IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "Butch" Otter – Governor
Richard Armstrong – Director

BUREAU OF FACILITY STANDARDS
DEBRA RANSOM, R.N., R.H.I.T. – Chief
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
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COPY

CERTIFIED MAIL: 7000 1670 0011 3315 1927

May 29, 2008

Rene Stephens
Campus View Home
1411 Falls Avenue East, Suite 703
Twin Falls, Idaho 83301

RE: Campus View Home, provider #13G070

Dear Ms. Stephens:

Based on the Medicaid/Licensure survey completed at Campus View Home on May 15, 2008, by our staff, we have determined that Campus View Home is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Campus View Home to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **June 27, 2008**. **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than June 18, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Campus View Home ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective May 15, 2008, through September 15, 2008. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **June 26, 2008**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 11, 2008. If a request for informal dispute resolution is received after June 11, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

Enclosures

Clearwater Care Center, Inc.
1411 Falls Avenue East - Suite 703 - Twin Falls, ID 83301

06/19/2008

Monica Williams, Surveyor
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Re: Letter of Credible Allegation
Campus View Home Survey - May 2008

Dear Sylvia,

Please allow this letter to serve as the required "letter of credible allegation" in response to the recent survey findings for Campus View Home. Items relating to the condition of participation will be identified by tag number and followed by a brief description of the remedies we have put into place. We feel we have sufficiently reviewed these items individually, but also systemically.

W234 – Each client's needs were reviewed and training programs designed to implement the objectives to specify the methods used have been added or revised. In addition, The Social Sexual (Circles) class has been scheduled to begin by 6/30/08.

W227– All restitution plan were removed and no other "more restrictive" measures have been introduced. In addition, each of the resident's IPPs has been reviewed to determine that only necessary restrictive measures are in place. Any additional restrictive measures have been and in the future will be revised by the Treatment Team, Human Rights Committee and Q.M.R.P.s prior to introduction. Documentation for the application of each restrictive measure will be followed in the Individual Program Plan and/or IPP Addendum as specified.

W237 – Each person's record was reviewed regarding the recording of data for training programs designed to implement the objectives in each individual's plan. These were revised to specify sufficient information reflecting the; date, time, duration, intensity, and other relevant information providing an accurate report of what is occurring so that appropriate monitoring can occur by the Q.M.R.P.

W260 – Each individual's Individual Program Plan was reviewed and revised to reflect current status and needs. This includes the need and completion of Functional Behavior Assessments (FBA). In the future the FBA will be assessed as part of the Comprehensive Functional Assessment for any new residents. If new behavior is demonstrated during the Individual Program Plan implementation, the FBA will be revised accordingly.

W278 – All records were reviewed for each person and any restitution plans were removed and no other "more restrictive" measures have been introduced. In addition, each Individual Program Plan has been reviewed to determine what restrictive measures were in place. Any additional restrictive measures have been and in the future will be revised by the Treatment Team, Human Rights Committee and Q.M.R.P.s prior to introduction. Documentation for the application of each restrictive measure will be followed in the Individual Program Plan and/or IPP Addendum as specified.

W285 – Each person's records were reviewed and revisions necessary were completed to ensure that sufficient safeguards and supervision were in place for safety, welfare and civil and human rights of clients are adequately protected. See W289

208-734-8973 ext 1006 □ 208-734-1075 Fax
208-308-3238 cell □ , rstephens@ddcare.us

PAGE 1/2 * RCVD AT 6/19/2008 3:28:38 PM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/1 * DNIS:1888 * CSID:208 734 1075 * DURATION (mm-ss):01-08

Clearwater Care Center, Inc.
1411 Falls Avenue East - Suite 703 - Twin Falls, ID 83301

W289 – Each individual's Individual Program Plan was reviewed and/or revised to ensure systematic interventions to manage inappropriate client behavior were incorporated into the client's Individual Program Plan.

W312 – Each person's Individual Program Plan was reviewed to ensure drugs used for control of inappropriate behavior, revisions were made as necessary to be used only as an integral part of the client's Individual Program Plan, directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

W313 – Each individual's file was reviewed to ensure drug used for control of inappropriate behavior to justify harmful effects of behavior outweigh potential harmful effects of drugs. In addition, appropriate adjustments were made as necessary.

At this time we have had adequate time to be sure the changes mentioned are running smoothly and that you will also find this to be true on your return visit. We invite you back to see the results of the work done. If you have questions, please call me at (208)308-3238.

Respectfully,

René Stephens
Administrator

208-734-8973 ext 1006 □ 208-734-1075 Fax
208-308-3238 cell □ rstephens@ddcare.us

PAGE 1/1 * RCVD AT 6/19/2008 3:52:26 PM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/1 * DNIS:1888 * CSID:208 734 1075 * DURATION (mm-ss):00-54

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G070		05/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(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 The following deficiencies were cited during the recertification survey. The surveyors conducting the survey were: Monica Williams, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: ADA - American Diabetes Association BMP - Behavior Management Plan DOP - Destruction of Property FBA - Functional Behavioral Assessment HM - Home Manager HRC - Human Rights Committee HS - Each Evening IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse QAM - Quality Assurance Manager QMRP - Qualified Mental Retardation Professional SAM - Self Administration of Medication WIC - Written Informed Consent	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to maintain a record keeping system that contained accurate information for 1 of 3 individuals (Individual #2) whose records were reviewed. This resulted in the potential for a restrictive diet	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Stephens
TITLE: Administrator
(X6) DATE: 7/23/08

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 111	Continued From page 1 to be implemented. The findings include: 1. Individual #2's IPP, dated 5/2/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. During an observation on 5/12/08 from 3:10 - 4:10 p.m., Individual #2 showed his individualized menu to the surveyors. His diet, listed on the menu, was identified as a 2400 (calorie) ADA diabetic diet. Individual #2's Medical Nutrition Therapy notes, dated 2/8/07 and 7/12/07, documented his diet was a 2400 (calorie) ADA diabetic diet. Additionally, his Physician's Orders, dated 4/10/08, documented his diet was a 2400 (calorie) ADA diabetic diet. However, Individual #2's record included two WICs for an 1800 calorie modified diabetic diet. The WICs were dated 5/2/07 and 5/13/08. When asked about the conflicting documents reflecting different diets, the QAM stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., she was not sure why the WICs were in Individual #2's record because he was on a 2400 (calorie) ADA diabetic diet. The facility failed to ensure Individual #2's record contained accurate information related to his dietary needs.	W 111	W111: The Written Informed Consent was removed for individual #2 as he is not on a restrictive caloric diet. Dietary information will be reviewed for each individual to ensure accurate records. The facility LPN and QMRP (Qualified Mental Retardation Professional) will meet in person to review dietary information for each individual a minimum of one time per month to supplement dietary information added into the QMRP notes. The Quality Assurance Manager will participate in the monthly QMRP meeting reviewing the individual's records at that time. Responsible: QMRP, LPN, Quality Assurance Manager Date of correction 7/27/08	
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.	W 159		

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W 159	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination of the status for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. That failure resulted in individuals not receiving the services and training required to meet their developmental and behavioral needs. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He was admitted to the facility on 11/1/06 and his weight at that time was 170 pounds. Individual #1's Physician Orders, dated 5/12/08, stated he received Trazodone (an antidepressant drug) 50 mg each evening for sleep. According to the Nursing 2008 Drug Handbook 28th Edition, adverse reactions (side effects) of Trazodone included insomnia, drowsiness, anger, vivid dreams, and nightmares. Individual #1's Counseling Notes, dated 10/07 - 3/30/08, showed Individual #1 reported the following sleep-related concerns to his counselor: - 10/4/07: "[Individual #1] also expressed that he was having a hard time sleeping at nights... [Individual #1] engaged in problem solving with clinician regarding his sleeping difficulty. He expressed that it bothers him to be in pitch darkness and that he would like a night light on	W 159	W159: Individual #1 was provided an additional light for night time with a dim and bright setting. The individual can self adjust the setting. This is in addition to the original night light, the bedroom door is kept open (as preferred by the individual), there is white noise created by the dryer which is located near the bedroom. Counseling notes, QMRP notes, and medical information will be reviewed by the QMRP to ensure there are no other individuals affected. The facility LPN and QMRP will meet in person to review medical and counseling information for each individual a minimum of one time per month. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the program. The Quality Assurance Manager will participate in the monthly QMRP meeting reviewing the individual's records at that time. Refer to W111 Refer to W214 Refer to W249 Refer to W252 Refer to W256 Refer to W262 Refer to W263 Refer to W266 Refer to W371 Refer to W436 Responsible: QMRP, Quality Assurance Manager Date of correction 7/27/08 W214:	

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W 159	Continued From page 3 and his door open. In order to ensure that the noise from the staff doesn't bother him, he would like to have some white noise like a fan or his radio going." - 10/14/07: "Clinician also checked in with [Individual #1] about his sleeping and found out that staff have not followed through with a bright night light or with a fan or some form of white noise. His bedroom door continues to be closed at night and [Individual #1] continues to have difficulty sleeping." - 3/30/08: "He also has been having trouble sleeping, has been having vivid dreams, some nightmares and is very tired during the day ...He indicates that he does have trouble sleeping. This seems to be in part due to the seizure activity and also due to fear of the dark. [Individual #1] was able to indicate that he likes the light on during the night and that he feels safer when he can see what's going on. He indicated that he would prefer to have control of a light rather than having to rely on staff to turn on/off lights. He indicated that he does have nightmares which bother him and make the fear of the dark worse. He also indicated that he has a lot of very vivid dreams which wake him periodically throughout the night. He further indicated that he is very sleepy during the day most every day." When asked, the LPN stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #1 was admitted on Trazodone 50 mg and his current weight was 128 pounds (a 42 pound weight loss since admission). When asked about Individual #1's reported sleep-related concerns identified in his Counselor Notes, the LPN stated	W 159		

