ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Long Term Care
P.O. Box 8059 slot S-404 · Little Rock, AR 72203-8059
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https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/index.aspx

CERTIFIED MAIL #7006 3450 0003 0882 1241

March 23, 2010

Charlie Green, Administrator
Alexander Human Development Center
14701 Highway 111 South
Alexander, AR 72002

Dear Mr. Green:

On February 19, 2010, a recertification and complaint survey was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by March 24, 2010.

We will be conducting a revisit to your facility to verify that substantial correction has been achieved and maintained. If we find that your facility has made substantial correction at the time of the revisit, we will certify your facility in compliance.

If you have any questions concerning this letter, please contact me at (501) 682-8430.

Sincerely,

Sandra Broughton, Program Manager
Office of Long Term Care
Survey & Certification Section

cc: file

T1 3/23/10 - B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2010
FORM APPROVED
OMB NO. 0938-0391

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
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. Revised CMS 2567. This CMS 2567 supercedes the previous CMS 2567 sent on 3/9/10.	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.	W 102	W102 (483.40) 1.On 2/10/10 at 4:30 p.m. the Interim Administrator/Superintendent notified the medical department and dept. heads that the facility will follow its on 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. 2. Client #17 was transported to hospital emergency room and received treatment for the fractured hip. Client#21 Proper standard of care was provided to this client. The staff was trained in proper Choking Rescue Procedure; the technique was administered by the Registered Nurse Supervisor and the client successfully recovered from the choking incident. The nursing staff followed standard post incident medical evaluation procedures and in doing so identified a lower than acceptable oxygen saturation level. At that time, following standard nursing practice, the client was transported to the hospital emergency room and received appropriate emergency medical evaluation and treatment. This incident has been used to reinforce and retrain nursing staff as to their proper protocol for post choking incident assessments and follow up respiratory treatment. Nursing staff was retrained on 2/10/10 and again on 3/18/10. Client #13 was appropriately assessed and appropriate emergency response stabilization and treatment was provided by nursing staff and recommendation for transfer by EMS to the nearest hospital was made. Client was transferred and admitted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Supt — (X6) DATE: 3/19/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 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 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	W 102	to the hospital for appropriate and successful surgical intervention. The Medical Emergency Transportation SS-BO-06 Policy was in place effective May 2009. The facility staff and medical staff were retrained on 2/10/10 and will continue to ensure that its own policies and procedures are followed consistently. Retraining of all staff on this policy will also continue on at least an annual basis. 3. Please see #1 above. a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m. b. Facility will follow its own practice and policy of the medical department making all decisions as to injury and required medical treatment outside the facility. c. Staff retraining regarding outside medical transfer on 2/10/10 by Interim Superintendent/Administrator and continued on each shift. Staff retraining was completed on 2/11/10. Outside medical treatment and transportation will be monitored monthly by Nursing Services Unit Manager and Quality Assurance Coordinator.	3/24/10

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W 102	Continued From page 2 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 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	W 104	W104 Facility treated for roaches facility wide on 2/4/10, 2/25/10 and 3/11/10. Facility will follow its pest control contract which indicates that the client housing areas are treated for pests twice monthly. Quality Assurance Coordinator has a copy of Pest Control documentation available for review effective 3/17/10. Pest Control Contract is in file in Business Manager's office.	3-24-10

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W 104	Continued From page 3 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 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	W 104	All drawers in chest drawers, end tables and dressers have been evaluated in each client room facility wide. Evaluation was completed on 3/17/10 by maintenance and Residential Services Director.. All furniture in client rooms will be repaired by 3/21/10 by maintenance.. Client furniture will be replaced on as needed basis effective 3/21/10. Facility stated being repainted on 3/1/10 and is being repainted on an ongoing basis. This will continue and be a constant and ongoing process. Bathroom sinks/showers have been cleaned by custodial staff and sinks have been secured to walls by maintenance and replaced where necessary effective 3/15/10. All staff has been retrained regarding regulations regarding covering, labeling and storing food effective 3/21/10 by Dietary manager and Program Coordinators.. Closet doors have been evaluated facility wide. Closet doors have been repaired by maintenance and replaced as appropriate effective 3/18/10. Tiles have been replaced by maintenance where necessary facility wide effective 3/18/10. Individual client rooms have had light switches installed by maintenance where needed or clients have been reassigned to rooms with working light switches effective 3/24/10. 1. Facility has pest treatment plan in place and plan has been reviewed by Administration and updated as necessary. Plan will be reviewed by management team every 6 months to ensure that plan is appropriate and effective in pest elimination. Staff will check and copy QA Coordinator any time that pests are observed within the facility and log will be kept regarding as needed pest control	

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W 104	Continued From page 4 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. 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	W 104	treatment. Facility Quality Assurance Coordinator will evaluate and report upon pest control log on a monthly basis. Client #15's room was treated for insects on 2/4/10, 2/25/10 and 3/11/10. Facility wide treatment for insects occurred on 2/25/10 and 3/11/10 and is continuing on a bi-weekly basis and more often as necessary. Clients will be encouraged not to bring food items into their rooms but to eat all snacks and meals in designated dining areas. Staff will be trained to encourage clients to eat snacks in designated dining areas in their individual living areas. 2. Please see #1 above. Kitchen was treated for pests on 2/25/10 and 3/11/10. Treatment is continuing on a bi-weekly basis and more often if necessary. 3. Please see #1 above in regard to pest control treatment in the bedroom of client#15. 4. 1 South Observations: a. Dresser Drawers of the chest in client room 113 will be repaired by maintenance. Please see above regarding specific action taken to address client furniture issues facility wide. b.Bath/Shower room has been thoroughly cleaned and treated for mildew by Residential Care Staff and Custodial Staff.. Client bathrooms will be cleaned daily effective date of 3/19/10 with documentation on a bathroom cleaning schedule form on each unit. Program Coordinators/QMRPs will check bathroom cleaning schedule for each client bathroom on their living unit on a weekly basis to	

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W 104	Continued From page 5 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 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	W 104	Ensure bathrooms were cleaned with a particular emphasis on elimination of mildew. Program Coordinators/QMRPs will forward all bathroom cleaning schedules to QA Coordinator for document retention and will maintain a copy for themselves. QA Coordinator. will conduct random bathroom audits on a monthly basis effective 3/19/10. c. The ceiling in Client Room 118 has been repaired and repainted by maintenance. Other areas in and around client room 118 have been repaired and repainted as necessary by maintenance also. Staff will be retrained to submit work orders when paint is seen peeling and/or bubbling. Please see above for specific information on repainting and repair facility wide on an ongoing basis. d. The Day Room has been repainted effective 3/24/10. An Ad hoc Facility Maintenance Task Force has been established to evaluate bubbly paint and exploding paint bubbles facility wide. The ad hoc Facility Maintenance Task Force will consist of QA Coordinator (chair) Business Manager (Vice Chair), Residential Services Director and Director of Maintenance. Task Force will meet weekly until all paint issue s are resolved facility wide Minutes of the meeting will be kept in the office of the QA Coordinator. The Task Force will evaluate this issue of moisture coming down through the walls and report will be issued. regarding moisture and/or structural issues that may be causing paint to bubble .	

