STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G001	A. BUILDING _____ B. WING _____	C 02/19/2010

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ALEXANDER HUMAN DEVELOPMENT CENTER	14701 HIGHWAY 111 SOUTH ALEXANDER, AR 72002

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W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A Full Survey and Complaint Survey were conducted on 1/25/10 through 2/19/10. Complaint #15117, was substantiated (all or in part) with deficiencies cited at W102, W122, W127, W191and W331.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Complaint #15117, substantiated, all or in part, in these findings. Based on interview and record review, the facility failed to meet the requirements of the Condition of Participation (CoP) for the Governing Body and Management as evidenced by the facility ' s	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 102	Continued From page 1	W 102		

failure to meet the Condition of Participation for Client Protection (W122). These failed practices resulted in Immediate Jeopardy (IJ) which caused or could have caused serious harm, injury or death to Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The facility also failed to ensure adequate supervision for Client #13 who had Pica, Impulse Control Disorder, Self Injurious Behavior and who swallowed a battery and two rocks which resulted in surgical removal. The Interim Administrator was informed of the Immediate Jeopardy on 2/10/10 at 4:00 p.m. The findings are:

1. The facility failed to meet the Condition of Participation at W122 as evidenced by the facility's failure to ensure the method of transportation for emergency medical was determined by medical personnel only and failure to provide adequate supervision to clients with Pica and poor impulse control. Refer to W122

2. The facility failed to meet the standard Protection of Client Rights at W127 by denying emergency medical transportation for Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The facility also failed to ensure adequate supervision for Client #13 who had Pica, Impulse Control Disorder, Self Injurious Behavior and who swallowed a battery and two rocks which resulted in surgical removal. Refer

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W 102	Continued From page 2 to W127 and W331 3. The facility fully removed the Immediate Jeopardy on 2/10/10 at 4:30 p.m. when they implemented the following Plan of Removal: a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m. b. On 2/10/10, at 4:30 p.m. The Interim Administrator/Superintendent notified the medical department and department heads that the facility will follow its own practice of the medical department making all decisions as to the method of transfer of clients who have received injury and required medical treatment outside the facility. This action was conducted in order to prevent any reoccurrence of this incident. c. Staff inservice started on 2/10/10 by the Interim Administrator/Superintendent and was continued on each shift.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure there were no roaches in 1 (Client #15) of 22 (Client #1 -11, 13 - 18, 20, 21, 23 and 24) sampled clients room and there were no roaches in the kitchen; the drawers in chest of drawers, end tables and dressers did not fall when pulled out; dressers and chest of drawers	W 104		

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W 104	Continued From page 3	W 104		

were in good repair; the paint was not peeling and bubbling; the bath and shower rooms were free of mold/mildew; bathroom sinks were secured to the wall; bathtubs were free of rust; food stored in the refrigerator was covered and marked with date and client name; food items were marked with expiration date; closet doors were in good repair; tiles were not missing from the shower stall wall; and light switches were installed in each client room. These failed practice had the potential to affect 13 clients who resided on 1 East Bond, 21 clients who resided in 3 East Bond, 20 clients who resided on 1 South Bond, and 20 clients who resided on 3 South Bond. The findings are:

1. On 2/2/10 at 10:00 a.m., in Client #15's room on 1 East 2 live roaches crawled across the bed after the bed post was shaken. Client #15 stated at that time that roaches have been around since Thanksgiving.

On 2/3/10 at 10:03 a.m., there was a live roach crawling in chest of drawers in Client #15's room.

2. On 2/3/10 at 10:08 a.m., there was a live roach in the west closet of the kitchen on 1 East where chemicals were kept.

3. On 2/18/10 at 3:10 p.m., there was a live roach crawling out of a slot in the footboard of Client #15's bed.

4. On 2/11/10 at 9:15 a.m., the following observations were made on 1 South:

a. In Client Room 113, the 4th and 6th drawers of the chest fell when pulled out 4-6 inches.

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b. The bath/shower room on the right, going down the hall, had mold/mildew on the grout going up 5 tiles from the floor, to the left of the shower stall. On the back of the right shower stall, 7 tiles up from the floor there was mold/mildew on the grout. The tub had rust around the ends and back. The middle lavatory had a 1/2" open space between the wall and the basin. The unit supervisor made rounds with the surveyor and stated that maintenance keep recaulking, but the rust keeps coming back, referring to the tub.

c. In Client Room 118, the area in front of the door had peeling paint on the ceiling with a brown area approximately 1 1/2 feet by 8 inches and the paint was bubbling on the edge of the brown area. Under this area was some more peeling paint and a larger (1 foot by 6 inches) bubble of paint.

d. In the Day Room, in the left hand, outside corner, there was a large area of bubbly paint. When touched by the surveyor, the bubble exploded and paint went all over the floor. The window to the right of this area had a crack approximately 1/4 inch wide, with orange mildew and bubbly paint.

The supervisor called the facility painter when the bubbly paint exploded. The painter said he thought it was caused by moisture, because there was a solid wall over the brick and moisture was coming down through the walls. The painter felt the wall and said it had moisture on those areas with the bubbled paint.

e. In Client Room 123, the top drawer of the

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W 104	Continued From page 5 chest fell when it was pulled out 4-6 inches. f. In Client Room 124, the top drawer of the armoire fell when it was pulled out 4-6 inches. g. In Client Room 126, the 3rd drawer of the chest wouldn't close all the way. It was open approximately 2 inches. 5. On 2/17/10 at 1:15 p.m., the following observations were made on 2 East: a. In Client Room 210, the 1st drawer in the dresser dropped when pulled out 3-4 inches, the 2nd drawer was unstable and difficult to pull out, and the 3rd drawer would not pull out when the front of the drawer was pulled. The client stated that he did not want a new chest, he liked this one. The 4-drawer chest wobbled when the drawers were opened and closed. b. In Client Room 215, the right corner on the back outside wall, appeared wet, and the ceiling was discolored with peeling paint. 6. On 2/17/10 at 1:50 p.m., the following observations were made on 3 South: a. In the Kitchen there was a small styrofoam bowl full of pineapple slices with no cover, name, or date in the refrigerator. The right cabinet drawer wouldn't close. The surveyor pulled the drawer out and found a 7-8 inch white plastic object. Staff #20 was asked to come see what the surveyor found and she stated she didn't know where it came from or how it got there. She laid the plastic object on a shelf in the refrigerator. There was no date on 2 catsup bottles in the refrigerator door.	W 104		

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W 104	Continued From page 6 b. In Client Room 310, the left hand closet door had a large hole (approximately 3 inches across) above the door handle, with wood splinters within easy access of a hand. c. In Client Room 312, both closet doors locked automatically and staff could not do anything that would keep the doors from locking. Staff #20 stated the facility did not have any doorknobs that were not self-locking. Staff #20 also stated that neither client had a key and both clients had to ask staff to unlock the door. d. In the 2nd Bathroom, the shower was missing five 1 inch tiles under the shower head on the floor. The edges were rough. e. In Client Room 332, the armoire doors did not close completely. f. In Client Room 326, the bottom drawer in the end table with the refrigerator on top, fell when pulled out 4-6 inches. g. In Client Room 320, there was no personal light switch in the room. The light had to be turned on in the office down the hall. h. In Client Room 318, the 2nd drawer in the chest, would not open more than 3 inches.	W 104		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.	W 111		

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W 111	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was documentation of the client behaviors that warranted the continued use of restraints for 2 of 2 sampled clients (Clients #13 and 14) who were restrained. The findings are: 1. The facility's policy and procedure AB-PO-15 for restraints, last updated 9/23/2009, documented the behaviors were to be observed and documented every 15 minutes when a client was in restraints and were to be documented on the Skills Training/Supervision Log. 2. Client #13 had diagnoses of Impulse Control Disorder and Self-Injurious Behaviors. a. The Human Rights Committee meeting dated 12/15/01 documented the resident was restrained for 11,055 minutes in November 2009. b. The IDT (Interdisciplinary Team) Authorized Restraint Forms dated from 11/23/09 thru 11/30/09 revealed a total of nineteen forms. The form documented the client was released from wrist restraints every hour for 5 minutes from 11/23/09 at 7:00 a.m. until 11/26/09 at 2:00 p.m., 11/27/09 at 7:00 a.m. till 2:00 p.m., and from 11/27/09 at 11:00 p.m. until 11/30/10 at 10:00 p.m. There was no documentation on the form of the behaviors associated with the continued use of Mendota wrist restraints. 3. Client #14 had diagnoses of Mild Mental Retardation, Mood Disorder, Pyromania, Psychotic Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder with Self Injurious Behaviors,	W 111		

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W 111	Continued From page 8 Suicide Attempts by history, Obesity, Hypercholesterolemia, Myopia Left Eye, and Mild Sensorineural Hearing Loss both ears. a. The IDT Authorized Restraint Form documented the client was in Mendota wrist restraints from 11/10/09 at 12:00 p.m. until 11/13/09 at 2:00 p.m. There was no documentation on the restraint form or Dangerous Behavior logs for this time period of any behaviors that required the continued use of wrist restraints. b. The IDT Authorized Restraint Form documented the client was in Mendota wrist restraints from 12/8/09 at 11:00 p.m. until 12/11/09 at 6:55 a.m. There was no documentation on the restraint form or Dangerous Behavior logs for this time period of any behaviors that required the continued use of wrist restraints. c. The IDT Authorized Restraint Form documented the client was in Mendota restraints from 12/14/09 at 3:00 until 10:55 (a.m. or p.m. not specified). There was no documentation on the restraint form of where the restraints were applied on the body and no documentation on the form or Dangerous Behavior logs for this time period of any behaviors that required the continued use of wrist restraints. d. The IDT Authorized Restraint Form documented the client was in Mendota restraints from 12/14/09 at 11:00 a.m. until 12/16/09 at 2:00 p.m. There was no documentation on the restraint form or Dangerous Behavior logs for this time period of any behaviors that required the continued use of wrist restraints.	W 111		

