

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

PRINTED: 09/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
(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 149}	Continued From page 97 arm 2 by 2 centimeters due to (possibly) insulin injection. The IDN's failed to note other bruises on other parts of the client's body due to insulin injection. [REDACTED] The client's health care plan identified the problem (initiated 12/31/12) of "spontaneous ecchymosis (bruises)." The record also indicated the client sometimes pinched herself. During an interview on 8/1/13 at 11:45 a.m., the client's physician stated that that problem had been opened primarily for frequent small (less than a centimeter) bruising on her lower legs. 5. On 7/30/13 at 11:10 a.m., Client 184 [REDACTED] [REDACTED] an out of the back door of room 30 at the Activity Center onto an adjacent loading dock. The client stepped off the ledge as staff approached. This dock had no railings except for a portable wheel chair ramp which the client did not use. The distance from the ground to the ledge was approximately one foot. Licensed Staff then ran after the client caught up with him and grabbed his arm until the client sat on the ground. Within a few minutes, other staff arrived and assisted the staff and the client returned to his residence. During an interview on 8/6/13 at 2:30 p.m., the classroom teacher stated that the clients do not use that exit and Client 184 had never gone out of that exit prior to 7/30/13. The client again exited this door on 8/6/13 and staff grabbed him by the left forearm and pulled him back into the room.	{W 149}	W149, #5 a. Classroom instructor restructured the environment to provide for the safety of client 184 and all other clients.* b. A work order was initiated to adjust the locking mechanism to provide for the safety of the client. c. A special meeting was held for Client 184 to discuss structuring environment for success. d. DTAC Coordinator trained classroom staff on Client 184's Approaches and Strategies, Risk Assessment Summary and documentation expectations regarding safety awareness and unusual events. e. Day training staff received training on "Professional Boundaries" regarding appropriate intervention. f. Day training staff received training on "Dignity In Care" regarding appropriate intervention. g. Day training staff received training on "Behavior Support Positive Practices" regarding appropriate intervention. h. Day training staff received training on "Respectful Interactions" regarding appropriate intervention. i. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will observe staff interactions and classroom structure during rounds conducted at various times/locations and provide coaching to staff as needed. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.* j. IPCs will monitor classroom structure and safety issues during site visits.* ##(see inserted page) W150 a. Staff involved removed from client contact and corrective action was taken.	8/7/13* 8/21/13 8/12/13 8/21/13 8/7/13 9/6/13 9/3/13 9/6/13 8/05/13	

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER-D/P-IGF/HD			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 HARBOR BOULEVARD COSTA MESA, CA 92626		
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			W149, #6 a. The Governing Body reviewed FDC 5.5.5 Attachment A "Types of Injuries" and determined that the definition is consistent with 42 CFR 483.420(d)(2) regarding injuries of unknown source.	8/12/13*	
			b. DCS received training on 5.5.5 Attachment A "Types of Injuries" with emphasis on the definition of injuries of unknown source.*	9/9/13*	
			W149, #7 a. A GER was completed upon discovery of scratch to arm.	7/31/13	
			b. Client 162 was assessed, treated, monitored and documentation was completed*	7/31/13	
			c. DCS assessed all clients for injury, documented findings and provided treatment as necessary.*	8/9/13*	
			d. US provided training to all DCS including those on Client 162's residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". *	9/9/13	
			e. Unit Supervisors provided training to all DCS including those on Client 162's residence on Facility Policy 5.5.5, "General Event Reporting".	9/9/13	

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			<p>f. PD/PA/US/IPC/HSS will monitor changes in client condition during the Management Debrief Meetings and follow up as indicated.*</p> <p>g. PD/designee reviews 24 hour report and NOD Report daily for changes in client condition to ensure that injuries and/or other change in condition are properly documented.*</p> <p>h. Staff will assess clients for injury or other physical conditions during naturally occurring times throughout the day</p> <p>i. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will observe staff interactions during rounds conducted at various times/locations and provide coaching to staff as needed. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*</p> <p>j. Change of condition will be discussed at Emerging Risk Review meetings for potential contributing factors and any additional action plans needed.*</p> <p>k. IPCs will document pertinent information regarding change of condition in monthly notes.*</p> <p>l. AE SCC will monitor IPC notes for completeness and content.*</p>	