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W 159	Continued From page 4 during an interview on 5/15/08 from 9:08 - 11:20 a.m., she did not have access to the computerized database that contained the Counselor Notes. When asked, the QMRP, who was present during the interview, stated she had not read the Notes. The Day Program Coordinator, who was present during the interview, stated Individual #1 was noted to be tired and fall asleep during the day. The QAM, who was also present during the interview, stated she brought the concerns to the treatment team but was told by another QMRP that the data did not support a change. The facility failed to ensure the QMRP sufficiently monitored and coordinated all services for Individual #1. 2. Refer to W111 as it relates to the facility's failure to ensure a record keeping system that contained accurate information was maintained. 3. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were conducted in a timely manner and contained comprehensive information. 4. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their IPPs. 5. Refer to W252 as it relates to the facility's failure to ensure data was collected in the frequencies specified in individuals' plans. 6. Refer to W256 as it relates to the facility's failure to ensure IPPs were revised when individuals demonstrated regression.	W 159		

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W 159	Continued From page 5 7. Refer to W262 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee. 8. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the parent/guardian. 9. Refer to W266 - Condition of Participation for Client Behavior and Facility Practices and related standard level deficiencies as they relate to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. 10. Refer to W371 as it relates to the facility's failure to ensure individuals were instructed in skills leading to self-administration of medication. 11. Refer to W436 as it relates to the facility's failure to ensure individuals were provided with and taught to care for their adaptive devices.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavioral assessments were conducted in a timely manner and contained comprehensive information for 1 of 1 individuals (Individual #1) whose behavioral assessment was reviewed.	W 214		

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W 214	Continued From page 6 This resulted in a lack of information being available prior to the development of an individual's behavior management plan. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. He was admitted to the facility on 11/1/06. Individual #1's BMP, dated 12/1/06 and 12/1/07, stated his target behavior was "disruptive" which included the following: "verbal aggression in the form of yelling, screaming and swearing. Physical aggressive [sic] behaviors such as, scratching, hitting, flailing his body (may result in hitting others that he comes into contact with), kicking, releasing his seatbelt on wheelchair and flailing until falling to the ground, and attempting to run over staff with electric wheelchair [sic]. He has also engaged in elopement or attempting to leave the facility unsupervised and exhibiting unsafe 'driving' in the street in his electric wheelchair. Property destruction, other socially offensive behaviors observed have been pushing others, spitting, and non-compliance to prompting [sic]." However, Individual #1's FBA, dated 2/21/08 and finalized 2/29/08, stated his maladaptive behaviors included hitting people, running over/into things and people, biting himself, rocking out of his (wheel) chair, and screaming. Individual #1's FBA did not address kicking, elopement or attempting to leave the facility unsupervised, exhibiting unsafe "driving" in the	W 214	**W214:** **The Functional Behavior Assessment was reviewed and updated on 6/18/08 for individual #1.** **Each Functional Behavior Assessment will be reviewed to ensure it is inclusive of all maladaptive behaviors exhibited by the individual and updated as necessary. A review/update of completed Functional Behavior Assessment 's will be done annually if not sooner, when the need is warranted, to ensure that the information contained is accurate and applicable to the client's current behavioral need.** **The Quality Assurance Manager will review the Functional Behavior Assessment as part of the quality assurance checks to each individual's records to ensure the assessment and individual program plan adequately addresses all maladaptive behavioral concerns.** **Responsible: QMRP, Quality Assurance Manager** **Date of correction 7/27/08**	

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W 214	Continued From page 7 street in his electric wheelchair, property destruction, pushing others, spitting, and non-compliance to prompting. Further, the FBA stated the "Suggested bx (behavior) to decrease" was "Hopefully decrease the need to act out for attention." However, Individual #1's FBA included the following questions and staff responses which identified communication as the eliciting and sustaining factor of his maladaptive behaviors. - "What could someone do to cause the behavior to occur?" The response was "Someone not communicating with him well." - "At what point will the behavior stop?" The response was "When the staff allows him the opportunity and independence to communicate what he wants." - "When did the bx (behavior) begin?" The response was "This in an ongoing issue." - "How long has it been going on (this time)?" The response was "For as long as he's been in our care." - "What skills does the person currently have to get the things he/she most wants or needs?" The response was "Some verbal responses, communication book, and communication computer." - "Does the person understand more or less than he or she can express?" The response was "Yes." - "Does the challenging bx (behavior) relate to this	W 214		

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W 214	Continued From page 8 communication deficit?" The response was "Yes." Under the section titled Support Plan Suggestions, it stated "We are going to try to revamp the goals to tie together communication and behavior issues." When asked why there was a time delay in completing the FBA (from Individual #1's admission on 11/1/06 to the date the assessment was completed on 2/29/08), the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., she was not sure why. The facility failed to ensure Individual #1's FBA addressed kicking, elopement or attempting to leave the facility unsupervised, exhibiting unsafe "driving" in the street in his electric wheelchair, property destruction, pushing others, spitting, and non-compliance to prompting, and that it was completed in a timely manner.	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the IPP included objectives to meet the needs for 3 of 3 individuals (Individuals #1 - #3) whose objectives were reviewed. This resulted in a lack of program plans designed to address the needs of individuals in areas most likely to impact their	W 227		

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	13G070		05/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

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W 227	Continued From page 9 and others' lives. The findings include: 1. Individual #2's IPP, dated 5/2/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. a. Individual #2's record included a WIC related to a restitution agreement. The agreement stated "To enter into restitution agreement requires [Individual #2] to participate in repair or replacement of any items he purposefully damages or destroys. [Individual #2] will be required to either physically participate in replacement, cleaning of items or monetary restitution for the repair or replacement of any items damaged or destroyed." Individual #2's record also included a maintenance bill, dated 12/5/07, which totaled $608.99 for replacing four (4) chairs, repairing holes in a kitchen wall, and replacing a planter box. Additionally, Individual #2's financial record showed that earlier in the year (on 3/6/07), Individual #2 was required to pay $71.71 in restitution. Individual #2's IPP did not contain an objective related to DOP. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., there was no objective related to DOP. b. Individual #2's IPP stated "In recent months, [Individual #2] began to display inappropriate behavior toward female staff ...programming will be implemented to address [Individual #2's] sexually inappropriate displays of behavior toward female staff. A social sexual class is recommended as a teaching strategy for a	W 227	W227: Each individual's program plan was reviewed and specifics objectives were implemented to address the identified individual's needs. Individual #1's Trazadone medication was discontinued and a PRN sleep medication was prescribed. An objective was added to address sleep specifically for individual #1. Individual #2's individual program plan includes an objective relating to DOP and inappropriate touching in addition to a social sexual class directed towards increasing the skills of boundaries and education. Individual #3's individual program plan was revised to include an objective relating to caring for his eye glasses. Each person's records were reviewed to ensure there were no needs identified by the comprehensive assessment which are not addressed through an objective. The QMRP with the Quality Assurance Manager and the nursing staff will meet monthly to ensure that current medical/behavioral needs are identified for specific individuals and that identified needs have corresponding programmatic approaches applied to their Individual Program Plans. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the individual program plans and assessments. Responsible: QMRP w/oversight from Administrator Date of correction 6/19/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 227	Continued From page 10 replacement behavior of the inappropriate sexual acting out." Individual #2's QMRP Review Notes showed notations related to his "sexually inappropriate displays of behavior" as follows: - 5/07: "The comments are as following [sic] leaning on my shoulder, tried rubbing shoulder, tried using shoulder as a pillow, kept rubbing my back, very huggy [sic], put arm around shoulder, while at mall [sic] kept putting hand on shoulder 3 x, very silly [sic] kept putting hands over my eyes, slapped my butt while restraining my arm, tickled another client, slapped butt, gave hug and slapped butt another time, slapped on bottom, after mom called he kissed staff's cheek." - 7/07: "The comments just that he kept touching staff at [the day program], same at home." - 10/07: "...[the day program] comments reflect that he kept rubbing staff's [sic] arms." - 12/07: "There were two comments at home saying that once he mooned someone...At [the day program] the only comment says that he kept trying to hug his staff." - 1/08: "There was one staff at [the day program] that gave comments and it looked like he just kept wanting to hug that staff." Individual #2's IPP did not contain an objective related to "sexually inappropriate displays of behavior." When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., there was no objective. 2. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental	W 227		

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W 227	Continued From page 11 retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. Individual #1's Physician Orders, dated 5/12/08, documented he received Trazodone HCL (an antidepressant drug) 50 mg each night for sleep. However, Individual #1's IPP did not include an objective related to sleep. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., there was no objective for sleep but the facility was tracking it. 3. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. Individual #3's Nursing Note, dated 12/10/07, documented his eyeglasses were broken and he needed new frames. A Nursing Note, dated 12/17/07, stated "This is the sixth time that he has damaged the frames on the glasses. I did talk with [the Administrator, the QAM, and the QMRP] about putting in a program for his glasses and putting him in charge of taking care of them...[The Administrator] went in and talked to [the QMRP] and told [the QMRP] to put in a program on [Individual #3]." However, Individual #3's IPP did not include an objective related to caring for his eye glasses. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #3 did not have a training program to care for his eyeglasses. 4. Refer to W371 as it relates to the facility's	W 227		

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W 227	Continued From page 12 failure to ensure individuals' IPPs included objectives related to the self-administration of medication.	W 227		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 2 of 3 individuals (Individuals #1 and #2) whose records were reviewed. This resulted in a lack of instructions to staff being included in an individual's programs. The findings include: 1. Individual #2's IPP, dated 5/3/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. a. Individual #2's IPP stated "In recent months, [Individual #2] began to display inappropriate behavior toward female staff...programming will be implemented to address [Individual #2's] sexually inappropriate displays of behavior toward female staff. A social sexual class is recommended as a teaching strategy for a replacement behavior of the inappropriate sexual acting out." Individual #2's QMRP Review Notes showed notations related to his "sexually inappropriate displays of behavior" as follows: - 5/07: "The comments are as following [sic]	W 234		