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W 111	Continued From page 9 4. On 2/19/10 at 10:35 a.m., the Program Director (Employee #1) was asked to provide the documentation of the client's behaviors that were required to be observed every 15 minutes. As of 2/19/10 at 1:10 p.m., the Program Manager could not provide this documentation.	W 111		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure Program Coordinator/Qualified Mental Retardation Professional's (PC/QMRP's) documented the date they signed entries into the medical record for 6 of 6 sampled clients (Client #1, 2, 3, 4, 7 and 8). The facility failed to ensure the Interdisciplinary Team meeting attendance sheet was signed by those in attendance for 1 (Client #13) of 25 (Client #1-15) sampled clients. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar disorder Type 1, Autistic Disorder, General Convulsive Epilepsy, Glaucoma, Cataract, Acne, Periodontal Disease, Chronic Tinea Pedis and Chronic Dry Skin. A form titled Resident 1's Observations for January - March 2009, April - June 2009, and July - September 2009, did not document the date of the PC/QMRP's signature. 2. Client #2 had diagnoses of Mild Mental Retardation, Obesity, Bilateral Strabismus surgery, Depressive Disorder and Psychotic	W 114		

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W 114	Continued From page 10 Disorder. A form titled Resident 2's Observations for January - March 2009, April - June 2009, and July - September 2009, did not document the date of the Program Coordinator/Qualified Mental Retardation Professional's (PC/QMRP's) signature. 3. Client #3 had diagnoses of Moderate Mental Retardation, Schizophrenia, Paranoid Type, Insulin Dependent Diabetes, History of Seizures, History of Anemia, Edentulous, Osteoarthritis, Knee Joint Space Narrowing, Bilaterally Knees Onychomycosis, Gastroesophageal Reflux Disorder, and Chronic Constipation. A form titled Resident 3's Observations for January - March 2009, April - June 2009, and July - September 2009, did not document the date of the Program Coordinator/Qualified Mental Retardation Professional's (PC/QMRP's) signature. 4. Client #4 had diagnoses of Profound Mental Retardation, Impulse Control Disorder, Autistic Disorder, Obsessive Control Disorder, Deafness, Non-verbal, PPD (Purified Protein Derivative) Reactor, History of TB (Tuberculosis), Meningitis, Presbyopia, Astigmatism, Myopia, Hemorrhoids, Abdominal Surgery excision of Cancerous Tumor, and Colon Cancer. A form titled Resident 4's Observations for January - March 2009, April - June 2009, and July - September 2009, did not document the date of the Program Coordinator/Qualified Mental Retardation Professional's (PC/QMRP's) signature.	W 114		

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W 114	Continued From page 11 5. Client #7 had diagnoses of Moderate Mental Retardation, Schizophrenia - Residual Type - Oppositional Defiant Disorder, Depressive Disorder NOS (not otherwise specified), Dysplastic Nevus Syndrome, and Bilateral Orchiectomy, A form titled Resident 7's Observations and the Review Quarter/Year for January - March 2009, April - June 2009, and July - September 2009, did not document the date of the PC/QMRP's signature. 6. Client #8 had diagnoses of Severe Mental Retardation, Psychotic Disorder NOS, Schizophrenia - Paranoid, Gastroesophageal Reflux Disorder, Periodontal Disease, Mild Constipation, History of Phimosis, and s/p (status post) Circumcision. A form titled Resident 8's Observations for April - June 2009, July - September 2009, and October - December 2009 did not document the date of the PC/QMRP's signature. 7. The following QMRP's were asked if they were supposed to date their signatures on clients' documents: a. On 2/18/10 at 1:18 p.m., Staff # 5 stated that he did not always date his signature if there was a date on the document. b. On 2/18/10 at 1:24 p.m., Staff #22 stated he didn't know until about 2 weeks ago. c. On 2/18/10 at 1:32 p.m., Staff #21 stated, "We just learned that 2 weeks ago."	W 114		

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W 114	Continued From page 12 d. On 2/19/10 at 10:20 a.m., Staff #1 that now she knew because she had had training and they are trying to correct that. 8. Client #13 had diagnoses of Mild Mental Retardation and Self-Injurious Behaviors. The Interdisciplinary Team meeting dated 1/7/10 was not signed by any of the 8 staff who attended the meeting. On 2/19/10 at 11:00 a.m., the Program Coordinator (Employee #1) was asked for this signature sheet, but was unable to provide this information.	W 114		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Complaint #15117, substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to meet the requirements of the Condition of Participation for Client Protection. These failed practices resulted in Immediate Jeopardy (IJ) which caused or could have caused serious harm, injury or death to Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The facility also failed to ensure adequate supervision for Client #13 who had Pica, Impulse Control	W 122		

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W 122	Continued From page 13 Disorder, Self Injurious Behavior and who swallowed a battery and two rocks which resulted in surgical removal. The Interim Administrator was informed of the Immediate Jeopardy on 2/10/10 at 4:00 p.m. The findings are: 1. The facility failed to meet the standard Protection of Client Rights at W127 by denying emergency medical transportation for Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The facility also failed to ensure adequate supervision for Client #13 who had Pica, Impulse Control Disorder, Self Injurious Behavior and who swallowed a battery and two rocks which resulted in surgical removal. Refer to W127 and W331 2. The facility removed the Immediate Jeopardy on 2/10/10 at 4:30 p.m. when they implemented the following Plan of Removal: a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m. b. On 2/10/10, at 4:30 p.m. The Interim Administrator/Superintendent notified the medical department and department heads that the facility will follow its own practice of the medical department making all decisions as to the method of transfer of clients who have received injury and required medical treatment outside the facility. This action was conducted in order to prevent any reoccurrence of this incident.	W 122		

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W 122	Continued From page 14 c. Staff inservice started on 2/10/10 by the Interim Administrator/Superintendent and was continued on each shift.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Complaint #15117, substantiated, all or in part, in these findings. A. Based on interviews and record review, the facility failed to ensure that two sampled Clients (#17 and 21) were transported to their respective Hospital Emergency rooms in a manner consistent to meet client's needs. These failed practices resulted in Immediate Jeopardy (IJ) which caused or could have caused serious harm, injury or death to Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The Interim Administrator was informed of the Immediate Jeopardy on 2/10/10 at 4:00 p.m. The findings are: 1. A memo received by the surveyors on 2/10/10 at 2:20 p.m., was addressed to all staff from the Quality Assurance Coordinator and was dated 3/26/08. The memo documented: "All falls should be reported to medical as soon as	W 127		

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possible. The client should not be moved until he has been seen by a nurse. If there should be broken bones or internal injuries to vital organs, it could cause more damage having them moved. Try to encourage them to remain where they are if the area is safe, offer them reassurance, but do not restrain them. If the client refuses to remain still, document on a Behavior Report as well as the Marks Report that the client was encouraged to remain still for medical to exam, but client refused."

2. Client #17 was admitted 5/22/78 with diagnoses of Severe Mental Retardation and Hypertension.

a. Nurses' Notes dated 4/23/09 documented the client experienced a fall and was transferred to the hospital.

Hospital emergency room records dated 4/23/09 documented the client had a fractured hip and the client was admitted. The hospital operative note dated 4/24/09 documented "...suffered a fall yesterday evening late and had a highly comminuted, unstable, 4-part intertrochanteric fracture of his right hip... "

b. On 2/3/10, Employee #6 stated there had been an incident where a client was transported to the emergency room via facility van following a probable hip fracture after instructions from the Superintendent to cancel the ambulance that had been called by Nursing Staff Member #10.

c. Written statements dated 4/23/09, from Staff #10 and Staff #23, documented Staff #13, the Evening Shift Coordinator, came to the scene and had a telephone conversation with the

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Administrator concerning the client. Staff #13 stated that the Administrator had said to cancel the ambulance and transfer the client to the hospital via a facility van. This directive was carried out.

On 2/5/10, a copy of written documentation from Employee #10 was received that described the findings that occurred on 4/23/09 regarding Client #17 fall and transfer to the emergency room. This was not dated but was signed by Employee #10. Employee #10 documented that Client #17 was pushed by another client to the floor and when she got to him, he was standing holding onto a file cabinet screaming he couldn't walk. Employee # 6, a registered nurse, was called and assessed the client and determined he had a possible fracture. Employee #10 and Employee #6 agreed for the RN (Employee #6) to stay with the injured client and for the LPN (Employee #10) to call the doctor and an ambulance for transfer. After doing this, the Shift Supervisor (Employee #13) stated we had to cancel the ambulance because the Superintendent said not to send him by ambulance. A staff member called and canceled the ambulance and Client #17 was transferred to the emergency room by facility van.

d. Staff #13 was interviewed per telephone on 2/19/10 at 9:15 a.m. In relation to the above fractured hip, he stated he had telephone contact with the Administrator concerning the injury, but he could not remember the exact discussion. He stated the end result of the conversation with the Administrator was to cancel the ambulance and transport Client #17 via the facility handicap van to the Emergency Room. He confirmed he cancelled the ambulance per the Administrator's

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direction.

e. On 2/17/10, a visit was made to the Ambulance Service. Records from 4/23/10 documented that a call was made at 8:52 p.m. for a transfer by Employee #10 with a cancel order (no name) prior to facility arrival with the facility transferring the client themselves.

f. On 2/2/10 at 1 p.m. and subsequent follow up interviews, the Interim Director of Nurses (IDON) described an incident on 4/23/09, where Client #17 had fallen in the living unit, fracturing his left hip. The IDON stated the client had been placed in a wheelchair, prior to her examining him and she noted a rotation of the left leg and foot which was indicative of a hip fracture. The client was screaming and in obvious pain as she examined his leg. The IDON stated she asked for an ambulance to be called. At this time, the IDON stated she was called away to handle an emergency on another unit.

On 2/10/10, at 4:00 p.m., the IA (Interim Administrator) stated the Administrator should not have had the ambulance cancelled, as it was the facility practice for medical to make that determination.

