The dietician noted "staff cont (continue) to provide hand over hand assistance - depends on res (resident) level of alertness."</p> <p>-Client #3's nutritional assessment dated 9/7/13 indicated Client #3 weighed 147 lbs. (pounds) which was down "20# (pounds) from last review." The assessment indicated Client #3 was prescribed "Reg (regular) cut food into bite size pieces." The assessment indicated Client #3's "feeding ability" was staff was to "cue to slow pace, take small bites." The dietician indicated "Hx (history) wt (weight) loss assoc (associated) w/ (with) med (medication) changes, decline in condition. Wt (weight) has stabilized, current BMI 25.6 - slightly above normal range."</p> <p>-Client #3's nutritional assessment dated 3/18/14 indicated Client #3 weighed 142 lbs. (pounds) which was down "5#</p>			

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	<p>(pounds) x (for) 6 months (months). The dietician indicated Client #3's BMI was "24.7 - WNR (within normal range)." The assessment indicated "Res (resident) has Hx (history) wt (weight) loss assoc (associated) w/ (with) multiple med changes, change in condition. Review x (in) 6 mths (months)." The dietician noted "swallow study scheduled - res (resident) will eat fast - take large bites of food + (and) swallow w/o (without) chewing."</p> <p>Record review indicated Client #3 had a swallow study report dated 4/3/2014. The swallow study report indicated results were "compared to last Swallow Function Study on 2/19/13 in which pt (patient) demonstrated decreased rotary chew, piecemeal deglutition (physiological phenomenon occurring when a bolus (chewed food) of a large volume is divided into two or three parts and swallowed separately) and oral residue." The report indicated Client #3's swallow study indicated Client #3 required "extra time per bolus due to piecemeal deglutition and oral residue." The report indicated Client #3 has "Dysphagia (symptom of difficulty in swallowing) characteristic as possibly related to cognitive impairment." The report recommended "Pt (patient) to continue chopped diet with focus on soft</p>			

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	<p>items... ." The report recommended "consider chopped pieces to 1/2 (half) " (inch) size, tender meats, avoid nuts/seeds/skins, etc. Continue 1:1 (direct supervision of client) supervision for mealtimes for cueing pt (patient) to take small bites, single sips, alternate liquid-solids, slow rate of intake, decrease talking during meals." The report recommended a "consideration of controlled flow cup or spout cup to reduce liquid bolus size. Consider placing 1 item of food in front of pt (patient) at a time to reduce impulsivity." No further documentation was available for review to indicate Client #3's IDT (interdisciplinary team) met in regards to Client #3's decline in chewing/swallowing abilities. The facility failed to coordinate an IDT meeting in regards to Client #3's chewing/swallowing decline and/or to monitor and track food intake as related to significant unintended weight loss.</p> <p>Client #3's nursing quarterly dated 10/25/13 indicated Client #3 was assessed for side effects of medication using a side effect scale called MOSES (abbreviation for Monitoring of Side Effects Scale) which indicated the following: #08 Headache = 1 (Minimal: Difficult to detect or easy to detect but occurs only once or twice in a short</p>			

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	<p>non-intense manner...), #31 Arm Swing - Decreased = 0 (not present), #33 Gait: Imbalance/unsteady = 0, #34 Gait: Shuffling = 0, #36 Movement: slowed/lack of = 0, #38 Restlessness/pacing/can't stand still = 1, #39 Rigidity/complaints of jitteriness/jumpiness/nervousness = 2 (Mild: Infrequent and easy to detect ("sometimes") or an annoyance to the client), #72 Agitation = 0, #73 Confusion = 1, #74 Crying/feelings of sadness = 1, #75 Drowsiness/lethargy/sedation = 0, #76 Irritability = 0, #77 Withdrawn = 0, #79 Morning "hangover" = not rated, #80 Nightmares/vivid dreams = not rated, #81 Perceptual: hallucinations/delusions = not rated, #82 Sleeps, excessive = not rated, #83 Sleeps: Insomnia = not rated.</p> <p>Client #3's nursing quarterly dated 1/22/14 indicated Client #3 was assessed for side effects of medication which indicated the following: #31 Arm Swing - Decreased = 0 to 1 (not present to minimal), #33 Gait: Imbalance/Unsteady = 0, #34 Gait: Shuffling = 0, #36 Movement; Slowed/Lack of = 0, #38 Restlessness/pacing/can't sit still = 1, #39 Rigidity = 0, #41 Complaints of jitteriness/jumpiness/nervousness = 2 (mild - infrequent and easy to detect or an annoyance to the client), #72 Agitation = 2, #73 Confusion = 1, #74</p>			

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	<p>Crying/feelings of sadness = 2, #76 Irritability = 2, #77 Withdrawn = 1, #78 Attention/concentration difficulty = not rated, #79 Morning "hangover" = not rated, #80 Nightmares/vivid dreams = not rated, #81 Perceptual = not rated, #82 Sleep: Excessive = not rated, #83 Sleep: Insomnia.</p> <p>No further documentation was available for review to indicate Client #3's potential medication side effects of insomnia, lip puckering, rigidity, gait shuffling and confusion were accurately assessed based on the reports from the neurologist, psychiatrist, hospital, and primary care physicians. The facility failed to thoroughly assess Client #3's potential side effects of medication in coordination with the frequent change of psychotropic medications.</p> <p>Client #3's BSP (Behavior Support Plan) dated 12/6/13 indicated Client #3's psychiatrist sees her for "mood disorder, impulse control disorder and nightmares. Staff reported that she is stable. She has outbursts periodically but is able to regain control fairly quickly. Follow up in three months." Client #3's BSP indicated the following "TARGET BEHAVIORS"; "Temper Tantrums: [Client #3] expressing angry emotions by slamming doors, yelling, cussing, storming around,</p>			
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	<p>stomping, and/or refusing to talk calmly. Following a temper tantrum, [Client #3] will often sit and pout for a period of time.</p> <p><u>Depression:</u> [Client #3] complaining of daily headaches or nightmares, or any time she exhibits a negative attitude, sadness, irritability, or tearfulness for no apparent reason.</p> <p><u>Aggression:</u> [Client #3] in anger striking, slapping, scratching, biting, or in any other way attempting to inflict pain/injury to another person.</p> <p><u>Self-injurious Behavior:</u> Any time [Client #3] picks at her skin with the intent of breaking the skin or any time she slaps, bites or inflicts any pain/injury to herself.</p> <p><u>Obsessive Statements:</u> repeating statements that represent compulsive, often anxious preoccupation with a fixed idea or unwanted emotion.</p> <p><u>Confusion:</u> unclear in mind or intent for example extremely forgetful and not able to follow instructions, and mistakes one thing for another. This also includes memory loss of recent events that affects her day to day schedule."</p> <p>Client #3's 12/6/13 BSP indicated a "MEDICATION ADJUSTMENT PLAN" which indicated "when [Client #3] has reached the goals prescribed in the Behavior Management Plan, the IDT</p>						

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W000153	<p>(Interdisciplinary Team) will consider recommending to the psychiatrist a reduction in the Lithium (mood stabilizer) by 150mg (milligrams) daily will be discussed with the psychiatrist." The medication adjustment plan indicated "if the behaviors exceed current levels for a period of one month, or the client's health and safety is in jeopardy due to the behavior problems, the IDT will recommend to the psychiatrist to increase the medications by a) Lithium to a level that will still maintain blood levels within normal levels with without HRC (human rights committee) and guardian approval, or b) change of medication within the same drug class without HRC and guardian approval. In the event of a change in medication within the same therapeutic class, the risks, benefits, side effects of and indications for medications will be reviewed with the client and/or parent, guardian or responsible party." Client #3's BSP indicated "staff in the group home</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for</p>	W000153	It is not noted in the report and the surveyor was notified that it	05/05/2014

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	<p>1 of 3 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report an allegation of client to client abuse to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services-APS) in accordance with state law (Client #4).</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Accident/Illness Report For Clients and/or investigations were reviewed on 4/9/14 at 1:27 PM. 10/24/13 "[Client #4] was walking through the door way when another client pushed his way past causing [client #4] to become unsteady and fall. [Client #4] said she was trying to walk in to the room and he pushed her walker into her and knocked her down...." The facility's internal incident report indicated client #4 complained of pain in her right side. The facility's internal incident report indicated client #4 had a bruise on her side from a previous incident.</p> <p>Client #4's record was reviewed on 4/8/14 at 9:57 AM. Client #4's 10/24/13 Progress Notes indicated client #4 was coming through a door in the wood working room when another client was coming out of the wood working room at</p>		<p>was not reported as peer to peer aggression because it was not that type of an incident rather an accident. A fire drill had just been completed and client #4 was walking through a doorway. Her peer came into the building and tried getting to the doorway with client #4 resulting in her fall. The Protective Service Coordinator was trained on 5/2/14 that all peer to peer incidents require investigation, and when there is injury, the incident will always be reported per BDDS policy. If within the investigation it is determined that a peer to peer incident is aggression with injury, the protective service coordinate will submit a BDDS report. The protective service coordinator has developed a new investigation form where he will clearly document who he spoke to and his findings. This will be attached to the accident illness report. The injury to the clients right side was from a previous incident that was clearly documented and share with the surveyor where another resident had struck her. In order to prevent future occurrences, the Protective Service Coordinator will complete immediate investigations of all Peer to peer instances. He will forward the investigation to the director for the next 90 days as well as his supervisor and CEO will receive all reports and discussion will take place about the need to file a BDDS report. Failure to comply</p>				

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W000154	<p>the same time and pushed client #4 causing the client to "...fall on her back and hit her head on the floor...." The progress note indicated 2 staff had to assist client #4 to get up off the floor. The progress note also indicated neurological checks were initiated.</p> <p>Client #4's 10/24/13 internal incident report did not indicate the facility reported the allegation of client to client aggression/abuse to BDDS and/or APS.</p> <p>Interview with administrative staff #1 on 4/9/14 at 1:27 PM indicated the above mentioned 10/24/13 incident involving client #4 was not reported to BDDS and/or APS.</p> <p>9-3-2(a)</p> <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 record review and interview, the facility failed to thoroughly investigate for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for allegation of abuse</p>	W000154	<p>will result in disciplinary action. Person Responsible: Protective Services ADDENDUM: Monitoring will be that the Protective service coordinator will forward his investigation of all peer to peer investigations to the DRO for review to make sure the filing of a BDDS report is completed when required such as an injury or the peer to peer resulted in a more significant altercation. After the 90 days of review, the DRO will complete random reviews of peer to peer incidents to make sure that the reporting is being completed. At all times the CEO will be notified of all BDDS reports.</p> <p>On 5/2/14 the protective service coordinator was trained on the importance of typing up investigation notes that include the interviews with clients and staff. The protective service coordinator has developed a new</p>	05/02/2014			

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	<p>and/or injury of unknown origin for 1 of 4 sampled clients (Client #4) and 1 additional client (Client #8).</p> <p>Findings include:</p> <p>1. On 4/7/14 at 2:51 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 6/27/13 to 4/7/14 were reviewed. A BDDS report dated 9/14/13 indicated Client #8 "reported to staff that on the previous evening, staff person [Direct Support Professional (DSP) #2], poured water on her. [Client #8] stated that she did not want to take a shower and [DSP #2] stated that she did not want to take a shower and [DSP #2] was attempting to get her out of bed to take a shower." The BDDS report indicated [DSP #2] has been suspended and an investigation has begun."</p> <p>-A follow up BDDS (Bureau of Developmental Disabilities Services) report dated 9/18/13 indicated "after interviewing staff and clients present, this incident is unsubstantiated." The report indicated "three staff and two clients were interviewed. The two clients [Client #8] and [Client #4] share a bedroom that has a bathroom attached. The staff interviewed were the two working at the time if (sic) the alleged</p>		<p>investigation form where he will clearly document who he spoke to and his findings. This will be attached to the accident illness report or BDDS report as required. The injury to the client #4 right side was from a previous incident that was clearly documented and share with the surveyor where another resident had struck her. In order to prevent future occurrences, the Protective Service Coordinator will complete immediate investigations of all Peer to peer instances. He will forward the investigation to the director for the next 90 days as well as his supervisor and CEO will receive all investigations and discussion will take place about the need to file a BDDS report. Failure to comply will result in disciplinary action. Person Responsible: Protective Services</p>				