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W 234	Continued From page 13 leaning on my shoulder, tried rubbing shoulder, tried using shoulder as a pillow, kept rubbing my back, very huggy [sic], put arm around shoulder, while at mall [sic] kept putting hand on shoulder 3 x, very silly [sic] kept putting hands over my eyes, slapped my butt while restraining my arm, tickled another client, slapped butt, gave hug and slapped butt another time, slapped on bottom, after mom called he kissed staff's cheek." - 7/07: "The comments just that he kept touching staff at [the day program], same at home." - 10/07: "...[the day program] comments reflect that he kept rubbing staff's [sic] arms." - 12/07: "There were two comments at home saying that once he mooned someone...At [the day program] the only comment says that he kept trying to hug his staff." - 1/08: "There was one staff at [the day program] that gave comments and it looked like he just kept wanting to hug that staff." Individual #2's IPP did not contain a program plan that identified what staff were to do if he engaged in "sexually inappropriate displays of behavior." When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., there was no program plan and Individual #2 had not attended a social sexual class. The facility failed to ensure program plans related to DOP and sexually inappropriate displays of behavior were developed for Individual #2. 2. Refer to W289 as it relates the the facility's failure to ensure techniques used to manage	W 234	W234: Each individual's program plan was reviewed and specific methods were implemented to address the identified individual's needs. Individual #1's Trazadone medication was discontinued and a PRN sleep medication was prescribed. An objective was added to address sleep specifically for individual #1. Individual #2's individual program plan includes training methods relating to DOP and inappropriate touching in addition to a social sexual class directed towards increasing the skills of boundaries and education. Individual #3's individual program plan includes training methods relating to caring for his eye glasses. Each person's records were reviewed to ensure there were no needs identified by the comprehensive assessment which are not addressed through training methods. The facility LPN and QMRP will meet in person to review dietary information for each individual a minimum of one time per month to supplement dietary information added into the QMRP notes. QMRP and Quality Assurance Manager will meet with nursing staff to ensure that current programming is aligned with established needs and meets scrutiny of having all necessary components (Lesser Restrictive, Hiuman Rights Committee, Written Informed Consent, Guardian Approval and other requirements) prior to the introduction of programming. This will occur at meetings at least monthly to review current client populations. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the individual program plans and training methods. Responsible: QMRP, Quality Assurance Manager, LPN Date of correction 6/19/08	

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W 234	Continued From page 14 inappropriate behavior were incorporated into the individuals' program plans.	W 234		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 1 of 1 individuals (Individual #1) whose behavior program and raw behavior data was reviewed. By not ensuring appropriate data collection, the facility could not make objective decisions regarding an individual's success or lack of success. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. Individual #1's IPP included an objective which stated "[Individual #1] will reduce the number of disruptive behaviors from current baseline of 3 to 1 per month for 3 consecutive months." Individual #1's BMP, dated 12/1/06 and 12/1/07, stated his target behavior was "disruptive" which included the following: "verbal aggression in the form of yelling, screaming and swearing.	W 237		

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W 237	Continued From page 15 Physical aggressive [sic] behaviors such as, scratching, hitting, flailing his body (may result in hitting others that he comes into contact with), kicking, releasing his seatbelt on wheelchair and flailing until falling to the ground, and attempting to run over staff with electric wheelchair [sic]. He has also engaged in elopement or attempting to leave the facility unsupervised and exhibiting unsafe 'driving' in the street in his electric wheelchair. Property destruction, other socially offensive behaviors observed have been pushing others, spitting, and non-compliance to prompting [sic]." Staff instructions included in the BMP stated if staff sensed Individual #1 was becoming agitated, staff were to take time to intervene using a calm discussion about how to self manage his emotional state. If he began to display disruptive behavior, staff were to use a verbal cue and tell him to stop. If he did not calm, staff were to redirect him to his room. If he refused to go to his room and was attempting to run into others with his wheelchair, staff were to disengage the electric motor from the power supply on his wheelchair. If he released his seatbelt (attached to the wheelchair) and attempted to throw himself to the floor, staff were to attempt to safely lower him to a floor mat and place a pillow under his head. The data collection form, attached to the BMP, stated staff were to record the duration in minutes and seconds as well as the intensity of the behavior based on the following scale: 1 = yelling, swearing (easily calmed almost immediately). 2 = yelling, swearing, throwing items (takes more	W 237	W237: The specific type of data and frequency of data is changed toward assessing progress toward the desired objective for individual #1. The data includes date, time, duration, antecedent, behavior observed as relating to the objective, the staff intervention, response to that intervention by the individual, and the identifying staff initials. This new data collection system has been incorporated into all behavior management plans. The standard data collection form will be this new system which includes the date, time, duration, antecedent, behavior observed, staff intervention, response to that intervention and the staff initials. As the QMRP reviews the monthly data, the documentation will be reviewed to ensure that the type of data and frequency of data collected provides the necessary information to assess the progress towards the objective. Responsible: QMRP Date of correction 6/19/08	

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W 237	Continued From page 16 than 3 - 5 minutes to calm). 3 = yelling, swearing, (calms after 5 - 10 minutes). 4 = yelling, swearing, threats of harm to self or others, minimal or no DOP (calms after 10 or more minutes). 5 = physical aggression toward self or others, actual DOP, scratching, hitting, flailing his body, kicking, releasing his wheelchair seatbelt until sliding or falling to the ground, purposefully running into others with wheelchair (may last 30 minutes to a [unreadable]). Raw behavior data, dated 4/08, was reviewed and showed that it was not possible to identify the actual time of the maladaptive behavior, what happened before the maladaptive behavior (antecedent), what actually occurred during the maladaptive behavior (behavior), what occurred after the maladaptive behavior (consequence) including when Individual #1's BMP was implemented and his response to the interventions, as follows: - 4/1/08: "yelling at staff - swearing, kicking [sic]. Wanted to get phone and call 911." The duration of the behavior was 30 minutes and the intensity was scored as a "3." - 4/2/08: "yelling at staff. something about his t.v. [sic]." The duration of the behavior was 30 minutes and the intensity was scored as a "1." - 4/6/08: "yelling at the staff about a movie." The duration of the behavior was 5 minutes and the intensity was scored as a "1." - 4/9/08: "angry that [a staff person] wasn't here [sic] yelling at staff." The duration of the behavior was 5 minutes and the intensity was scored as a	W 237		

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W 237	Continued From page 17 "1." - 4/11/08: "Angry when he saw [a staff person] and found out she wasn't working." The duration of the behavior was 5 minutes and the intensity was scored as a "1." - 4/18/08: "mad about movies that needed to go back to the library." The duration of the behavior was 5 minutes and the intensity was scored as a "2." - 4/18/08: "mad about turning television off in living room [sic] yelling, screaming, hitting." The duration of the behavior was 1 hour and the intensity was scored as a "3." - 4/22/08: "Refused to problem solve so I don't know what was wrong, but he was screaming and attempted to hit his head." The duration of the behavior was 20 minutes and the intensity was scored as a "2." - 4/26/08: "mad about staffing." The duration of the behavior was 5 minutes and the intensity was scored as a "2." Individual #1's QMRP Review Notes, dated 5/07 - 4/08, showed behavioral data was reported to the QMRP by the total number of incidents each month, an average number of minutes, and the average intensity. For example, the 4/08 raw data showed 9 incidents with an average of 18 minutes and an average intensity of "2." When asked about the data, the HM stated on 5/15/08 at 12:30 p.m., it was not possible to know what happened before or after the maladaptive behaviors, and the data did not show at what	W 237		

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W 237	Continued From page 18 point the BMP was implemented nor Individual #1's response to the interventions. The facility failed to ensure Individual #1's BMP specified the type of behavioral data collected was sufficient to determine the efficacy of the intervention strategies in the BMP.	W 237		
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, record review, and staff interviews it was determined the facility failed to ensure individuals received training and services consistent with their IPPs for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in individuals not receiving training as specified in their IPPs and programs. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. Individual #1's IPP included a training program for him to utilize his computer communication system. The program stated staff were to use	W 249		

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W 249	Continued From page 19 opportunities throughout the day to implement the program. Observations were conducted at the facility and at Individual #1's day program on 5/12/08 and 5/13/08 for a cumulative 5 hours and 22 minutes. At no time throughout the observations was Individual #1 noted to have access or be provided with his computer communication system nor was the program noted to be implemented. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., the training program was to be implemented at least three times a day and the communication device was to be used as much as possible. 2. Individual #2's IPP, dated 5/3/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. Individual #2's IPP stated "In recent months, [Individual #2] began to display inappropriate behavior toward female staff...programming will be implemented to address [Individual #2's] sexually inappropriate displays of behavior toward female staff. A social sexual class is recommended as a teaching strategy for a replacement behavior of the inappropriate sexual acting out." Individual #2's QMRP Review Notes showed notations related to his "sexually inappropriate displays of behavior" as follows: - 5/07: "The comments are as following [sic] leaning on my shoulder, tried rubbing shoulder, tried using shoulder as a pillow, kept rubbing my	W 249	W249: In regards to individual #1 and individual #3, staff retraining was conducted in regards to program implementation of training objectives on 5/20/08. At that time review of accurate and adequate data collection including additional noted information to provide sufficient information for program monitoring was discussed. Individual #2's individual program plan has been updated to include more specific objective and training methods for personal space. This will be implemented when needed throughout the day. In addition individual #2 will attend a social sexual class beginning 7/2/08. The curriculum for this five week class was fully developed on 6/20/08. Each of the other individuals was assessed to ensure their active treatment is implemented as scheduled; this was also discussed during the staff training on 5/20/08. The facility managers will conduct shift observation to ensure the active treatment schedules are being implemented as well as incidental learning opportunities that may present themselves. Intermittent observation will occur by each member of the treatment team (Facility Manager, Nurse, QMRP, Quality Assurance Manager, day program manager) in each individual's natural setting to ensure active treatment and individual program plans are being implemented, recorded and feedback is applied through the Facility Manager. Responsible: QMRP, Quality Assurance Manager Date of correction 7/2/08	