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W 104	Continued From page 6 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. 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	c. The top drawer of the chest of drawers will be repaired by maintenance. Please see above for facility wide corrections in regard to furniture in clients rooms. f. The armoire in client room 124 will be repaired by maintenance. Please see above for facility wide corrections in regard to furniture in clients rooms. g. The chest of drawers in client room 126 will be repaired/replaced by maintenance. 5. 2 East Observations a. The dresser in client room 210 was repaired by maintenance. Please see above regarding facility wide corrective action for furniture in client rooms. b. Maintenance and Residential Services Director reviewed facility campus and did not identify client room 215, however, maintenance has reviewed all client rooms and identified those rooms in need of painting and/or repair effective 3/19/10. See above for facility wide plan of correction regarding repair and repainting of client living areas. 6. 3 South Observations a. Kitchen staff was retrained on 3-10-10 regarding the regulation on covering, dating and labeling food items. Right cabinet door will be repaired by maintenance. Kitchen staff was retrained on 3-10-10 by Dietary manager regarding the importance of knowing what is in the drawers and what's appropriate and inappropriate use of the refrigerator. Kitchen and living area staff will receive update training on a quarterly basis regarding proper food storage.	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's	W 111		

W104 Continued

b. The left hand closet door was repaired on 3/18/10 by maintenance staff. Please see above regarding facility wide plan of correction regarding doors in client living areas.	
c. Closet doors in rooms 312 were both locked because individuals residing there had rights restrictions identified by interdisciplinary team and reviewed by Human Rights Committee regarding access to their personal belongings due to maladaptive behavioral issues. Program Coordinator/QMRP was retrained effective 3-18-10 by QA Coordinator and will retrain Residential Care staff/supervisors regarding the importance of all living unit staff being aware of client rights restrictions and why access to personal belongings may be restricted. Staff #20 will be retrained by Program Coordinator by 03-24-10 regarding door knobs and the incorrect statement be made regarding facility not having any door knobs that were not self locking d. The tiles in the 2nd bathroom shower under the shower head will be replaced by maintenance by 3/24/10. e. The armoire doors in client room 332 will be repaired by 3/24/10 by maintenance f. The bottom drawer in the end table with the refrigerator on top in client room 326 will be repaired by maintenance by 3/24/10 g. A personal light switch will be installed in client room 320 by maintenance. The chest of drawers in client room 318 will be repaired by maintenance by 3/24/10. This will be monitored by monthly audit by QA Coordinator/designee.	3-24-10

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W 111	Continued From page 7 health care, active treatment, social information and protection of the client's rights. 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	W 111	W111 – Client Records Facility Notes that total restraint usage facility wide has decreased from 21,246 minutes in November 09 to 1665 minutes in February 10 (most recent month in which data is available). This is a total decrease in restraint usage of 20, 581 minutes or 97% decrease in restrain usage from November 09 til February 10. Percentage of total restraint minutes for the facility was 52% due to preventing self injurious behavior to one client in November 09. In February 2010, 49% of facility wide use of restraints was due to prevention of self injurious behavior to the same individual. I. Psychology staff retrained Program Coordinators/QMRPs on proper usage and documentation of restraints on 3/16/10 and 3/18/10. Facility Policy and Procedure AB-PO-15 regarding restraint usage was revised on 3/4/10. Facility Wide Training on new policy AB-PO-15 was performed by Psychology Staff on 3/16/10 and 3/18/10. 2. Client#13 a. Restraint log documentation shows that client #13 was restrained for 11,055 minutes in November 09, 2056 in December 09, 520 minutes in Jan 10 and 825 minutes in February 10. This indicates a 92.54% decrease in restraint usage for this individual from Nov 09-Feb 10. b. Please see page 8, number I of Alexander Human Development Center Plan of correction under tag W111 regarding staff retraining on proper restraint usage and documentation.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 8 Retardation, Mood Disorder, Pyromania, Psychotic Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder with Self Injurious Behaviors, 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	W 111	3. Client #14 a. Psychology staff retrained Program Coordinators/QMRPs on proper usage and documentation of restraints on 3/16/10 and 3/18/10. Facility Policy and Procedure AB-PO-15 regarding use of restraints was revised on 3/4/10. Facility Wide Training on new policy AB-PO-15 was performed by Psychology Department Staff on 3/16/10 and 3/18/10. b. Please see 3. a. above. c. Please see 3.a. above d. Please see 3.a. above 4. Psychology staff provided facility-wide training for all staff including Employee#1 on 3/16/10 and 3/18/10. Facility policy and Procedure AB-PO-15 regarding use of restraints was revised on 3/4/10. Facility wide training on new policy AB-PO-15 was conducted by Psychology Department on 3/16/10 and 3/18/10. Restraint usage will be monitored by QA Coordinator/Chief Psychologist on a monthly basis.	3/24/10

PRINTED: 03/15/2010
FORM APPROVED
OMB NO. 0938-0391

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W 111	Continued From page 9 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. 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	W 114	W114 Client Records Facility retrained Program Coordinators/QMRPs regarding documentation including signing and dating medical/facility records on 03-18-10. Interdisciplinary team members were retrained regarding signing signature sheets at meetings. Quality Assurance Coordinator and Central Records staff will review client records monthly effective immediately to ensure Program Coordinators/QMRPs signing, signature sheets and dating documentation. 1.PC/QMRP for Client #1 signed and dated Observations on January-Mar 2009, April-June 2009 and July-Sept 2009 . Please see above for facility wide plan of correction regarding PC/QMRP/IDT documentation procedures for signatures and dates. 2.PC/QMRP for Client #2 signed and dated Observations for Jan-Mar 09, April –June 09 and July-Sept 09 by 3-24-10	

