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	14G263	A. BUILDING _____ B. WING _____	12/01/2011

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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 000	INITIAL COMMENTS ANNUAL CERTIFICATION - FUNDAMENTAL INSPECTION OF CARE	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the day training program failed to provide necessary contact guard assistance, to enable day training outings for R5, for 1 of 2 individuals who require walkers for ambulatory assistance, and attend the same day training site. Findings include: 1. In review of R5's 11/11 physician's orders, R5 functions in the severe range of mental retardation. Additional diagnoses include Parkinsonism and Osteoporosis. During observations at the facility on 11/29/11, at 3:30 p.m., R5 is ambulatory with the assistance of a gait belt and walker. In a 11/30/11, 2:40 p.m., interview with E1 (Residential Services Director - RSD), R1 stated that R5 does not require contact guard assist (CGA) while in the facility, but does require CGA when outside. In review of a 6/15/11 day training incident report, R5 was on a day training outing. When stepping	W 120		12/31/11

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

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W 120	Continued From page 1 down from a curb, R5 fell, landing on the frontal part of her face and legs. R5 received an abrasion to both knees, a bruise to her left cheek and a 2 centimeter gash above her left eye. 6/18/11 nursing notes document that R5 required four sutures to an area over her left eye. In an interview with E1, on 11/29/11, at 10:00 a.m., R1 stated R5 is in the seniors program at the day training site. In her communications with the day training program, day training cannot ensure CGA for R5. Therefore, R5 will no longer be provided outings from the day training site. In a review of day training documents that document outings, R5 has not been on an outing with the seniors at the day training site since 8/26/11.	W 120		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to notify the Department of the full extent of injuries obtained during a fall, for 1 of 1 individual who fell while on a day training outing, requiring 4 sutures (R5). Findings include:	W 153		12/31/11

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W 153	Continued From page 2	W 153		

1. In review of R5's 11/11 physician's orders, R5 functions in the severe range of mental retardation. Additional diagnoses include Parkinsonism and Osteoporosis.

A 6/14/11 fall risk evaluation documents that R5 is a high fall risk.

During observations at the facility on 11/29/11, at 3:30 p.m., R5 is ambulatory with the assistance of a gait belt and walker.

In a 11/30/11, 2:40 p.m., interview with E1 (Residential Services Director - RSD), R1 stated that R5 does not require contact guard assist (CGA) while in the facility, but does require CGA when outside.

In review of a 6/15/11 day training incident report, R5 was on a day training outing. When stepping down from a curb, R5 fell, landing on the frontal part of her face and legs. R5 received an abrasion to both knees, a bruise to her left cheek and a 2 centimeter gash above her left eye.

6/18/11 nursing notes document that R5 required four sutures to an area over her left eye.

On 6/16/11, the facility faxed a report to the Department. This report states that while on an outing from the day training site, R5 stepped down off the curb and fell. R5 was sent to the emergency room for evaluation, and will follow up with her physician on 6/23/11.

Per this report to the Department, there is no evidence that the Department was notified of the full extent of R5's injuries, and the need for

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W 153	Continued From page 3 sutures.	W 153		
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 observation, record review and interview, the facility failed to investigate falls for 1 of 1 in the sample and 1 outside the sample (R's 3 and 5). Findings include: 1. In review of R3's 11/11 physician's orders, R3 functions in the severe range of mental retardation. Additional diagnoses include Parkinsonism and Osteoporosis. Per R3's 10/13/11 Individual Program Plan (IPP), R3 is a high fall risk, with a history of falls. R3 is 83 years old, and requires a gait belt, walker and staff assist for all ambulation. During observations at the facility on 11/29/11 at 3:15 p.m., R3 ambulates very slowly, with a shuffling gait. In review of a 6/24/11 facility incident report, R3 was sitting on his bed. The staff person stepped out of the room to get some supplies for R3. R3's roommate came to find the staff, stating that R3, "was on the floor." In review of facility investigations, there is no evidence that the facility investigated R3's fall.	W 154		12/31/11

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W 154	Continued From page 4	W 154		

In a 11/29/11, 10:00 a.m., interview with E1, E1 confirmed that the facility had not conducted an investigation regarding R3's fall.

2. In review of R5's 11/11 physician's orders, R5 functions in the severe range of mental retardation. Additional diagnoses include Parkinsonism and Osteoporosis.

During observations at the facility on 11/29/11, at 3:30 p.m., R5 is ambulatory with the assistance of a gait belt and walker.

In a 11/30/11, 2:40 p.m., interview with E1 (Residential Services Director - RSD), R1 stated that R5 does not require contact guard assist (CGA) while in the facility, but does require CGA when outside.