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W 249	Continued From page 20 back, very huggy [sic], put arm around shoulder, while at mall [sic] kept putting hand on shoulder 3 x, very silly [sic] kept putting hands over my eyes, slapped my butt while restraining my arm, tickled another client, slapped butt, gave hug and slapped butt another time, slapped on bottom, after mom called he kissed staff's cheek." - 7/07: "The comments just that he kept touching staff at [the day program], same at home." - 10/07: "...[the day program] comments reflect that he kept rubbing staff's [sic] arms." - 12/07: "There were two comments at home saying that once he mooned someone...At [the day program] the only comment says that he kept trying to hug his staff." - 1/08: "There was one staff at [the day program] that gave comments and it looked like he just kept wanting to hug that staff." When asked if Individual #2 attended a social sexual class as specified in his IPP, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., no. 3. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. He had a Baclofen pump implanted on 8/12/02 and used a wheelchair for mobility purposes. Individual #3's Physician Order, dated 9/5/07, stated "[Individual #3] should use his harness while in his w/c (wheelchair) for positioning."	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 21 Individual #3's Physical Therapy Notes, dated 12/10/07 and 1/31/08, documented that he (Individual #3) had a chronic problem with his posture and the chest harness kept him in an upright position. Individual #3's Nursing Notes, dated 5/07 - 3/08, documented Individual #3 was not consistently wearing his chest harness. Examples included, but were not limited to, the following: - 10/1/07: "Everytime [sic] I've seen [Individual #3] within a ½ hour period he has been slumped down in his chair. Have mentioned this numerous times with staff." - 12/22/07: "He is slumped over in the wheelchair. I keep mentioning to staff and [Individual #3] that he needs to be sitting upright." - 3/25/08: "[Individual #3] is continuing to slump over sideways in the wheelchair...It is noted that his harness is not on him. Did bring this up with the facility manager and the staff." Individual #3's IPP included a training program for him to wear his chest harness (when he was in his wheelchair) independently. The program stated if Individual #3 was in his wheelchair and was not wearing his chest harness, staff were to provide him with the necessary prompts in order for him to wear the harness. If he refused to wear the harness, staff were to implement his non-compliance program. Observations were conducted at the facility and at Individual #3's day program on 5/12/08 and 5/13/08 for a cumulative 5 hours and 22 minutes.	W 249		

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W 249	Continued From page 22 During that time, Individual #3 was noted to be consistently leaning forward in his wheelchair. At no time throughout the observations was Individual #3 noted to be wearing his chest harness and staff were not noted to prompt him to do so. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #3 did not like the harness but staff were to implement the training program. The facility failed to ensure programs and services, as identified in Individual #1 - Individual #3s' IPPs, were implemented as written.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure data was collected in the frequencies specified in the plans of 3 of 3 individuals (Individuals #1 - #3) whose QMRP Review Notes were reviewed. Failure to document data consistently had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 23 peptic ulcer disease. He was edentulous (no teeth). Individual #1's QMRP Review Notes, dated 7/07 - 3/08, showed data was missing on programs, identified below. When asked about the missing data, the HM and QMRP both stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., staff were implementing programs but were not consistently collecting data. a. His 12/1/06 and 12/1/07 IPP contained an objective to use a napkin to wipe food from his face. His QMRP Review Notes showed data was missing at the following rates: 7/07: 15 instances of missing data. 8/07: 7 instances of missing data. 9/07: 2 instances of missing data. 10/07: 11 instances of missing data. 11/07: 11 instances of missing data. 12/07: 4 instances of missing data. 1/08: 7 instances of missing data. 2/08: 5 instances of missing data. b. His 12/1/06 and 12/1/07 IPP contained an objective to move his toothbrush to all areas of his gums. His QMRP Review Notes showed data was missing at the following rates: 7/07: 26 instances of missing data. 8/07: 11 instances of missing data. 9/07: 2 instances of missing data. 10/07: 10 instances of missing data. 11/07: 14 instances of missing data. 12/07: 9 instances of missing data. 1/08: 8 instances of missing data. 2/08: 9 instances of missing data. 3/08: 4 instances of missing data. c. His 12/1/06 and 12/1/07 IPP contained an	W 252	W252: A staff retraining was conducted in regards to accurate and adequate data collection including additional noted information to provide sufficient information for program monitoring on 5/20/08. This discussion included specifically the ongoing concern affecting the identified individuals. The staff training on 5/20/08 was directed towards all other individuals that may be impacted by the deficient practice. The staff discussed a team process of reviewing each other's work to ensure that the data is taken as specified in the plans. Systematically, Clearwater has implemented an employee coaching model to utilize when addressing any identified performance issues such as missing data. If an employee is unable or unwilling to improve data collection then more punitive disciplinary measures will be taken following the company policy and procedures. The details regarding data collection and missing data will be reviewed at least one time per month with the QMRP, LPN, Quality Assurance Manager and Facility Manager. Responsible: QMRP, Quality Assurance Manager and Facility Manager. Date of correction 7/27/08	

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W 252	Continued From page 24 objective to pull up his pants. His QMRP Review Notes showed data was missing at the following rates: 7/07: 6 instances of missing data. 8/07: 7 instances of missing data. 9/07: 5 instances of missing data. 10/07: 12 instances of missing data. 11/07: 11 instances of missing data. 12/07: 8 instances of missing data. 1/08: 8 instances of missing data. 2/08: 6 instances of missing data. d. His 12/1/06 and 12/1/07 IPP contained an objective to use problem solving. His QMRP Review Notes showed data was missing at the following rates: 7/07: 22 instances of missing data. 8/07: 13 instances of missing data. 9/07: 12 instances of missing data. 10/07: 16 instances of missing data. 11/07: 9 instances of missing data. 12/07: 17 instances of missing data. 1/08: 10 instances of missing data. 2/08: 6 instances of missing data. e. His 12/1/06 and 12/1/07 IPP contained an objective to use his communication book throughout the day. His QMRP Review Notes showed data was missing at the following rates: 7/07: 18 instances of missing data. 8/07: 14 instances of missing data. 9/07: 7 instances of missing data. 10/07: 15 instances of missing data. 11/07: 11 instances of missing data. 12/07: 23 instances of missing data. 1/08: 17 instances of missing data. 2/08: 13 instances of missing data. 3/08: 6 instances of missing data.	W 252		

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W 252	Continued From page 25 f. His 12/1/06 and 12/1/07 IPP contained an objective to use his computer communication system three times a day. His QMRP Review Notes showed data was missing at the following rates: 7/07: 9 instances of missing data. 8/07: computer being repaired. 9/07: computer being repaired. 10/07: 5 instances of missing data. 11/07: 5 instances of missing data. 12/07: 20 instances of missing data. 1/08: 13 instances of missing data. 2/08: 13 instances of missing data. 3/08: 5 instances of missing data. g His 12/1/06 and 12/1/07 IPP contained an objective to complete his occupational therapy exercises each day. His QMRP Review Notes showed data was missing at the following rates: 7/07: 57 instances of missing data. 8/07: 32 instances of missing data. 9/07: 10 instances of missing data. 10/07: 18 instances of missing data. 11/07: 17 instances of missing data. 12/07: 8 instances of missing data. 1/08: 18 instances of missing data. 2/08: 16 instances of missing data. 2. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. He had a Baclofen pump implanted on 8/12/02 and used a wheelchair for mobility purposes. Individual #3's QMRP Review Notes, dated 7/07 - 3/08, showed data was missing on programs, identified below. When asked about the missing	W 252		

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W 252	Continued From page 26 data, the HM and QMRP both stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., staff were implementing programs but were not consistently collecting data. a. His 11/17/06 and 11/14/07 IPP contained an objective to drink 8 ounces of water every two hours. His QMRP Review Notes showed data was missing at the following rates: 7/07: 31 instances of missing data. 8/07: 30 instances of missing data. 9/07: 26 instances of missing data. 10/07: 32 instances of missing data. 12/07: 9 instances of missing data. 1/08: 17 instances of missing data. 2/08: 7 instances of missing data. 3/08: 12 instances of missing data. b. His 11/17/06 and 11/14/07 IPP contained an objective to sit unsupported on the edge of a firm chair. His QMRP Review Notes showed data was missing at the following rates: 7/07: 10 instances of missing data. 8/07: 13 instances of missing data. 9/07: 5 instances of missing data. 10/07: 6 instances of missing data. 12/07: 23 instances of missing data. 1/08: 31 instances of missing data. 2/08: 8 instances of missing data. 3/08: 23 instances of missing data. c. His 11/17/06 and 11/14/07 IPP contained an objective to complete his physical therapy exercises. His QMRP Review Notes showed data was missing at the following rates: 7/07: 104 instances of missing data. 8/07: 136 instances of missing data. 9/07: 15 instances of missing data. 10/07: 40 instances of missing data.	W 252		

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W 252	Continued From page 27 12/07: 62 instances of missing data. 1/08: 76 instances of missing data. 2/08: 75 instances of missing data. 3/08: 38 instances of missing data. d. His 11/17/06 and 11/14/07 IPP contained an objective to complete his occupational therapy exercises. His QMRP Review Notes showed data was missing at the following rates: 7/07: 24 instances of missing data. 8/07: 41 instances of missing data. 9/07: 16 instances of missing data. 10/07: 16 instances of missing data. 12/07: 11 instances of missing data. 1/08: 12 instances of missing data. 2/08: 10 instances of missing data. 3/08: 10 instances of missing data. e. His 11/14/07 IPP contained an objective to wear his C-Pap mask each night. His QMRP Review Notes showed data was missing at the following rates: 12/07: 30 instances of missing data. 1/08: 30 instances of missing data. 2/08: 27 instances of missing data. 3/08: 20 instances of missing data. 3. Individual #2's IPP, dated 5/3/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. Individual #2's QMRP Review Notes, dated 7/07 - 3/08, showed data was missing on programs, identified below. When asked about the missing data, the HM and QMRP both stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., staff were implementing programs but were not consistently collecting data.	W 252		