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{W 149}	<p>Continued From page 98</p> <p>Review of the facility policy Client Protection Principles 5-2-01 Risk Management Protection from Harm Section 3.4, indicated that a Temporary Support Plan is initiated "when risk warning signs are noted and additional communication and attention is needed." In addition the event is noted on the 24 hour log.</p> <p>Review of the record on 8/8/13 revealed no documentation of the incident which occurred on 7/30/13. On 8/9/13 documentation was requested of any documentation that this potentially harmful incident had been communicated. No documentation was provided to this affect.</p> <p>6. On 8/7/13 review of the Client Protections General Event Reporting policy Number 5-5-5 attachment A issued June 2013 page 1 defined "Injuries of Unknown Origin - An Injury should be classified as an "Injury of unknown origin" when both the following conditions are met: a) The source of the injury was not observed by any person and the source of the injury could not be explained by the client and b) the injury is suspicious because of the extent of the injury, or the location of the injury (e.g. the injury is located [in] an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time, or the incidence of injuries over time."</p> <p>During an interview on 8/9/13 at 10 a.m., the Director of Agency Evaluation was informed of the identified injuries of unknown origin not reported. The Director was also queried regarding the section of the facility policy that indicated that two conditions had to be met to qualify as an injury of unknown origin. The Director stated that</p>	{W 149}	<p>b. A new instructor was assigned to classroom 133 and received a comprehensive orientation*</p> <p>c. DCS and IPCs received training on Dignity in Care.</p> <p>d. DCS and IPCs received training in Respectful Interaction</p> <p>e. DCS and IPCs received training in Professional Boundaries</p> <p>f. DCS and IPCs received training in Behavior Support Positive Practices</p> <p>g. US/designee will monitor to ensure all DCS will receive training in items c-f*</p> <p>h. A case disposition meeting was held for Client 162 and corrective action was implemented.*</p> <p>i. Case disposition meeting are held for all abuse allegations and action plans implemented as indicated.*</p> <p>j. AE Director will provide data on abuse allegations to Executive Committee monthly including repeat allegations and repeat staff subjects.*</p> <p>k. Executive Committee will meet with OPS weekly to review status of pending abuse cases and follow up as indicated.*</p> <p>l. AE Risk Analyst will provide monthly abuse data to Program Management for review at PRMR meeting.*</p> <p>m. AE Risk Analyst will report on abuse including data trends and analyst to AE committee quarterly and annually with follow up action plans.</p> <p>n. AE Director will present abuse trends and action plans initiated to Governing Body quarterly and annually.*</p> <p>W 153</p> <p>a. Facility Policy 5:1.1 Clinical Standards of Care was revised to include a section on assessing skin integrity during client care.</p>	<p>7/31/13</p> <p>8/22/13</p> <p>8/22/13</p> <p>8/17/13</p> <p>7/30/13</p> <p>9/26/13</p> <p>8/16/13</p>
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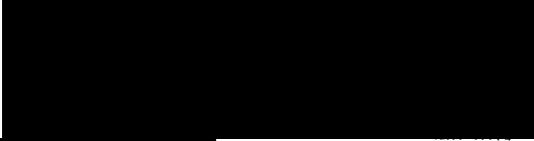
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(W 149)	Continued From page 99 the policy was newly revised and the governing body would need to review it. Residence 30 7. Surveyor observation at 8:15 a.m. on 7/31/13 revealed a 5 cm x 8 cm bruise with a scratch on Client 162 's arm. When asked what caused this bruise, the US stated that this was an injury of unknown origin. The facility failed to ensure that staff followed policy and procedures for promptly identifying bruises of unknown origin. US stated that a General Event Report (GER) injury should have been initiated. This GER had not been initiated.	(W 149)	b. Nursing Procedure 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention were developed to set expectations and provide guidance to DCS regarding changes in a client's usual behavior or change in physical condition. c. A Problem/TC/Temporary Support Plan Log was developed and implemented to ensure DCS communicate and display continuity in documentation of identified health issues/injuries.	8/09/13
W 150	Refer to W331 483.420(d)(1)(i) STAFF TREATMENT OF CLIENTS. Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, interviews and review of documents the facility failed ensure that facility staff did not verbally abuse clients, when a Licensed Staff used harsh and loud commands during her interactions with clients, and further displayed disrespect when speaking about them as if children and in front of them. This objectifying attitude demonstrated by a staff towards dependent adults had the potential to result in further abuse and mistreatment when neither co-workers nor supervisors noted the staff interactions as abusive. Findings:	W 150	d. Nursing Procedure 11.04 Daily Care Flow Sheets was developed and implemented, along with Daily Care Flow Sheets to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day. e. A Physical Observation and Documentation Checklist was developed to assist DCS in assessing, notifying appropriate people, and documenting injuries. f. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS staff to capably assess individuals on an ongoing basis. g. A Quality Assurance Performance Improvement (QAPI) log was established to monitor adherence to assessment and documentation protocols. h. Training for DCS was completed on the following: o FDC Policy 5.1.1 Clinical Standards of Care (Skin Integrity) o FDC 5.4.2 Change of Condition o FDC 5.5.5 General Event Reporting (reporting/documenting Minor Unknown Injuries) o FDC Policy 5.5.5 Attachment A - Types of Incidents (Falls) o NP 10.02 Helmet Usage o NP 10.06 Neuro Checks o NP 11.01 Temporary Conditions	9/01/13 8/19/13 8/16/13 8/13/13 8/1/13