In review of a 6/15/11 day training incident report, R5 was on a day training outing. When stepping down from a curb, R5 fell, landing on the frontal part of her face and legs. R5 received an abrasion to both knees, a bruise to her left cheek and a 2 centimeter gash above her left eye.

6/18/11 nursing notes document that R5 required four sutures to an area over her left eye.

In review of facility investigations, there is no evidence that the facility investigated R5's fall with subsequent injuries.

In a 11/29/11, 10:00 a.m., interview with E1 (Residential Services Supervisor - RSD), E1 confirmed that the facility had not conducted an investigation regarding R5's 6/15/11 fall.

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W 249	Continued From page 5	W 249		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to implement R3's formal eating program, for 1 of 1 in the sample who has a documented tendency to shove food into his mouth and eat fast (R3). Findings include: 1. In review of R3's 11/11 physician's orders, R3 functions in the severe range of mental retardation, and is 83 years of age. Additional diagnosis includes Parkinsonism. Per observations at the facility, on 11/29/11, at 3:15 p.m., R3 is edentulous. 11/11 physician's orders for R3 document that R3 is to receive a mechanical soft diet, cut foods into bite size pieces, with ground meat. An 8/3/11, "Speech Therapy Dysphagia/Discharge Summary", documents that R3 is impulsive at times when eating and was discharged from therapy due to poor carry-over/compliance. This report further states	W 249		12/31/11

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W 249	Continued From page 6 that R3 eats fast and takes large bites at times, and does not wait prior to the next bite. In review of R3's formal programs, R3 has a 11/3/11 eating program. Per the goal, R3 is to eat all meals slowly, following the bite, chew, swallow, eating sequence, for all meals. "Staff will sit by (R3) during meals and snacks...Staff will continue to monitor through his meal and snack." On 11/30/11, at 6:30 a.m. - 6:40 a.m., R3 was observed at the breakfast meal. E's 3 and 4 (direct service persons - DSP), were the staff on duty. Staff did not sit with R3 during this meal, and there were periods of time when there were no staff in the dining room.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, nursing failed to ensure a fluid restriction was followed for 1 of 1 individuals in the sample who is on a fluid restriction, (R1). Findings include: According to the facility submitted roster that validates level of functioning, undated, R1 functions in the mild range of mental retardation. Per the 11/11 POS (Physician's Order Sheet), R1 has additional diagnosis of Schizophrenia, Anxiety. Per the 9/16/11 Renal Consult, R1 was	W 331		12/31/11

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W 331	Continued From page 7	W 331		

hospitalized with the diagnosis of Hyponatremia. The physician ordered to continue the fluid restriction.

In an interview on 11/29/11 at 12:15 p.m., when asked if R1 had already eaten, Z1, Developmental Trainer, stated, "Yes". When asked what R1 had to drink at lunch, Z1 stated, a fruit juice packet. That's all he gets.

Observations on 11/30/11 at 6:30 a.m. to 6:35 a.m., R1 had a glass of milk at the table for breakfast. No other liquids were on the table in front of him.

In an interview on 11/30/11 at 6:35 a.m., when asked if he had any other liquids at breakfast, R1 stated, No. That's all I get. I'm on a fluid restriction.

Observation at the facility on 11/30/11 at 1:45 p.m., the fruit juice packet is 6 ounces. E5, Administrator was present and verified that this juice packet is 6 ounces. E5 was present and stated that the glass was a 10 ounce glass R1 had his milk in.

In review of the 50 ounce Fluid Restriction for R1, it documents that R1 is to receive 12 ounces at breakfast and 10 ounces at lunch.

In review of the Intake/Output Chart for R1, there is no documentation of R1's fluid intake on 11/30/11 for his breakfast.

In an interview on 11/30/11 at 1:50 p.m., E5 verified that staff are not consistently following R1's fluid restriction by the documentation. When asked if the Day Training documents R1's fluid

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W 331	Continued From page 8 intake, E5 stated, No.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drink supplements are provided for 4 of 4 in the facility who have physician ordered drink supplements (R's 2, 3, 4 & 5); and, the facility failed to ensure physician ordered cream was available and given as ordered for 1 of 1 individuals outside the sample, (R4). Findings include: 1. In review of 11/11 physician's orders for R's 2, 3, 4 & 5, R2 has orders for a dietary drink supplement three times a day; R3 has orders for a dietary drink supplement daily at breakfast; R4 and R5 are to receive a dietary drink supplement in the a.m. and the p.m. daily. In review of the Medication Administration Record (MAR), there is no evidence of R's 2, 3, 4 & 5 receiving their physician ordered drink supplements. In an interview with E5 (Administrator), on 11/30/11, 1:30 p.m., E5 stated that the facility has not been documenting that these physician orders are being completed, but should be documenting that R's 2, 3, 4 & 5 are receiving	W 368		12/31/11