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	<p>incident and the overnight staff." The report indicated "the overnight staff was the first interviewed. Her knowledge of the incident was only what [Client #8] told her, and that [Client #8] was upset." The report indicated "the next staff interviewed was the staff that was also working at the time of the incident, [DSP #3]. [DSP #3] was assisting [Client #4] to prepare and take a shower during this incident. She stated that prior to that she had tried to get [Client #8] to take a shower and she had refused. Typically when [Client #8] refuses one staff she will be receptive to a second staff. Because of this [DSP # 2] stepped in and [DSP #3] went to assist the second client with her shower." The report indicated DSP #3 "did not hear [DSP #2] raise her voice, say anything that would have been considered verbally abusive, or do anything physically abusive."</p> <p>The investigation packet indicated a written statement from DSP #3. DSP #3 indicated "when I gave [Client #8] her shower today, she said, "Thanks for doing my shower, I really do not like [DPS #2]. She is not nice to me and it really hurts that she threw water on me." DSP #3 indicated she "asked her to please talk to me next time something happens that she does not like." DSP #3 indicated Client #8 responded "I'm sorry I didn't tell you, I</p>			

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	<p>was afraid." DSP #3 indicated Client #8 "had went (sic) to bed early, had an accident and did not want to take a shower." DSP #3 indicated she tried to assist Client #8 with her shower "10 minutes off and on, then went and asked [DSP #2] to try." DSP #3 indicated she "moved on to [Client #4] and asked her to do her shower. I was walking in and out of the room while [Client #4] was getting ready, getting gloves and towels for [Client #4's] shower. During this time [DSP #2] was talking with [Client #8] about getting in the shower. [Client #8] was yelling and screaming at [DSP #2] telling her she was not getting in the shower." DSP #2 indicated DSP #2 "was not yelling at [Client #8] and was talking very calm." DSP #2 indicated "I heard her (DSP # 2) tell [Client #8] 'you had an accident, you really need to get in the shower'." DSP #2 indicated Client #8 indicated she "did not care." DSP #3 indicated DSP #2 "had asked [Client #8] if she wanted her to give her a shower in her bed. Like using a rag and water. [Client #8] said I don't care what you do I am not getting up. They went back and forth for a while, then I heard a noise. I looked out of the bathroom and [Client #8] had broke (sic) the cabinet next to her bed and was walking to the other bathroom. [DSP #2] told me she was going to take her shower." DSP #3</p>			

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	<p>indicated "...when I looked out about the cabinet, [DSP #2] did have a cup of water, it was full, I assumed she was talking to her about the sponge bath." DSP #3 indicated "she was not going to actually give her a sponge bath that I know of, I think she was just saying it." DSP #3 indicated "I do not know if she did anything with the water that she had."</p> <p>A written statement from DSP #4 indicated she "worked a overnight at [group home] Friday night when I went to woke (sic) [Client #8] up she was upset." DSP #4 indicated Client #8 "proceeded to tell me that a staff member named [DSP #2] poured a cup of water on her head because she refused to take a shower."</p> <p>The investigation packet indicated Client #8 was interviewed (not dated) and indicated she "told her (DSP #2) she wanted to take a shower w (with) [DSP #3]." Client #8 indicated staff was "saying 'I'm not good and bad stuff.'" Client #8 indicated DSP #2 "called me R 'word' (derogatory for mental retardation)." The investigation notes indicated Client #8 indicated "it was a cup" but she "indicated mixing bowl size." The notes indicated Client #8 indicated she "was trying to get up."</p>						

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W000159	<p>The investigation packet indicated DSP #2 was interviewed (not dated or timed) and indicated DSP #2 "asked - [Client #8] refused." The note indicated "kept asking to get up." The notes indicated "got up - to drink." The notes indicated "brought in cup of water. Do you want to shower in bed?" The notes were not clear whether those were the questions being asked or whether those were the answers DSP #2 gave in the interview.</p> <p>On 4/8/14 at 4:33 PM during an interview, the Administrator indicated she believed the investigation was thorough. The Administrator indicated she did not know why DSP #2 brought a cup of water into Client #8's bedroom. The Administrator indicated the Human Rights Officer (HRO) who did the investigation should have been more thorough in documenting DSP #2's statement regarding why she had the cup of water in Client #8's bedroom.</p> <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 4 sampled clients (#4), the facility QIDP (Qualified Intellectual Disabilities Professional)</p>	W000159	On 4/9/14 client #4 was moved to the sewing room of choice. This is simply the homeroom and where she has lunch. She is fine to move about the facility as she chooses going from room to	05/09/2014

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	<p>failed to give the client an opportunity of choice which would allow the client to have say in what day program/activities the client participated in and failed to monitor day program services in regard to use of a restricted behavioral program being implemented at the facility's own day program.</p> <p>Based on record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate a revision of a BSP (Behavior Support Plan) for non-pharmacological interventions when 1 of 4 sampled clients (Client #3) failed to progress and failed to coordinate a revision of a ISP (Individual Support Plan)/BSP to include a program which specifically addressed nightmares and sleeplessness (Client #3) for which the client was prescribed a psychotropic (Trazodone, antidepressant) medication.</p> <p>Based on observation, record review, and interview, the QIDP failed to ensure needed supports were in plan for Dementia (#3).</p> <p>Findings include:</p> <p>1) During the 4/8/14 observation period between 8:57 AM and 10:05 AM, at the facility owned day program, client #4 sat</p>		<p>room. The QIDP was trained on completing the change of status form including the reason for moving a person within a program. This was done on 5/2/14. Client #4 indeed chose to move from the sewing homeroom when her favorite staff left on leave. At that time she chose to begin her day in the ceramic room. The QIDP will be more attentive to reason for moves. When the administrator was made aware of the PAR program it was immediately discontinued. All facility staff and day service staff are being trained on the behavior support plan of client #4 as well as all others who reside in the facility. All staff have been trained that only the measures noted in the behavior support plan can be utilized at any time, and that there are no restrictions within any of the plans including client #4. Client #4 as of 5/1/14 will be given a dollar a week to carry in her change purse to spend as she wishes. She will be given a dollar week and if not spent and add up to 5 dollars will be asked to put money back into safe keeping other than one dollar as she is at high risk of financial exploitation. In order to prevent this practice in the future, the QIDP will conduct day service audits and staff interviews three times per week to make sure that the BSP for client #4 and all others are being followed appropriately, and that no</p>				

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	<p>in a chair at a table without an activity and/or training until 10:55 AM when the client stood to walk over to clay table area. Client #4 was in a ceramics program room.</p> <p>Client #4's record was reviewed on 4/8/14 at 9:57 AM. Client #4's 2/25/14 Change of Status form indicated client #4 attended day services at the ADEC day program. The form indicated client #4 was moved from the photography room to the ceramics room on 2/25/14. The form indicated a section for "Comments," but the section was blank. The 2/25/14 form did not indicate a reason for the change and/or indicate client #4 was given a choice of rooms she could move to.</p> <p>Interview with client #4 on 4/8/14 at 9:00 AM indicated client #4 did not like being in the ceramic program room. Client #4 stated she was moved from the photography room to the ceramic room as the photography was "too far for me to walk." Client #4 indicated there was a sewing room across the hallway where she wanted to be. Client #4 indicated she liked to sew, make purses and make items with beads. Client #4 stated "I sit and stare at the thick walls all day."</p> <p>Interview with day program staff #2 on</p>		<p>restrictive measures that have not been approved by the IDT and Human Rights Committee are being used. By 5/9/14 the staff will be trained on the addendum to the behavior plan for client #3 including specifics addressing dementia, sleeplessness and nightmares. The QIDP was trained on 5/2/14 on updating behavior plans and ISP's as an individuals changes or shows significant change in status. The QIDP was trained on the requirement of having a behavior plan change prior to medication implementation for a targeted behavior this is to include baseline data. A process has been implemented with the QIDP's and nurses that no client will be seen by a psychiatrist for medications prior to a behavior plan change. the nurse will not add the person to the list of individuals to be seen by the psychiatrist until this is done. Failure to comply with any of the corrections listed above may result in disciplinary action. Person Responsible: QIDP</p>		

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	<p>4/8/14 at 9:05 AM indicated client #4 was moved to the ceramic room from the photography room. Day program staff #2 stated "She (client #4) was put in here due to closer to door." Day program staff #2 stated client #4 was "originally in sewing room, moved to photography room which was located at the back of the building. Long walk for her." Day program staff #2 stated "She has not liked it since she has been in here. She has been here 1 month." Day program staff #2 indicated client #4 wanted to go back to the photography room and/or go across the hall to the sewing room. Day program staff #2 indicated client #4 would not participate in any activities in the training room. Day program staff #2 stated "She likes to sew and do beads." Day program staff #2 indicated they would have to have a meeting to have client #4 moved to another area/room.</p> <p>Interview with administrative staff #1 on 4/9/14 at 1:30 PM indicated client #4 was moved to the ceramics room as the staff in the photography room went on maternity leave. Administrative staff #1 stated client #4 wanted to move to the ceramic room to "follow staff she liked." Administrative staff #1 stated she was not aware client #4 did not want to be in the ceramic room and indicated client #4 was "moved today." Administrative staff</p>			

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	<p>#1 indicated the 2/25/14 Change of Status form should have indicated why client #4 was changed from the photography room to the ceramics room.</p> <p>2) Please refer to W125. The QIDP failed to ensure the client's right to due process in regard to the use of a restricted behavioral program being implemented at the facility's own day program (Client #4).</p> <p>3) Please refer to W240. The QIDP failed to ensure the client's ISP (Individual Support Plan) included/indicated how facility staff were to provide additional monitoring for signs and symptoms of Dementia (Client #3).</p> <p>4) Please refer to W257. The QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate a revision of a BSP (Behavior Support Plan) for non-pharmacological interventions when the client failed to progress, failed to coordinate a revision of a ISP (Individual Support Plan)/BSP to include a program which specifically addressed nightmares and sleeplessness for which the client was prescribed a psychotropic medication (Trazodone, antidepressant) (Client #3).</p> <p>9-3-3(a)</p>						

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#4), the client's Individual Program Plan (IPP) failed to address the client's refusals to participate in Physical Therapy exercises.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 4/8/14 at 9:57 AM. Client #4's 11/11/13 typed note from client #4's pain management specialist indicated client #4 had experienced pain in her knee for 10 years. The note indicated "...The pain is burning and sharp. The pain is</p>	W000227	<p>Client #4 has a pain plan in place that is being trained with staff. A new procedure has been developed and the nurse will monitor the frequency of PRN meds used with prescribed routine pain meds. Client #4's pain management physician reviewed her current regimen on 4/28/14 and does not feel he ought to change the meds. He is concerned that if he increases her medication she will be at high risk for fall. She is scheduled to see him on 5/9/14. The team agreed to have client #4 be seen by her PCP in order to determine the course of action to take with her knee. The team will recommend a second opinion for</p>	05/09/2014	