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W 150	<p>Continued From page 100</p> <p>On 7/29/13 at 10:30 a.m., observations at a work-site in Building 25 room 133 revealed clients seated at a long table with newspapers in front of them. Client 136 yelled loudly from the far corner of the room. Licensed Staff responded in a very loud and harsh tone to the client: "I told you to do this. You don't need to do that." "Sit down" staff commanded to a client with a loud voice and sharp tone.</p> <p>On 7/30/13 at 1:40 p.m. observations in Building 25 room 133 revealed Client 162 yelling and Licensed Staff responded: "Hey, hey, hey you know what you need to do." Client 162 began to get up and the Licensed Staff responded in a loud angry tone "No, No, No!" Client 162 continued screaming and then repeating "[Client's name] hit me, I wanna go home." Licensed Staff then stated to the client: "You need to quit saying that you're gonna get people in trouble". Neither Licensed Staff nor the Direct Care Staff in the classroom responded to the client's allegation or request to leave.</p> <p></p> <p>The Licensed Staff then remarked to the surveyors in a loud voice and in front of Client 162 and the other clients in the room: "She's [Client 162] really a drama queen." "I feel really bad about this. They're [referring to and in front of all the clients] never this bad." All of the individuals in the room were older adults.</p> <p>These observations were immediately reported to the Quality Assurance Department.</p>	W 150	<ul style="list-style-type: none"> o NP 11.02 Client Injury Assessment and Intervention o NP 11.04 Daily Care Flow Sheets/Daily Care Flow Sheet Form o Problem/Temporary Condition/Temporary Support Plan Log o Physical Observation and Documentation Checklist o Change In Usual Self/Behavior Document o Behavior Support Positive Practices <p>W153, #1</p> <ul style="list-style-type: none"> a. The Residence Physician conducted an examination of Client 76 and treatment was provided. A Dermatology consultation was also initiated. b. Level of Care Staff conducted an assessment of all individuals on Client 76's residence for any observed injuries with findings provided to the Unit Supervisor for immediate follow-up. c. The Unit Supervisor/designee on Client 76's residence provided in-service training to staff who failed to report and document the event on Facility Policy 5-04-02 "Changes in Clients Medical Condition" and "The Physical Observation and Documentation Checklist" with emphasis on timely reporting to required disciplines and documentation requirements. d. The Unit Supervisor/designee on Client 76's residence provided in-service training to Level of Care Staff on Facility Policy 5-04-02 "Changes in Clients Medical Condition" and "The Physical Observation and Documentation Checklist" with emphasis on timely reporting to required disciplines and documentation requirement. e. The Shift Supervisor will monitor during daily rounds for injuries and notify the Residence Physician as appropriate. 	7/20/13 8/8/13 8/17/13 8/9/13	

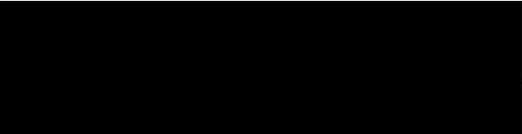
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W 150	Continued From page 101 During an interview on 8/5/13 at 3:30 p.m., Direct Care Staff who worked both 7/29/13 and 7/30/13 at the time of the above observations in classroom 133, stated that he had not heard the last comments made by the Licensed Staff. He noted that the Licensed Staff tone or verbal interactions with clients, was no different on those days than it was usually. This staff did not view the Licensed Staff interactions with clients as inappropriate. During an interview on 8/5/13 at 4 p.m., the Licensed Staff's Supervisor stated that she had not observed or heard of anything inappropriate by the Licensed Staff. The staff described the Licensed Staff as having a deep voice with mannerisms and a demeanor that could come across as tough and further described this staff as direct and firm in giving instruction. Both the Licensed and Unlicensed Staff have worked at this facility for over 30 years. Each had evidence of abuse prevention training in 2013.	W 150	f. The US/designee on Client 76's Residence will monitor documentation of injuries of unknown origin to ensure documentation requirements are complete and notifications are timely. g. The Health Service Specialist on Client 76's residence will conduct a semi-annual audit of injury assessment documentation and will present findings to the Agency Evaluation Committee. h. The facility "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will monitor during rounds for injuries and report findings to the Agency Evaluation Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. W153, #2 a. This event regarding Clients 78 and 64 was reported to CDPH via email on 7/13/13 at 1734. A follow-up letter was sent on 7/15/13 at 1502. RDC met the required timeframe for reporting.	7/13/13	
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, record and facility document review the facility failed to report all allegations of mistreatment, neglect or abuse as well as	{W 153}	W 153, #3 a. DCS assessed, documented and monitored affected area for any change in condition and ensured prompt medical attention obtained * b. DCS assessed all clients for injury, documented and provided treatment as necessary* c. Unit supervisors provided training to all DCS including those assigned to Client 121 residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention".*	8/1/13* 8/9/13* 9/9/13*	