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W 252	Continued From page 28 a. His IPP contained an objective to stay on topic during a group discussion. His QMRP Review Notes showed data was missing at the following rates: 7/07: 6 instances of missing data. 8/07: 18 instances of missing data. 11/07: 8 instances of missing data. 2/08: 5 instances of missing data. b. His IPP contained an objective to respect the personal space of others. His QMRP Review Notes showed data was missing at the following rates: 7/07: 77 instances of missing data. 8/07: 83 instances of missing data. 9/07: 57 instances of missing data. 11/07: 13 instances of missing data. 1/08: 6 instances of missing data. 2/08: 10 instances of missing data. c. His IPP contained an objective to self administer his medications. His QMRP Review Notes showed data was missing at the following rates: 7/07: 13 instances of missing data. 8/07: 5 instances of missing data. 9/07: 4 instances of missing data. 11/07: 20 instances of missing data. 2/08: 9 instances of missing data. The facility failed to ensure data was collected at the required frequency for Individual #1 - Individual #3.	W 252		
W 256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation	W 256		

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W 256	Continued From page 29 professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure IPPs were revised as appropriate for 2 of 3 individuals (Individuals #1 and #2) whose IPPs and program summaries were reviewed. This resulted in a regression of the individuals' skills without appropriate programmatic revisions being made. Findings include: 1. Individual #2's IPP, dated 5/3/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. Individual #2's QMRP Review Notes, dated 6/07 - 4/08, showed the following objectives with a lack of consistent progress and no revisions were completed. a. The objective for oral care was set at 80% a month for 3 consecutive months. His QMRP Review Notes, dated 6/07 - 4/08, showed the following status of the objective: - 6/07: 44% - 7/07: 54% - 8/07: 36% - 9/07: 52% - 10/07: 53% - 11/07: 61% - 12/07: 40% - 1/08: 45% - 2/08: 50% - 3/08: 44%	W 256	W256: Each client's Q notes have been reviewed to ascertain if there is need to adjust programming to facilitated progress. The rule of 3 months without positive progress was utilized to determine what programs need to be addressed. Notations were made and changes will be implemented in the next 30 days. Each individual's Q notes will be reviewed to ensure that revisions are made as necessary when there is notable regression or evidence of loss of skill already gained. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the QMRP notes and the monthly meeting. A new coding system to note changes has been added to the Q notes to indicate a revision for staff instruction, training method, objective (criteria), a new Individual Program Plan or to note when the data is investigated for accuracy. The progress of each person's individual program plan will be reviewed at least one time per month with the QMRP, LPN, Quality Assurance Manager and Facility Manager to ensure that program revisions are identified and implemented in a timely fashion. Responsible: QMRP Date of correction 7/27/08	

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W 256	Continued From page 30 - 4/08: 45% Individual #2 failed to show consistent or sustained progress since 11/07, and no revisions were made to address the issue. b. The objective for SAMs was set at 90% a month for 12 consecutive months. His QMRP Review Notes, dated 6/07 - 4/08, showed the following status of the objective: - 6/07: 65% - 7/07: 51% - 8/07: 26% - 9/07: 3% - 10/07: 7% - 11/07: 5% - 12/07: 8% - 1/08: 3% - 2/08: 3% - 3/08: 0% - 4/08: 0% Individual #2 failed to show consistent or sustained progress since 6/07, and no revisions were made to address the issue. c. The objective for verbalizing time was set at 80% for 3 consecutive months. His QMRP Review Notes, dated 9/07 - 3/08, showed the following status of the objective: - 9/07: 90% - 10/07: 63% - 11/07: 94% - 12/07: 45% - 1/08: 59% - 2/08: 30% - 3/08: 31% Individual #2 failed to show consistent or sustained progress since 11/07, and no revisions were made to address the issue.	W 256		

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W 256	Continued From page 31 When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., the objectives had not been revised. 2. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He was edentulous (no teeth) and used a wheelchair for mobility purposes. Individual #1's QMRP Review Notes, dated 6/07 - 4/08, showed the following objective with a lack of consistent progress and no revisions were completed. His objective for using his communication book was set at 90% a month for 6 consecutive months. His QMRP Review Notes, dated 6/07 - 4/08, showed the following status of the objective: - 6/07: 62% - 7/07: 60% - 8/07: 50% - 9/07: 57% - 10/07: 69% - 11/07: 20% - 12/07: 8% - 1/08: 5% - 2/08: 18% - 3/08: 6% - 4/08: 22% Individual #1 failed to show consistent or sustained progress since 10/07, and no revisions were made to address the issue. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., the objective had not been revised.	W 256		

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W 256	Continued From page 32	W 256		
	The facility failed to ensure objectives were revised when Individual #1 and Individual #2 failed to make progress toward them.			
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE	W 260		
	At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.			
	This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' IPPs were revised to accurately reflect and respond to individuals' current needs and functional changes for 2 of 3 individuals (Individual #1 and #3) whose IPPs were reviewed. That failure resulted in an individual's IPP which was not reflective of his current status. The findings include:			
	1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He was edentulous (no teeth) and used a wheelchair for mobility purposes. He was admitted to the facility on 11/1/06.			
	Individual #1's FBA, dated 2/21/08 and finalized 2/29/08, included the following questions and staff responses which identified communication as the eliciting and sustaining factor of his maladaptive behaviors.			
	- "What could someone do to cause the behavior			

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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 260	Continued From page 33 to occur?" The response was "Someone not communicating with him well." - "At what point will the behavior stop?" The response was "When the staff allows him the opportunity and independence to communicate what he wants." - "When did the bx (behavior) begin?" The response was "This in an ongoing issue." - "How long has it been going on (this time)?" The response was "For as long as he's been in our care." - "What skills does the person currently have to get the things he/she most wants or needs?" The response was "Some verbal responses, communication book, and communication computer." - "Does the person understand more or less than he or she can express?" The response was "Yes." - "Does the challenging bx (behavior) relate to this communication deficit?" The response was "Yes." Under the section titled Support Plan Suggestions, it stated "We are going to try to revamp the goals to tie together communication and behavior issues." Further, Individual #1's Counseling Notes, dated 3/11/07 - 3/30/08, documented the goal of the counseling sessions was "To increase [Individual #1's] ability to communicate frustration and anger appropriately."	W 260	W260: Each individual's program plan was reviewed and revised to ensure meeting current needs and reflecting those needs. Individual #1's Functional Behavior Assessment was revised to accurately reflect current maladaptive behavioral concerns displayed. A change to the communication program occurred as part of this aligned system. Individual #3's individual program plan was revised to include an objective relating to caring for his eye glasses. Each person's records were reviewed to ensure there were no needs identified by the comprehensive assessment which are not addressed through an objective. The QMRP with the Quality Assurance Manager and the nursing staff will meet monthly to ensure that current needs are identified for specific individuals and that identified needs have corresponding programmatic approaches applied to their Individual Program Plans. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the individual program plans and assessments. Responsible: QMRP, Quality Assurance Manager Date of correction 6/19/08	

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W 260	Continued From page 34 However, Individual #1's BMP and both of his communication programs were dated 12/1/07, prior to the completion of the FBA. When asked if Individual #1's BMP or communication plans were revised based on the suggestions in the FBA, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., no. The facility failed to ensure Individual #1's IPP was revised to included necessary changes to his BMP and communication plans. 2. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. Individual #3's Nursing Note, dated 12/10/07, documented his eyeglasses were broken and he needed new frames. A Nursing Note, dated 12/17/07, stated "This is the sixth time that he has damaged the frames on the glasses. I did talk with [the Administrator, the QAM, and the QMRP] about putting in a program for his glasses and putting him in charge of taking care of them...[The Administrator] went in and talked to [the QMRP] and told [the QMRP] to put in a program on [Individual #3]." When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #3 did not have a training program to care for his eyeglasses. The facility failed to ensure Individual #3's IPP	W 260		

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W 260	Continued From page 35 was revised to included an objective and programming related to the care of his glasses.	W 260		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. Findings include: 1. Individual #1's IPP, dated 12/1/07, stated he was a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. a. Individual #1's Physician Orders, dated 5/12/08, stated he received Trazodone (an antidepressant drug) 50 mg each evening for sleep. His WIC for Trazodone, dated 11/30/07, contained a hand written note which stated "verbal consent given by [HRC member] on 5/13/08." The consent contained no additional	W 262		

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W 262	Continued From page 36 information that the facility's HRC approved the continued use of Trazodone between the dates of 11/30/07 and 5/13/08. However, Individual #1 continued to receive the medication during that time. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the Medical Assistant stated the failure to update the consent was an oversight. The QAM, who was present during the interview, stated the facility was aware that the consent had lapsed. b. Individual #1's record contained a WIC, dated 4/11/07, titled "Remove to Bedroom." The WIC stated staff were to disengage his power wheelchair and escort him to his bedroom when he engaged in maladaptive behavior. The consent expired on 4/12/08. His record contained a second consent titled "Remove to Bedroom" which was dated 5/13/08. However, the document contained no evidence that the facility's HRC approved the continued use of disengaging Individual #1's power wheelchair and escorting him to his bedroom between the dates of 4/12/08 and 5/13/08. However, the interventions continued to be implemented during that time. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the Medical Assistant stated the failure to update the consent was an oversight. The QAM, who was present during the interview, stated the facility was aware that the consent had lapsed. c. Individual #1's record contained a WIC, dated 11/1/06, titled "Mechanical Soft Diet." The	W 262	W262: Each of the individual's files has been reviewed and the Written Informed Consents and associated programs have been revised to accommodate the appropriate dates in question. Updates to the Written Informed Consents have been obtained from the Human Rights Committee. A scrutiny of each resident's file has been done to ensure that for every restrictive program or medication, appropriate Written Informed Consent has been obtained from parent guardian and garnered Human Rights Committee approval. A stronger scrutiny of annual reviews will be done by QMRP and Quality Assurance Manager with nursing to ensure that Human Rights Committee reviews take place prior to implementation and at least annually, if not sooner. Quarterly file reviews by QMRPs and Quality Assurance Manager will be done to ensure that current restrictive programming, medications have Human Rights Committee approval prior to (concurrent to) implementation. Responsible: QMRP, Quality Assurance Manager Date of correction 7/27/08	