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	<p>aggravated by movement and walking. The pain is relieved by pain/RX (prescription) meds." The 11/11/13 note indicated client #4 "Has had increase in pain especially during activity. Will add a mid day hydrocodone (narcotic pain), to be given before activity. Will also send her for Physical Therapy." The 11/11/13 note indicated client #4 was diagnosed with "Osteoarthritis NOS (no other symptoms), lower leg (715.96) She is to schedule a follow-up visit for recheck 6 Months. Referral: Physical Therapy (PT). Evaluate and treat."</p> <p>Client #4's 11/22/13 PT evaluation indicated "...Treatment Diagnosis: Difficulty Walking 719.70, Muscle Wasting 728.20, Pain-Lower legs 719.46, Stiff-lower leg 719.56..." The 11/22/13 PT assessment indicated "Pt's (patient's) caregiver states that pt might have had history of R (right) knee pain in the past 10 years.Pt (sic) has received silicone and cortisone injections without improvement in pain. Pt has been taking pain medication. Caregiver states that a total knee replacement has been considered but the doctor will not do it since pt will not participate in exercises. Pt wants to have surgery due to pain.Pt (sic) lives in ADEC and has been walking with AD (assistive device) approx (approximately) 50 ft (feet)-100 ft with c/o (complaints</p>		<p>knee replacement. A d/c order was given for ice and heat. The pain doctor prescribed aspercreme in its place. Client #4 has a wheelchair at her disposal at all times for use as she chooses. The hoyer for client #4 has been D/C for nonuse. Client #4 does not want to use it. Client #4 continues with her PT exercises. Staff will be retrained by 5/9/14 on her PT exercises as there are times that she does not refuse and that is due to staff approach. The QIDP will monitor the refusals weekly and recommend changes as needed.Failure to comply with this correction will result in disciplinary action. Person Responsible QIDP ADDENDUM: The monitoring of the refusals of PT is being completed by the QIDP on a weekly basis. The QIDP is documenting this activity on a tracking form. If she notices a trend in refusals she will bring the IDT together to develop an intervention.</p>		

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	of) severe pain using a rollator walker)...Functional Limitations: constant pain in the R knee that limits ambulation, transfers, bed mobility and with knee movements. Pt needs full assistance with bathing and is able to dress self with constant cueing...." The assessment indicated "...GAIT:PT (sic) ambulates with rollator walker with trunk flexion posture, increased thoracic kyphosis (abnormal curvature of the spine) and slow gait due to c/o severe R knee pain. Pt needs extended amount of time to walk short distances...." The assessment indicated client #4 took a long time to stand and/or sit due to the pain in the client's knee. The 11/22/13 assessment indicated "...pt has poor tolerance to lying in supine due to knee pain. Caregiver states that the pt is observed crying due to R knee pain. Pt demonstrates R knee genu vagum (a condition commonly known as "knocked-kneed") deformity...Pt presents to Physical Therapy with the diagnosis of Osteoarthritis NOS lower leg R. Pt c/o constant R knee pain that limits all functional activities. Caregiver states that pt appears to have knee pain at all times and is worse with standing, walking and changing positions. Pt will like to have knee replacement but pt will have to be willing to do exercises since in the past pt has refused to do them. Pt has			

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	<p>significant restriction of R knee extension, mod knee swelling and LE (lower extremity) weakness...." The 11/22/13 PT assessment indicated client #4 was to receive PT services 2 times a week for 3 weeks with completion of home exercises.... "</p> <p>Client #4's 12/17/13 PT Note indicated an "Assessment of progress Pt's caregiver states that patient's R knee pain, behavior and function has not improved with therapy. Pt has been participating in HEP (home exercise program) at the group with exercise program but pt is selective with whom she exercises. Pt scheduled to do exercises 3x (times)/day but most pt only agrees to participate 1x/day...PT advised pt/caregiver to continue working on HEP for at least 1 more month.... "</p> <p>Client #4's Progress Notes indicated the following (not all inclusive):</p> <p>-11/12/13 "...[Client #4] was seen by her pain management doctor, [name of doctor]. He recommended that her PRN of hydrocodone be increased to 3 times a day to be given 1/2 hour before an activity that might cause her pain. He also wrote a prescription for a physical therapy evaluation...."</p>			

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	<p>-11/24/13 Client #4 was seen for an initial PT evaluation. The note indicated client #4 was to compete PT exercises at the group home 3 times a day.</p> <p>-12/5/13 PT indicated client #4 "...is doing good and wants her to continue her therapy at home...."</p> <p>-12/17/13 "[Client #4] went back to [name of PT facility] for a re-eval. The physical therapist wants her to continue doing her therapy at home. try (sic) using a stationary bike and to get up and move around as much as she can. She also said that she (client #4) is doing a lot better and her knee mobility is a lot better. Not as much knee popping sounds or grinding. She discharged her from her care."</p> <p>Client #4's 2/28/14 faxed order indicated client #4 needed to participate in "...Weight bearing exercises.... "</p> <p>Client #4's 2/17/14 physician's orders indicated client #4 was to complete PT exercises for the client's hip, knee, ankle and foot 2 times a day.</p> <p>Client #4's December 2013 Medication Administration Record (MAR) indicated client #4 refused to complete her PT exercises on 12/8/13 (PM &</p>			

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	<p>HS-bedtime), 12/12/13 (PM), 12/19/13 (HS), 12/20/13 (AM) and on 12/31/13 (AM and HS).</p> <p>Client #4's January 2014 MAR indicated client #4 refused to participate in her PT exercises on 1/1/14 (AM & PM), 1/2/14 (AM), 1/5/14 (PM), 1/12/14 (AM & HS), 1/14/14 (PM & HS), 1/21/14 (AM), 1/22/14 (PM & HS), 1/23/14 (PM), 1/24/14 (PM & HS), 1/25/14 (PM & HS) and 1/28/14 (PM & HS).</p> <p>Client #4's February 2014 MAR indicated client #4 refused to participate in her PT exercises on 2/1 (PM & HS), 2/2 (PM & HS), 2/4 (AM, PM & HS), 2/5 (PM & HS), 2/7 (PM & HS), 2/8 (PM & HS), 2/9 (PM & HS), 2/11 (PM & HS), 2/12 (PM), 2/13 (AM & HS), 2/16 (PM & HS), 2/17 (PM & HS), 2/18 (PM & HS), 2/19 (PM & HS), 2/20 (PM & HS), 2/21 (AM, PM & HS), 2/22 (PM & HS), 2/24 PM & HS), 2/25 (PM & HS), 2/26 "refused" and 2/27/14 "refused."</p> <p>Client #4's 3/1/14 MAR indicated client #4 refused to participate in PT exercises on 3/1 (AM, PM & HS), 3/2 (PM & HS), 3/4 (AM), 3/5 (AM, PM & HS), 3/6 (AM), 3/7 (AM, PM & HS), 3/8 (PM & HS), 3/9 (PM & HS), 3/11 (AM), 3/12 (AM), 3/13 (PM & HS), 3/14 (PM & HS), 3/15 (PM & HS), 3/16 (PM & HS),</p>						

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	<p>3/17 (PM & HS), 3/19 (PM), 3/21 (PM), 3/22 (PM), 3/23 (PM & HS), 3/24 (PM & HS), 3/26 (PM & HS) and 3/27/14 (AM).</p> <p>Client #4's 10/8/13 Program Plan (IPP) indicated "...She (client #4) is having considerable more pain when walking and getting into the van. It was discussed whether the team thought it was a good idea to pursue surgery on her knees, if she would cooperate with the Physical Therapy afterwards.... "</p> <p>Client #4's 1/3/13 Behavior Support Plan (BSP) indicated client #4 demonstrated verbal aggression, physical aggression and lying. Client #4's 1/13/13 BSP and/or 10/8/13 IPP indicated the facility failed to address the client's refusals to participate in PT exercises.</p> <p>Interview with the Qualified Intellectual Disabilities Professional, the Nursing Coordinator (NC) and administrative staff #1 on 4/9/14 at 1:30 PM indicated client #4's interdisciplinary team (IDT) discussed her knee surgery and the doctor had indicated client #4 was not a candidate for the surgery as the client refused to participate in her PT exercises. The QIDP, the NC and/or administrative staff #1 indicated client #4's IDT had not addressed the client's refusals to complete her PT exercises.</p>			

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W000240	<p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview, the facility failed to ensure the client's ISP (Individual Support Plan) included/indicated how facility staff were to provide additional monitoring for signs and symptoms of Dementia for 1 of 4 sampled clients (#3).</p> <p>Findings include:</p> <p>On 4/7/14 at 2:51 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/7/13 to 4/7/14 were reviewed. A BDDS report dated 3/3/14 indicated Client #3 "was eating some apple slices and began choking on a piece of apple. Staff began back blows and she was able to clear the apple. She did not lose consciousness at any time. She reported being fine after the incident but was taken to [Hospital] ER (emergency room) for eval (evaluation). Chest X-ray was negative. She was discharged back to</p>	W000240	<p>Client #3 had a swallow study completed on 4/4/2014. The order is for mechanical soft meat and fruit cut into 1/2" pieces. Staff have been trained on the diet, and with the review of the dietitian to fork smash soft fruits only. Staff has 1:1 supervision of client #3 at meals and she is prompted to take a drink between each bite. On 5/2/14 the nursing staff met with the agency consulting Nurse Practitioner to review new procedures for weight loss, psychotropic medications pain monitoring and dementia assessing. From this meeting, the following procedures are being implemented: Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will</p>	05/09/2014	

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	<p>SGL (supported group living) home with no new orders...". The BDDS report indicated Client #3 had a diet order for "regular/cut food into bite size pieces (size of a one inch cube) using example: size of a sugar cube." The BDDS report indicated Client #3 "has no history of swallowing/chewing difficulties but had a choking incident 1/17/2013 d/t (due to) putting too big of bite into her mouth at once, so staff will now monitor during meal times to ensure [Client #3]'s safety." The BDDS report indicated Client #3 "had oral surgery removing 8 teeth on 12/6/2013. New diet order after surgery was for liquid diet/soft foods for 10 days slowly increasing to solid foods and resuming to bit (sic) size pieces."</p> <p>On 4/8/14 at 3:09 PM, record review indicated Client #3 had a MRI (magnetic resonance imaging) on 9/24/12 due to "new onset of confusion and disorientation." The report indicated Client #3 had "no trauma" to explain the confusion and disorientation. Client #3's MRI report indicated "no acute pathology. No findings to explain provided symptoms." The report indicated Client #3 was "referred in evaluation of seizure disorder. There have been no witnessed convulsive seizures, just behavioral disturbance and anger outbursts."</p>		<p>be completed within seven days of the medication and will be compared to a baseline assessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications. QIDP's were trained on this practice on 5/2/14. Weight loss and nutrition tracking. The facility nurses met with the agency Nurse Practitioner and dietitian and devised the following nutrition tracking program: All individuals including client #3 will be weighed one to two times per month. If there is a weight gain or loss of 5 lbs a reweigh will be completed. The nurse will be notified of any person with a 5lb weight gain or loss. If there is a weight loss, a food consumption log will be put into place and the client will be seen by the dietitian on the next visit and monthly until their weight is stable. The clients physician will be notified about the weight loss and dietitian recommendations. If there is a 5 lb weight gain interventions will include portion monitoring, increased physical activity if applicable, monitoring possible</p>				