3. Client # 21 had diagnoses of Schizophrenia, Severe Mental Retardation, Disc Herniation and Stenosis, Osteopenia, Lumbar Spine, Osteoporosis Left Hip, Hemorrhoids, Internal Hyperplastic Rectal Polyp, and Malformation in the Rectum.

a. An Incident report dated 5/7/09 documented that on 5/7/09 at 5:30 p.m. Client # 21 choked on a piece of corned beef. The Heimlich procedure

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was immediately administered and the piece of meat was removed. Client # 21 was then taken to Saline Memorial Hospital for evaluation. He was subsequently admitted for pneumonia in his right lung.

b. The Nurses Notes dated 5/7/10 at 5:30 p.m. and signed by Staff # 10 documented: "Client in dining room eating meal- got choked on a large piece of meat, Heimlich Maneuver started with no avail, client turning blue and losing consciousness, 911 was called. Mouth sweep done by Staff #6 large piece of meat removed- Doctor notified. Received order to transfer to ER for evaluation. B/P 167/107, Pulse 123, Respiration 24 and pulse ox 78. [Oxygen Saturation 78%] Client condition to be shaky - Staff # 14 notified and said not to send client out by ambulance." The Nurses Notes dated 5/7/10 at 6:30 p.m. and signed by Staff # 10 documented: "Transferred to[Hospital Name] Emergency Room via Staff."

c. The Nurses Notes dated 5/7/10 @ 6:30 p.m. and signed by Staff # 6 documented: "Doctor was notified immediately of the trauma the client had experienced and his decrease in sat. rate secondary to trauma and ordered client to be transported to nearest facility for noted distress. Client transport was delayed for forty and minutes to be transported by facility van. Client medically by Vital Sign report and pulse ox unstable."

4. Nursing Standard of Practice in event of Emergency/Incident 1) Nursing assesses Client 2) Nursing notifies the Physician and the Physician makes the decision after the Nurse relates the information to him/her of how the

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W 127	Continued From page 19 client should be transported. Clients #17 and #21 were transported via facility van with no Emergency Equipment available or Staff present who were qualified for emergency care during transport. 5. After the system failure on April 23, 2009 with Client # 17 and then again on 5/7/10 with Client # 21. The Administrator called a meeting at 1 p.m. on May 8, 2009 regarding the incident of Client # 21 and " it was decided to make some guidelines for incidents of this kind." A document dated May 8, 2009 titled GUIDELINES FOR EMERGENCY INCIDENTS documented: 1) When an emergency/incident arises on a unit and a nurse is needed a call needs to be placed to the switchboard announcing "NURSE NEEDED STAT" on that unit. 2) Medical will assess and determine whether a client needs to go out to the hospital. 3) 911 will be called and no 911 calls will be cancelled unless medical makes the cancellation. 4) Superintendent will be notified of the incident by the Evening Supervisor/Shift Coordinator and a follow up telephone call will be made to Superintendent by Medical Department by the end of the Shift. 6. The facility fully removed the Immediate Jeopardy on 2/10/10 at 4:30 p.m. when they implemented the following Plan of Removal:	W 127		

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a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m.

b. On 2/10/10, at 4:30 p.m. The Interim Administrator/Superintendent notified the medical department and department heads that the facility will follow its own practice of the medical department making all decisions as to the method of transfer of clients who have received injury and required medical treatment outside the facility. This action was conducted in order to prevent any reoccurrence of this incident.

c. Staff inservice started on 2/10/10 by the Interim Administrator/Superintendent and was continued on each shift.

B. Based on interview and record review, the facility failed to ensure that 3 of 3 (Clients #12, 13 and 18) sampled clients who were identified to need enhanced supervision were adequately supervised to prevent harmful behaviors. The failed practice resulted in Client #13 swallowing a battery that had to be surgically removed and Client #18 having inappropriate sexual activity with another client. The findings are:

1. Client #13 had diagnoses of Mild Mental Retardation, Pica, Impulse Control Disorder, Self Injurious Behavior, and a Mood Disorder.

a. A Psychological update dated 3/11/09 in the master file noted this client had exhibited a long history of inappropriate behaviors including swallowing objects, cutting self, hitting walls, and attempting to run away. According to an IDT (Interdisciplinary Team) meeting case-note dated

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W 127	Continued From page 21 8/21/09, Client #13 swallowed a battery and two rocks in August of 2009 which resulted in surgical removal on September 3rd, 2009. After this incident, he was placed on Level III supervision which was 1-1 supervision that involved continuous 24 hour supervision by staff in which the staff member's was always to be within arm's length of the client. b. An IDT team meeting report dated 1/7/10, documented it was a team decision to reward Client #13 with two items of choice following a significant period of appropriate behavior with a TV and a plug-in game controller chosen. The team agreed that he could have these specific items as long as they did not include batteries or pieces that could be swallowed. The team continued the Level III continuous 1-1 supervision by a staff member within arms length of the client. c. Following the IDT meeting, documentation in the behavior log 01/07/10 noted that this client had his items returned at approximately 3:15 p.m. An Incident Report (#29723) dated 1/8/10 documented: The client came out of his room at approximately 6:00 p.m. on 01/07/10 and stated to Employee #15 that he had swallowed a battery. He was evaluated by medical personnel at the facility and was then transferred to the hospital where an X-ray confirmed an ingested battery. The client was hospitalized 1/7/10 thru 1/13/10. d. On 2/10/10 at 2:35 p.m., an interview was conducted with Employee #15. He stated that Client #13 received a box on 1/7/10 that had been in storage and contained various items including batteries belonging to a TV remote that	W 127		

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opened via a slide mechanism. He stated that Client #13 was 1-1 with a staff member sitting in the doorway during this timeframe but apparently Client #13 turned his back to the staff member and ingested the battery.

2. Client # 12 had diagnoses of Profound Mental Retardation, PICA, and Autistic Disorder, Obsessive-Compulsive Disorder, Allergic Rhinitis, Chronic Ear Infection, GERD, Onychomycosis, Obesity, Acne Vulgaris, Dysphagia, Anemia.

a. As of 2/2/10 the resident's Individual Program Plan, under "Medical Information" documented: "Client # 12 had a physical exam on 12/12/08 ... my increased risk for aspiration and PICA behaviors continue to be major concerns....Client had 10 visits to the facility clinic....and for PICA behavior review." The next paragraph documented there were 11 outside Physician visits most were for x-rays of foreign bodies swallowed. Under "Psychology/Behavior", the plan documented staff were concerned that client would engage in PICA behavior, so client had enhanced supervision at all times. The doctor (psychiatrist) recommended this level of supervision continue at this time. Paragraph 2 documented, during the past 12 months the client had a total of 14 incidents of PICA.

There were no changes made to the Active Treatment plan after the 14 incidents of PICA behaviors.

b. On 1/26/10 at 3 p.m. and on 1/27/10 at 6:30 p.m. during observation of Unit 2-East, Client # 12 was sitting in the hallway with 4 other clients,

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W 127	Continued From page 23 one staff member was sitting in an office doing paperwork, approximately 10 feet from Client # 12. c. On 2/19/10 at 1:00 p.m. during Exit Conference this resident and others who needed supervision were discussed. Client #12 had PICA behaviors documented14 times while having Enhanced Supervision and the Superintendent/Administrator stated that was too many times for client being supervised. 3. Client # 18 had diagnoses of Impulse Control Disorder, Pedophilia, Schizoaffective Disorder, Moderate Mental Retardation, Hydrocephalus with cranial/peritoneal shunt, and possible seizure disorder. a. The Master Record documented under "Psychology/Behavior": The behavior Support Committee met on 7/10/09 and determined that Sexually Inappropriate Behavior and Noncompliance would remain target areas for Client # 18. The Client has averaged 4 incidents per month in both areas. Paragraph # 3 documented: The supervision needs which are in place for home visits, on the grounds and in the community remain valid and still need to be strictly followed. b. The Individual Program Plan page 14 documented: My Supervision Needs .....Direct Supervision: Toileting, Bathing Grooming, Off Unit (in building) Grounds, On campus, Off Campus Activities, Emergency Procedures. Direct supervision defined: Must have close supervision to and from all destinations..." page 15: "...Rights: Time and Space for Privacy: Comments Staff will make sure the bathroom is	W 127		

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W 127	Continued From page 24 vacant before Client # 18 enters." c. DHHS Incident Report Dated 12/6/09 documented: "...On 12/6/09 at approximately 3:05 p.m. staff reported that Client # 18 and Client # 23 participated in inappropriate sexual activity, both anally and orally. Client # 18 indicated he initiated the activity, but Client # 23 indicated he consented. Both were sent to UAMS for evaluation. Superintendent initiated an investigation. Client # 18 will be restricted to his room which is equipped with an alarm on the door which will alert staff if he attempts to leave..." The report documented: "Interviews: [Staff # 23] stated when she arrived all of the men were in the dayroom [Client # 23] came and talked to her. [Staff # 23] stated that [Staff # 24] told her [Client # 18] had asked him if he could use the bathroom and [Staff # 24] told him to ask another staff as he was one on one with another client..." There was no follow up documentation to show that Staff # 24 assisted Client # 18 to get someone to go with Client # 18 to the bathroom. d. The client's IPP documented: "Since Admission on 11/24/99 [Client #18] the concerns are: ...# 3 on Special things to Consider About [Client #18] ...has a diagnosis pedophilia and a history of inappropriate sexual activity and contact with small children or vulnerable adults, placing them at risk. [Client #18] requires direct supervision in all his environments to prevent the behavior from occurring. When [Client #18] to use the bathroom in all my environments, [Client #18] is to notify staff to ensure that no other person is in the bathroom before he enters. Staff needs to escort him back to his designated area	W 127		