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{W 153}	Continued From page 102 Injuries of unknown source immediately to the administrator and the Department within twenty four hours and the facility failed to ensure that injuries of unknown origin were identified and reported immediately to the administrator, and that the policy and procedure for reporting such injuries was in compliance with federal regulations and implemented. This failure affected unsampled Clients 61, 64, 76, 78, 121, 180, 193, 198 and potentially affected all individuals receiving care and services at the facility. Findings: 1. Review of a General Event Report (GER 13-07-67) dated 7/19/13 at 8:10 p.m. revealed Client 76's family member visited on 7/15/13 and reported to facility staff a "bruise" on Client 76's groin. The facility staff failed to immediately notify the physician, administrator or document the findings by initiating a GER. A GER is part of the facility system to initiate a collection of evidence, investigate and take corrective actions for an unusual occurrence such as injury of unknown source, and allegations of mistreatment, neglect or abuse. On 7/19/13, four days later, the social worker opened an e-mail from Client 76's family member concerning a bruise on his groin, notified the physician and initiated the GER process. 	{W 153}	d. Unit Supervisors provided training to all DCS including those assigned to Client 121 residence on Facility Policy 5.5.5, Attachment A "Minor Injury Reporting"* e. Program Director/Program Assistant/Unit Supervisor/IPC/HSS monitors changes in client condition during the Management Debrief Meetings.* f. Program Director/designee review 24 hour report and NOD Report daily for changes in client condition to ensure that injuries and/or other change in condition are properly documented.* g. The facility "Rounds Team" (Governing Body, Program Management, Unit Supervisors, Shift Leads, Case Coordinators) conducted focus rounds to ensure injuries were being identified, treated and documented. *	9/9/13* 9/9/13	

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{W 153}	<p>Continued From page 103</p> <p>[REDACTED]</p> <p>The facility reported the injury of unknown source to the Department on 7/22/13, seven days after Client 76's family member informed facility staff.</p> <p>2. Review of GER 13-07-37, revealed Client 78 punched Client 64 in the mouth on 7/13/13 at 12:46 p.m. The facility did not report the incident to the Department within 24 hours. The facility reported the incident on 7/15/13 at 3:02 p.m. 48 hours later.</p> <p>Interview with facility staff at 3 p.m. on 8/8/13 confirmed the facility policy and state law was to report all alleged client rights violations to the California Department of Public Health within 24 hours.</p> <p>3. On 7/28/13 at 12:30 p.m. observations revealed that a non-sampled Client 121 had a large bruise on her left upper arm. [REDACTED]</p> <p>During an interview on 8/1/13 at 11:30 a.m., a Registered Nurse on Residence 29 stated that the bruise on the arm would not be reported as an injury of unknown origin because it was probably due to her insulin injection and because it did not meet the criteria of reporting of bruising greater than 5 centimeters or more and it was not on the head, breast or genital area. Asked if it was certain that the bruise was due to an injection, the nurse stated no but that the client bruised easily and she had gotten bruises on other parts of her body from the injection.</p>	{W 153}	<p>W153, #4</p> <p>a. DCS assessed, documented and monitored affected area for change in condition and ensure prompt medical attention if needed. *</p> <p>b. DCS assessed all clients for injury, documented and provided treatment as needed.*</p> <p>c. Unit supervisors provided training to all DCS including those assigned to Client 193's residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". *</p> <p>b. Unit Supervisors provided training to all DCS including those assigned to Client 193's on Facility Policy 5.5.5, Attachment A "Minor Injury Reporting"*</p> <p>c. Program Director/Program Assistant/Unit Supervisor/IPC/HSS monitor changes in client condition during the Management Debrief Meetings.*</p> <p>d. Program Director/designee review 24 hour report and NOD Report daily for changes in client condition to ensure that injuries and/or other change in condition are properly documented.*</p> <p>e. The facility "Rounds Team" (Governing Body, Program Management, Unit Supervisors, Shift Leads, Case Coordinators) conducted focus rounds to ensure injuries were being identified, treated and documented. *</p> <p>W153, #5</p> <p>a. DCS assessed and monitored affected area for any change in condition and to ensure prompt medical attention obtained if needed. *</p> <p>b. DCS assessed all clients for injury, documented and provided treatment as necessary.*</p> <p>c. Unit supervisors trained all DCS including on Client 180's unit on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". *</p>	<p>8/8/13*</p> <p>8/9/13*</p> <p>9/9/13*</p> <p>9/9/13*</p> <p>8/6/13</p> <p>8/9/13</p> <p>9/09/13</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626	
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(W 153)	Continued From page 104 On 7/29/13 review of the client's record indicated an interdisciplinary note dated 7/28/13 that identified "discoloration" on the client's upper left arm 2 by 2 centimeters due to (possibly) insulin injection. The IDN's failed to note other bruises on other parts of the client's body due to insulin injection. [REDACTED] The client's health care plan identified the problem (Initiated 12/31/12) of "spontaneous ecchymosis (bruises)." During an interview on 8/1/13 at 11:45 a.m., the client's physician stated that that problem had been opened primarily for frequent small (less than a centimeter) bruising on her lower legs. 4. On 7/29/13 at 6:40 p.m., non-sampled Client 193 on Residence 31 was observed with a red dime size mark on the front of her leg just above her foot where the tongue of the shoe she wore hit her lower leg. The client was not wearing socks. [REDACTED] On 8/6/13 at 5 p.m., the client's lower leg injury had a scab. On 8/7/13 a focus review of the client's record revealed no documentation of the open area on the client's leg until 8/8/13, after surveyor inquiry. 5. On 8/6/13 at 4:50 p.m., non-sampled Client 180 had redness/abrasion on her right forehead. During a concurrent interview, Licensed Staff stated they heard that it happened [REDACTED] earlier in the day. A concurrent focus review of the client's record documented	(W 153)	d. US trained all DCS including on Client 180's unit on Facility Policy 5.5.5, Attachment A "Minor Injury Reporting" e. PD/PA/US/IPC/HSS monitor changes in condition during the Management Debrief Meetings. f. PD/designee review 24 hour report and NOD Report daily for changes in condition to ensure injuries and/or other change in condition is properly documented. g. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, Case Coordinators) conducted focus rounds to ensure injuries were being identified, treated and documented. * W153, #6 a. The Governing Body reviewed FDC 5.5.5 Attachment A "Types of Injuries" and determined that the definition is consistent with 42 CFR 483.420(d)(2) regarding injuries of unknown source. b. DCS received training on 5.5.5 Attachment A "Types of Injuries". W153, #7 a. US provided training to DCS on Client 198's Health Care Plans, including documentation expectations b. US provided training to all DCS on Facility Procedure 05.04.02 "Change in Condition" * c. US provided training to DCS on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". d. The AE Director provided training to Risk Analyst regarding ###	9/9/13 8/9/13 9/1/13 8/15/13 9/9/13* 9/9/13*