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	Record review indicated Client #3 had a "psychological evaluation" dated "June 3 through June 17, 2013." The evaluation indicated "apparently there has been a tremendous decline in her functioning in the last two years or so, and especially since about September of 2012. Staff have noticed that her body is very rigid, that she does a lot of lip puckering, and that she has lost at least 75 percent of her hand functioning. Additionally, her cognitive functioning seems to be deteriorating rapidly and no one seems to know why." The evaluation indicated "one suggestion that the neurologist made was that it might be somewhat due to her medication, and the neurologist suggested that the Lorazepam (generic for Ativan, anti-anxiety) be given as needed instead of on a regular basis." The evaluation indicated "staff members indicated that [Client #3]'s speech has declined. She used to talk in sentences but no longer does. She also has lost so much of hand functioning that she can no longer turn doorknobs. She gets very frustrated with things she cannot do. There are significant changes in coordination and she often bumps or walks into things." The report indicated Client #3's "medications have been decreased and discontinued because it has been thought that some of them may		effects of medications. Weekly weights until weight is stable. Physician and dietitian will be notified of continued weight increase. Dementia assessment and monitoring: If Dementia is suspected the following should be completed: · Ask physician for an evaluation order · Baseline exhibiting behaviors to show the day of the evaluation If a diagnosis of Dementia is confirmed, the following must be completed · The team will meet and complete the Dementia Comprehensive Risk/Benefit Assessment Tool to identify risk factors that need to be addressed. · The nurse will put "high risk" plans into place for anything that triggers a high or medium risk · The nurse will put "at risk" plans into place for anything that triggers a low risk · Symptoms such as aggression, BM tracking, Wandering, SIB, depression symptoms, labile mood, insomnia will be tracked on care tracker · Pain and nutritional intake will be monitored on separate flow sheets If there is a noted increase in symptoms or behaviors relating to the Dementia The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a				

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	<p>have been contributing to her problems. Abilify (anti-depressant) seemed to make her worse, chlorpromazine (Thorazine, antipsychotic) seems to have led to more symptoms of tardive dyskinesia, which she is displaying with the lip puckering and rigidity. She was on Seroquel about two years ago and has been lip puckering at least that long, which is probably a symptom of tardive dyskinesia." The report indicated Client #3 "was still fairly high functioning until about two years ago. Her records indicate that she has a history of Bipolar Disorder and Impulse Control Disorder. She has been on lithium (mood stabilizer) a lot in the past, also Zyprexa (antipsychotic) off and on over the years. The Exelon patch (Rivastigmine Transdermal System, used for the treatment of dementia) was started in 2012 and increased and then discontinued because it seemed to be making her worse. She was started on Abilify (anti-depressant) in January (2013) but made her worse. She has lost a lot of weight, but eats even more than before at the present time." The report indicated Client #3's "sleep patterns have improved, however. The September, 2012 neurologist reports mention that she was exhibiting hypersomnolence (excessive sleepiness), sleeping much of the time." The report indicated "during the winter months of 2012-2013, she was</p>		<p>quarterly basis the IDT will re-evaluate and ensure risks have not increased. A Dementia plan has been implemented and trained for client #3 A food consumption log has been put into place for client #3. If her weight remains stable for 30 days, the log will be discontinued and monitored per our procedure. On 5/2/14 the QIDP's were trained on the requirement to update the IPP when there is a significant change. Client #3's lpp was updated as needed. By 5/9/14 the staff will be trained on the addendum to the behavior plan for client #3 including specifics addressing dementia, sleeplessness and nightmares. The QIDP was trained on 5/2/14 on updating behavior plans and ISP's as an individuals changes or shows significant change in status. The QIDP was trained on the requirement of having a behavior plan change prior to medication implementation for a targeted behavior this is to include baseline data. A process has been implemented with the QIDP' s and nurses that no client will be seen by a psychiatrist for medications prior to a behavior plan change. the nurse will not add the person to the list of individuals to be seen by the psychiatrist until this is done. Failure to comply with any of the corrections listed above may result in disciplinary action. Person Responsible:</p>				

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	up screaming at night, according to staff reports." The report indicated "January and February of 2013 were the worst in terms of symptoms, staff reports, but December 2013 (sic, 2012) was also very bad. She has still not recovered her full functioning from that time." The evaluation indicated "[Client #3]'s Visual Working memory Index (VWMI) was predicted to be at a score of about 63 from her cognitive ability, and instead was at a standard score of 40. This 23 standard score difference is statistically significant, and indicated significant cognitive decline in this area. Her Immediate Memory (IM) score of 40 is significantly below the score of 64 which would be predicted from her cognitive level, and her Delayed Memory (DM) score of 40 is significantly below the score of 68 which would be predicted from her cognitive level." The report indicated "these results suggest that there has been significant cognitive decline in memory functioning even relative to her very low General Ability Index, or in other words IQ (intelligence quotient), which at this point is 45 according to this testing. This is consistent with some type of dementia process." In the "Summary & Recommendations" of the psychological evaluation, the report indicated "some of her difficulties may have been due to overmedication, and		QIDPADDENDUM: The following indicates the monitoring system for each targeted area:psychotropic meds:Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baselineassessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications.Weight gain/loss: The nurse will monitor monthly for the needed interventions as stated above. If an intervention is needed, a note will be completed on an IDT or the dietary form Dementia Screening:The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a				

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	<p>there seemed to be opinions to support this idea. However, there also appear to be unknown dementing factors at work, since she continues to decline even when many of her medications have been discontinued. She is showing signs of what appears to be tardive dyskinesia in the repetitive lip puckering and rigidity of muscle tone. She has seen two neurologists and apparently no one has been able to determine what is wrong. However, there clearly is a dementia process at work, and it will be necessary to pursue further neurological assessment to see what might be an effective level of treatment."</p> <p>Client #3's BSP (Behavior Support Plan) dated 12/6/13 indicated Client #3's psychiatrist sees her for "mood disorder, impulse control disorder and nightmares. Staff reported that she is stable. She has outbursts periodically but is able to regain control fairly quickly. Follow up in three months." Client #3's BSP indicated the following "TARGET BEHAVIORS";</p> <p><u>"Temper Tantrums:</u> [Client #3] expressing angry emotions by slamming doors, yelling, cussing, storming around, stomping, and/or refusing to talk calmly. Following a temper tantrum, [Client #3] will often sit and pout for a period of time.</p>		quarterly basis the IDT will re-evaluate and ensure risks have not increased. This will be completed by the QIDP or nurse.				

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	<p><u>Depression:</u> [Client #3] complaining of daily headaches or nightmares, or any time she exhibits a negative attitude, sadness, irritability, or tearfulness for no apparent reason.</p> <p><u>Aggression:</u> [Client #3] in anger striking, slapping, scratching, biting, or in any other way attempting to inflict pain/injury to another person.</p> <p><u>Self-injurious Behavior:</u> Any time [Client #3] picks at her skin with the intent of breaking the skin or any time she slaps, bites or inflicts any pain/injury to herself.</p> <p><u>Obsessive Statements:</u> repeating statements that represent compulsive, often anxious preoccupation with a fixed idea or unwanted emotion.</p> <p><u>Confusion:</u> unclear in mind or intent for example extremely forgetful and not able to follow instructions, and mistakes one thing for another. This also includes memory loss of recent events that affects her day to day schedule."</p> <p>Client #3's ISP (Individual Support Plan) dated 9/26/13 indicated "[Client #3] is doing well, both at the group home and at day program. [Client #3] had dementia testing done this year, and it was determined that she does have dementia. However, the dementia medications were not helping her so she is on no medications for this. [Client #3] has some chewing difficulties and is</p>			
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W000257	<p>reminded to take small bites and eat slow. Her food is cut into bite sized pieces to assist with swallowing." Client #3's ISP (Individual Support Plan) and/or BSP (Behavior Support Plan) did not indicate how facility staff were to provide additional monitoring for signs/symptoms of dementia. On 4/9/14 at 1:41 PM during interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #3 did not have a care plan for Dementia. The QIDP indicated no special IDT (Interdisciplinary team) meetings were held to discuss Client #3's signs and symptoms of Dementia to indicate how facility were to handle/monitor the client's Dementia. 9-3-4(a)</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be</p>				

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	<p>reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate a revision of a BSP (Behavior Support Plan) for non-pharmacological interventions when 1 of 4 sampled clients (Client #3) failed to demonstrate progress after reasonable efforts had been made.</p> <p>Findings include:</p> <p>On 4/8/14 at 3:09 PM, record review indicated Client #3 had a MRI (magnetic resonance imaging) on 9/24/12 due to "new onset of confusion and disorientation." The report indicated Client #3 had "no trauma" to explain the confusion and disorientation. Client #3's MRI report indicated "no acute pathology. No findings to explain provided symptoms." The report indicated Client #3 was "referred in evaluation of seizure disorder. There have been no witnessed convulsive seizures, just behavioral disturbance and anger outbursts."</p> <p>Record review indicated Client #3 had a</p>	W000257	<p>Client #3 had a swallow study completed on 4/4/2014. The order is for mechanical soft meat and fruit cut into 1/2" pieces. Staff have been trained on the diet, and with the review of the dietitian to fork smash soft fruits only. Staff has 1:1 supervision of client #3 at meals and she is prompted to take a drink between each bite. On 5/2/14 the nursing staff met with the agency consulting Nurse Practitioner to review new procedures for weight loss, psychotropic medications pain monitoring and dementia assessing. From this meeting, the following procedures are being implemented: Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baseline assessment. If the individual is on no psychoactive medications, a baseline assessment will be</p>	05/09/2014

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	her worse, chlorpromazine (Thorazine, antipsychotic) seems to have led to more symptoms of tardive dyskinesia, which she is displaying with the lip puckering and rigidity. She was on Seroquel about two years ago and has been lip puckering at least that long, which is probably a symptom of tardive dyskinesia." The report indicated Client #3 "was still fairly high functioning until about two years ago. Her records indicate that she has a history of Bipolar Disorder and Impulse Control Disorder. She has been on lithium (mood stabilizer) a lot in the past, also Zyprexa (antipsychotic) off and on over the years. The Exelon patch (Rivastigmine Transdermal System, used for the treatment of dementia) was started in 2012 and increased and then discontinued because it seemed to be making her worse. She was started on Abilify (anti-depressant) in January (2013) but made her worse. She has lost a lot of weight, but eats even more than before at the present time." The report indicated Client #3's "sleep patterns have improved, however. The September, 2012 neurologist reports mention that she was exhibiting hypersomnolence (excessive sleepiness), sleeping much of the time." The report indicated "during the winter months of 2012-2013, she was up screaming at night, according to staff reports." The report indicated "January		<p>suspected the following should be completed:</p> <ul style="list-style-type: none"> · Ask physician for an evaluation order · Baseline exhibiting behaviors to show the day of the evaluation <p>If a diagnosis of Dementia is confirmed, the following must be completed</p> <ul style="list-style-type: none"> · The team will meet and complete the Dementia Comprehensive Risk/Benefit Assessment Tool to identify risk factors that need to be addressed. · The nurse will put "high risk" plans into place for anything that triggers a high or medium risk · The nurse will put "at risk" plans into place for anything that triggers a low risk · Symptoms such as aggression, BM tracking, Wandering, SIB, depression symptoms, labile mood, insomnia will be tracked on care tracker · Pain and nutritional intake will be monitored on separate flow sheets <p>If there is a noted increase in symptoms or behaviors relating to the Dementia The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. A Dementia plan has been implemented and trained for client #3 A food consumption log has been put</p>		

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	<p>and February of 2013 were the worst in terms of symptoms, staff reports, but December 2013 (sic, 2012) was also very bad. She has still not recovered her full functioning from that time." The evaluation indicated "[Client #3]'s Visual Working memory Index (VWMI) was predicted to be at a score of about 63 from her cognitive ability, and instead was at a standard score of 40. This 23 standard score difference is statistically significant, and indicated significant cognitive decline in this area. Her Immediate Memory (IM) score of 40 is significantly below the score of 64 which would be predicted from her cognitive level, and her Delayed Memory (DM) score of 40 is significantly below the score of 68 which would be predicted from her cognitive level." The report indicated "these results suggest that there has been significant cognitive decline in memory functioning even relative to her very low General Ability Index, or in other words IQ (intelligence quotient), which at this point is 45 according to this testing. This is consistent with some type of dementia process."</p> <p>Progress notes from 1/1/2013 to 2/24/14 were reviewed. The progress notes indicated the following:</p> <p>1/01/13 - Client #3 "saw [psychiatrist].</p>		<p>into place for client #3. If her weight remains stable for 30 days, the log will be discontinued and monitored per our procedure. On 5/2/14 the QIDP's were trained on the requirement to update the IPP when there is a significant change. Client #3's lpp was updated as needed. By 5/9/14 the staff will be trained on the addendum to the behavior plan for client #3 including specifics addressing dementia, sleeplessness and nightmares. The QIDP was trained on 5/2/14 on updating behavior plans and ISP's as an individuals changes or shows significant change in status. The QIDP was trained on the requirement of having a behavior plan change prior to medication implementation for a targeted behavior this is to include baseline data. A process has been implemented with the QIDP' s and nurses that no client will be seen by a psychiatrist for medications prior to a behavior plan change. the nurse will not add the person to the list of individuals to be seen by the psychiatrist until this is done. Failure to comply with any of the corrections listed above may result in disciplinary action. Person Responsible: QIDP</p>		