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W 114	Continued From page 10 2. Client #2 had diagnoses of Mild Mental Retardation, Obesity, Bilateral Strabismus surgery, Depressive Disorder and Psychotic 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	W 114	3. PC/QMRP for client #3 signed and dated Observations for Jan-Mar 09, April –June 09 and July-Sept 09 by 3-24-10 4. PC/QMRP for client #4 signed and dated Observations for Jan-Mar 09, April –June 09 and July-Sept 09 by 3-24-10 5. PC/QMRP for client #7 signed and dated Observations for Jan-Mar 09, April –June 09 and July-Sept 09 on by 3-24-10. 6. PC/QMRP for client #8 signed and dated Observations for Jan-Mar 09, April –June 09 and July-Sept 09 by 3-24-10. 7. Please see above regarding retraining of QMRPs regarding the necessity of signing and dating client documents. a. Staff#5 was retrained on dating and signing documents on 3-18-10. b. Staff#22 was retrained on dating and signing documents on 3-18-10 by QA Coordinator c.Staff#21 was retrained by QA Coordinator on dating and signing documents on 3-18-10. d.Staff #1 was retrained on dating and signing documents on 3-18-10 by QA Coordinator. 8. Program Coordinators/QMRPs for client#13 were retrained on the requirement of signing meeting attendance records. Dating and Signing will be monitored by monthly record audits completed by QA Coordinator/designee/Program Coordinators/QMRPs.	3/24/10

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W 114	Continued From page 11 July - September 2009, did not document the date of the Program Coordinator/Qualified Mental Retardation Professional's (PC/QMRP's) signature. 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	W 114		

PRINTED: 03/16/2010
FORM APPROVED
OMB NO. 0938-0391

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W 114	Continued From page 12 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." 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. B. 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	W 122	W122 Client Protections In regard to this Condition of Participating and Immediate Jeopardy (IJ) please see Page 1 of Alexander Human Development Center Plan of Correction at Tag 102 (483.410) 1. Please see number 1 page 1 of AHDC Plan of Correction at tag W102 (483.410) 2. Please seepage 1 of AHDC Plan of Correction at tag W102 (483.410) a. Please see page 2, number 3.a. at tag W102 (483.410) b. Please see page 1 number 1 at tag W102 (483.410) c. Please see page 2, number 3 c at tag W102 (483.410). Medical Procedures/Transportation of clients will be monitored by Nursing Services Unit Manager and QA Coordinator on a monthly basis.	3-24-10

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W 122	Continued From page 13 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 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	W 122		

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W 122	Continued From page 14 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 122	W127 (483.420) Protection of Clients Rights Monitored by Nursing Services Unit Manager with results of reviews A.Please refer to pages I and 2, AHDC Plan of Correction under tag W 102 (483.410) 1. 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 type of incident. Staff in-service started on 2/10/10 by the Administrator/Interim Superintendent and was continued on each shift. 2. Client #17 a. Please refer to Pages I and 2, Alexander HDC Plan of Correction under tag W102 (483.410) b. Please refer to Pages I and 2, Alexander HDC Plan of Correction under tag W102 (483.410) c. Please refer to Pages I and 2, Alexander HDC Plan of Correction under tag W102 (483.410) d. Please refer to Pages I and 2, Alexander HDC Plan of Correction under tag W102 (e. Please refer to Pages I and 2, Alexander HDC Plan of Correction under tag W102	
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	W 127		

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W 127	Continued From page 15 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 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.	W 127	3. Client #21 a. Please refer to Pages 1 and 2, AHDC Plan of Correction under tag W102, (483.410) b. Please refer to Pages 1 and 2, AHDC Plan of Correction under tag W102 (483.410) c. Please refer to Pages 1 and 2, AHDC Plan of Correction under tag W102 (483.410) 4. Proper standard of care was provided to client number 21. a. The staff had received training in proper Choking Rescue Procedure prior to choking incident. b. The technique was administered by the RN Supervisor and the client successfully recovered from the choking incident. c. The nursing staff followed standard post incident medical evaluation procedures and in doing so identified a lower than acceptable oxygen saturation level; d. At that time, following standard nursing practice, the client was transported to hospital emergency room and received appropriate emergency medical evaluation and treatment. e. This incident has been used to reinforce and retrain nursing staff as to the proper protocol for post choking incident assessment and follow up respiratory treatment. Nursing staff were trained on 2/10/10 and again on 3/18/10 by Nursing Services Unit Manager.	

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W 127	Continued From page 18 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 #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	W 127	5. On May 8, 2009, facility Superintendent/Administrator issued Guidelines for Emergency Incidents. a. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) b. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) c. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) d. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) 6. Please see page 2 #3 of AHDC Plan of Correction under tag W 102 (483.410) Governing Body and Management a. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) b. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410) c. Please see page 2 #3 a. AHDC Plan of Correction under 102 (483.410)	

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W 127	Continued From page 17 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, Severe Mental Retardation, Disc Herniation and Stenosis, Osteopenia, Lumbar Spine, Osteoporosis Left Hip, Hemorrhoids, Internal Hyperplastic Rectal Polyp, and Malformation in the Rectum.	W 127		

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OMB NO. 0938-0391

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W 127	Continued From page 18	W 127		

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 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

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W 127	Continued From page 19 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. 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.	W 127		

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W 127	Continued From page 20 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. 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	W 127	B.I. client #13 A.Psychological update dated 3-11-09 appropriately documented target behaviors. Interdisciplinary team meeting case note date 8-21-09 indicates interdisciplinary Team acted appropriately in placing client on continuous 24 hour 1:1 supervision to ensure client was not a harm to himself. b. IDT Team meeting report dated 1-7-10 appropriately documented client#13 had a significant period of appropriate behavior	

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W 127	Continued From page 21 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 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	W 127	and that personal items would be returned to client for reward. IDT report specifically states the team indicated that "client could have specific items if they were battery free and items that could cause swallowing." c. Items were returned to individuals as directed by IDT team. Staff failed to ensure items did not contain batteries. Program Coordinators/QMRPs were retrained on 3/18/10 regarding the importance of follow up with living unit staff regarding Interdisciplinary Team decisions. Program Coordinators/QMRPs have direct line supervision over living unit staff. Living unit staff are required participants in the IDT meetings. All living unit staff will be retrained by PC/QMRPs by 3-24-10 regarding their responsibilities in regard to implementation of team decisions and client safety issues. On 3/17/10 facility requested expert consultation in regard to client#13 and the self injurious behaviors that he engages in. Chief Psychologist will monitor progress in located expert consultation of #13 and will notify QA for additional follow up and documentation on a weekly basis until expert consultation is identified, has examined and evaluated #13, issued a report and trained staff in appropriate techniques to be utilized in treatment of this individual's maladaptive behavior. Clients 12 and 18's level of care will be monitored by Chief Psychologist weekly. d. PCs will retrain living unit supervisors and all living units staff including employee #15 on the importance of strictly following all team decisions particularly when client's health and safety and/or target maladaptive behaviors are concerned.	3-24-10