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{W 153}	Continued From page 105 that the client was transported to [REDACTED] accompanied by two staff between 7:35 a.m. and 11 a.m. An Interdisciplinary Note (IDN) at 3:36 p.m. noted that the client bumped her head [REDACTED] several times causing some redness. The note failed to indicate which part of the client's head she had bumped. Another IDN identified right forehead redness at 9:30 p.m. There was no evidence that the physician was notified of this head injury, no evidence of an incident report initiated; no evidence of a Temporary Support Plan identified on the 24 hour log and no evidence of a change of condition report. The client was not able to be interviewed. 6. On 8/7/13 review of the Client Protections General Event Reporting policy Number 5-5-5 attachment A issued June 2013 page 1 defined "injuries of Unknown Origin - An injury should be classified as an "injury of unknown origin" when both the following conditions are met: a) The source of the injury was not observed by any person and the source of the injury could not be explained by the client and b) the injury is suspicious because of the extent of the injury, or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time, or the incidence of injuries over time." During an interview on 8/9/13 at 10 a.m., the Director of Agency Evaluation was informed of the identified injuries of unknown origin not reported. The Director was also queried regarding the section of the facility policy that indicated that two conditions had to be met to qualify as an injury of unknown origin. The Director stated that	{W 153}	d. Unit Supervisor provided training to DCS on expectation that health care plans for any client returning from Acute Hospitalization (in the community or at the facility) will be reviewed by all pertinent staff (including but not limited to Medication Nurse and Health Services Specialist) upon readmission to home residence. e. US, SPT and IPC will monitor by conducting random reviews of IDNs and/or MARs for clients with open temporary conditions/problems f. Program Directors/designees will review 24 hour report and NOD Report daily for changes in client condition to ensure that changes are being monitored.* g. Any changes in client condition will be reviewed, discussed and action plans implemented as indicated at Management Debrief Meetings. h. DCS received training on 5.5.5 "General Event Reporting"* W153, #8 a. The injury to Client 61 was discovered on 6/29/13 at 8:30 AM; however, the General Event Report date is documented as 6/27/13. This is the date the client provided as the date the incident occurred when asked about the bruises on 6/29/13. The event was reported to CDPH on the same day it was discovered (6/29/13 at 11:25 AM), within the 24 hour time period required by regulations.	9/9/13 9/9/13 9/9/13	