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	<p>Med (medication) changes were made. Return in 1-2 months."</p> <p>2/7/13 - Client #3 "saw [psychiatrist]. Labs ordered. Med (medication) changes made."</p> <p>2/7/13 - "5:30pm accident illness filled out due to client digging into her behind, pulling out feces and dropping it into the tub. Staff then noticed that client had some blood on her fingers...."</p> <p>2/10/13 - Client #3 "is requiring an EXTREME amount of redirection/attention. She has spent this entire evening walking around the house, SCREAMING and being disruptive to everyone else in the home. Redirection has been unsuccessful by all staff. She is refusing to have pants on outside of her bedroom, excessive crying and screaming (no words, just screaming)."</p> <p>2/17/13 - "Client was being disruptive during lunch. Client was asked to leave the table, and then started punching staff in the back of the head. Client was redirected to another room."</p> <p>2/25/13 - Client #3 "laid in her bed from 11pm until 11:45pm screaming. Staff went into her room several times she did not answer any questions, nor did she</p>						

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	<p>open her eyes."</p> <p>3/01/13 - Client #3 "has been constantly walking around in circles today repeating each request in (sic) with one word, over and over without stopping even after staff assists her with what she is wanting."</p> <p>3/17/13 - Client #3 "was screaming at another housemate "GOOOOO (sic) TO BED!!!!!" several times, redirection successful for a short period of time in each situation."</p> <p>4/18/13 - Client #3 "saw [psychiatrist]. D/C (discontinue) all psych (psychiatric) meds for two weeks. Return in two weeks."</p> <p>5/17/13 - "Went into [Client #3]'s room, she had a small BM (bowel movement) in her toilet along with blood, blood/bm smeared all over her toilet, sink, floor, and walls, all over [Client #3] and her hands...."</p> <p>12/5/13 - Client #3 "saw [psychiatrist] for her psychotropic medication review. She will be getting Zyprexa (antipsychotic) 5mg (milligrams) at am and at HS (evening)."</p> <p>12/6/13 - "Due to the family not wanting [Client #3] to be on the Zyprexa,</p>						

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	<p>[psychiatrist] discontinued it."</p> <p>1/9/14 - Client #3 "saw [psychiatrist] today for a Psyche (sic) (psychotropic) med review. Her temper tantrums have increased, so she will start taking Saphris 5mg. Trazodone 200mg and she will get an extra 150mg of Lithium in the evening."</p> <p>2/6/14 - Client #3 "saw [psychiatrist] today for a psych med review. She is going to start taking Trilafon (antipsychotic) and increase her Trazodone due to not sleeping and an increase in bowel and bladder control."</p> <p>Client #3's BSP (Behavior Support Plan) dated 12/6/13 indicated Client #3's psychiatrist sees her for "mood disorder, impulse control disorder and nightmares. Staff reported that she is stable. She has outburst periodically but is able to regain control fairly quickly. Follow up in three months." Client #3's BSP indicated the following "TARGET BEHAVIORS"; <u>"Temper Tantrums:</u> [Client #3] expressing angry emotions by slamming doors, yelling, cussing, storming around, stomping, and/or refusing to talk calmly. Following a temper tantrum, [Client #3] will often sit and pout for a period of time. <u>Depression:</u> [Client #3] complaining of</p>						

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	<p>daily headaches or nightmares, or any time she exhibits a negative attitude, sadness, irritability, or tearfulness for no apparent reason.</p> <p><u>Aggression:</u> [Client #3] in anger striking, slapping, scratching, biting, or in any other way attempting to inflict pain/injury to another person.</p> <p><u>Self-injurious Behavior:</u> Any time [Client #3] picks at her skin with the intent of breaking the skin or any time she slaps, bites or inflicts any pain/injury to herself.</p> <p><u>Obsessive Statements:</u> repeating statements that represent compulsive, often anxious preoccupation with a fixed idea or unwanted emotion.</p> <p><u>Confusion:</u> unclear in mind or intent for example extremely forgetful and not able to follow instructions, and mistakes one thing for another. This also includes memory loss of recent events that affects her day to day schedule.</p> <p>An "ADDENDUM TO BEHAVIOR PROGRAM" dated 7/3/13 indicated "[Client #3] was seen by [psychiatrist] for her psychotropic medication review. Due to clients increase in confusion, SIB (self-injurious behavior), depression with associated mania, and temper tantrums [psychiatrist] decided to prescribe [Client #3] Lithium 450mg (milligrams) BID (twice daily).</p> <p>An "ADDENDUM TO BEHAVIOR</p>			

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	<p>PROGRAM" dated 1/09/14 indicated "On 1/09/2014 [Client #3] was seen by [psychiatrist] for her psychotropic medication review. Due to clients increase in depression with associated mania, increase in manic behaviors, not sleeping at night and temper tantrums [psychiatrist] decided to increase [Client #3]'s Lithium (mood stabilizer) by adding 150mg (milligrams) with supper (total of Lithium at supper = 600mg). A new order for Saphris (atypical antipsychotic used in the treatment of schizophrenia and/or bipolar disorder) 5mg SL (sublingual, dissolves under the tongue) BID (twice daily) was received as well as Trazodone (antidepressant) 200mg q HS (evening)."</p> <p>Client #3's ISP (Individual Support Plan) and/or (Behavior Support Plan) did not indicate the QIDP revised Client #3's BSP since 12/6/13 to include/address the client's behavioral changes, sleeplessness, nightmares and/or dementia prior to pharmacological interventions.</p> <p>On 4/9/14 at 1:41 PM during interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #3 did not have a care plan for Dementia. The QIDP indicated no special IDT (Interdisciplinary team) meetings were held to discuss Client #3's weight loss, increase in behavior, increase in sleep disturbances, or her signs and symptoms</p>			

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	of Dementia. The QIDP indicated Client #3's physical aggression and confusion are addressed in her BSP (Behavior Support Plan). The QIDP indicated Client #3's BSP's behavioral interventions/strategies had not been revised. 9-3-4(a)				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 3 sampled clients (#3, #4). The facility's Health Care Services failed to ensure its nursing services met the nursing needs of the clients in regards to their health, health status changes, to obtain clarification in regards to physician orders, and to follow up on recommendations of medical specialist and/or doctors recommendations. The facility's Health Care Services failed to ensure nursing services developed risk plans for clients' health needs, failed to accurately assess side effects of behavioral medications, to monitor Medication Administration Records in regards to PRN (given as needed) usage, to ensure physician orders</p>	W000318	<p>Client #3 had a swallow study completed on 4/4/2014. The order is for mechanical soft meat and fruit cut into 1/2" pieces. Staff have been trained on the diet, and with the review of the dietitian to fork smash soft fruits only. Staff has 1:1 supervision of client #3 at meals and she is prompted to take a drink between each bite. On 5/2/14 the nursing staff met with the agency consulting Nurse Practitioner to review new procedures for weight loss, psychotropic medications pain monitoring and dementia assessing. From this meeting, the following procedures are being implemented: Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their</p>	05/09/2014

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	<p>were implemented as written, and to ensure a client was assessed for needed adaptive equipment.</p> <p>Findings include:</p> <p>Please refer to W331. The facility nursing services failed to monitor and address a client's significant weight loss (Client #3). The facility nursing services failed to monitor and assess for signs and symptoms of Dementia (Client #3). The facility nursing services failed to assess a client for side effects of psychotropic medication (Client #3). The facility's nursing services failed to meet the nursing needs of client #4 in regard to assessing/monitoring the client's pain/level due to the client's Osteoarthritis. The facility's nursing services failed to ensure facility staff followed/offered physician ordered treatments for the client's pain. The facility's nursing services failed to develop a specific risk plan for the client's pain, to obtain orders for the use of adaptive equipment and/or failed to clarify orders in regard to the client's PRN medication and/or use of Hoyer Lift. The facility's nursing services failed to follow up recommendations with the client's doctor in regard to possible surgery and to ensure a pharmacist recommendation was addressed. The</p>		<p>psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baseline assessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications. QIDP's were trained on this practice on 5/2/14. Weight loss and nutrition tracking. The facility nurses met with the agency Nurse Practitioner and dietitian and devised the following nutrition tracking program: All individuals including client #3 will be weighed one to two times per month. If there is a weight gain or loss of 5 lbs a reweigh will be completed. The nurse will be notified of any person with a 5lb weight gain or loss. If there is a weight loss, a food consumption log will be put into place and the client will be seen by the dietitian on the next visit and monthly until their weight is stable. The clients physician will be notified about the weight loss and dietitian recommendations. If there is a 5 lb weight gain interventions will</p>				

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	<p>facility's nursing services failed to ensure a program was developed to assist the client to complete physical therapy exercises to reduce the client's pain/increase her strength.</p> <p>9-3-6(a)</p>		<p>include portion monitoring, increased physical activity if applicable, monitoring possible effects of medications. Weekly weights until weight is stable. Physician and dietitian will be notified of continued weight increase. Dementia assessment and monitoring: If Dementia is suspected the following should be completed:</p> <ul style="list-style-type: none"> · Ask physician for an evaluation order · Baseline exhibiting behaviors to show the day of the evaluation <p>If a diagnosis of Dementia is confirmed, the following must be completed</p> <ul style="list-style-type: none"> · The team will meet and complete the Dementia Comprehensive Risk/Benefit Assessment Tool to identify risk factors that need to be addressed. · The nurse will put "high risk" plans into place for anything that triggers a high or medium risk · The nurse will put "at risk" plans into place for anything that triggers a low risk · Symptoms such as aggression, BM tracking, Wandering, SIB, depression symptoms, labile mood, insomnia will be tracked on care tracker · Pain and nutritional intake will be monitored on separate flow sheets <p>If there is a noted increase in symptoms or behaviors relating to the Dementia The Dementia</p>	

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			<p>Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. A Dementia plan has been implemented and trained for client #3 A food consumption log has been put into place for client #3. If her weight remains stable for 30 days, the log will be discontinued and monitored per our procedure. On 5/2/14 the QIDP's were trained on the requirement to update the IPP when there is a significant change. Client #3's lpp was updated as needed. Client #4 has a pain plan in place that has been trained with staff. A new procedure has been developed and the nurse will monitor the frequency of PRN meds used with prescribed routine pain meds. Client #4's pain management physician reviewed her current regimen on 4/28/14 and does not feel he ought to change the meds. He is concerned that if he increases her medication she will be at high risk for fall. She is scheduled to see him on 5/9/14. The team agreed to have client #4 be seen by her PCP in order to determine the course of action to take with her knee. The team will recommend a second opinion for knee replacement. A d/c order was given for ice and heat. The pain doctor prescribed aspercreme in its place. Client #4</p>		

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			<p>has a wheelchair at her disposal at all times for use as she chooses. The hoyer for client #4 has been D/C for nonuse. Client #4 does not want to use it. Client #4 continues with her PT exercises. See correction at W153 See correction at W154 The facility nurses will meet with the nurse practitioner monthly or more to discuss specific client needs or concerns. The physician for client #4 did not agree with the pharmacy recommendation and no changes have been made. Failure to complete and comply with any of these corrections will result in disciplinary action. Person Responsible: QIDP, NurseADDENDUM: The following indicates the monitoring system for each targeted area:psychotropic meds:Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baselineassessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given</p>	