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W 127	Continued From page 25 once he has finished using the bathroom. This need has been in place since admission in 1999..." An FYI [For Your Information] MEMO dated 12/22/09 was sent to the Residential Training Supervisor and 3 South Residential Training Staff. "Special Equipment or Environmental Modifications I need: Due to my sexual issues I have a chime on my door..."	W 127		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure sufficient clothing was available for 1 (Client #13) and clothing was not torn for 1 (Resident #4) of 25 sampled clients (Client #1-25) who resided at the facility. The findings are: 1. Client #13 had diagnoses of Mild Mental Retardation, Pica, Impulse Control Disorder, Self Injurious Behavior, and Mood Disorder. a. A Team Action Memo dated 4/21/09 documented, "Have lost a significant amount of weight during the past year and need all new clothing to fit new size. Pants, shirts, socks, underwear, T-shirts, and shoes." b. On 1/26/10 at 3:40 p.m., the client stood up and his pants fell, exposing his buttocks. The	W 137		

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W 137	Continued From page 26 client did not have on any underwear or socks. Staff #3 encouraged the client to pull up his pants. The client's closet contained one pair of socks and no clean underwear. c. On 1/28/10 at 8:55 a.m., the client's pants had fallen down around his hips and he did not have on any underwear. d. On 2/2/10 at 6:45 a.m., Employee #2 stated that underwear was borrowed from another client the night before because none was available for this client. e. On 2/3/2010 at 10:20 a.m., the I East Program Coordinator (Employee #1) checked in the storage area for underwear and socks for the client and none were available. The client had soiled spots on his jeans and shirt. 2. Client #4 had diagnoses of Profound Mental Retardation, Impulse Control disorder, Autistic Disorder, Obsessive Compulsive Disorder, and Deafness, Non-verbal. On 2/4/10 at 8:13 a.m., the back of the left leg of the client's pants was open approximately 8 inches up from the bottom. It flopped around his ankle as he walked. The Supervisor stated the pants were torn. As he looked closer, he said they were unzipped and ripped.	W 137		
W 152	483.420(d)(1)(iii) STAFF TREATMENT OF CLIENTS The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.	W 152		

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W 152	Continued From page 27 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Criminal Record Check (CRC) was completed every 5 years in accordance with State law for Employee #12. This failed practice had the potential to all 111 clients. The findings are: 1. On 2/17/10 at 3:00 p.m., Employee #16 (employee in charge of screenings) stated that the state Criminal Record Check was one of the required screenings for all employees and this was updated every five years as required. 2. On 2/17/10, Employee #12's personnel file documented a hire date of 4/21/96. The last Criminal Record Check (CRC) was dated 6/4/03. 3. On 2/18/10 at 2:45 p.m., Employee #16 stated this five-year update was overlooked.	W 152		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that a facility investigation (DHS Incident Report #30141), dated 2/5/10, contained non-conflicting and accurate information 2 of 2 sampled clients (Client #17 and 21) who had incident reports completed. The findings are: 1. The facility Incident Report #30141 regarding Client #17's fractured hip and the events	W 154		

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surrounding this incident were reviewed. This incident report was dated 2/5/10 and paragraph #7 with the heading, Clear, Concise Narrative Description on February 12, 2010 at 4:03 p.m. by Employee #16 documented: "There is no evidence of destruction of documents or falsification of documents. Nurse's Notes alluded to as "missing" were found to be on another incident and do indeed exist in that client's record. They are not found in Client #17's record as they were not regarding him."

a. The facility's own investigation for Incident #30141 regarding Client #17's fractured hip and subsequent transfer to the hospital, on page 4 of 11 documented, "[Employee #14] was asked if she asked [Employee #6] to rewrite an entry she had made in the nurse's notes. [Employee #14] said the next day the Director of Nurses [DON], [XX] came to her and asked her if she knew that it was written in the nurse's note that [Employee #14] had refused to send [Client #17] out by ambulance. [Employee #14] said she told [DON] that information was not correct, that she had asked [Employee #6] if [Client #17] could be transported by [facility name] staff. [Employee #14] said they needed to make an error correction. [Employee #14] said it was her understanding that the nurses do it all the time, they mark out an error, write the correction, and sign and date the entry, add to the notation. [Employee #14] said the nurse's notes are put into the resident's file their official record. The nurse's notes for [Client #17] were reviewed and they did not have an entry regarding [Employee #14] ordering that an ambulance be cancelled. [Employee #14] said the following day she saw a nurse's note that said she had cancelled an ambulance and that the note was written by

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W 154	Continued From page 29 [Employee#10)." b. On 2/3/10 at 3:10 p.m., [Employee #6] stated her nurse's notes in regards to Client #17 that described the incident with his fractured hip and the ambulance cancellation were missing from the chart . On 2/3/10 at 3:50 p.m., the Advance Practice Nurse [Employee #9] stated she had reviewed this documentation in Client #17's chart that was written by Employee #6 regarding Client #17's fractured hip and the ambulance cancellation and this documentation was indeed located in Client #17's chart. She stated she was unsure of the exact date, but it was not very long after the fractured hip occurred. c. Documentation of the nurse's notes for Client #17, dated 4/23/09 through 4/28/09 was reviewed and did not contain documentation from Employee #6 regarding the fractured hip incident, or any documentation of an ambulance cancellation or any corrections made by Employee #10. However, the facility's own documented interview with the Administrator/Superintendent, dated 2/10/10, has documented in her witness statement that she saw a nurse's note written by Employee #10 that she had cancelled the ambulance. d. Documentation for another client, (Client #21) and another Investigation-Incident Report #30178 was reviewed, there was no documented notation made by Employee #10 regarding an ambulance. The Nurses Notes for the May 7th, 2009 incident for this resident were dated 5/11/09, as a late entry.	W 154		
W 159	483.430(a) QUALIFIED MENTAL	W 159		

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W 159	Continued From page 30 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Program Coordinator/Qualified Mental Retardation Professional (PC/QMRP) monitored behaviors and recommended modifications or changes to the active treatment program for 3 of 3 sampled clients (Client #9, 13 and 14) who were kept in physical restraints (Mendota) for long periods of time. The findings are: 1. Client #9 had diagnoses of Bipolar Disorder and Impulse Control Disorder. a. The Human Rights Committee (HRC) meeting conducted on 2/18/09, documented the client was in Mendota restraints for 720 minutes in 1/09. b. The HRC meeting conducted on 3/18/09, documented the client was in Mendota restraints for 4,955 minutes in 2/09. c. The HRC meeting conducted on 4/15/09, documented the client was in Mendota restraints for 12,540 minutes in 3/09. d. The HRC meeting conducted on 5/13/09, documented the client was in Mendota restraints for 3,820 minutes in 4/09. e. The HRC meeting conducted on 7/15/09,	W 159		

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documented the client was in Mendota restraints for 5,390 minutes in 6/09.

f. The HRC meeting conducted on 8/12/09, documented the client was in Mendota restraints for 17,809 minutes in 7/09.

g. The HRC meeting conducted on 11/24/09, documented the client was in Mendota restraints for 4,124 minutes in 10/09.

h. The HRC meeting conducted on 12/15/09, documented the client was in Mendota restraints for 2,464 minutes in 11/09.

2. Client #13 had diagnoses of PICA, Impulse Control Disorder and Self Injurious Behaviors.

a. The HRC meeting conducted on 5/13/09, documented the client was in Mendota restraints for 765 minutes in 4/09.

b. The HRC meeting conducted on 8/12/09, documented the client was in Mendota restraints for 7,048 minutes in 7/09.

c. The HRC meeting conducted on 9/16/09, documented the client was in Mendota restraints for 15,181 minutes in 8/09.

d. The HRC meeting conducted on 10/21/09, documented the client was in Mendota restraints for 8,895 minutes in 9/09.

e. The HRC meeting conducted on 11/24/09, documented the client was in Mendota restraints for 33,805 minutes in 10/09.

f. The HRC meeting conducted on 12/15/09,

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documented the client was in Mendota restraints for 11,055 minutes in 11/09.

g. The HRC meeting conducted on 1/20/10, documented the client was in Mendota restraints for 2,056 minutes in 12/09.

3. Client #14 had diagnoses of Mood Disorder, Pyromaniac, and Impulse Control Disorder.

a. The HRC meeting conducted on 3/18/09, documented the client was in Mendota restraints for 12,925 minutes in 2/09.

b. The HRC meeting conducted on 4/15/09, documented the client was in Mendota restraints for 14,120 minutes in 3/09.

c. The HRC meeting conducted on 5/13/09, documented the client was in Mendota restraints for 11,675 minutes in 4/09.

d. The HRC meeting conducted on 7/15/09, documented the client was in Mendota restraints for 13,157 minutes in 6/09.

e. The HRC meeting conducted on 8/12/09, documented the client was in Mendota restraints for 2,860 minutes in 7/09.

f. The HRC meeting conducted on 9/16/09, documented the client was in Mendota restraints for 4,987 minutes in 8/09.

g. The HRC meeting conducted on 12/15/09, documented the client was in Mendota restraints for 4,125 minutes in 11/09.

h. The HRC meeting conducted on 1/20/10,

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W 159	Continued From page 33 documented the client was in Mendota restraints for 6,719 minutes in 12/09. 4. On 1/27/10 at 10:00 a.m., Staff Member #7, the PhD Psychologist in charge of the Behavior Programming for these 3 clients, who resided on the locked living unit on Bond 1 East, was asked about the type of programming or changes in programming that was utilized to reduce the behaviors that caused the clients to be restrained. He stated they have group meetings on the unit to discuss the "Level" (more or less privileges) the clients had reached and what they had to do to increase in Levels. When asked if there was any individual counseling or therapy provided, he stated "No."	W 159		
W 183	483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure there was a sufficient number of staff to provide required supervision for 4 (Client #12, 15, 16 and #18) of 6 (Clients #12, 13, 14,15, 16, and 18) sampled clients who required special supervision. The	W 183		

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findings are:

1. Client #15 had diagnoses of Mild Mental Retardation (MR), Impulse Control Disorder, PTSD, and Depressive Disorder.

Client #16 had diagnoses of Moderate MR, Disruptive Behavior Disorder, Sexual Abuse of a Child Perpetrator, Parent Child Relational Problem, Nocturnal Enuresis and Obesity.

a. On 1/28/10 at 10:35 a.m., Client #15 was observed through a peephole in the bedroom door asleep after being placed on unit restriction. The only staff in the living unit were two staff (Employee #4 and Employee #32) providing one-to-to supervision for Client #13 and 14.

b. On 1/28/10 at 11:10 a.m. , Client #15 was still unattended in his bedroom. Client #16 was in the dayroom and the only staff present were the two staff providing one-on-one supervision for Client #13 and #14.

c. On 1/28/2010 at 11:15 a.m., Employee #4 stated that the 1 East unit staff member who was responsible for Client #15 had left the unit around 10:15 a.m. that morning.

d. On 1/28/2010 at 11:20 a.m., the Assistant Superintendent, Employee #5 was notified of the lack of supervision and confirmed the 1- on-1 staff were just responsible for the clients they were assigned to and there should have been a staff member left on the unit to attend to Client #15 and #16.