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{W 153}	Continued From page 106 the policy was newly revised and the governing body would need to review it. 7. GER 13-07-28 was reviewed on 8/6/13. This documented that redness and swelling of Client 198's eye was discussed on 7/9/13 during an Emerging Risk Review meeting but had been observed on 7/3/13 but not reported until 7/9/13 and there was no documentation of the condition in the client's clinical record. The GER further documented that the Executive Director had not been notified of the situation until 7/10/13 at 12:14 p.m. and the Department had not been notified until 7/11/13. During an interview on 8/6/13 at 10:30 a.m., administrative staff stated the notifications were later than required. 8. GER 13-06-59 was reviewed on 7/31/13. This documented observations of multiple bruises and areas of discoloration on the face, head, and ears of Client 61 on 6/29/13 at 7:38 p.m. The client indicated he was hit by a staff member. The Department was not notified of the allegation of abuse of a client by a staff member within 24 hours, as required by regulation and facility policy.	{W 153}	W154 #1-15* (Corrective actions specific to individual clients are included under the specific tag item number) The GER is one of several tools utilized by FDC to review, investigate, and follow up on unusual events or occurrences. The GER is an integral component of the facility's Protection From Harm program, along with a number of other investigatory and review protocols. • Program Management, Unit Supervisors, IPCs and HSS's meet daily (during regular work days) to identify and immediately address developing issues. This includes an immediate investigation and a review of any restrictive interventions utilized the previous day. • Emerging Risk Review Meetings (ERR) are held within 7 days of an event and are attended by the US/IPC/Psychologist/Social Worker/RN. They review events, including GERS, identify contributing factors, complete a root cause analysis, and make action plans to reduce and/or eliminate the risk. • An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body developed improvement plans for addressing identified issues. • Inconsistencies found during the internal investigation will be discussed and resolved at Executive Debriefing, Management Debriefing, Emerging Risk Reviews and Program Risk Management Reviewed*	8/9/13
{W 154}	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview, record and policy review the facility failed to implement policy number 5-05-5	{W 154}		

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{W 154}	<p>Continued From page 107</p> <p>litled "General Event Reporting" and "Guidelines for Completing Level I and II Review" of the GER dated 8/13/13 and ensure timely, complete and through investigations were done for all alleged violations of individual rights (Clients 3, 10, 12, 17, 34, 45, 48, 50, 60, 61, 63, 71, 74, 76, 81, 114 and potentially all clients residing at the facility); failed to implement the Plan of Correction for reopening the case to determine if staff were neglectful (Client 81); and failed to implement the Plan of Correction to determine the effectiveness of the facility's response to the behavior emergency called for one client added to the sample who was attacked by three clients and who sustained, among other injuries, a fractured nose and required emergency room treatment and who later alleged staff failed to help him during the attack. (Client 48)</p> <p>Findings:</p> <p>Beginning on 8/5/13 a review of the facility policy and procedure number 5-05-5 titled "General Event Reporting" (GER) and "Guidelines for Completing Level I and II Review" of the GER dated 8/13/13 was conducted. A GER is part of the facility system to initiate a collection of evidence, investigate and take corrective actions for an unusual occurrences such as injury of unknown origin, and allegations of mistreatment, neglect or abuse.</p> <p>The GER process was revised on 6/13/13 to include specific instructions to facility staff when initiating a GER and reviewing its contents. The revision include but was not limited to documentation regarding interviews with staff and client witnesses, staff accountability at the time of the event, behavior interventions tried, client</p>	{W 154}	<ul style="list-style-type: none"> • Behavior Progress Reviews (BPR) are held monthly and are attended by the Unit Supervisor, Physician, Psychologist, IPC, HSS and Psychiatrist (as indicated). They review events and data related to behavioral events, restrictive interventions, and effectiveness of current behavioral plans. • The Program Risk Management Review (PRMR) meeting process has been fully implemented. It is attended by Program Management, Unit Supervisor, QA Risk Manager, Psychologist, IPC. This meeting includes a close review of OPS reports/investigations and/or other investigative reports, review of client injuries or other changes in condition, restrictive interventions utilized, cumulative data related to GERs, and other health and safety concerns. Improvement plans are established by Program Management to ensure clients are free from harm and that individual rights and freedoms are in place. • The QA Risk Manager prepares monthly and quarterly data reports based on GERs, including risk rating, multiple events between individuals, repeat victims and perpetrators, staff with repeated abuse allegations made against them, total numbers of incidents by individual, etc. and forwards that information to Program Management and the Governing Body. • The Governing Body reviews monthly run charts of "dashboard" items, including significant GER information, fractures, abuse allegations, injury in restraint, denial of rights, and frequency and duration of restraints. 	7/01/13