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W 262	Continued From page 37 consent expired on 11/7/07. An updated consent, dated 11/30/07, was present but did not contain evidence that the facility's HRC approved the continued use of the diet. However, Individual #1 continued to receive the "Mechanical Soft Diet" during that time. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the QAM stated Individual #1 received a mechanical soft diet and the facility felt the diet was restrictive because Individual #1 was not allowed to have potato chips and crackers, which he liked. The Medical Assistant, who was present during the interview, stated the failure to update the consent was an oversight. The facility failed to ensure HRC approval was obtained for Individual #1's restrictive interventions prior to their continued use.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include:	W 263		

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W 263	Continued From page 38 1. Individual #1 was a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive asphasia, chronic pain and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. a. Individual #1's Physician Orders, dated 5/12/08, stated he received Trazodone (an antidepressant drug) 50 mg each evening for sleep. His WIC for Trazodone, undated, showed evidence that guardian consent was obtained on 11/1/06 and expired on 11/1/07. An updated consent was not obtained until 11/30/07. However, Individual #1 continued to receive the medication from 11/1/07 to 11/30/07. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the Medical Assistant stated the failure to update the consent was an oversight. The QAM, who was present during the interview, stated the facility was aware that the consent had lapsed. b. Individual #1's record contained a WIC, dated and signed by Individual #1's guardian on 4/11/07, and was titled "Remove to Bedroom." The WIC stated staff were to disengage Individual #1's power wheelchair and escort him to his bedroom when he engaged in maladaptive behavior. The WIC expired on 4/11/08 and Individual #1's record did not contain evidence of an updated consent. However, the interventions continued to be used. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the Medical Assistant stated the failure to renew the consent was an oversight.	W 263	W263: Individual #1 has Trazadone removed from doctor's orders. The Written Informed Consent updates have been obtained for the removal from wheelchair. A systematic review of all files of individuals residing in the home has been done to determine if there are any restrictive measures that have Written Informed Consents that have lapsed or need annual/update or procedural review. Quarterly review of files will take place by QMRPs and Quality Assurance Manager to ensure that any established programming associated with restrictive measures has approved Written Informed Consent on file and are current to date. QMRP with Quality Assurance Manager and nursing will meet at least monthly to review current programming, and medical needs to ensure that any new restrictive programming will gain appropriate approval after Team review. Responsible: QMRP, Quality Assurance Manager Date of correction 7/27/08 W266: Refer to W227 Refer to W234 Refer to W237 Refer to W260 Refer to W278 Refer to W285 Refer to W312 Refer to W313 Date of correction 6/19/08 W278: An immediate suspension of the restrictive restitution agreement was implemented for	

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W 263	Continued From page 39 The QAM, who was present during the interview, stated the facility was aware that the consent had lapsed. c. Individual #1's record contained a WIC, dated 11/1/06, titled "Mechanical Soft Diet." The consent expired on 11/1/07. An updated consent was not obtained until 11/30/07. However, Individual #1 continued to receive the "Mechanical Soft Diet" from 11/1/07 to 11/30/07. When asked during an interview on 5/15/08 from 9:08 - 11:20 a.m., the QAM stated Individual #1 received a mechanical soft diet and the facility felt the diet was restrictive because Individual #1 was not allowed to have potato chips and crackers, which he liked. The Medical Assistant, who was present during the interview, stated the failure to update the consent was an oversight. The facility failed to ensure consent was garnered from Individual #1's guardian prior to the continued use of his restrictive interventions.	W 263		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate	W 266		

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W 266	Continued From page 40 behavioral services and interventions. The findings include: 1. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their behavioral needs. 2. Refer to W234 as it relates to the facility's failure to ensure individuals' behavior plans included sufficient direction to staff. 3. Refer to W237 as it relates to the facility's failure to ensure the type of behavioral data collected was sufficient to determine the efficacy of the intervention strategies in the BMP. 4. Refer to W260 as it relates to the facility's failure to ensure individuals' IPPs were revised to accurately reflect and respond to individuals' current behavioral needs and functional changes. 5. Refer to W278 as it relates to the facility's failure to ensure evidence of least restrictive or more positive techniques were utilized prior to more restrictive techniques to manage an individual's maladaptive behaviors. 6. Refer to W285 as it relates to the facility's failure to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the individuals' safety, welfare and civil and human rights. 7. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination	W 266	**W266:** **Refer to W227** **Refer to W234** **Refer to W237** **Refer to W260** **Refer to W278** **Refer to W285** **Refer to W312** **Refer to W313** **Date of correction 6/19/08**	

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W 266	Continued From page 41 of the behaviors for which the drugs were employed. 8. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs.	W 266		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 3 individuals (Individual #2) whose behavioral management plans were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #2's IPP, dated 5/2/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. His IPP stated that he (Individual #2) was his own guardian.	W 278		

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W 278	Continued From page 42 Individual #2's record included a WIC related to a restitution agreement. The agreement stated "To enter into restitution agreement requires [Individual #2] to participate in repair or replacement of any items he purposefully damages or destroys. [Individual #2] will be required to either physically participate in replacement, cleaning of items or monetary restitution for the repair or replacement of any items damaged or destroyed." Individual #2's record also included a maintenance bill, dated 12/5/07, which totaled $608.99 for replacing four (4) chairs, repairing holes in a kitchen wall, and replacing a planter box. Additionally, Individual #2's financial record showed that earlier in the year (on 3/6/07), Individual #2 was required to pay $71.71 in restitution. When asked for evidence of less restrictive alternatives that were systematically tried and proven ineffective prior to restitution, the QAM and QMRP both stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., they thought other things were tried but would have to search historical records. No evidence was provided to the survey team by 5/20/08. The facility failed to ensure there was sufficient evidence of less restrictive alternatives that were systematically tried and proven ineffective prior to implementing a restitution agreement for Individual #2.	W 278	W278: An immediate suspension of the restrictive restitution agreement was implemented for individual #2. In addition, programming directed towards prevention of property destruction, teaching methods and response instructions were implemented. Individual #2's family was contacted concerning guardianship and is pursuing legal action at this time. Each individual's record was reviewed to ensure that restrictive measures were not being utilized prior to more restrictive techniques to manage maladaptive behaviors. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of the individual program plans and assessments. Each person will have behavioral management plans directed to least restrictive or more positive techniques prior to the application of more restrictive techniques. The QMRP with the Quality Assurance Manager and the nursing staff will meet monthly to ensure that current needs are identified for specific individuals and that identified needs have corresponding programmatic approaches applied to their Individual Program Plans. Responsible: QMRP, Quality Assurance Manager Date of correction 6/19/08	
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient	W 285		

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W 285	Continued From page 43 safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights for 2 of 2 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of adequate protections related to individuals' rights and physical safety. The findings include: 1. Refer to W289 as it relates to the facility's failure to ensure restrictive interventions used to manage inappropriate behavior were incorporated into program plans.	W 285	**W285:** **Refer to W313** **Date of correction 6/19/08**	
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into program plans for 2 of 2 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This	W 289		

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W 289	Continued From page 44 resulted in restrictive interventions being used with were not included in the individual's program plans. The findings include: 1. Individual #2's IPP, dated 5/3/07, documented a 27 year old male diagnosed with moderate mental retardation, Down syndrome, asthma, and diabetes mellitus type 2. Individual #2's record included a WIC related to a restitution agreement. The agreement stated "To enter into restitution agreement requires [Individual #2] to participate in repair or replacement of any items he purposefully damages or destroys. [Individual #2] will be required to either physically participate in replacement, cleaning of items or monetary restitution for the repair or replacement of any items damaged or destroyed." Individual #2's record also included a maintenance bill, dated 12/5/07, which totaled $608.99 for replacing four (4) chairs, repairing holes in a kitchen wall, and replacing a planter box. Additionally, Individual #2's financial record showed that earlier in the year (on 3/6/07), Individual #2 was required to pay $71.71 in restitution. Individual #2's IPP did not contain an objective or plan related to destruction of property and restitution. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., there was no program plan related to destruction of property and restitution. The facility failed to ensure the use of restitution was incorporated in to a program plan for Individual #2.	W 289	W289: The behavior management plan for Individual #1 was revised and behavioral goals are entered in the Individual Program Plan and corresponding Behavior Management Plan include specific instructions to staff to ensure that the restrictive measures can be systematically addressed by staff. The behavior management plan for individual #2 was revised to remove the use of restitution methods due to restrictive measures not being systematically approached and approved. Review of each residents files were reviewed to determine if there was a consistent application of interventions from Written Informed Consent, Individual Program Plan, Human Rights Committee approval and direction to staff. Each person's records were reviewed to ensure there were no restrictive interventions being used that were not included in the individual's program plan. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the over site and management of maladaptive behavior plans and restrictive techniques to ensure these are implemented as part of the Individual Program Plan. The QMRP with the Quality Assurance Manager and the nursing staff will meet monthly to ensure that restrictive techniques are applied to their Individual Program Plans. Responsible: QMRP, Quality Assurance Manager Date of correction 6/19/08	