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility nursing services failed to monitor and address a client's significant weight loss for 1 of 4 sampled clients (#3). Based on record review and interview, the facility nursing services failed to monitor and assess for signs and symptoms of Dementia for 1 of 4 sampled clients (#3). Based on record review and interview, the facility nursing services failed to assess a client for side</p>	W000331	<p>the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications. Weight gain/loss: The nurse will monitor monthly for the needed interventions as stated above. If an intervention is needed, a note will be completed on an IDT or the dietary form Dementia Screening: The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. This will be completed by the QIDP or nurse.</p> <p>Client #3 had a swallow study completed on 4/4/2014. The order is for mechanical soft meat and fruit cut into 1/2" pieces. Staff have been trained on the diet, and with the review of the dietitian to fork smash soft fruits only. Staff has 1:1 supervision of client #3 at meals and she is prompted to take a drink between each bite. On 5/2/14 the nursing staff met with the agency consulting Nurse Practitioner to review new procedures for weight loss, psychotropic medications pain</p>	05/09/2014

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	<p>effects of psychotropic medication for 1 of 4 sampled clients (#3).</p> <p>The facility's nursing services failed to meet the nursing needs of client #4 in regard to assessing/monitoring the client's pain/level due to the client's Osteoarthritis. The facility's nursing services failed to ensure facility staff followed/offered physician ordered treatments for the client's pain. The facility's nursing services failed to develop a specific risk plan for the client's pain, to obtain orders for the use of adaptive equipment and/or failed to clarify orders in regard to the client's PRN medication and/or use of Hoyer Lift. The facility's nursing services failed to follow up recommendations with the client's doctor in regard to possible surgery and to ensure a pharmacist recommendation was addressed. The facility's nursing services failed to ensure a program was developed to assist the client to complete physical therapy exercises to reduce the client's pain/increase her strength.</p> <p>Findings include:</p> <p>On 4/7/14 at 2:51 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/7/13 to 4/7/14 were reviewed. A</p>		<p>monitoring and dementia assessing. From this meeting, the following procedures are being implemented: Prior to any new psychotropic medication being added to an individuals drug regimen, method changes will be made to the individuals BSP methodology for the targeted behavior. If no success with programmatic changes the individual will be seen by their psychiatrist for a medication review. If a new medication is added, a MOSES assessment will be completed within seven days of the medication and will be compared to a baseline assessment. If the individual is on no psychoactive medications, a baseline assessment will be completed prior to the individual being given the medication and then within seven days thereafter. This will be done so that nursing staff can evaluate the negative side-effects of the medication and notify the physician promptly. Facility staff will continue to monitor all individuals for adverse side effects of medications. QIDP's were trained on this practice on 5/2/14. Weight loss and nutrition tracking. The facility nurses met with the agency Nurse Practitioner and dietitian and devised the following nutrition tracking program: All individuals including client #3 will be weighed one to two times per month. If there is a weight gain or loss of 5 lbs a reweigh will be completed.</p>		

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	<p>BDDS report dated 3/3/14 indicated Client #3 "was eating some apple slices and began choking on a piece of apple. Staff began back blows and she was able to clear the apple. She did not lose consciousness at any time. She reported being fine after the incident but was taken to [Hospital] ER (emergency room) for eval (evaluation). Chest X-ray was negative. She was discharged back to SGL (supported group living) home with no new orders...". The BDDS report indicated Client #3 had a diet order for "regular/cut food into bite size pieces (size of a one inch cube) using example: size of a sugar cube." The BDDS report indicated Client #3 "has no history of swallowing/chewing difficulties but had a choking incident 1/17/2013 d/t (due to) putting too big of bite into her mouth at once, so staff will now monitor during meal times to ensure [Client #3]'s safety." The BDDS report indicated Client #3 "had oral surgery removing 8 teeth on 12/6/2013. New diet order after surgery was for liquid diet/soft foods for 10 days slowly increasing to solid foods and resuming to bit (sic) size pieces."</p> <p>-The follow up BDDS (Bureau of Developmental Disabilities Services) report dated 3/5/14 indicated Client #3's "choking/swallowing plan has been updated stating: Staff are to ensure that</p>		<p>The nurse will be notified of any person with a 5lb weight gain or loss. If there is a weight loss, a food consumption log will be put into place and the client will be seen by the dietitian on the next visit and monthly until their weight is stable. The clients physician will be notified about the weight loss and dietitian recommendations. If there is a 5 lb weight gain interventions will include portion monitoring, increased physical activity if applicable, monitoring possible effects of medications. Weekly weights until weight is stable. Physician and dietitian will be notified of continued weight increase. Dementia assessment and monitoring:If Dementia is suspected the following should be completed:</p> <ul style="list-style-type: none"> ·Ask physician for an evaluation order ·Baseline exhibiting behaviors to show the day of the evaluation <p>If a diagnosis of Dementia is confirmed, the following must be completed</p> <ul style="list-style-type: none"> ·The team will meet and complete the Dementia Comprehensive Risk/Benefit Assessment Tool to identify risk factors that need to be addressed. · The nurse will put "high risk" plans into place for anything that triggers a high or medium risk ·The nurse will put "at risk" plans into place for anything that 		

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	<p>[Client #3] has soft fruit only for meals and snacks until further notice...". The report indicated Client #3 "eats too fast, pockets food and often talks or screams while eating." The report indicated "a swallow study was not recommended. We are contacting her PCP (primary care physician) asking for a new referral for a swallow study."</p> <p>During the 4/7/14 observation period between 4:55 PM and 5:20 PM (group home went on an outing) and on 4/8/14 between 6:30 AM and 7:30 AM, at the group home, Client #3 walked with a shuffle. Client #3 dragged her feet as she walked. Client #3 had a flat affect. Specifically, during the 4/8/14 observation period, Client #3 demonstrated slowed/delayed movement when reaching to get a hair brush from staff.</p> <p>Record review indicated a nurse quarterly assessment dated 3/2014 which indicated Client #3 had a "Choking/Swallowing Management Plan" dated 9/17/2013. Client #3's choking plan indicated Client #3's diet order "Regular/Cut food into bite size pieces (size of a one inch cube) using example: size of sugar cube. Soft fruit only until further notice - Updated 3/04/2014." Client #3's choking plan indicated "[Client #3] has no history of</p>		<p>triggers a low risk</p> <ul style="list-style-type: none"> ·Symptoms such as aggression, BM tracking, Wandering, SIB, depression symptoms, labile mood, insomnia will be tracked on care tracker ·Pain and nutritional intake will be monitored on separate flow sheets <p>If there is a noted increase in symptoms or behaviors relating to the Dementia The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. A Dementia plan has been implemented and trained for client #3 A food consumption log has been put into place for client #3. If her weight remains stable for 30 days, the log will be discontinued and monitored per our procedure. On 5/2/14 the QIDP's were trained on the requirement to update the IPP when there is a significant change. Client #3's lpp was updated as needed. Client #4 has a pain plan in place that has been trained with staff. A new procedure has been developed and the nurse will monitor the frequency of PRN meds used with prescribed routine pain meds. Client #4's pain management physician reviewed her current regimen on 4/28/14 and does not feel he ought to change the meds. He is concerned that if he increases</p>		

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	<p>swallowing/chewing difficulties but had a choking incident on 1/17/13 d/t (due to) putting too big of bite into her mouth at once, so staff will now monitor during meal times to ensure [Client #3]'s safety." Review of Client #3's nurses quarterly dated 3/2014 indicated Client #3 had careplans and/or monitoring of the following: choking/swallowing, allergies, "eyes, ears, nose, throat and upper respiratory", TMJ (Temporomandibular joint disorder)/jaw pain, nutritional/diet, history of falls, and bowel movements. Client #3's "Nutritional/Diet" plan indicated the following interventions:</p> <p>"a. Regular/Cut food into bite size pieces (1/4 to 1 inch cube size) Updated 6/2013.</p> <p>b. Monitor and record weight monthly (frequency).</p> <p>c. At risk for obesity/labs done and monitored as ordered by PCP (primary care physician).</p> <p>d. Monitor amount of fluid intake.</p> <p>e. Staff to monitor at all meal times. Updated 1/17/2013.</p> <p>f. Staff to ensure that [Client #3] eats slowly and take (sic) smalls bites. Updated 1/17/2013."</p> <p>Review of Client #3's monthly weights from December 2012 to April 2014 indicated the following weights: December 2012 - 183 lbs. (pounds) January 2013 - 179 lbs.</p>		<p>her medication she will be at high risk for fall. She is scheduled to see him on 5/9/14. The team agreed to have client #4 be seen by her PCP in order to determine the course of action to take with her knee. The team will recommend a second opinion for knee replacement. A d/c order was given for ice and heat. The pain doctor prescribed aspercreme in its place. Client #4 has a wheelchair at her disposal at all times for use as she chooses. The hoyer for client #4 has been D/C for nonuse. Client #4 does not want to use it. Client #4 continues with her PT exercises. See correction at W153 See correction at W154 The facility nurses will meet with the nurse practitioner monthly or more to discuss specific client needs or concerns. Failure to complete and comply with any of these corrections will result in disciplinary action. Person Responsible: QIDP, Nurse ADDENDUM: The agency nurse will monitor each individual on psychotropic medications to be sure that there are no adverse side effects using the MOSES once as a baseline, after one week on the medicaton and then quarterly thereafter.Weight gain/loss: The nurse will monitor monthly for the needed interventions as stated above. If an intervention is needed, a note will be completed on an IDT or the dietary form Dementia</p>				

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	<p>February 2013 - 170 lbs. March 2013 - 166 lbs. April 2013 - 164 lbs. May 2013 - 162 lbs. June 2013 - 159 lbs. July 2013 - 154 lbs. August 2013 - 151 lbs. September 2013 - 147 lbs. October 2013 - 144.2 lbs. November 2013 - 143 lbs. December 2013 - 136 lbs. January 2014 - 134 lbs. February 2014 - 136 lbs. March 2014 - 141 lbs. April 2014 - 141 lbs.</p> <p>Client #3's "Nutritional Assessments" were reviewed from 3/2/13 to 3/18/14. On Client #3's 3/20/13 nutritional assessment, the dietician noted Client #3 weighed "200.8# (pounds)", she was on a "Regular/regular diet", and was able to feed "self". The assessment indicated Client #3's BMI (body mass index, measure of body fat based on height and weight) was 34.4 (less than 18.5 BMI is considered underweight, between 18.5 to 24.9 BMI is average, between 25 and 29.9 BMI is overweight, and over 30 BMI is obese, source National Heart, Lung, and Blood Institute).</p> <p>-Client #3's nutritional assessment on 2/19/13 indicated she weighed "170#"</p>		<p>Screening: The Dementia Comprehensive Risk/Benefit Assessment Tool will be re-evaluated as well as on a quarterly basis the IDT will re-evaluate and ensure risks have not increased. This will be completed by the QIDP or nurse.</p>				

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	<p>which was down "30# p (past) year". The assessment indicated Client #3's BMI was 29.1. The assessment indicated Client #3 required "one on one @ (at) meals" and ate a "reg. (regular) cut food into bite sized pieces" diet. The dietician noted "Res (resident) had wt (weight) decline over p (past) year r/t (related to) change in condition; possible dementia."</p> <p>-Client #3's nutritional assessment dated 3/19/13 indicated Client #3 weighed 168.4 lbs., BMI 28.9, ate a regular diet with bite size pieces and required one on one at meals for "pockets food (holds in mouth without swallowing)." The dietician noted Client #3 had a swallow study which resulted in "0 (no) prob. (problem) w/ (with) swallow." The dietician noted "staff cont (continue) to provide hand over hand assistance - depends on res (resident) level of alertness."</p> <p>-Client #3's nutritional assessment dated 9/7/13 indicated Client #3 weighed 147 lbs. (pounds) which was down "20# (pounds) from last review." The assessment indicated Client #3 was prescribed "Reg (regular) cut food into bite size pieces." The assessment indicated Client #3's "feeding ability" was staff was to "cue to slow pace, take small bites." The dietician indicated "Hx</p>			