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{W 154}	<p>Continued From page 108 response and activity occurring at the time of the incident.</p> <p>Guidelines for the Level I and II include an "Investigation of the circumstances surrounding the event." The initial reporting, notifications, and medical reviews in the GER are reviewed for accuracy and completeness.</p> <p>A sample review from 42 GER's on Residences 28, 30, 41, 42, 44 and 45 dated 5/28/13 through 8/6/13 were completed.</p> <p>GER's failed to consistently indicate complete and through documentation of the circumstances surrounding the incident, the active treatment occurring, staffing accountability and involvement, specific behavior interventions attempted and the client response as directed in the policy 5.5.5.</p> <p>The lack of complete and through documentation of the GER's impacted the ability of the facility to analyze the incident and assure active treatment programs and supervision were provided and / or the need for revision of plans. (SEE W153, W154, W157, W196, 278, W331)</p> <p>In an interview beginning on 8/6/13 with facility staff in standards compliance, she indicated staff had received training to include details on the GER's.</p> <p>Residence 44</p> <p>1. Review of GER # 13-06-50 dated 7/23/13 at 5:30 p.m. revealed Client 74 was discovered with a fractured rib of undetermined origin. The GER documented Client 74 was participating in group</p>	{W 154}	<ul style="list-style-type: none"> The Executive Committee/Governing Body conducts a morning debriefing of events, including review of previous days' incidents, nursing log, and police log. As discrepancies in information are noted, they will be reviewed with information clarified and documented. The Governing Body prepares quarterly reports including an in depth analysis of GERs and reviews their findings with DCD Headquarters. The Agency Evaluation Risk Manager prepares a quarterly and annual report using GER data to compare and analyze trends, perform a root cause analysis and make recommendations for performance improvement. Quality Indicator Projects are initiated as determined to focus on specific areas of concern. Facility Policy 5.5.5 Attachment I – Guidelines for Completing Level I and II Review was revised to include information specific to investigating fall/suspected falls. A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. The revised process for Case Disposition has been fully implemented to ensure thoroughness of investigations. Any discrepancies between the internal and external investigations will be addressed and any corrective actions taken to resolve inconsistencies.* The newly developed process for administrative investigation has been fully implemented to provide a mechanism for further investigation of events after the GER has been completed and the OPS investigation presented at Case Review. 	8/30/13 9/9/13 8/1/13	

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(W 154)	<p>Continued From page 109</p> <p>██████████ Client 74 was described as frantically running around the room and running into tables, chairs and attempted to aggress staff. Staff attempted to "de-escalate" Client 74 and "behavior plans were implemented." Client 74 was placed in "sitting containment" by facility staff. After he was released for containment Client 74 was assessed and no injuries were noted. Approximately 30 minutes later Client 74 complained of pain and was discovered after an x-ray to have a fracture of the 7 th distal rib.</p> <p>Elements not documented clearly on the GER included what group activity was being provided, how many clients were in the room and activity, staff accountability; how many were in the room, on the residence and what were they doing, brief summary of behaviors interventions used based on behavior plans, how many people were involved in the restrictive intervention; sitting containment, where did the sitting containment occur and how long did it last.</p> <p>The Level 1 review indicated the GER was complete and through and its conclusions indicated "Client 74 sustained the fracture ██████████ in which he was running around the room frantically and running into tables and chairs." The addendum to the Level 1 included "...although we cannot state emphatically that the injuries did not occur during this ██████████ incident, these are the events that occurred prior to him complaining of pain."</p> <p>The Office of Protective Services (OPS) described the fracture caused by a tantrum and the log shows Client 74 lost his balance, the notification to the Executive Director details</p>	(W 154)	<ul style="list-style-type: none"> A general event report (GER) is initiated by clinical staff, and thoroughly investigated by supervisors and managers any time OPS involvement is associated with a behavioral issue. OPS Officers also generate a police report that is reviewed by the Commander. The Governing Body reviews all instances of LEI with the Commander/designee and makes recommendations as indicated. The HRC Committee criteria for reviewing LEI was revised to be more inclusive of these investigations. The HRC chairperson is responsible for monitoring that the review is completed accurately and thoroughly. The Human Rights Committee (HRC) Manual was revised to include Law Enforcement Involvement (LEI) in Behavior Emergencies. A collaborative workgroup consisting of representatives from OPS, Governing Body, Managerial, and Clinical areas was formed to discuss delineation of clinical and police responsibilities during behavioral events that endanger self or others. The Human Rights Committee members received training on their responsibilities related to LEI. The Focus Calendar will include the changes in the HRC manual to ensure DCS are acquainted with its contents and use. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to review and investigate client injuries and other changes in condition. Unit Supervisors provided training to all DCS including staff assigned on Facility Policy 5.5.5 "General Event Reporting" 	8/1/13 8/1/13 9/9/13 8/15/13 9/09/13 9/09/13