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W 368	Continued From page 9 their physician ordered drink supplements. 2. According to the facility submitted roster that validates level of functioning undated, R4 functions in the severe range of mental retardation. In review of the 11/11 POS (Physician's Order Sheet, R4 has additional diagnosis of Dry Skin. During review of a "Reporting to the On Call Personnel and/or RN (Registered Nurse)" dated 5/28/11, it is documented that R4's Eucerin Cream had not been delivered from the pharmacy. In review of the physician's order, dated 5/26/11, R4 is to receive Eucerin Cream three times a day to her hands. In review of the 05/11 and 06/11 MAR (Medication Administration Record), R4 did not receive the Eucerin Cream until 06/1/11. In an interview on 11/29/11 at 1:30 p.m., E1 (Residential Services Director - RSD) stated that the pharmacy did not send the Eucerin Cream, and R4 had to wait until after the Holiday weekend to get it.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 369		12/31/11

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W 369	Continued From page 10	W 369		

review, the facility failed to ensure that physician prescribed medications are administered without error, for 3 of 5 individuals, at the 10/29/11, p.m. medication administration (R's 3, 4 & 5).

Findings include:

1. On 11/29/11, the p.m. medication administration was monitored by E2 (direct service person - DSP).

At 4:11 p.m., R4 entered the medication administration area. Per observation, R4 received Valproic Acid, Haloperidol and Eucerin Cream.

In review of R4's 11/11 physician's orders, R4 is to receive Benefiber Powder, 1 tablespoon in liquid 3X daily.

R4 did not receive her physician ordered Benefiber Powder at the p.m. medication administration of 11/29/11.

2. On 11/29/11, at 4:17 p.m., R5 entered the medication administration area. Per observation, R5 received Oyster Shell Calcium, Artificial Tears, and Eucerin Cream.

In review of R5's 11/11 physician's orders, R5 is to receive Benefiber Powder, 1 teaspoon, with 8 ounces of liquid 3X daily, by mouth.

R5 did not receive her physician ordered Benefiber Powder at the p.m. medication administration of 11/29/11.

3. On 11/29/11, at 4:24 p.m., R3 entered the

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W 369	Continued From page 11 medication administration area. Per observation, R3 received Oyster Shell Calcium, Ropinirole HCL, Acetaminophen, and Meloxicam. While E2 was assisting R3 with his medications, E2 (11/29/11, at 4:26 p.m.), stated that R3 also has a physician's order for Polyethylene Glycol, but that he will receive this medication with a drink at his supper meal. R3's 11/11 physician's orders document a diagnosis of Constipation. In review of R3's 11/11 physician's orders, R3 is to receive Triamcinolone 0.1% cream, 3X daily to the top of his head; and, Polyethylene Glycol 3350 Powder 100%, by mouth, 17 gm, with 8 ounces of liquid 2X daily. R3 did not receive his Polyethylene Glycol and Triamcinolone Cream. In an 11/29/11, 5:05 p.m., interview with E1 (Residential Services Director - RSD), E1 stated that there is no protocol to provide R3's bowel medication at the p.m. meal, and that R3's bowel medication should be administered at the p.m. medication administration.	W 369		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 460		12/31/11

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W 460	Continued From page 12	W 460		

review, the facility failed to ensure that physician specially-prescribed diets are provided, for 1 of 1 in the sample with current orders for a mechanical soft diet (R3).

Findings include:

1. In review of R3's 11/11 physician's orders, R3 functions in the severe range of mental retardation, and is 83 years of age. Additional diagnosis includes Parkinsonism.

Per observations at the facility, on 11/29/11, at 3:15 p.m., R3 is edentulous.

11/11 physician's orders for R3 document that R3 is to receive a mechanical soft diet, cut foods into bite size pieces, with ground meat.

An 8/3/11, "Speech Therapy Dysphagia/Discharge Summary", documents that R3 is impulsive at times when eating and was discharged from therapy due to poor carry-over/compliance. This report further states that R3 eats fast and takes large bites at times, and does not wait prior to the next bite.

In review of R3's formal programs, R3 has a 11/3/11 eating program. Per the goal, R3 is to eat all meals slowly, following the bite, chew, swallow, eating sequence, for all meals. "Staff will sit by (R3) during meals and snacks...Staff will continue to monitor through his meal and snack."

At the day training site, on 11/29/11, at 11:47 a.m., R3 was observed at his noon meal. R3 received a meat sandwich on two slices of bread. The meat on the sandwich was not ground.

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W 460	Continued From page 13 On 11/30/11, at 6:30 a.m., at the facility, R3 was observed eating his a.m. meal. One of the items received was bacon. R3's bacon was not ground. In an interview with E1 (Residential Services Director - RSD), on 11/30/11 at 11:30 a.m., E1 confirmed that R3's meat is to be ground.	W 460		