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	<p>(history) wt (weight) loss assoc (associated) w/ (with) med (medication) changes, decline in condition. Wt (weight) has stabilized, current BMI 25.6 - slightly above normal range."</p> <p>-Client #3's nutritional assessment dated 3/18/14 indicated Client #3 weighed 142 lbs. (pounds) which was down "5# (pounds) x (for) 6 months (months). The dietician indicated Client #3's BMI was "24.7 - WNR (within normal range)." The assessment indicated "Res (resident) has Hx (history) wt (weight) loss assoc (associated) w/ (with) multiple med changes, change in condition. Review x (in) 6 mths (months)." The dietician noted "swallow study scheduled - res (resident) will eat fast - take large bites of food + (and) swallow w/o (without) chewing."</p> <p>Record review indicated Client #3 had a swallow study report dated 4/3/2014. The swallow study report indicated results were "compared to last Swallow Function Study on 2/19/13 in which pt (patient) demonstrated decreased rotary chew, piecemeal deglutition (physiological phenomenon occurring when a bolus (chewed food) of a large volume is divided into two or three parts and swallowed separately) and oral residue." The report indicated Client #3's</p>			

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	<p>swallow study indicated Client #3 required "extra time per bolus due to piecemeal deglutition and oral residue." The report indicated Client #3 has "Dysphagia (symptom of difficulty in swallowing) characteristic as possibly related to cognitive impairment." The report recommended "Pt (patient) to continue chopped diet with focus on soft items... ." The report recommended "consider chapped pieces to 1/2 (half) " (inch) size, tender meats, avoid nuts/seeds/skins, etc. Continue 1:1 (direct supervision of client) supervision for mealtimes for cueing pt (patient) to take small bites, single sips, alternate liquid-solids, slow rate of intake, decrease talking during meals." The report recommended a "consideration of controlled flow cup or spout cup to reduce liquid bolus size. Consider placing 1 item of food in front of pt (patient) at a time to reduce impulsivity." No further documentation was available for review to indicate Client #3's IDT (interdisciplinary team) met in regards to Client #3's decline in chewing/swallowing abilities. The facility failed to coordinate an IDT meeting in regards to Client #3's chewing/swallowing decline and/or to monitor and track food intake as related to significant unintended weight loss.</p>			

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	<p>On 4/8/14 at 3:09 PM, record review indicated Client #3 had a MRI (magnetic resonance imaging) on 9/24/12 due to "new onset of confusion and disorientation." The report indicated Client #3 had "no trauma" to explain the confusion and disorientation. Client #3's MRI report indicated "no acute pathology. No findings to explain provided symptoms." The report indicated Client #3 was "referred in evaluation of seizure disorder. There have been no witnessed convulsive seizures, just behavioral disturbance and anger outbursts."</p> <p>Record review indicated Client #3 had a "psychological evaluation" dated "June 3 through June 17, 2013." The evaluation indicated "apparently there has been a tremendous decline in her functioning in the last two years or so, and especially since about September of 2012. Staff have noticed that her body is very rigid, that she does a lot of lip puckering, and that she has lost at least 75 percent of her hand functioning. Additionally, her cognitive functioning seems to be deteriorating rapidly and no one seems to know why." The evaluation indicated "one suggestion that the neurologist made was that it might be somewhat due to her medication, and the neurologist suggested that the Lorazepam (generic</p>			

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	<p>for Ativan, anti-anxiety) be given as needed instead of on a regular basis." The evaluation indicated "staff members indicated that [Client #3]'s speech has declined. She used to talk in sentences but no longer does. She also has lost so much of hand functioning that she can no longer turn doorknobs. She gets very frustrated with things she cannot do. There are significant changes in coordination and she often bumps or walks into things." The report indicated Client #3's "medications have been decreased and discontinued because it has been thought that some of them may have been contributing to her problems. Abilify (anti-depressant) seemed to make her worse, chlorpromazine (Thorazine, antipsychotic) seems to have led to more symptoms of tardive dyskinesia, which she is displaying with the lip puckering and rigidity. She was on Seroquel about two years ago and has been lip puckering at least that long, which is probably a symptom of tardive dyskinesia." The report indicated Client #3 "was still fairly high functioning until about two years ago. Her records indicate that she has a history of Bipolar Disorder and Impulse Control Disorder. She has been on lithium (mood stabilizer) a lot in the past, also Zyprexa (antipsychotic) off and on over the years. The Exelon patch (Rivastigmine Transdermal System, used</p>			

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	for the treatment of dementia) was started in 2012 and increased and then discontinued because it seemed to be making her worse. She was started on Abilify (anti-depressant) in January (2013) but made her worse. She has lost a lot of weight, but eats even more than before at the present time." The report indicated Client #3's "sleep patterns have improved, however. The September, 2012 neurologist reports mention that she was exhibiting hypersomnolence (excessive sleepiness), sleeping much of the time." The report indicated "during the winter months of 2012-2013, she was up screaming at night, according to staff reports." The report indicated "January and February of 2013 were the worst in terms of symptoms, staff reports, but December 2013 (sic, 2012) was also very bad. She has still not recovered her full functioning from that time." The evaluation indicated "[Client #3]'s Visual Working memory Index (VWMI) was predicted to be at a score of about 63 from her cognitive ability, and instead was at a standard score of 40. This 23 standard score difference is statistically significant, and indicated significant cognitive decline in this area. Her Immediate Memory (IM) score of 40 is significantly below the score of 64 which would be predicted from her cognitive level, and her Delayed Memory (DM)			

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	<p>score of 40 is significantly below the score of 68 which would be predicted from her cognitive level." The report indicated "these results suggest that there has been significant cognitive decline in memory functioning even relative to her very low General Ability Index, or in other words IQ (intelligence quotient), which at this point is 45 according to this testing. This is consistent with some type of dementia process." In the "Summary & Recommendations" of the psychological evaluation, the report indicated "some of her difficulties may have been due to overmedication, and there seemed to be opinions to support this idea. However, there also appear to be unknown dementing factors at work, since she continues to decline even when many of her medications have been discontinued. She is showing signs of what appears to be tardive dyskinesia in the repetitive lip puckering and rigidity of muscle tone. She has seen two neurologists and apparently no one has been able to determine what is wrong. However, there clearly is a dementia process at work, and it will be necessary to pursue further neurological assessment to see what might be an effective level of treatment."</p> <p>Record review indicated the facility neglected to document Client #3 had further neurological assessment</p>			

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	<p>following the recommendations of the psychological evaluation.</p> <p>Progress notes from 1/1/2013 to 2/24/14 were reviewed. The progress notes indicated the following:</p> <p>1/01/13 - Client #3 "saw [psychiatrist]. Med (medication) changes were made. Return in 1-2 months."</p> <p>1/17/13 - Client #3 "went to [hospital] ER (emergency room) after a choking incident at day program to make sure no aspiration had occurred."</p> <p>1/24/13 - Client #3 "put her pm (evening) pills in her mouth, and refused to drink water to swallow them with. Instead, she held them in her mouth for @ (sic) a few seconds, then spit them on the floor. Staff punched new pills/flushed the ones that were on the floor, and she took the new pills in a spoonful of pudding."</p> <p>2/7/13 - Client #3 "saw [psychiatrist]. Labs ordered. Med (medication) changes made."</p> <p>2/7/13 - "5:30pm accident illness filled out due to client digging into her behind, pulling out feces and dropping it into the tub. Staff then noticed that client had</p>						

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	<p>some blood on her fingers...."</p> <p>2/10/13 - Client #3 "is requiring an EXTREME amount of redirection/attention. She has spent this entire evening walking around the house, SCREAMING and being disruptive to everyone else in the home. Redirection has been unsuccessful by all staff. She is refusing to have pants on outside of her bedroom, excessive crying and screaming (no words, just screaming)."</p> <p>2/17/13 - "Client was being disruptive during lunch. Client was asked to leave the table, and then started punching staff in the back of the head. Client was redirected to another room."</p> <p>2/19/13 - Client #3 "saw the dietician. No changes to current plan."</p> <p>2/19/13 - "Client slipped in the shower. She fell and hit her lower back on the back on the tub and then slid down onto her bottom...."</p> <p>2/25/13 - Client #3 "laid in her bed from 11pm until 11:45pm screaming. Staff went into her room several times she did not answer any questions, nor did she open her eyes."</p> <p>2/26/13 - "3:45 am - [Client #3] was</p>			

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	<p>walking on the living room floor back to her bedroom. The floor had just been mopped and was wet. [Direct Support Professional] helped her back to her room but she slipped and fell onto her bottom."</p> <p>2/26/13 - Client #3 "had a Doctors appointment today with [primary care physician]. She went in to get checked for hemorrhoids. [Primary care physician] and her nurse noticed that [Client #3] was very unstable and confused, more than she's ever seen her. [Primary care physician] sent orders for a CT (x-ray computed tomography) to be done STAT (immediately) and labs to be done before the scan."</p> <p>2/26/13 - Client #3 "saw [neurologist] to go over her CT scan results. The CT Scan came back normal. Labs were ordered and completed today. A lumbar puncture with sedation was scheduled for 3/7/13 at noon. [Neurologist] thinks that [Client #3]'s stiffness is due to psych (psychiatric) medication side effects."</p> <p>3/01/13 - Client #3 "has been constantly walking around in circles today repeating each request in (sic) with one word, over and over without stopping even after staff assists her with what she is wanting."</p> <p>3/7/13 - Client #3 "went to [psychiatrist].</p>						

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	<p>No changes were made at this time. Return in 2-3 months."</p> <p>3/13/13 - Client #3 "went to the ER (emergency room) to see about her left arm and why she was not using it. ER doctor took and (sic) x-ray of her wrist and hand which came back as normal. Doctor found some swelling around her wrist due to her past physical aggression. [Client #3's] wrist is wrapped in an ace bandage and is to be worn day and night."</p> <p>3/17/13 - Client #3 "was screaming at another housemate "GOOOOO (sic) TO BED!!!!!" several times, redirection successful for a short period of time in each situation."</p> <p>4/18/13 - Client #3 "saw [psychiatrist]. D/C (discontinue) all psych (psychiatric) meds for two weeks. Return in two weeks."</p> <p>5/2/14 - "Saw [psychiatrist], no changes at this time."</p> <p>5/17/13 - "Went into [Client #3]'s room, she had a small BM (bowel movement) in her toilet along with blood, blood/bm smeared all over her toilet, sink, floor, and walls, all over [Client #3] and her hands...."</p>						

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	<p>6/03/13 - Client #3 "started her dementia testing with [psychologist]...."</p> <p>6/5/13 - Client #3 "was seen by [psychiatrist] for a psych (psychiatric) med review. Staff state that [Client #3] is very stiff in her arms and staff still have to help feed her. No changes were made."</p> <p>9/4/13 - Client #3 "saw [psychiatrist] today. She said that she seems to be doing well. She would like her Luthium (sic) levels checked and is going to start her on Aricept (used in treatment of dementia) 5 mg (milligrams) for 1 month then increase to 10mg. Will see her back in 3 months."</p> <p>12/5/13 - Client #3 "saw [psychiatrist] for her psychotropic medication review. She will be getting Zyprexa (antipsychotic) 5mg (milligrams) at am and at HS (evening)."</p> <p>12/6/13 - "Notified [psychiatrist] of [Client #3]'s family concerned with new order for Zyprexa and that she does not want [Client #3] taking that medication."</p> <p>12/6/13 - "Due to the family not wanting [Client #3] to be on the Zyprexa, [psychiatrist] discontinued it."</p>						