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W 127	Continued From page 22 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 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.	W 127		

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W 127	Continued From page 23 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, 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/perttoneal 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.	W 127		

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W 127	Continued From page 24 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 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	W 127		

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W 127	Continued From page 25 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 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	W137 (483.410) (a) (12) Protection of Clients Rights 1.client #13 Clothes were purchased on 2/3/10 by [redacted], Program Coordinator for Client #13 and #40. a. Program Coordinators/QMRPs for client #13 were retrained by QA Coordinator regarding the failure to follow up on Team Action Memo dated on 4/29/09 which identified the need for new clothing to fit new size due to significant weight loss over the past year. PCs/QMRPS were retrained by QA Coord. regarding their responsibility to follow up with Living Unit staff to ensure client needs are being met in regard to decisions made by the Interdisciplinary Team. Central Records personnel and Quality Assurance Coordinator will monitor 10% percentage of client records on a monthly basis effective immediately to ensure that all Interdisciplinary Team decisions and directives have been carried out. Documentation of this monitoring will be maintained in QA Coordinator's office.Additonally Program Coordinators will review their entire caseload on at least a monthly basis with Living Unit Supervisor to ensure that all Interdisciplinary Team decisions and directivns have been carried out. Documentation will be maintained by each program coordinator/QMRP with copy sent to QA Coordinator's office. b.Living Unit staff will be retrained by Residential Service Director regarding the facilities procedures in obtaining funds for purchase of client clothing and personal items. Living Area staff will be counseled by Residential b. Services Director by 3-24-10 regarding the the necessity of all clients having clean	
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,	W 137		3/24/10

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W 137	Continued From page 26 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 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	underwear and socks and their responsibility to ensure that clients are dressed appropriately (including underwear and socks) on a daily basis. Residential Services Director will maintain a log of Living Unit Staff training regarding the above including names and dates of individual staff trained. Staff Development will reinforce during initial new employee training and again at annual facility update training 2. Client #4 Please see I.b. above. Clothing inventory sheets will be monitored on an ongoing basis by facility staff with documentation of monthly clothing audits with Living Unit Supervisor completed and forwarded to QA Coordinator. Monthly audits will be completed by QA Coordinator.	3-24-10
W 152	483.420(d)(1)(iii) STAFF TREATMENT OF CLIENTS The facility must prohibit the employment of	W 152		

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W 152	Continued From page 27 individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment. 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	W152 483.420(d)(1)(iii) Staff Treatment of Clients All personnel files will be reviewed by 3-24-10 by Human Resources Asst. to ensure that current background checks are available for all staff. Weekly review of the DHS data base for "Employee Criminal Background Check Control" will identify all staff with rechecks coming due in the next 30 days. Human Resources Department will continue to advise staff so that proper forms can be completed to conduct updated checks prior to their due date. A monthly file will be maintained by the Human Resource Assistant identifying that all checks for that month have been completed and Monitored by Human Resources Director and verified by monthly audits of the QA coordinator/designee.	3/24/10
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	W 154	W154 483.420 9d) (3) Staff Treatment of Clients. Monitored by Nursing Services Unit Manager and the QA Coordinator. When follow up information is submitted on an incident (IRIS) report, an email will be sent to the Superintendent/Administrator, DHS Program Manager and DDS Program Specialist for review of information to ensure that non-conflicting and accurate information is provided. Upon approval of the information by Superintendent/Administrator, the email, indicating approval, will be forwarded to the Quality Assurance Coordinator for retention and monitoring..	3-24-10

PRINTED: 03/15/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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W 154	Continued From page 28 incident reports completed. The findings are: 1. The facility Incident Report #30141 regarding Client #17's fractured hip and the events 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	W 154		

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W 154	Continued From page 29 #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 [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	W 154		

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W 154	Continued From page 30 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 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,	W 159	Quality Assurance Coordinator and Chief Psychologist will meet on a monthly basis to review frequency of restraint usage of client #9 and for all clients facility wide effective 3/16/10. Quality Assurance Coordinator and Chief Psychologist will attend each Human Rights Committee meeting to ensure that interventions are being implemented to reduce the use of client restraints and that the interdisciplinary teams are addressing these issues. Total restraint usage facility wide decreased 97% from Nov 2009 to Feb 2010. 52% of facility wide restraint usage in November 09 was with one individual to prevent self-injurious behavior. In February 2010, 49% of restraint usage was to prevent self injurious behavior in the same individual. b-h Quality Assurance Coordinator and Chief Psychologist will attend each Human Rights Committee meeting to ensure that interventions are being implemented to reduce the use of client restraints and that the interdisciplinary teams are addressing these issues. Total restraint usage facility wide decreased 97% from Nov 2009 to Feb 2010. 52% of facility wide restraint usage in November 09 was with one individual to prevent self-injurious behavior. In February 2010, 49% of restraint usage was to prevent self injurious behavior in the same individual.	

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W 159	Continued From page 31 documented the client was in Mendota restraints for 3,820 minutes in 4/09. e. The HRC meeting conducted on 7/15/09, 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.	W 159	2. Client #13 a-g Restraint log documentation reflects that client #13 was restrained in order to protect him from harming himself for 11,055 minutes during Nov 09, 2056 minutes during Dec 09, 520 minutes during Jan 2010 and 825 minutes during Feb 10. This indicates a 92.54% decrease in restraint usage for this individual from Nov 09 in comparison to February 2010 (the most recent month in which data is available) Program Coordinators/QMRPs were retrained on 3-18-10 regarding mandatory actions that occur when an increase is seen in the minutes of restraint usage for client#13 and for all clients facility wide. Quality Assurance Coordinator and Chief Psychologist will attend each Human Rights committee meeting to ensure that interventions are being implemented to reduce the use of client restraints and that the interdisciplinary Teams are addressing these issues on an ongoing and constistent basis.	

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W 159	Continued From page 32 documented the client was in Mendota restraints for 33,805 minutes in 10/09. f. The HRC meeting conducted on 12/15/09, 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,	W 159	3. Client #14 a-h. Client #14 went from a high of 15,373 minutes in Mendota restraints in May 09 to a low on 0 minutes in restraints in Sept 09, October 09, January 10 and February 2010. Client #14 is currently undergoing an evaluation at the Psychiatric Hospital that began on Friday, March 5, 2010. Human Rights Committee and Interdisciplinary Team members will be retrained regarding measures that will be taken when an increase is seen in the use of restraints for client #14 and for all clients' facility wide. Quality Assurance Coordinator and Chief Psychologist will meet on a monthly basis to review the frequency of restraint usage on client #14 and for all clients facility wide. The first meeting occurred on March 16th, 2010 and will continue on a monthly basis and on an emergency basis as often as necessary. Quality Assurance and Chief Psychologist will attend each Human Rights Committee meeting to ensure that interventions are being implemented to reduce the use of client restraints and that the interdisciplinary Teams are addressing these issues on an ongoing and consistent basis.	