2. Client #12 had diagnoses of Profound Mental Retardation, PICA, Autistic Disorder, and

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W 183	Continued From page 35 Obsessive-Compulsive Disorder. a. The Individual Program Plan dated 2/11/09 under Medical Information documented, "My increased risk for aspiration and PICA behaviors continue to be major concerns... I had 10 visits to the facility clinic... and for PICA behavior review... I also had eleven outside visits. Most were for x-rays of foreign bodies swallowed." The plan under Psychology/Behavior documented, "...staff is concerned that I will engage in PICA behavior, so I have enhanced supervision [watched at all times] at all times. [Psychiatrist] recommends that this level of supervision continue at this time... during the past 12 months I had a total of 14 incidents of PICA." b. On 1/26/10 at 3:00 p.m. and 1/27/10 at 6:30 p.m., Client #12 was sitting in the hallway with 4 other clients. There was one staff member sitting in an office doing paperwork, approximately 10 feet from Client #12. 3. Client #18 had diagnoses of Impulse Control Disorder, Pedophilia, Schizoaffective Disorder, Moderate Mental Retardation, Hydrocephalus with cranial/peritoneal shunt, and Possible Seizure Disorder. a. The Person Centered Planned Annual Review Update dated 10/22/09 documented under Psychology/Behavior "The Behavior Support Committee met on 7/10/09 and determined that Sexually Inappropriate Behavior and Noncompliance would remain target areas for me. I have averaged 4 incidents per month in both areas... The supervision needs which are in	W 183		

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place for home visits, on the grounds and in the community remain valid and still need to be strictly followed..."

The IPP documented on page 14 "My Supervision Needs in Specific Activities: ...Toiling----Direct... Bathing/Grooming----Direct... Off Unit (in building)----Direct... Grounds----Direct... On campus----Direct... Off Campus Activities----Direct... Emergency Procedures----Direct.... Direct - Must have close supervision to and from all destinations..."

The IPP documented on page 15: "...Rights: Time and Space for Privacy: Comments Staff will make sure the bathroom is vacant before I enter."

b. DHHS (Department of Health and Human Services) Incident Report with a Date of Incident 12/5/09 and Time of Incident 3:05 p.m. documented, "On 12/5/09 at approximately 3:05 p.m. staff reported that [Client #18] and [Client #23] participated in inappropriate sexual activity, both anally and orally. [Client #18] indicated he initiated the activity, but [Client #23] indicated he consented. Both were sent to [hospital] for evaluation. [Superintendent] initiated an investigation. [Client #18] will be restricted to his room which is equipped with an alarm on the door which will alert staff if he attempts to leave..."

Interviews: "On 12/7/09 at 3;00 p.m... [Staff #23] said all of the men were in the dayroom when she arrived on the unit [she works evening shift, 3:00 p.m. to 11:00 p.m.]. She said that [Client #23] came and talked to her, said he missed her. She stated that [Staff #24] said [Client #18] had

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W 183	Continued From page 37 asked him if he could use the bathroom and he told him to ask another staff as he was one on one with another client." c. An FYI [For Your Information] MEMO dated 12/22/09 was sent to the Residential Training Supervisor and 3 South Residential Training Staff. "Special Equipment or Environmental Modifications I need: Due to my sexual issues I have a chime on my door..."	W 183		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was sufficient staff on duty to provide supervision in accordance with individual program plans for 5 (Clients #13, 16, 18, 23 and 25) of 25 (Clients #1 - 25) sampled clients who required supervision. The findings are: 1. Client #13 had diagnoses of Mild Mental Retardation (MR), PICA, Impulse Control Disorder, Self Injurious Behavior, and Mood Disorder. a. A psychological update dated 3/11/09 documented the client exhibited a long history of inappropriate behaviors including swallowing	W 186		

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W 186	Continued From page 38 objects, cutting self, hitting walls, and attempting to run away. b. The IDT [Interdisciplinary Team] Meeting, Unit: Special Treatment Team form dated 8/21/09 documented, "[Client 13's] met today following a report of [Client #13] being sent to the ER [Emergency Room] on this day for X-ray. According to staff, [Client #13] reported last evening ingesting objects, which were discovered through the X-rays today. Three objects were found: 2 rocks and 1 battery.... This is a crisis situation requiring Specific Safety Precautions to prevent further harm to himself. [Client #13] is currently at high risk of harm to himself and will remain in Wrist Mendota restraints with 1:1 supervision will be assessed every 24 hours." An Incident Report documented under section "Clear, Concise Narrative Description... Sept 2, 2009 9:18 a.m.... [Client #13] came to my office complaining of severe abdominal pain... He was transported to [hospital ER] and is scheduled for exploratory surgery/removal of objects on 9/2/09... Sept 14, 2009 at 11:06 a.m. [Client #13] returned to the facility after recovering from his surgery..." c. The IDT [Interdisciplinary Team] Meeting, Unit: Special Treatment Team form dated 1/7/10 documented, "The team met with [Client #13] as part of a group process meeting. It was noted that [Client #13] had been doing well for a period of time... He had earned Yellow level which carries as a reward, access to two of his personal electronics. He indicated the two items he would like to get were his TV and his plug in game controller... The team indicated he could have those specific items but only if they did not	W 186		

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W 186	Continued From page 39 include batteries or pieces that could be swallowed..." d. The Behavior Log documented the client obtained the TV and game controller at 3:15 p.m. on 01/07/10. e. An Incident Report dated 1/8/10 documented under "Clear, Concise Narrative Description: "On 17/10 at approximately 5:45 p.m., [Client #13] walked out of his room and stated to [Staff #15] , Shift Coordinator that he had swallowed a battery. He stated he turned his back to staff and put the battery in his mouth. [Physician] provided orders for [Client #13] to be transported to [hospital] for evaluation. He was subsequently admitted..." f. On 2/10/10 at 2:35 p.m., Employee #15 stated that Client #13 received a box on 1/7/10 that had been in storage and contained various items including batteries belonging to a TV remote that opened via a slide mechanism. He stated that Client #13 was on 1 to1 with a staff member sitting in the doorway during this time frame but apparently Client #13 turned his back to the staff member and ingested the battery. 2. A facility investigation, IRIS #29353, dated 12/7/09 through 12/9/09, documented the following information concerning "inappropriate sexual activity" between Clients #18 and 23 on 12/6/09 at 3:30 p.m. in the restroom on living unit Bond 3 South. a. Client #23 had diagnoses of Moderate MR, Mood Disorder and Schizophrenia Undifferentiated Type.	W 186		

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W 186	Continued From page 40 b. Client #18 had diagnoses of Impulse Control Disorder, Pedophilia, Schizoaffective Disorder, and Moderate MR. 1) The Person Centered Planned Annual review dated 10/22/09 documented, "Possible Barriers to Personal Goals: I am diagnosed as a Pedophile; therefore, I do not need to be around children or vulnerable adults without close supervision..." 2) A form with "Special Things to Consider About Me" dated October 2009 documented, "...When I need to use the bathroom in all my environments, I am to notify staff to ensure that no other person is in the restroom before I enter. 3) A DHHS (Department of Health and Human Services) Incident Report documented, the date and time of incident as 12/5/09 at 3:05 p.m. and the type of incident as "Client to client sexual activity." Under Clear, Concise Narrative Description" documented "On 12/5/09 at 3:05 p.m. staff reported that [Client #18] and [Client #23] participated in inappropriate sexual activity. [Client #18] indicated he initiated the activity, [Client #23] indicated he consented... [Administrator] initiated an investigation..." c. The "Synopsis" completed by the Administrator documented, "On 12/6/09 at approximately 3:30 p.m. it was reported that [Client #23] and [Client #18] engaged in inappropriate sexual activity in the restroom on Bond 3-South. I have reviewed the investigative report submitted by [Staff #16], Investigator. It is substantiated that sexual activity occurred and that although it was initiated by [Client #18], [Client #23] did not object to participating in the	W 186		

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activity. The Team will meet to review the need for increased supervision during shift change to ensure that [Client #18] does not go into the restroom without staff supervision when he is in the common area on the unit. [Client #18] has an alarm on his door to alert staff when he leaves the room." "CLOSED".

d. Page 2 of 2 of the "Administrative Directives" documented, "It is substantiated that [Client #18] and [Client #23] willingly participated in sexual activity. [Client #18] took advantage of an opportunity to enter the restroom without proper supervision during shift change. [Client #23] did not object to the sexual activity. This is determined by the following reasons:

1) [Client #18] admitted to entering the restroom without advising staff and engaged in sexual activity with [Client #23].

2) [Client #23] admitted to agreeing to participate in the sexual activity with [Client #18]."

e. NOTE: Client #23's Person Centered Planned Annual Review dated 12/8/09 documented the parents were the legal guardian. Client #18's Person Centered Planned Annual Review dated 10/22/09 documented his sister was the legal guardian. Both guardians have appointed legal guardian and could not consent to consensual sex.