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	<p>1/9/14 - Client #3 "saw [psychiatrist] today for a Psyche (sic) (psychotropic) med review. Her temper tantrums have increased, so she will start taking Saphris 5mg. Trazodone 200mg and she will get an extra 150mg of Lithium in the evening."</p> <p>2/6/14 - Client #3 "saw [psychiatrist] today for a psych med review. She is going to start taking Trilafon (antipsychotic) and increase her Trazodone due to not sleeping and an increase in bowel and bladder control."</p> <p>The "Psychiatric Progress Notes" from 3/6/13 to 4/2/14 were reviewed. A psychiatric progress note dated 3/6/13 indicated "Lately, I am having a difficult time with this patient. She had regressed significantly and was a puzzle to me, so a lot of things were done. I had ordered lab work, including CMP (comprehensive metabolic profile), CBC (complete blood count) with differential (white blood cell differential which counts the number of each type of white blood cell) and TSH (thyroid stimulating hormone). I had also, out of desperation, started her on chlorpromazine (antipsychotic). She was also started on Exelon (used in the treatment of Dementia) patch because she was so confused and forgetful. She used</p>			

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	to be on Zyprexa and lithium for a long time and was fairly stable." The note indicated Client #3 had seen a neurologist and the neurologist sent a report to the psychiatrist which indicated "the patient had tardive dyskinesia (a movement disorder caused by long term use of antipsychotics), which is totally wrong." The note indicated "the family is saying to see if I can decrease and discontinue her Exelon patch, which I did, and she had done well. Apparently her confusion at that time was maybe with the increase in Exelon patch, which is very surprising. The patient is scheduled to have lumbar puncture (collection of cerebrospinal fluid for diagnostic testing and/or to treat elevated intracranial pressure) as suggested by her neurologist, and we do not see that there is a need for that." The note indicated the psychiatrist "suggested the staff to call [neurologist]'s office to tell that the patient had already improved and, in my opinion and staff's opinion, she does not need lumbar puncture. I doubt the neurologist is going to agree to that..." The note indicated the psychiatrist indicated "my plan is to gradually wean her off of Exelon patch. She is taking 4.6mg currently, and then it will be discontinued." The note indicated "she will stay on chlorpromazine (antipsychotic) 50 mg (milligram) q (each) a.m. and 200 mg q (each) HS			

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	<p>(evening)." The note indicated "In the MAR (medication administration record), it says she is on lithium (mood stabilizer), but my notes indicate that I have discontinued that. I think this must be a mistake by staff."</p> <p>A psychiatric progress note dated 4/18/13 indicated "after discussing the case with staff, it is the impression that I should wean her off of all her medications to see how she does and start all over again...."</p> <p>A psychiatric progress note dated 1/17/14 indicated "the patient is having significant problems and it had been very difficult to stabilize her during the last visit. I started her back on Zyprexa (antipsychotic) because of her aggressive behavior, difficulty with sleeping." The note indicated Client #3's "family did not want her to be on that medication...." The progress note indicated "I have very limited choices to treat this patient because of limitations. Either it does not work for her or she has some side effect to certain medication. Staff indicates she does not sleep at night because of her mind is racing and she is talking to herself." The progress note indicated "she is hyper. She has temper tantrums and acts out rather quickly with no</p>			

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	<p>provocation even for simple requests by the staff." The progress note indicated "the patient had lost a lot of weight being off zyprexa, I believe. Her appetite is fair." The note indicated the psychiatrist was to order an increase in Client #3's lithium (mood stabilizer) to "450mg (milligrams) q (each) a.m. and 450mg plus 150mg q (each) supper...." The note indicated the psychiatrist "will try her Trazodone (antidepressant) 200mg q (each) hs (evening)." The note indicated the psychiatrist "will try her on Saphris (antipsychotic) 5mg b.i.d. (twice daily) sublingual (dissolves under the tongue) tablet." The note indicated Client #3 "was on Aricept (used in treating dementia) but did not work for her, so I am not going to start that back."</p> <p>The "Psychiatric Progress Note" dated 2/6/14 indicated Client #3's "speech is rambling and unable to be followed. Her mood and affect are labile and irritable. Thought process is disorganized. Thought associations loose. Thought content is difficult to assess. Her insight and judgement are very poor. Her attention and concentration are poor. Her memory is poor. For orientation, she does not know today's day, month, year." The psychiatrist noted "I have been trying to stabilize her for the last many months</p>			

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	<p>but it has been difficult." The note indicated "Currently she is on lithium and I have just started her on Saphris 5mg (milligrams) b.i.d. (twice daily) last time, which was last month and trazodone 200mg q (each) hs (evening). Staff has not seen any improvement in her behaviors with Saphris. Trazodone worked for a couple of days but now she is not sleeping at all, maybe hardly a couple of hours. She is aggressive, she is calling staff names. She goes to bed and for a couple of hours she is out and just paces around or does things she should not be doing. I do not even think she knows what she is doing, she is so confused. They have noticed she has bowel and bladder accidents all over the house as well, which is a major issue." The note indicated the psychiatrist discontinued the Saphris "because it did not do much for her, not at all. Try Trilafon (antipsychotic) 2 mg b.i.d. (twice daily) and 4 mg q (each) hs (evening) for psychotic behavior and racing thoughts." The note indicated the lithium was continued at the current dose (450mg q (each)am and 450mg plus 150mg q supper) and Trazodone (antidepressant) was increased to 300mg each evening.</p> <p>The "Psychiatric Progress Note" dated</p>			

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	<p>3/3/14 indicated Client #3 "had lost weight and she was casually dressed. She looks disheveled. Her mood is very labile (unstable) and somewhat hypomanic (persistent and pervasive elevated (euphoric) or irritable mood). Her speech is repetitious. Her thought process is disorganized...." The psychiatrist indicated "I have discussed the case with staff with and have asked them to look into her medications from six months to see whether she has been tried on Depakote (anticonvulsant) so that I can try that. She (Client #3) is already taking enough of lithium. I do not want to see her getting toxic." The note indicated the psychiatrist "will discontinue saphris (already discontinued on 2/6/14) because it is not doing much. Increase Trilafon (antipsychotic) to 4 mg (milligrams) q (each) a.m. and 1 p.m. and 8 mg q (each) hs (evening) hoping to improve her sleep as well as her thinking." The note indicated the psychiatrist was continuing Client #3's Lithium for 450mg each morning and 600mg each supper time. The note indicated the psychiatrist "will try Depakote ER (extended release) 500mg q (each) supper for one week, then increase to 750mg q supper. Depakote level to be done in one week after that dosage." The note indicated the psychiatrist was continuing Client #3's Trazodone 300mg</p>			

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	<p>in PM. The note indicated "the patient did not show any benefit from Aricept or Exelon (both used in the treatment of Dementia), instead she had some problems with them, so she is not on any one of those medications. I do not remember about Namenda (used in the treatment of Dementia). If she has not been tried on that when I come next time I may try that medication."</p> <p>Review of a "telephone order" dated 3/18/14 indicated Client #3's [psychiatrist] ordered "discontinue Depakote (anticonvulsant) ER (extended release) 500mg (milligrams) q (each) supper. Continue Depakote ER 250mg q (each) supper."</p> <p>Client #3's BSP (Behavior Support Plan) dated 12/6/13 indicated Client #3's psychiatrist sees her for "mood disorder, impulse control disorder and nightmares. Staff reported that she is stable. She has outbursts periodically but is able to regain control fairly quickly. Follow up in three months." Client #3's BSP indicated the following "TARGET BEHAVIORS";</p> <p><u>"Temper Tantrums:</u> [Client #3] expressing angry emotions by slamming doors, yelling, cussing, storming around, stomping, and/or refusing to talk calmly. Following a temper tantrum, [Client #3]</p>						

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	<p>will often sit and pout for a period of time.</p> <p><u>Depression:</u> [Client #3] complaining of daily headaches or nightmares, or any time she exhibits a negative attitude, sadness, irritability, or tearfulness for no apparent reason.</p> <p><u>Aggression:</u> [Client #3] in anger striking, slapping, scratching, biting, or in any other way attempting to inflict pain/injury to another person.</p> <p><u>Self-injurious Behavior:</u> Any time [Client #3] picks at her skin with the intent of breaking the skin or any time she slaps, bites or inflicts any pain/injury to herself.</p> <p><u>Obsessive Statements:</u> repeating statements that represent compulsive, often anxious preoccupation with a fixed idea or unwanted emotion.</p> <p><u>Confusion:</u> unclear in mind or intent for example extremely forgetful and not able to follow instructions, and mistakes one thing for another. This also includes memory loss of recent events that affects her day to day schedule."</p> <p>Client #3's 12/6/13 BSP indicated a "MEDICATION ADJUSTMENT PLAN" which indicated "when [Client #3] has reached the goals prescribed in the Behavior Management Plan, the IDT (Interdisciplinary Team) will consider recommending to the psychiatrist a</p>			

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	<p>reduction in the Lithium (mood stabilizer) by 150mg (milligrams) daily will be discussed with the psychiatrist." The medication adjustment plan indicated "if the behaviors exceed current levels for a period of one month, or the client's health and safety is in jeopardy due to the behavior problems, the IDT will recommend to the psychiatrist to increase the medications by a) Lithium to a level that will still maintain blood levels within normal levels with without HRC (human rights committee) and guardian approval, or b) change of medication within the same drug class without HRC and guardian approval. In the event of a change in medication within the same therapeutic class, the risks, benefits, side effects of and indications for medications will be reviewed with the client and/or parent, guardian or responsible party." Client #3's BSP indicated "staff in the group home will carefully monitor for any continuing side effects or the Medication Review Committee will review any new side effects of the medication Medications (sic) and behaviors at least every month."</p> <p>An "ADDENDUM TO BEHAVIOR PROGRAM" dated 7/3/13 indicated "[Client #3] was seen by [psychiatrist] for her psychotropic medication review. Due</p>			

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NAME OF PROVIDER OR SUPPLIER ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 58808 ST MARYS LN GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to client's increase in confusion, SIB (self-injurious behavior), depression with associated mania, and temper tantrums [psychiatrist] decided to prescribe [Client #3] Lithium 450mg (milligrams) BID (twice daily)."</p> <p>An "ADDENDUM TO BEHAVIOR PROGRAM" dated 1/09/14 indicated "On 1/09/2014 [Client #3] was seen by [psychiatrist] for her psychotropic medication review. Due to clients increase in depression with associated mania, increase in manic behaviors, not sleeping at night and temper tantrums [psychiatrist] decided to increase [Client #3]'s Lithium (mood stabilizer) by adding 150mg (milligrams) with supper (total of Lithium at supper = 600mg). A new order for Saphris (atypical antipsychotic used in the treatment of schizophrenia and/or bipolar disorder) 5mg SL (sublingual, dissolves under the tongue) BID (twice daily) was received as well as Trazodone (antidepressant) 200mg q HS (evening)."</p> <p>Client #3's behavior data for her BSP (Behavior Support Plan) reviewed from the week of 1/09/14 to the week of 04/03/14 indicated the following data: <u>AGGRESSION:</u> Week of 1/09/14 - 1 Week of 1/16/14 - 1 Week of 1/23/14 - 1</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G366	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
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	Week of 1/30/14 - 1 Week of 2/6/14 - 0 Week of 2/13/14 - 0 Week of 2/20/14 - 0 Week of 2/27/14 - 2 Week of 3/6/14 - 4 Week of 3/13/14 - 2 Week of 3/20/14 - 3 Week of 3/27/14 - 0 Week of 4/03/14 - 1 <u>DEPRESSION:</u> Week of 1/09/14			