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W 158	Continued From page 33 documented the client was in Mendota restraints for 4,125 minutes in 11/09. h. The HRC meeting conducted on 1/20/10, 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	1. To reduce clients' behavioral issues, all Program Coordinators will meet with the Interdisciplinary Teams by 3-24-10 to discuss each individual residing within the facility regarding the benefit to each individual of receiving counseling from a mental health professional on a regular basis. Discussion will include at minimum: client diagnosis, target behaviors, behavior reports for the 90 day period preceding the meeting, review of last consult with the Psychiatrist, review of psychotropic medication regimen and restraint usage/frequency for the 6 months preceding the meeting. Director of Nursing will meet with Psychiatrist to inform him of Interdisciplinary Team recommendations and to elicit his input. Program Coordinator/QMRP for those identified as potentially benefiting from counseling and progress reports will be documented on each individuals PCP. Quality Assurance Coordinator and Chief Psychologist will meet on a monthly basis to review frequency of restraint usage of client #9 and for all clients facility wide effective 3/16/10.	3-24-10
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	W 183	W183 483.430 (c)(2) Facility Staffing 1. Client #1 and Client #16 a. Effective 3-17-10Residential Services Director will ensure that adequate staffing occurs at the facility 24 hours a day/7 days a week. Residential Services Director will report immediately to the Superintendent/Administrator any issues regarding insufficient staffing. Living Unit Supervisor and Shift Supervisor will make a written report at the beginning of each shift to ensure that each unit has adequate staffing to cover clients that require 1:1 supervision and other individuals assigned	

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W 183	Continued From page 34 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 findings are: 1. Client #15 had diagnoses of Mild Mental Retardation (MR), Impulse Control Disorder, PTSD, and Depressive Disorder. Client #18 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	W 183	to the living unit. Verbal notification from Living Unit Supervisor and/or Shift Supervisor will be made to Residential Services Director in any event that staffing is not sufficient to provide adequate supervision to all individuals on all living units. Residential Services Director will then advise Living Unit Supervisor/Shift Supervisor of action that must be taken to ensure adequate staffing including calling in additional staff, approving overtime for staff to work extra shifts, habilitation and/or supervisory staff working living units to maintain adequate staffing ratios, etc. 2. Client #12 a. Residential Services Manager will ensure that there are adequate staff available to provide supervision to those individuals with supervision needs beyond that those requiring supervision at normal staffing levels. Living Unit Supervisors/Shift Supervisors will make a written report at the beginning of each shift and make a verbal report immediately to Residential Services Manager if the situation results in staffing levels below that needed to provide adequate supervision to all clients. Residential Services Director will then advise Living Unit Supervisor/Shift Supervisor of action that must be taken to ensure adequate staffing including calling in additional staff, approving overtime for staff to work extra shifts, habilitation and/or supervisory staff working living units to maintain adequate staffing ratios, etc.	

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W 183	Continued From page 35 #15 and #16. 2. Client #12 had diagnoses of Profound Mental Retardation, PICA, Autistic Disorder, and 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	W 183	Maintain adequate staffing levels at all times. b. Facility staff will be retrained regarding the responsibilities and requirements when assigned to an individual on 1:1 basis by Psychology staff. Staff Development will train new staff on the responsibilities of staff assigned to a client 1:1 and what action must be taken if they find themselves with clients in addition to the individual that they are assigned to be 1:1. Please see #2.a. above regarding responsibilities of living unit supervisor/shift supervisor and Residential Services Director in regard to maintaining adequate staffing levels. 3. Client#18 a. Program Coordinators/QMRPs were retrained by QA Coordinator on3-18-10regarding their responsibility to follow through with all Interdisciplinary Team decisions including but not limited to those documented in each individuals' Individual Program Plan and Person Centered Plan. b. Living unit staff will receive retraining on responsibilities regarding supervision of clients by Residential Services Director by 3/24/10. Sexually active clients will be monitored as stated in documentation of Interdisciplinary Team decisions. Please see #1 and #2 above regarding facility practices and retraining regarding staffing issues. c. Mechanical features such as chimes on doors will be reviewed by IDT and the HR Committee as a rights restriction. Living unit staff will be trained in procedures and response necessary in the event that door chimes and similar devices are activated.	3-24-10

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W 183	Continued From page 36 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..." 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	W 183	Sexual incidents and mechanical features will be monitored by Residential Director and QA Coordinator monthly	3-24-10

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W 183	Continued From page 37 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 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.	W 186	W186 483.430 9d) (1-2) Direct Care Staff Monitored by PC/QMRP, Residential Services Manager and QA Coordinator Clients13, 16, 18, 23 and 25's PCP will be reviewed by QA Coordinator by 3/24/10 to determine the amount of supervision needed. All staff will be inserviced by 3/24/10 by Residential Director/designee concerning staffing needs for those clients. 1.client #13 a. Psychological updates dated 03-11-09 appropriately documented client's maladaptive target behaviors b. Residential Director will ensure that there is adequate staff available to provide supervision to those individuals with supervision needs beyond that those requiring supervision at normal staffing levels. Living Unit Supervisors/Shift Supervisors will make a written report at the beginning of each shift and make a verbal report immediately to Residential Services Manager if the situation results in staffing levels below that needed to provide adequate supervision to all clients. Residential Services Director will then advise Living Unit Supervisor/Shift Supervisor of action that must be taken to ensure adequate staffing including calling in additional staff, approving overtime for staff to work extra shifts, habilitation and/or supervisory staff working living units to maintain adequate staffing levels at all times.	