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W 289	Continued From page 45 2. 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. Individual #1's Incident Reports, dated 1/18/08 - 5/8/08, showed the following time-out procedures being used by staff: - 1/18/08 from 3:00 - 5:00 p.m.: "[Individual #1] was upset when he got home from [the day program]. Staff tried to see if there was anything that we could do for him and he began to yell. He then started to run his chair into the office door. Staff then disabled his chair and tried to problem solve with him. He refused and continued to yell and throw himself around in his chair. Staff then took him to his room and tried to problem solve with him. He refused and continued to yell. He then unbuckled himself so staff transferred him to his bed. He still refused to problem solve. Staff continued to do 10 minute bed checks on him. He began to hit the wall by his bed with his fist. Once, when I went to check on him, he was between his bed and his safety bar. Staff then helped to put him back on his bed. He still yelled. At about 5 PM he calmed down and we transferred him back to his wheelchair. He problem solved with me, and he was upset that his pillow cases were not on his bed. He didn't know where they were." - 2/26/08 from 8:00 - 9:10 a.m.: "He was put in his bed. He continued to yell and swear until around 9:45 am. I did get his meds down him at this time. He is staying home from [the day program]	W 289		

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	13G070		05/15/2008

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W 289	Continued From page 46 today. He has calmed down and relaxing in bed." - 5/8/08 from 3:15 - 5:45 p.m.: "As soon as [a staff person] tried to assist [Individual #1] out of the van, he started screaming, spitting, hitting at her, and pinching her. I tried to switch her places [sic] and help [Individual #1] out of the van, but he did the same to me. He eventually unbuckled himself and rocked out of his chair onto the floor in between his wheelchair and the backseat [sic] of the van. I asked [a second staff person] to take the other guys, switch us vans, and take them home. She did and [the staff person] and I sat with [Individual #1] to observe and make sure he didn't injure himself. [A staff person] asked [Individual #1] if he wanted help out of the van, and he said yes. Her [sic] and [another staff person] were able to get [Individual #1] into his chair and out of the van. As soon as he got in the house, he said 'f****er' and [another individual] got very upset. He started yelling and cussing back. [Individual #1] tried to run at him with his chair. [Individual #1's] chair was disengaged and [Individual #1] was moved to his bedroom. [A staff person] stayed to observe him, and shortly after, [Individual #1] was trying to get out of his chair again. We moved him onto his bed and positioned pillows around him so that he did not harm himself. He stayed in bed until 5:45 pm when he had finally calmed down." Individual #1's WIC, titled "Remove to Bedroom" was dated 5/13/08. The WIC stated "If [Individual #1] engages in yelling behavior, redirect him to leave the area and follow the direction of behavior management plan (reduce disruptive behavior). If [Individual #1] does not leave the area and continues to engage in disruptive behavior AND: He yells for 5 minutes or more, shows no sign of	W 289		

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W 289	Continued From page 47 calming himself, shows signs of increasing escalation such as swearing, screaming, flailing his body, kicking, etc. Staff will: Disengage the power chair, Assist [Individual #1] to his bedroom (escort), observe and support [Individual #1]. If [Individual #1] continues to escalate and becomes unsafe in his chair (attempting to throw him self [sic] out of the chair or flailing to an extent that he may fall from the chair), two people transfer [Individual #1] onto his bed. [Individual #1] must be monitored: Maintain line of sight during this time period, Raise the railing on the bed, Use pillows to prevent [Individual #1] from banging himself or scratching himself on the railing, Use pillows to prevent [Individual #1] from lowering the railing as this becomes a safety issue and he has fallen from the bed in the past." However, Individual #1's BMP, dated 12/1/06 and 12/1/07, did not contain the same information or staff instructions as his WIC. Both BMPs stated his target behavior was "disruptive" which included the following: "verbal aggression in the form of yelling, screaming and swearing. Physical aggressive [sic] behaviors such as, scratching, hitting, flailing his body (may result in hitting others that he comes into contact with), kicking, releasing his seatbelt on wheelchair and flailing until falling to the ground, and attempting to run over staff with electric wheelchair [sic]. He has also engaged in elopement or attempting to leave the facility unsupervised and exhibiting unsafe 'driving' in the street in his electric wheelchair. Property destruction, other socially offensive behaviors observed have been pushing others, spitting, and non-compliance to prompting [sic]." Staff instructions included in the 12/1/06 and	W 289		

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W 289	Continued From page 48 12/1/07 BMPs stated if staff sensed Individual #1 was becoming agitated, staff were to take time to intervene using a calm discussion about how to self manage his emotional state. If he began to display disruptive behavior, staff were to use a verbal cue and tell him to stop. If he did not calm, staff were to redirect him to his room. If he refused to go to his room and was attempting to run into others with his wheelchair, staff were to disengage the electric motor from the power supply on his wheelchair. If he released his seatbelt (attached to the wheelchair) and attempted to throw himself to the floor, staff were to attempt to safely lower him to a floor mat and place a pillow under his head. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #1 could not get out of bed on his own and staff were to keep him in line of sight if he was placed in his bed when he was agitated. When asked, the HM, who was present during the interview, stated the instructions to staff were in the WIC but were not in Individual #1's BMP. The facility failed to ensure instructions related to the use of time-out procedures were incorporated into Individual #1's BMP.	W 289		
W 291	483.450(c)(1) TIME OUT ROOMS A client may be placed in a room from which egress is prevented only if the following conditions are met: (i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.) (ii) The client is under the direct constant visual	W 291		

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W 291	Continued From page 49 supervision of designated staff. (iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged. This STANDARD is not met as evidenced by: Based on incident reports, record review, and staff interviews it was determined the facility failed to ensure time-out procedures were incorporated into an approved systematic time-out program for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in an individual being placed in his bed without specific staff instructions to do so. The findings include:	W 291	W291 was not cited per call to surveyors.	
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure a behavior modifying drug was used only as a comprehensive part of the individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behavior for which the drug was used for 1 of 1 individual (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without an appropriate plan that identified drug usage and how it may change in relation to progress or regression. The	W 312		

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W 312	Continued From page 50 findings include: 1. Individual #1 was a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive asphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. His Physicians Orders, dated 5/12/08, stated he received Trazodone (an antidepressant drug) 50 mg each evening for sleep. According to the Nursing 2008 Drug Handbook 28th Edition, adverse reactions (side effects) of Trazodone included insomnia, drowsiness, anger, vivid dreams, and nightmares. His Medication Reduction Plan, updated 5/13/08, stated Trazodone would be reduced based upon the following criteria: a. "Reduce Trazadone [sic] to 25 mg HS once he has shown an ability to sleep more than 7.5 hours or more for more [sic] than 6 months." Individual #1's IPP did not contain an objective related to sleep. Further, the criteria was not clearly defined as to whether 7.5 hours of sleep was required per night or if the criteria was a nightly average over the course of 6 months. Additionally, "for more than 6 months" was not clearly defined (i.e., 6 months and 1 day or 7 months, 8 months, etc.). Individual #1's medication plan also stated "[Individual #1] is participating in counseling services to address some of the concerns with his dreams and other issues," he "also has a problem solving goal that he can utilize to address any sleep concerns he may have," and he "has a program in place to reduce his disruptive behaviors." However, there was no specific	W 312	W312: Each individual's program plan was reviewed and specifics methods were implemented to address the identified individual's needs. Individual #1's Trazadone medication was discontinued and a PRN sleep medication was prescribed. Each person's records were reviewed to ensure there were no prescribed medications which were not part of the Individual Program Plan with a specific reduction plan. The facility LPN and QMRP will meet in person to review each person's file for drugs used for the control of inappropriate behaviors to ensure it is used only as part of an integral part of the Individual Program Plan and a specific reduction and eventual elimination is employed. QMRP and Quality Assurance Manager will meet with nursing staff to ensure that current programming is aligned with established needs and meets scrutiny of having all necessary components (Lesser Restrictive, Human Rights Committee, Written Informed Consent, Guardian Approval and other requirements) prior to the introduction of programming. This will occur at meetings at least monthly to review current client populations. A new full time QMRP began working at the facility on 6/18/08, this deficient practice will be addressed systematically as this new QMRP addresses the oversite and management of the individual program plans and training methods. Responsible: QMRP, Assurance Manager, LPN Date of correction 6/19/08	

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W 312	Continued From page 51 criteria related to a reduction of the Trazodone for the interventions (i.e. counseling, problem solving, and disruptive behaviors). When asked about the implementation of Individual #1's Medication Reduction Plan, given the above noted information and Individual #1's expressed concerns related to sleep, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., "it's not going to work." The facility failed to ensure an appropriate drug reduction plan related to the use of Trazodone was developed for Individual #1.	W 312		
W 313	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity of the behavior was show to outweigh the associated risks of the drugs for 1 of 1 individual (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual continuing to receive a behavior modifying drug after reporting adverse reactions. The findings include. 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. He was admitted to the	W 313		

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W 313	Continued From page 52 facility on 11/1/06 and his weight at that time was 170 pounds. Individual #1's Physician Orders, dated 5/12/08, stated he received Trazodone (an antidepressant drug) 50 mg each evening for sleep. According to the Nursing 2008 Drug Handbook 28th Edition, adverse reactions (side effects) of Trazodone included insomnia, drowsiness, anger, vivid dreams, and nightmares. Individual #1's Counseling Notes, dated 10/07 - 3/30/08, showed Individual #1 reported the following sleep-related concerns to his counselor: - 10/4/07: "[Individual #1] also expressed that he was having a hard time sleeping at nights... [Individual #1] engaged in problem solving with clinician regarding his sleeping difficulty. He expressed that it bothers him to be in pitch darkness and that he would like a night light on and his door open. In order to ensure that the noise from the staff doesn't bother him, he would like to have some white noise like a fan or his radio going." - 10/14/07: "Clinician also checked in with [Individual #1] about his sleeping and found out that staff have not followed through with a bright night light or with a fan or some form of white noise. His bedroom door continues to be closed at night and [Individual #1] continues to have difficulty sleeping." - 3/30/08: "He also has been having trouble sleeping, has been having vivid dreams, some nightmares and is very tired during the day ...He indicates that he does have trouble sleeping. This seems to be in part due to the seizure	W 313	**W313:** **Upon reviewing the information regarding the Trazadone for individual #1, the medication was discontinued and a PRN sleep medication was prescribed.** **Each individual's information will be reviewed to ensure no drugs used for control of inappropriate behavior is used until it is justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.** **QMRP and Quality Assurance Manager will meet with nursing staff to ensure that current programming is aligned with established needs and meets scrutiny of having all necessary components (Lesser Restrictive, Human Rights Committee, Written Informed Consent, Guardian Approval and other requirements) prior to the introduction of programming. This will occur at meetings at least monthly to review current client populations. The QMRP (Qualified Mental Retardation Professional) with the Quality Assurance Manager and the nursing staff will meet at least monthly to ensure that drugs used to manage inappropriate behaviors are considered to determine the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. These will be discussed as part of the treatment team process as well.** **Responsible: QMRP, Quality Assurance Manager** **Date of correction 6/19/08**	