3. Client #14 had diagnoses of Impulse Control Disorder, Depressive Disorder and Mood Disorder.

The Behavior Plan dated 8/14/09 documented, "[Client #14] behavior over a significant period of

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time both in this facility and environment and in numerous other treatment programs demonstrated an ongoing threat to self and others. ... The IDT [Interdisciplinary Team] determined that in order for [Client #14] to receive sufficient support at all times he must be consistently supervised, therefore he will always be on Dangerous Behavior Precautions [see comment section below for instructions]... Comments The client will remain in continuous sight of staff at all times..."

Client #16 had diagnoses of Disruptive Behavior and Sexual Abuse as a Child.

a. A DHHS Incident Report documented an incident occurred on 12/5/09, time unknown and the type of incident was "Mal-Physical". The alleged perpetrator was Client #14 and the victim was Client #16.

b. The "Synopsis" signed by the Administrator documented, "On 12/8/09 [Client #14] reported to staff on the evening shift that on 12/5 he was involved in inappropriate sexual activity with another client, [Client #16]. [Client #14] stated that he tied up [Client #16] with a shoe string and had anal sex. He stated he had to tell somebody because it was on his conscience. [Client #16] was questioned and stated the incident occurred but that it was not anal sex, that [Client #14] inserted an ink pen into [Client #16's] rectum. I have reviewed the investigative report submitted by [Staff #16]. It appears that sexual activity did occur between [Client #14] and [Client #16]. However, it does not appear that [Client #16] objected to the act. [Client #14] is currently on one-on-one supervision and has been placed in restraints due to a physical attack of staff. Both

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clients will [be] separated and are under close supervision. Guardian notification of the results of the investigation will be made."

c. Page 2 of 2 of the "Administrative Directives" documented, "Sexual maltreatment is not substantiated for the following reasons:

1) [Client #14] and [Client #16] both have a history of engaging in sexual activity and making false allegations.

2) [Client #14] and [Client #16] both have a history of not telling the truth when questioned.

3) [Client #16], by history, is a sexual perpetrator rather than victim.

4) [Client #16] did not ask for help to stop the incident, nor did he report it."

d. [Client #14] is documented as his own guardian, however [Client #16] had been adjudicated incompetent and has a legal guardian.

d. NOTE: Client #16 has an appointed legal guardian, as documented on the incident report, and cannot legally consent to consensual sexual activities.

4. Client #25 had diagnoses of Mild MR, Bipolar Disorder and Oppositional Defiant Order.

a. A DHS Incident Report documented an incident dated 1/15/10 at 8:05 p.m. and the type of incident was "Mal-Sexual".

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b. Page 1 of 5 of the "Synopsis" signed by the investigator [Staff #28] documented, "On January 15, 2010, [Staff #3], Residential Care Staff, on [Bond] 1 East, reported that he found [Client #16] and [Client #25], clients, in the courtyard having oral sex. Both clients stated they had consensual oral sex in the courtyard around 8:05 p.m. on the above date. Report was made to [Staff #4], Superintendent [Administrator]"

c. On page 1 of 2 the Administrator documented in the "Synopsis", "I have reviewed the investigative report submitted by [Staff #28], Investigator. Due to evidence gathered during this investigation, it is clear that this incident did happen but seems each client was a willing participant."

d. Page 2 of 5 of the investigative report documented [Client #25] was a Respite Admission on 10/2/09. He had diagnoses of Mild MR, Bipolar Disorder and Oppositional Defiant Disorder.

e. Page 4 of 5 of the investigative report documented under "Relevant Facts":

"1. [Client #16] and [Client #25] admitted to meeting in the courtyard on the date and time listed above and having consensual oral sex. They both stated there was no aggression or force on either part.

2. According to medical, there were no signs of trauma.

3. Reporter [Staff #3], RCT [Residential Care Technician], and [Staff #13], Evening Supervisor,

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W 186	Continued From page 45 and clients, [Client #16] and [Client #25] were interviewed. 4. All appropriate departments/agencies/guardians were contacted." f. NOTE: Client #16 has had appointed a legal guardian according to the incident report and cannot legally consent to consensual sexual activities. This was not identified by the investigative officer or the Administrator.	W 186		
W 191	483.430(e)(2) STAFF TRAINING PROGRAM View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs. In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as: · Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals, refer to W150); Use of behavioral principles in training	W 191		

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W 191	Continued From page 46 interactions between staff and individuals; · Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures; · Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.; · Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and · Use of positive behavior intervention programming. §483.430(e)(2) Probes Does the staff training program reflect the basic needs of the individuals served within the program? Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served? For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Complaint #15117, substantiated, all or in part, in these findings.	W 191		

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W 191	Continued From page 47 Based on record review and interview, the facility failed to ensure that they followed their own policy and procedure for retraining staff following a maltreatment allegation for 4 facility employees (Employee #4, 7, 17 and 18). The findings are: 1. Facility policy #3004-1 F 4 documented, "Any employee who is involved in any way with any aspect of a case of maltreatment and who is not terminated will be required to attend training relative to maltreatment prevention, reporting and investigation. The on-site administrator shall specify the training course (s) and ensure that documentation of training is maintained." 2. IRIS #26773 dated 2/25/09 documented, Employee #19 reported that she witnessed Employee #7 place a belt around Client #13's neck. An investigation was conducted with the maltreatment unsubstantiated, but the investigative report documented this technique was not appropriate for demonstrating to Client #13 the correct and incorrect method of keeping track of his belt. On 2/12/10 at 9:30 a.m., Employee #11, in charge of training, could not provide any documentation that Employee #7 had received retraining following the above incident. On 2/18/10 at 10:45 a.m., the Superintendent/Administrator stated that the technique Employee #7 mishandled the incident and she understood he had a refresher. 3. IRIS 28752 dated 10/7/09 documented, Client #22 alleged that Staff Member #18 kicked and slapped him. An investigation was conducted	W 191		

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W 191	Continued From page 48 with the maltreatment unsubstantiated. On 2/17/10, Employee #11 could not provide any documentation that Employee #18 had received retraining following the above incident. 4. IRIS #29884 dated 1/16/10 documented, Client #14 alleged that Staff Member #4 and Staff Member #17 pushed him into the wall causing him to hit his head on the wall. Client #14 sustained facial injuries consisting of his lip being cut, a bump on his head and a bloody nose and was taken to the emergency room for treatment. An investigation was conducted with maltreatment unsubstantiated. On 2/17/10, Employee #11 could not provide any documentation that Employee #4 and 17 had received retraining following the above incident. 5. On 2/18/10 at 10:45 a.m., the Administrator stated that if a client retracts an allegation of maltreatment, then retraining is not required.	W 191		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client	W 249		

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received a continuous active treatment program. This failed practice had the potential to affect 5 (Clients # 1, 3, 4, 12, 18) of 18 sampled clients. The findings are:

1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder, Autistic Disorder, General Convulsive Epilepsy, Glaucoma, Cataract, Acne, Peridontals Disease, Chronic Tinea Pedis and Chronic Dry Skin.

a. The Client's 24 hour Schedule dated 01/19/10, documented "Daily Activities" between the hours of 5:30 p.m. through 9:00 p.m.

b. The client was not observed in the day room on 1/27/10 at 6:30 p.m.. At 6:45 p.m., he came in with his coat and hat on and went to his room. The surveyor did not see him again before she left the facility at 7:30 p.m..

2. Client #3 had diagnoses of Moderate Mental Retardation, Schizophrenia, Paranoid Type, Insulin Dependent Diabetes, History of Seizures; History of Anemia, Edentulous, Osteoarthritis, Knee Joint Space narrowing, Bilaterally Knees Onychomycosis, Bilaterally LE, Gastroesophageal Disorder and Chronic Constipation.

a. The Client's 24 Hour Schedule dated 10/09/09 documented only daily activities from 5:30 p.m. to 7:00 p.m.. From 7:00 p.m. to 9:00 p.m., the schedule documented "PCP Trng/Laundry (W & F - 3-E-B). There was nothing else listed for this 2 hour time slot.

b. On 01/27/10 at 6:30 p.m., the client was in the day room sitting in a chair in the television area,

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W 249	Continued From page 50 just looking around, watching everyone else, not interacting with anyone. 3. Client #4 had diagnoses of Profound Mental Retardation, Colon Cancer, Deaf and Mute, Impulse Control Disorder, Autistic Disorder, Obsessive Compulsive Disorder, PPD Reactor, History of TB Meningitis, Presbyopia, Astigmatism, Myopia, Hemorrhoids, and Abdominal Surgery - excision of cancerous tumor. a. The Client's 24 Hour Schedule dated 9/21/09 documented only daily activities from 5:30 p.m. to 9:00 p.m. b. On 1/27/10 at 7:05 p.m., Client #4 was found sitting in the day room on the left side of the room on the end of a couch. There was no interaction with anyone else in the room. He was still sitting there when the surveyor left the facility at 7:30 p.m. c. There were no structured activities in evidence in the unit from 7:05 p.m. through 7:30 p.m.. One staff was in the day room constantly with another staff in and out. Again, there was no client/staff interaction. d. On 2/3/10 at 3:15 p.m., Client #4 was seen in his room lying on his bed with his street clothes on. He appeared to be asleep, the surveyor did not touch him. 4. On 2/18/10 at 10:45 am, an interview was conducted with the Administrator addressing the absence of activity offered after supper. The Administrator stated that they are supposed to be doing objectives and they are supposed to be	W 249		

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doing structured leisure activities. She also stated that they had purchased games and videos for the clients.

a. On 1/27/10 at 7:00 p.m., Staff #28 and #29 were playing dominoes with 3 other clients. The surveyor asked them what the other clients were supposed to do and they stated that they all could do whatever they wanted to do. When asked about games or programs, they stated that no, they are playing dominoes because [a client] brings the dominoes from his room to play.