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

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W 186	Continued From page 38 a. A psychological update dated 3/11/09 documented the client exhibited a long history of inappropriate behaviors including swallowing 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 persona	W 186	c. Program Coordinators/QMRPs were retrained on 03-18-10 regarding the importance of follow up with living unit staff regarding interdisciplinary Team decisions. Program Coordinators/QMRPs have direct line supervision over living unit staff. Living unit staff is required participants in interdisciplinary Team meetings. All living unit staff will be retrained by Program Coordinators/QMRPs by 3/24/10 regarding their responsibilities in regard to implementation of team decisions and client safety issues. f. Please see #1 c.d. and e. above under tag W186 regarding correction of communication issues between interdisciplinary Teams and living unit staff, client supervision and safety issue. Residential Director/designee/shift coordinator will monitor staffing daily by shift to ensure there is sufficient staff on duty to provide supervision in accordance to IPPs.	3/24/10

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W 186	Continued From page 39 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 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 12/8/09 at 3:30 p.m. in the restroom on living unit Band 3 South.	W 186		

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W 186	Continued From page 40 a. Client #23 had diagnoses of Moderate MR, Mood Disorder and Schizophrenia Undifferentiated Type. 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	W 186		

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W 186	Continued From page 41 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 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			

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W 186	Continued From page 42 Disorder. The Behavior Plan dated 8/14/09 documented, "[Client #14] behavior over a significant period of 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].	W 186		

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W 186	Continued From page 43 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 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.	W 186		

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W 186	Continued From page 44 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". 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	W 186		

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W 186	Continued From page 45 trauma. 3. Reporter [Staff #3], RCT [Residential Care Technician], and [Staff #13], Evening Supervisor and clients, [Client #16] and [Client #25] were interviewed. 4. All appropriate departments/agencies/guardians were contacted." I. 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	W 191	W191 483.430 (E) (2) Monitored by HR Director with documentation to QA. 1. Facility will follow DDS policy 3004-1 F 4 "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 investigating. The on-site Administrator shall specify the training course(s) and ensure that documentation of training is maintained. The facility will retrain all employees and review maltreatment policies at least every 12 months. Quality Assurance Coordinator and facility Administrator/Designee will review all maltreatment investigations and	3-24-10

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W 191	Continued From page 46 individuals (e.g., how staff refers to individuals, refer to W150); Use of behavioral principles in training 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.	W 191	advise Staff Development to conduct retraining as per policy. Staff Development trains new staff regarding all maltreatment policies prior to staff having any contact with clients. Quality Assurance Coordinator will review investigations monthly and ensure that all parties involved have been retrained according to DDS Policy 3004-1. 2. Employee#7 will be retrained according to policy 3004-1 F4 by 3/24/10 3. Staff member#18 will be retrained per Policy 3004-1 F4 by 3/24/10. 4. Staff member #18 will be retrained per Policy 3004 – 1 by 3/24/10. 5. Facility will follow policy 3004-1 F4. Please see #1 above under tag W191.	

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W 191	Continued From page 47 This STANDARD 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 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.	W 191		

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W 191	Continued From page 48 3. IRIS 28752 dated 10/7/09 documented, Client #22 alleged that Staff Member #18 kicked and slapped him. An investigation was conducted 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 1/18/10 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.	W 249	W249 (483.440) (d) (1) Program Implementation – Monitored by Program Coordinator/QMRP with data to QA Coordinator with random audits by QA Coordinator/Designee 1.Client#1 a. Program Coordinator/QMRPs were retrained by Quality Assurance Coordinator on 3/18/10 regarding client schedules being individualized and Interdisciplinary Teams discussing each individual's ability to handle free-time, leisure time and structured vs. unstructured leisure activities. Program Coordinators/QMRPs are gathering information relating to additional items required to keep on the units to offer clients an appropriate variety of activities to choose from. List of items needed will be purchased and additional leisure items will be purchased	3/24/10

PRINTED: 09/15/2010
FORM APPROVED
OMB NO. 0938-0391

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W 249	Continued From page 49 This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client 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 "POP Trng/Laundry (W & F - 3-E-B). There was nothing else listed for this	W 249	and available on all the units. b. Client's schedule will be revised to indicate specific of independence in determining the use of recreation/leisure time by 3-24-10. Program Coordinator/QMRPs will review each individual's 24 hour schedule during their annual program plan review and staffing to ensure that it is individualized according to their ability to choose from structured vs. non-structured leisure activities and ability to handle free time as stated above. 2. Client#3 a. Please see plan of correction under tag W249above. b. Program Coordinator/QMRPs were retrained on 3/18/10 regarding the individualization of client schedules (see above). Client #3's 24 hour schedule will be reviewed by Interdisciplinary Team by 3-24-10 to determine appropriateness and make revisions as necessary. Each individual's 24 hour schedule will be reevaluated and revised during their annual program plan review/staffing according to their individual abilities to participate in appropriate leisure activities and activities of daily living. 3. Client #4 a. Interdisciplinary Team will review his 24 hour schedule to determine appropriateness and individualize schedule based upon his assessed ability to participate in activities of daily living and structures vs. unstructured leisure/recreational activities..	3-24-10

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W 249	Continued From page 50 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, 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	W 249	b.c.d. Program Coordinator/QMRP will retrain living unit supervisors/shift supervisors regarding staff's responsibility to interact with clients and to encourage them to participate in constructive recreational/leisure activities. This will include retraining for staff working with client #4 as well as all individuals on all living units. Documentation of retraining will be maintained in the office of the QA Coordinator. QA Coordinator will perform monthly recreational/leisure activity audits on the second shift to ensure appropriate staff interaction with clients and that appropriate leisure activities are being offered to all individuals according to their assessed strengths and needs. 4.a. Administrator/Designee will ensure that appropriate leisure/recreation items are available for all individuals on all units by 3-24-10 Program Coordinators/QMRPs will retrain living unit supervisors/shift supervisors regarding the importance of staff interacting with clients and providing an appropriate variety of recreational/leisure activities in accordance with their individual strengths and needs as identified by the Interdisciplinary Team. 5.Client#12 a. By 3/24/10, Program Coordinators/QMRPs will retrain living unit supervisors and shift supervisors regarding the importance of providing structured leisure activities on all units every evening including staff on the living unit where client#12 resides. Documentation of retraining will be available for review in the office of the QA Coordinator. Additionally the QA Coordinator will conduct random recreation/leisure audits on 2nd shift and maintain documentation in the QA Office.	3-24-10

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W 249	Continued From page 51 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 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	W 249	b. Uses of the term "enhanced supervision" will be eliminated at this facility and all staff will be retrained by Residential Services Director/designee on use of appropriate terminology including: 1:1 staffing, visual monitoring, phone monitoring, monitoring while in presence of certain individuals, objects, etc. Each individual will be assessed prior to their individual program plan staffing on at least an annual basis and documentation will be maintained in each client's plan regarding the level of supervision that he required in order to ensure health and safety as well as an aggressive and ongoing active treatment program. c. Please see plan of correction above at W249. 6. Client#18 a. Person Centered Plan Annual review update dated 10-22-09 appropriately assessed and documented client #18's specific supervision needs. b. Program Coordinators/QMRPs will retrain living unit supervisors and shift coordinators by 3-24-10 in the importance of following all Interdisciplinary Team decisions particularly in relation to an individuals' specific supervision needs. Retraining will occur on all living units including the unit where client #18 resides. QA Coordinator will conduct monthly audits on all shifts to ensure that individuals are receiving the levels of supervision that have been documented in their individual program plans.	3-24-10