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W 313	Continued From page 53 activity and also due to fear of the dark. [Individual #1] was able to indicate that he likes the light on during the night and that he feels safer when he can see what's going on. He indicated that he would prefer to have control of a light rather than having to rely on staff to turn on/off lights. He indicated that he does have nightmares which bother him and make the fear of the dark worse. He also indicated that he has a lot of very vivid dreams which wake him periodically throughout the night. He further indicated that he is very sleepy during the day most every day." When asked, the LPN stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #1 was admitted on Trazodone 50 mg and his current weight was 128 pounds (a 42 pound weight loss since admission). When asked about Individual #1's reported sleep-related concerns identified in his Counselor Notes, the LPN stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., she did not have access to the computerized database that contained the Counselor Notes. When asked, the QMRP, who was present during the interview, stated she had not read the Notes. The Day Program Coordinator, who was present during the interview, stated Individual #1 was noted to be tired and fall asleep during the day. The QAM, who was also present during the interview, stated she brought the concerns to the treatment team but was told by another QMRP that the data did not support a change. The facility failed to ensure the severity of Individual #1's sleep behavior clearly outweighed the adverse reactions of Trazodone which he continued to report to his counselor.	W 313		

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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 record review and staff interviews, it was determined the facility failed to ensure individuals were instructed in skills leading to self-administration of medication for 2 of 3 individuals (Individuals #1 and #3) whose IPPs were reviewed. This resulted in a lack of skills attainment and a lack of increased independence in self-administration. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive aphasia, chronic pain, and chronic peptic ulcer disease. His IPP did not contain a training objective related to self administration of medications. When asked, the QAM stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #1 used to have a program but he didn't like naming his medications so the program was discontinued. 2. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. His IPP did not contain a training objective related	W 371	W371: The individual program plans were revised to teach the two identified individuals to become more independent in their self medications by storing their own medications. Each individual's file was reviewed to ensure a self administration of medications skill is being taught as part of their Individual Program Plan. The facility's file review, assessment process, and monthly review will specifically include within verifying the Self Administration of Medications being taught extends into the independence of managing the storage of the person's own medications. Quality Assurance Manager will review the Individual Program Plans semi-annually to ensure the Self Administration of Medications is addressed with learning techniques being taught to each person. Responsible: QMRP, Quality Assurance Manager Date of correction 7/27/08	

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W 371	Continued From page 55 to self administration of medications. When asked, the QAM and LPN both stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #3 was independent in taking his medications. When asked about the location of his medications, the QAM stated they were kept locked with everyone else's. When asked about his ability to access his medications in his own lock box, the QAM and LPN both stated they didn't know they could do that. The facility failed to ensure Individual #1 and Individual #3 received training related to self administration of medications.	W 371		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on record review and staff interviews, and it was determined the facility failed to ensure individuals were provided with and taught to care for their adaptive devices for 2 of 3 individuals (Individuals #1 and #3) reviewed, who required adaptive devices. This resulted in an individual not being provided adequate foot support and a second individual not learning to care for his eyeglasses. The findings include: 1. Individual #1's IPP, dated 12/1/07, documented a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder,	W 436		

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W 436	Continued From page 56 expressive aphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. a. Observations were conducted at the facility and at Individual #1's day program on 5/12/08 and 5/13/08 for a cumulative 5 hours and 22 minutes. During that time, it was noted that Individual #1 had no footrests on his wheelchair and his feet did not touch the ground. Both feet were noted to be purple and dangling. When asked, present staff stated on 5/12/08 at 3:15 p.m., Individual #1's regular wheelchair was being repaired and the current one he was using was brought to the facility, without footrests, by a family member. When asked, the staff stated Individual #1 had been without his regular wheelchair for about three weeks. Individual #1's Nursing Notes, dated 1/17/08, documented he had foot drop and some swelling to his feet. Further, his Physical Therapy Evaluation, dated 10/25/07, stated "[Individual #1] has been troubled in the past with bilateral ankle/foot edema..." When asked, the LPN stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., a new wheelchair had been ordered. The HM, who was present during the interview, stated she checked with the local medical supply company and they stated new footrests for the current chair would take as long to get as the new wheelchair. When asked about foot support until the new wheelchair arrived, the QAM, who was also present during the interview, stated she talked with staff and they reported they (the facility) had a footstool but it was not used with Individual #1.	W 436	**W436:** **The wheelchair for individual #1 was out for repairs and a new wheelchair was being ordered through Medicaid. The relief wheelchair is missing foot pegs. The nursing staff attempted with no success to obtain foot pegs. The direct care staff was providing a foot stool for support. However, at the time of observation the foot stool was not offered. This was reviewed with all staff and has been more consistently utilized. Individual #1's new wheelchair and the chair which was out for repairs are both available to him. The chair without foot peg is no longer at the facility. In addition, the communication device for individual #1 has been made available at all times by designating a convenient usage/storage area. Individual #3 has a training program in place to care for his eye glasses. Additionally, he had previously purchased a neck strap that diminished the potential of damage to the glasses.** **Each individual's adaptive equipment will be reviewed to identify any necessary repairs and/or training programs.** **The facility manager will bring to the team any concerns regarding adaptive equipment and a plan will be determined as to the corrective action at that time.** **The QMRP with the Quality Assurance Manager and the nursing staff will meet at least monthly to ensure that any adaptive equipment is addressed on an ongoing basis as necessary.** **Responsible: QMRP, Quality Assurance Manager** **Date of correction 7/27/08**	

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	13G070		05/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 436	Continued From page 57 The facility failed to provide Individual #1 with adequate support for his feet. b. Individual #1's IPP included a training program for him to utilize his computer communication system. The program stated staff were to use opportunities throughout the day to implement the program. Observations were conducted at the facility and at Individual #1's day program on 5/12/08 and 5/13/08 for a cumulative 5 hours and 22 minutes. At no time throughout the observations was Individual #1 noted to have access or be provided with his computer communication system. When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., the training program was to be implemented at least three times a day and the communication device was to be used as much as possible. The facility failed to provide Individual #1 with his communication device. 2. Individual #3's IPP, dated 11/14/07, documented a 29 year old male diagnosed with moderate mental retardation, cerebral palsy, osteopenia, osteoarthritis, and acid reflux disease. Individual #3's Nursing Note, dated 12/10/07, documented his eyeglasses were broken and he needed new frames. A Nursing Note, dated 12/17/07, stated "This is the sixth time that he has damaged the frames on the glasses. I did talk with [the Administrator, the QAM, and the QMRP] about putting in a program for his glasses and putting him in charge of taking care of them...[The	W 436		

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W 436	Continued From page 58 Administrator] went in and talked to [the QMRP] and told [the QMRP] to put in a program on [Individual #3]." When asked, the QMRP stated during an interview on 5/15/08 from 9:08 - 11:20 a.m., Individual #3 did not have a training program to care for his eyeglasses. The facility failed to ensure a program related to caring for his eyeglasses was developed for Individual #3.	W 436		

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MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167	**MM167 – W125 was not cited as deficient.** RECEIVED AUG 04 2008 FACILITY STANDARDS	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278.	MM191	**MM191 – see response to W278**	
MM193	16.0311.075.10 Protection from Unwarranted Behavior Modifica Protection from Unwarranted Use of Behavior Modification Programs. Every resident admitted to the facility is to participate in behavior modification programs involving the use of restraints, timeout, or aversive stimuli only when the program:	MM193	**MM193 – see response to W313**	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/23/08

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MM193	Continued From page 1 This Rule is not met as evidenced by: Refer to W313.	MM193		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**MM194 – see response for W262**	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**MM196 – see response for W263**	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W285, W289, and W312.	MM197	**MM197 – see response W313, W289, and W312**	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and	MM212	**MM212 - see response for W249 & W266**	

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NAME OF PROVIDER OR SUPPLIER CAMPUS VIEW HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 875 MONROE TWIN FALLS, ID 83301		

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MM212	Continued From page 2 This Rule is not met as evidenced by: Refer to W249 and W266.	MM212		
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	**MM429 - response for W436**	
MM566	16.03.11.210.04(j) Authorizations and Consents Appropriate authorizations and consents; and This Rule is not met as evidenced by: Refer to W111.	MM566	**MM566 - response for W111**	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159 and W256.	MM725	**MM725 - response for W159 & W256**	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The	MM729		

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MM729	Continued From page 3 objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	**MM729 - response for W227**	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	**MM730 - response for W214**	
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237 and W252.	MM731	**MM731 - response for W237 & W252**	
MM756	16.03.11.270.02(f)(ii)(b) Resident is Capable of Self-Administration If the resident is capable of self-administration under staff supervision, this fact must be documented in the resident's assessment. A responsible, trained staff member must observe and record the resident's act of self-administration. This Rule is not met as evidenced by: Refer to W371.	MM756	**MM756 - response for W371**	
MM855	16.03.11.270.08(c) Training and Habilitation Record	MM855		

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MM855	Continued From page 4 There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855	**MM855 - response for W234**	
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861	**MM861 - response for W260**	