5. Client # 12 had diagnoses of Profound Mental Retardation, PICA, and Autistic Disorder, Obsessive-Compulsive Disorder, Allergic Rhinitis, Chronic Ear Infection, GERD, Onychomycosis, Obesity, Acne Vulgaris, Dysphagia, and Anemia.

a. On 1/26/10 at 3:30-4:30 p.m. and on 1/27/10 at 6:30 p.m. during observation of Unit 2-East, Client # 12 was sitting in the hallway with 4 other clients, one staff member was sitting in an office doing paperwork, approximately 10 feet from Client # 12. There were 2 clients sitting in the TV area. Five (5) clients were walking around the halls. There was no structured activity going on for the clients who needed structured leisure activities.

b. The Individual Program Plan, in Medical Information documented: [Client # 12] had a physical exam on 12/12/08 and documented : my increased risk for aspiration and PICA behaviors continue to be major concerns....Client had 10 visits to the facility clinic....and for PICA behavior review. The next paragraph documents there were 11 outside Physician visits most were for

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W 249	Continued From page 52 x-rays of foreign bodies swallowed. The plan Under Psychology/Behavior documented, staff is concerned that client will engage in PICA behavior, so client had enhanced supervision at all times. The doctor (psychiatrist) recommends that this level of supervision continue at this time. Paragraph 2 documented, during the past 12 months the client had a total of 14 incidents of PICA There were no changes made to the Active Treatment plan after the 14 incidents of PICA behaviors. c. On 2/19/10 at 1:00 p.m. during Exit Conference this resident and others who needed supervision were discussed. Client #12 had PICA behaviors 14 times while having Enhanced Supervision. The Superintendent/Administrator stated that was too many times for client being supervised. 6. Client #18 had diagnoses of Impulse Control Disorder, Pedophilia, Schizoaffective Disorder, Moderate Mental Retardation, Hydrocephalus with cranial/peritoneal shunt, and possible seizure disorder. a. The Person Centered Planned Annual Review Update dated 10/22/09 documented under Psychology/Behavior "The Behavior Support Committee met on 7/10/09 and determined that Sexually Inappropriate Behavior and Noncompliance would remain target areas for me. I have averaged 4 incidents per month in both areas... The supervision needs which are in place for home visits, on the grounds and in the community remain valid and still need to be strictly followed..."	W 249		

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W 249	Continued From page 53 The IPP documented on page 14 "My Supervision Needs in Specific Activities: ...Toiling----Direct... Bathing/Grooming----Direct... Off Unit (in building)----Direct... Grounds----Direct... On campus----Direct... Off Campus Activities----Direct... Emergency Procedures----Direct.... Direct - Must have close supervision to and from all destinations..." The IPP documented on page 15: "...Rights: Time and Space for Privacy: Comments Staff will make sure the bathroom is vacant before I enter." b. DHHS Incident Report Dated 12/6/10 documented: On 12/6/10 at approximately 3:05 p.m. staff reported that [Client # 18] and [Client # 23] participated in inappropriate sexual activity, both anally and orally. [Client # 18] indicated he initiated the activity, but [Client # 23] indicated he consented. Both were sent to UAMS for evaluation. Superintendent initiated an investigation. [Client # 18] will be restricted to his room which is equipped with an alarm on the door which will alert staff if he attempts to leave..... DHHS Incident Report Dated 12/6/10 at 3 p.m. Interviews documented : "... [Staff # 23] stated when she arrived all of the men were in the dayroom (third paragraph) [Client # 23] came and talked to her. [Staff # 23] stated that [Staff # 24] told her [Client # 18] had asked him if he could use the bathroom and [Staff # 24] told him to ask another staff as he was one on one with another client..." There was no follow up documentation to show that Staff # 24 assisted Client # 18 to get someone to go with Client # 18 to the bathroom.	W 249		

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W 249	Continued From page 54 c. An FYI [For Your Information] MEMO dated 12/22/09 was sent to the Residential Training Supervisor and 3 South Residential Training Staff. "Special Equipment or Environmental Modifications I need: Due to my sexual issues I have a chime on my door..." d. Client #18's medical chart documented the need for direct supervision and that the client averaged 4 incidents per month in sexually inappropriate behavior or aggression through the year 2009 to 2/19/10. The Active Treatment Plan did not document new interventions to prevent behaviors or decrease risk of harm to other clients.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Complaint #15117, substantiated, all or in part, in these findings. Based on interviews and record review, the facility failed to ensure that two sampled Clients (#17 and 21) were transported to their respective Hospital Emergency rooms in a manner consistent to meet client's needs. These failed practices resulted in Immediate Jeopardy (IJ) which caused or could have caused serious harm, injury or death to Client #17 who sustained a fall that resulted in a fractured hip and Client #21 who had an oxygen saturation of 78% after a choking incident and staff cancelled or failed to contact the ambulance service to transport the clients for emergency medical care. The Interim	W 331		

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W 331	Continued From page 55 Administrator was informed of the Immediate Jeopardy on 2/10/10 at 4:00 p.m. The findings are: 1. A memo received by the surveyors on 2/10/10 at 2:20 p.m., was addressed to all staff from the Quality Assurance Coordinator and was dated 3/26/08. The memo documented: "All falls should be reported to medical as soon as possible. The client should not be moved until he has been seen by a nurse. If there should be broken bones or internal injuries to vital organs, it could cause more damage having them moved. Try to encourage them to remain where they are if the area is safe, offer them reassurance, but do not restrain them. If the client refuses to remain still, document on a Behavior Report as well as the Marks Report that the client was encouraged to remain still for medical to exam, but client refused." 2. Client #17 was admitted 5/22/78 with diagnoses of Severe Mental Retardation and Hypertension. a. Nurses' Notes dated 4/23/09 documented the client experienced a fall and was transferred to the hospital. Hospital emergency room records dated 4/23/09 documented the client had a fractured hip and the client was admitted. The hospital operative note dated 4/24/09 documented "...suffered a fall yesterday evening late and had a highly comminuted, unstable, 4-part intertrochanteric fracture of his right hip... " b. On 2/3/10, Employee #6 stated there had been an incident where a client was transported	W 331		

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to the emergency room via facility van following a probable hip fracture after instructions from the Superintendent to cancel the ambulance that had been called by Nursing Staff Member #10.

c. Written statements dated 4/23/09, from Staff #10 and Staff #23, documented Staff #13, the Evening Shift Coordinator, came to the scene and had a telephone conversation with the Administrator concerning the client. Staff #13 stated that the Administrator had said to cancel the ambulance and transfer the client to the hospital via a facility van. This directive was carried out.

On 2/5/10, a copy of written documentation from Employee #10 was received that described the findings that occurred on 4/23/09 regarding Client's #17 fall and transfer to the emergency room. This was not dated but was signed by Employee #10. Employee #10 documented that Client #17 was pushed by another client to the floor and when she got to him, he was standing holding onto a file cabinet screaming he couldn't walk. Employee # 6, a registered nurse, was called and assessed the client and determined he had a possible fracture. Employee #10 and Employee #6 agreed for the RN (Employee #6) to stay with the injured client and for the LPN (Employee #10) to call the doctor and an ambulance for transfer. After doing this, the Shift Supervisor (Employee #13) stated we had to cancel the ambulance because the Superintendent said not to send him by ambulance. A staff member called and canceled the ambulance and Client #17 was transferred to the emergency room by facility van.

d. Staff #13 was interviewed per telephone on

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2/19/10 at 9:15 a.m. In relation to the above fractured hip, he stated he had telephone contact with the Administrator concerning the injury, but he could not remember the exact discussion. He stated the end result of the conversation with the Administrator was to cancel the ambulance and transport Client #17 via the facility handicap van to the Emergency Room. He confirmed he cancelled the ambulance per the Administrator's direction.

e. On 2/17/10, a visit was made to the Ambulance Service. Records from 4/23/10 documented that a call was made at 8:52 p.m. for a transfer by Employee #10 with a cancel order (no name) prior to facility arrival with the facility transferring the client themselves.

f. On 2/2/10 at 1 p.m. and subsequent follow up interviews, the Interim Director of Nurses (IDON) described an incident on 4/23/09, where Client #17 had fallen in the living unit, fracturing his left hip. The IDON stated the client had been placed in a wheelchair, prior to her examining him and she noted a rotation of the left leg and foot which was indicative of a hip fracture. The client was screaming and in obvious pain as she examined his leg. The IDON stated she asked for an ambulance to be called. At this time, the IDON stated she was called away to handle an emergency on another unit.

On 2/10/10, at 4:00 p.m., the IA (Interim Administrator) stated the Administrator should not have had the ambulance cancelled, as it was the facility practice for medical to make that determination.

3. Client # 21 had diagnoses of Schizophrenia,

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Severe Mental Retardation, Disc Herniation and Stenosis, Osteopenia, Lumbar Spine, Osteoporosis Left Hip, Hemorrhoids, Internal Hyperplastic Rectal Polyp, and Malformation in the Rectum.

a. An Incident report dated 5/7/09 documented that on 5/7/09 at 5:30 p.m. Client # 21 choked on a piece of corned beef. The Heimlich procedure was immediately administered and the piece of meat was removed. Client # 21 was then taken to Saline Memorial Hospital for evaluation. He was subsequently admitted for pneumonia in his right lung.

b. The Nurses Notes dated 5/7/10 at 5:30 p.m. and signed by Staff # 10 documented: "Client in dining room eating meal- got choked on a large piece of meat, Heimlich Maneuver started with no avail, client turning blue and losing consciousness, 911 was called. Mouth sweep done by Staff #6 large piece of meat removed- Doctor notified. Received order to transfer to ER for evaluation. B/P 167/107, Pulse 123, Respiration 24 and pulse ox 78. [Oxygen Saturation 78%] Client condition to be shaky - Staff # 14 notified and said not to send client out by ambulance." The Nurses Notes dated 5/7/10 at 6:30 p.m. and signed by Staff # 10 documented: "Transferred to[Hospital Name] Emergency Room via Staff."

c. The Nurses Notes dated 5/7/10 @ 6:30 p.m. and signed by Staff # 6 documented: "Doctor was notified immediately of the trauma the client had experienced and his decrease in sat. rate secondary to trauma and ordered client to be transported to nearest facility for noted distress. Client transport was delayed for forty and

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minutes to be transported by facility van. Client medically by Vital Sign report and pulse ox unstable."