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W 249	Continued From page 52 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 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	W 249	c. Human Rights Committee and Interdisciplinary Team for client #18 will meet to discuss chimes on door and staff's ability to monitor mechanical devices will be reviewed as a rights restriction by human rights committee and each individual's interdisciplinary team on at least an annual basis. d. Client#18's Interdisciplinary Team will meet by 3-24-10 to discuss new interventions to prevent maladaptive behaviors or decrease risk of harm to other clients. Interdisciplinary Teams for each individual will review and document discussion of new intervention to address as above part of the annual individual program plan staffing.	3-24-10

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W 249	Continued From page 53 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 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	W 249		

PRINTED: 03/16/2010
FORM APPROVED
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W 249	Continued From page 54 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. 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 295	483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure 1 of 1 sampled (Client #14) who was documented in mechanical restraint (Mendota) was released when his behavior was documented as calm or asleep and did not document behaviors that required the continued use of restraints. The findings are: Client#14 had diagnoses of Mild Mental	W 295	W295 (483.450) (1) (i) Physical Restraints Please refer to AHDC Plan of Correction under tag W111 (above) Please refer to Alexander HDC Plan of Correction under tag W111 (above) a-b.Psychology staff will retrain Program Coordinators/QMRPs, Living Unit Spvsrs.	

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W 295	Continued From page 55 Retardation, Mood Disorder, Pyromania, Psychotic Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder with Self Injurious Behaviors, and Suicide Attempts by history. a. The "Dangerous Behavior Log" dated 11/10/09 documented the client was "sleeping" from 9:15 p.m. through 11:00 p.m. The "IDT (Interdisciplinary Team) Authorized Restraint Form" dated 11/10/09 documented the client was in Mendota wrist restraints from 3:00 p.m. through 10:55 p.m. There was no documentation on either form of the behaviors that warranted the continued use of wrist restraints while the client was sleeping. The "Restraint Form" also documented the client was in Mendota restraints from 12:00 p.m. through 11:55 p.m. and there was no documentation of the behaviors that required the use of restraints. b. The "Dangerous Behavior Log" dated 11/12/09 documented the client was "quiet/sleep" from 5:15 a.m. through 6:00 a.m. and "Cooperative" from 7:00 a.m. through 10:55 p.m. The "IDT Authorized Restraint Form" dated 11/12/09 documented the client was in Mendota wrist restraints from 12:00 a.m. through 10:55 p.m. There was no documentation on either form of the behaviors that warranted the continued use of wrist restraints while the client was sleeping and cooperative. The Restraint Form also the client was in Mendota restraints from 12:00 a.m through 11:55 p.m. and there was no documentation of the behaviors that required the use of restraints. c. The "Dangerous Behavior Log" dated 11/13/09 documented the client was "in bed asleep" from	W 295	And shift supervisors regarding the proper use of restraints. All facility staff were retrained on new restraint policy AB-PO-15 on 3/16/10 and 3/18/10. Documentation on restraint usage and documentation of behaviors that require the continued use of restraints are currently kept in different locations within the facility. By 3-24-10 all documentation regarding restraint usage will be kept in a central designated area with a copy maintained in the office of the QA Coordinator. Restraint Usage will be monitored by Chief Psychologist and QA Coordinator on a monthly basis.	3-24-10

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W 295	Continued From page 56 12:00 a.m. through 3:15 a.m. The "IDT Authorized Restraint Form" dated 11/13/09 documented the client was in Mendota wrist restraints from 12:00 a.m. through 6:55 a.m. There was no documentation on either form of the behaviors that warranted the continued use of wrist restraints while the client was asleep. The "Restraint Form" also documented the client was in Mendota restraints from 7:00 a.m. through 2:55 p.m. and there was no documentation of the behaviors that required the use of restraints. d. The "Restraint Form" dated 12/9/09 documented the client was in Mendota restraints from 12:00 a.m. through 11:55 p.m. and there was no documentation of the behaviors that required the use of restraints. e. The "Dangerous Behavior Log" dated 12/10/09 documented the client was "asleep/quiet" from 12:15 a.m. through 6:45 a.m. The "IDT Authorized Restraint Form" dated 12/10/09 documented the client was in Mendota wrist restraints from 12:00 a.m. through 6:55 a.m. There was no documentation on either form of the behaviors that warranted the continued use of wrist restraints while the client was asleep/quiet. The "Restraint Form" dated 12/10/09 also documented the client was in Mendota restraints from 7:00 a.m. through 11:55 p.m. and there was no documentation of the behaviors that required the use of restraints. f. The "Restraint Form" dated 12/11/09 documented the client was in Mendota restraints from 12:00 a.m. through 6:55 p.m. and there was no documentation of the behaviors that required the use of restraints.	W 295		

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W 295	Continued From page 57 g. The "Restraint Form" dated 12/14/09 documented the client was in Mendota restraints from 3:00 through 11:55 (a.m. or p.m. not specified) and there was no documentation of the behaviors that required the use of restraints. h. The "Restraint Form" dated 12/15/09 documented the client was in Mendota restraints from 12:01 a.m. through 11:55 p.m. and there was no documentation of the behaviors that required the use of restraints. I. The "Dangerous Behavior Log" dated 12/16/09 documented the client was "in bed or asleep" from 12:00 a.m. through 6:45 a.m. The "IDT Authorized Restraint Form" dated 12/16/09documented the client was in Mendota wrist restraints from 12:00 a.m. through 6:55 a.m. There was no documentation on either form of the behaviors that warranted the continued use of wrist restraints while the client was in bed or asleep.	W 295		
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	W 331	W331 (483.460) (c) Nursing Services Please refer to Alexander HDC Plan of Correction tags W-102 and W127 above. .On 2/10/10 at 4:30 p.m. the Interim Administrator/Superintendent notified the medical department and dept. heads that the facility will follow its 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.	

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W 331	Continued From page 58 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 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	W 331	2. Client #17 was transported to hospital emergency room and received treatment for the fractured hip. Client#21 Proper standard of care was provided to this client. The staff was trained in proper Choking Rescue Procedure; the technique was administered by the Registered Nurse Supervisor and the client successfully recovered from the choking incident. The nursing staff followed standard post incident medical evaluation procedures and in doing so identified a lower than acceptable oxygen saturation level. At that time, following standard nursing practice, the client was transported to the hospital emergency room and received appropriate emergency medical evaluation and treatment. This incident has been used to reinforce and retrain nursing staff as to their proper protocol for post choking incident assessments and follow up respiratory treatment. Nursing staff was retrained on 2/10/10 and again on 3/18/10.	

PRINTED: 03/15/2010
FORM APPROVED
OMB NO. 0938-0391

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W 331	Continued From page 59 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 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	W 331	By nursing staff and recommendation for transfer by EMS to the nearest hospital was made. Client was transferred and admitted to the hospital for appropriate and successful surgical intervention. The Medical Emergency Transportation SS-BO-06 Policy was in place effective May 2009. The facility staff and medical staff were retrained by Nursing Services Unit Manager on 2/10/10 and will continue to ensure that its own policies and procedures are followed consistently. Retraining of all staff on this policy will also continue on at least an annual basis. Director of Nurses will meet with Administrator/Superintendent and Psychiatric Director on a weekly basis and on an emergency basis as needed to ensure that all medical issues are dealt with according to policy and procedure. This will occur effective immediately. Medical issues will be monitored monthly. B. Please see #1 above. a. Administrator/Superintendent was placed on administrative leave on 2/5/10 at 1:45 p.m. b. Facility will follow its own practice and policy of the medical department making all decisions as to injury and required medical treatment outside the facility. c. Staff retraining regarding outside medical transfer on 2/10/10 by Interim Superintendent/Administrator and continued on each shift. Staff retraining was completed on 2/11/10.	3/24/10

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W 331	Continued From page 60 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 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	W 331		

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W 331	Continued From page 61 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 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	W 331		

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W 331	Continued From page 62 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 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	W 331		

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W 331	Continued From page 63 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. 8. 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.	W 363		

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W 363	Continued From page 64 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 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	W363 (483.460) (j) (2) Drug Regimen Review Pharmacist has been instructed by Director of Nursing on 2/22/10 to provide a quarterly pharmacy review to include irregularities observed to be monitored by the Director of Nursing and the AHDC Quality Assurance Coordinator. a.The consultant pharmacist was interviewed by Superintendent on 2/18/10 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. Monitored by Pharmacist with monthly reports to Director of Nursing and documentation sent to QA Coordinator on a monthly basis.	3-24-10
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	W 371	W371 (483.460) (k) (4) Drug Administration All Medical Staff have been retrained one-on-one and as documented in Medical Staff Training beginning on 3/18/10 by the Director of Nurses, have successfully verbalized understanding of appropriate SAM training procedures. This will be repeated and documented for new and temporary Medical Staff during orientation and monthly during the next 9 months. Director of Nurses/designee will observe one med pass monthly to ensure SAMS training is being conducted.	3-24-10

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W 371	Continued From page 66 assessed for SAM training. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder, and Manic without Psychotic Features. 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	W 371		

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W 371	Continued From page 66 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. 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	W418 (483.470) (4) (ii) Client Bedrooms Mattress in client bedroom 332 was replaced on 3/18/10. Residential Services Manager/Designee and Inventory Control Manager have audited all client mattresses effective 3/18/10. All client mattresses that are torn or in disrepair will be replaced by 3/24/10. Conditions of mattresses will be monitored on a monthly basis by Living Unit staff, PC/QMRP and documentation sent to QA Coordinator.	3/24/10
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:	W 456	W456 (456.483) (1) (2) Infection Control The Cpap machine identified has been cleaned and disinfected by Director of Nurses on 3/18/10. All other c-pap machines in use on AHDC campus have been inspected clean and disinfected by the Director of Nurses on 3-18-10. AHDC Cpap cleaning protocol has been implemented and all nursing staff inserviced by D.O.N. regarding said protocol on 3-18-10. Proper cleaning of CPAP machines will be reviewed weekly by the Director of Nursing/designee with inspection results forwarded to the QA Coordinator for verification.	3/24/10

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W 456	Continued From page 87 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 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.	W 456		

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W 456	Continued From page 68 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 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	W 456		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 456	Continued From page 69 Practice Nurse] for continued running nose per staff. No new orders."	W 456	W468 (483.60)(b) (1) Meal Services The protocol for ensuring that adequate snacks are available on each unit has been changed. The Food Production manager will deliver the weekend snacks to each unit on Friday. This includes snacks for 10:00 a.m. and 2:00 p.m. on Saturdays and Sundays. If, for any reason, weekend snacks are not delivered on Friday, direct care staff should call dietary to obtain snacks. There will be a list posted on the bulletin board detailing what snacks are needed for each client on each unit. The bedtime snacks will continue to be sent to the units on the food cart as usual. Monday through Friday daytime snacks are provided to the workshop areas for the clients. Snack list will be monitored by Living Unit Supervisors, Program Coordinators / Human Resources Director and Residential Services Manager and documentation forwarded to QA Coordinator. Dietary manager will monitor inventory of snacks available to ensure availability.	3-24-10
W 468	483.480(b)(1) MEAL SERVICES Each client must receive meals at regular times comparable to normal mealtimes in the 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.	W 484	W484 (483.480) (d) (3) Dining Areas Services All condiments needed on the living units should be requested of dietary staff. All dietary staff will sign that they understand this process and the sign off document will be maintained by the Dietary Secretary and QA Coord.. Residential Care Supervisors will in-service all direct care staff on the condiment protocol by 3-24-10 and provide documentation to the QA Coord. Availability of condiments will be monitored by Living Unit Supervisors, Program Coord/HR Director and Residential Services Mgr and documentation forwarded to QA	3/24/10

PRINTED: 03/15/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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W 484	Continued From page 70	W 484		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G001	A. BUILDING 01 B. WING	02/01/2010

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K 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. The findings on this statement of deficiencies demonstrate non-compliance with Title 42, Code of Regulations 483.70(a), life safety from fire. The requirement is not met, as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited.	K 000		
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by Based on observation, the facility failed to ensure the air handlers shut down when the fire alarm system was activated. This failed practice had the potential to affect 108 clients who resided in the Bond building on the East and South Halls	K 067	K067 NFPA 101 Life Safety Code Standard The facility heat and air system was inspected and repaired by contract heat/air/alarm tech and will be monitored by Maintenance Supervisor, Business Manager monthly with documentation sent to QA Coordinator.	3-16-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Supt — (X6) DATE: 3/16/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 03/23/2010
FORM APPROVED
OMB NO. 0938-0391

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	04G001	A. BUILDING 01 B. WING _____	02/01/2010

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K 067	Continued From page 1 according to the Administrator on 2/1/10. The findings are: On 2/1/10 at 2:00 p.m., the air handlers did not shut down on the first, second and third floor of the East and South halls in the Bond building when the fire alarm system was activated.	K 067		