4. Nursing Standard of Practice in event of Emergency/Incident 1) Nursing assesses Client 2) Nursing notifies the Physician and the Physician makes the decision after the Nurse relates the information to him/her of how the client should be transported.

Clients #17 and #21 were transported via facility van with no Emergency Equipment available or Staff present who were qualified for emergency care during transport.

5. After the system failure on April 23, 2009 with Client # 17 and then again on 5/7/10 with Client # 21. Administrator called a meeting at 1 p.m. on May 8, 2009 regarding the incident of Client # 21 and " it was decided to make some guidelines for incidents of this kind."

A document dated May 8, 2009 titled GUIDELINES FOR EMERGENCY INCIDENTS documented:

1) When an emergency/incident arises on a unit and a nurse is needed a call needs to be placed to the switchboard announcing "NURSE NEEDED STAT" on that unit.

2) Medical will assess and determine whether a client needs to go out to the hospital.

3) 911 will be called and no 911 calls will be cancelled unless medical makes the cancellation.

4) Superintendent will be notified of the incident

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W 331	Continued From page 60 by the Evening Supervisor/Shift Coordinator and a follow up telephone call will be made to Superintendent by Medical Department by the end of the Shift. 6. The facility fully removed the Immediate Jeopardy on 2/10/10 at 4:30 p.m. when they implemented the following Plan of Removal: a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m. b. On 2/10/10, at 4:30 p.m. The Interim Administrator/Superintendent notified the medical department and department heads that the facility will follow its own practice of the medical department making all decisions as to the method of transfer of clients who have received injury and required medical treatment outside the facility. This action was conducted in order to prevent any reoccurrence of this incident. c. Staff inservice started on 2/10/10 by the Interim Administrator/Superintendent and was continued on each shift.	W 331		
W 363	483.460(j)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on record review and interview, the consultant pharmacist during the past 12 months failed to identify and report to the physician and IDT whether or not there were any irregularities	W 363		

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W 363	Continued From page 61 found in the drug regimen reviews of 12 (Clients #1 - 12) of 12 sampled clients (Client #1-12) who received medications. The findings are: For the past 4 quarters, the consultant pharmacist signed beside typed statements that documented, "I have performed a quarterly pharmacy review." There was no documentation whether there were any irregularities found or not. a. The consultant pharmacist was interviewed on 2/18/10 at 2:30 p.m. concerning these reports. She asked what information was required on the quarterly reviews. When it was explained to her, she stated she would get it corrected.	W 363		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Self-Administration of Medications (SAM) training was provided as recommended by the Interdisciplinary Team (IDT) for 3 of 3 (Clients #1, 19 and 20) sampled clients who were assessed for SAM training. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder, and Manic without Psychotic Features.	W 371		

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W 371	Continued From page 62 a. The Individual Program Plan (IPP) dated 1/13/10 documented, in Training Objectives During Self-Administration of Medication (SAM) training, "I will independently identify by pointing to the medication Lithium during each medication pass for 60 consecutive days." b. On 2/3/10 at 7:45 a.m., Staff #25 administered Lithium 300 mg, but did provide any SAM training. 2. Client #20 had diagnoses of Mild Mental Retardation and Hyperlipidemia. a. The Individual Program Plan (IPP) dated 1/10/09 documented,: Service Objectives... During SAM training I will Independently state the name of my medication Lipitor during morning med pass for 30 consecutive days through 3/19/10. b. On 2/3/10 at 7:42 a.m., Staff #25 administered the client's medications but did not provide any SAM training. c. On 2/3/10 at 7:55 a.m., Staff #25 was asked if there was anything else she needed to do and she stated that was all. This surveyor went to observe another nurse passing medications while Staff #25 finished passing the rest of the clients' medications. 3. Client #19 had diagnoses of Profound Mental Retardation, Impulse Control Disorder, Cerebral Palsy, Severe Spastic Quadriplegia, Profound Sensorineural Hearing deficit, PUD with hx of bleeding, Seizure Disorder, Osteoporosis, and Severe Periodontal Disease.	W 371		

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W 371	Continued From page 63 a. The Individual Program Plan dated 1/17/09 documented, "During prerequisite SAM training, I will with gestural prompts cooperate with the nurse and swallow my medications at each medication pass per month by 11/17/10." b. On 2/3/10 at 7:30 a.m., Staff #26 administered the client's medications. Staff #26 punched medications into a medication cup and administered them to the client. The client swallowed the pills without gestural prompting. Staff #26 did not provide any SAM training.	W 371		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure a mattress was in good shape. This failed practice had the potential to affect all 101 clients. The findings are: In Client Room 332, there were indentations on both sides of the mattress that was facing up.	W 418		
W 456	483.470(l)(2) INFECTION CONTROL The facility must implement successful corrective action in affected problem areas. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the C-PAP mask was stored in a bag to prevent potential contamination and the humidifier reservoir was cleaned for 1 of 1 (Client #22) sampled client who required the use of a C-PAP machine. The	W 456		

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W 456	Continued From page 64 findings are: Client # 24 had diagnoses of Schizo-Affective Disorder, Childhood Disintegrated Disorder, PICA, Bipolar Disorder Type I, Profound Mental Retardation, Hypertension, Obstructive Sleep Apnea, and Allergic Rhinitis. a. On 2/17/10 at 1:30 p.m., the client's C-Pap machine face mask was lying in the floor and was not in a protective bag. The C-Pap was hooked to an oxygen concentrator and had a humidifier reservoir. The water in the reservoir was brown with floating brown slimy looking debris in the water. b. The February 2010 Medication Administration Record: (MAR) documented, "1. C-PAP on qhs [every bedtime]. If humidifier is used make sure distilled water is replaced daily prior to use. 2 Daily: Wash mask with warm soapy water, rinse, allow to air dry on paper towel q am [morning], then place in plastic bag for storage during time not in use... Weekly: 3. wash humidifier [if used] and tubing with warm soapy water, rinse and soak in 1 part white vinegar and 3 parts water for 30 minutes, rinse, allow to dry, date and initial when done. Weekly: 4. change plastic bag date and initial. Store this in bin if reusable foam filter is used wash with warm soapy water, rinse, dry with paper towel., If disposable filter is used replace as needed." There was no date as to when these orders were written. c. The active treatment plan titled "My Plan" dated 7/15/09 documented, "S4 To help me manage my sleep apnea, I will be provided with: A) Monitoring proper functioning of CPAP machine B) Nightly monitoring of CPAP	W 456		

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W 456	Continued From page 65 machine by life skills Staff for correct usage of CPAP machine C) Medical staff will clean CPAP weekly." d. On 2/17/10 at 1:37 p.m., Nursing Staff #6 stated she didn't know what that was but she did know they changed the humidifier water once a week and cleaned it with Vinegar and water. Staff #6 stated she did not know that the C-Pap had that reservoir and two other Licensed Practical Nurses, LPN #25 and 26 in the Medication room did not know about it either, they knew the humidifier on the Oxygen Concentrators were there. f. On 2/17/10 at 1:45 p.m., Nursing Staff # 6 brought the humidifier down to the Medication room and stated she tried to clean it but after she put water in it still had the brown algae looking stuff sticking up from the bottom like tentacles. She stated they would clean it with Vinegar and water and soak it to see if it would come clean. g. Nurses notes dated 12/4/09 at 9:30 a.m. documented, "Seen clinic by [Advanced Practice Nurse] for greenish nasal drainage, New order received." h. Nurses notes dated 12/4/09 at 11;10 a.m. documented, "Order rec'd [received[for Z-pak..." i. Nurses notes dated 12/11/09 at 10:00 a.m. documented, "Seen in clinic by [Advanced Practice Nurse] for continued running nose per staff. No new orders."	W 456		
W 468	483.480(b)(1) MEAL SERVICES Each client must receive meals at regular times comparable to normal mealtimes in the	W 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G001	A. BUILDING _____ B. WING _____	C 02/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 468	Continued From page 66 community. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure snacks were provided for all 101 clients. The findings are: 1. On 2/11/10 at 9:15 a.m., Staff #23 was asked if they always had snacks available for the clients. She stated, No, they didn't always, but when they did, it would be sent up on the supper food cart. 2. On 2/17/10 at 1:50 p.m., Staff #20 was asked if they always had snacks available. She stated that they did not always have snacks. 3. On 2/18/10 at 2:45 p.m., the kitchen supervisor was asked if the kitchen always had snacks for the clients. She stated, no, but they had sent some out earlier in the week, when fruit came into the kitchen. She also stated, "No, we don't always have them. I guess we don't have the money. When we have snacks, we send them on the supper cart and if the cart is too full, we will take the snacks up later."	W 468		
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients were provided condiments for meal service. This practice has	W 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 484	Continued From page 67 the potential to affect all 101 clients. The findings are: 1. On 2/2/10 at 7:50 a.m., a client living on Bond 3 East, asked for some jelly as he held out a piece of bread. The staff told them there was not any, but he could have syrup. 2. On 2/11/10 at 9:15 a.m., Staff #23 was asked why they didn't have any condiments (mustard, mayonaisse, catsup, jelly, and jelly) in the kitchen. She stated that they do not have any and sometimes there is no "sweet and low" and the clients have to use syrup on their oatmeal. 3. On 2/17/10 at 1:50 p.m., Staff #20 was asked about the availability of fruit and snacks. She stated that they didn't have them all the time.	W 484		