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(W 154)	<p>Continued From page 110</p> <p>[REDACTED]</p> <p>The GER does not detail an account of Client 74 losing his balance, [REDACTED]</p> <p>In an interview on 8/7/13 at 11 a.m. with the Unit Supervisor and Assistant Program Director they indicated Client 74 required an emergency use of "sitting containment" implemented by two staff. The Unit Supervisor demonstrated how each staff person sat directly next to Client 74 holding his arms and legs intertwined.</p> <p>The facility risk report indicated four staff persons were involved in the restraint of Client 74 not two.</p> <p>The facility policy titled Manual Restraint dated August 20, 2010 defined sitting restraint as placement of a client in a chair, sofa, etc requiring physical assistance to maintain the client in a sitting position. A staff person not involved in the restraint shall observe the clients for signs of duress and be responsible for monitoring the duration, this was not evident in the GER's documentation.</p> <p>Residence 44</p> <p>2. Review of a General Event Report (GER # 13-07-67) dated 7/19/13 at 8:10 p.m. revealed Client 76's family member visited on 7/15/13 and reported to facility staff a "bruise" on Client 76's groin. The facility staff failed to notify the physician, administrator or document the findings by initiating a GER.</p> <p>Four days later on 7/19/13 the social worker opened an an e-mail from Client 76's family</p>	(W 154)	<ul style="list-style-type: none"> • Director of Quality Assurance developed guidelines for consistent documentation of information related to General Event Reports* • AE Risk Managers/Risk Analysts assist Program Risk Managers with identifying discrepancies and making corrections as needed* • AE Director provided instruction to Level I reviewers and Agency Evaluation Risk Analysts to ensure reconciliation of information that is inconsistent between nursing, medical and OPS staff.* • The "Rounds Team" (Governing Body, Program Management, Unit Supervisors, Shift Leads, Case Coordinators) conducted focus rounds to ensure injuries were being identified, treated and documented. Findings reported to the Agency Evaluation Committee* <p>W154, #1</p> <p>a. An ERR meeting was conducted for Client 74 and the incident that occurred on 7/19/13 was reviewed along with the behavioral plans, antecedents, services/supports to ensure that a complete root cause analysis was conducted and risk management issues identified. *</p> <p>b. A BPR meeting was conducted, behavior of Running Into/Throwing Self Against Objects was discussed and added to his behavior plan. *</p> <p>c. A Special Interdisciplinary Team Conference was held for Client 74 to discuss conditions at the time of the incident for contributing factors to the behavior exhibited and a formal training program was initiated for Running Into/Throwing Self Against Objects.</p> <p>d. The Psychologist/designee for Client 74 initiated training to DCS on Client 74's behavior plan with emphasis on identifying behavioral and environmental precursors including appropriate action steps.</p>	<p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>7/24/13</p> <p>8/15/13</p> <p>8/1/13</p> <p>9/9/13</p>	

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{W 154}	<p>Continued From page 111</p> <p>member concerning the bruise, notified the physician and initiated the GER process.</p> <p>On 7/19/13 at 6:19 a.m., the physician described an 11 centimeter (cm) by 6 cm purplish blue discoloration to the right right groin/upper right thigh. The physician indicated in the GER; skin lesion with discoloration of ecchymosis (passage of blood from ruptured blood vessels into subcutaneous tissue, marked by a purple discoloration of the skin) of right thigh/groin area with asymptomatic fading bruise. Unknown cause.</p> <p>The OPS daily log dated 7/19/13 indicated most of the details surrounding the complaint were unknown but the report could have originated on July 10, 2013.</p> <p>The facility conclusion on 7/24/13 indicated it was still unclear if Client 76 had an injury of unknown source or a medical condition but determined there had been "no significant impact" on the him.</p> <p>Residence 44</p> <p>3. Review of a GER # 13007-17 dated 7/6/13 at 8:20 p.m. revealed Client 63 left his group unsupervised and bit Client 76 twice on the left forearm.</p> <p>The injury summary indicated upon assessment Client 76 was noted to have a 5 cm diameter bite mark to his left forearm in circular shape, and another bite mark to left arm with redness, 4 cm in diameter. No break in skin noted. He was discovered to also have a linear mark measuring 2 cm on upper arm.</p>	{W 154}	e. Program Management for Client 74 will schedule a review of the behavioral intervention at the Program Risk Management Review (PRMR) for appropriateness and correct implementation of the behavioral intervention.	9/09/13	

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(W 154)	<p>Continued From page 112</p> <p>The assessment documentation by the physician on 7/6/13 at 11:02 p.m. indicated a 4 cm circular erythematous faintly purple discoloration without skin breakdown, and a 2 cm linear excoriation (removal of outer layers of skin) due to bite injury.</p> <p>The licensed nurse assessment on 7/6/13 at 11:33 p.m. indicated no open skin lesion with regard to the bite injuries.</p> <p>The Office of Protective Services daily log shows that on 7/6/13 at 2:00 Client 76 had two fresh bite marks on his left arm. There was a 5 cm diameter bite mark of the upper left arm that "broke the skin."</p> <p>On four days later, 7/10/13 the information on the GER was reviewed and closed. There is no identification of the discrepancies documented regarding the broken skin and if the clients most recent tetanus was reviewed. The investigation was not through and incomplete.</p> <p>Residence 43</p> <p>4. Review of GER #13-07-85 dated 7/29/13 at 6:40 a.m. revealed Client 60 had been unable to sleep and sitting in the group area since 3 a.m. At 6:40 a.m. Client 60 "suddenly ran across the room, lunged and bit Client 50 on the right bicep." The bite injury measured 10 cm by 3 cm with skin breakage and /or puncture wounds.</p> <p>The GER Level 1 summary acknowledged Client 60's Individual Program Plan identified antecedents for biting include disturbed sleep cycle, the client had been up since 3 a.m. and so based on that information, there was "no need for modifications to the plan." The Level II review</p>	(W 154)	<p>W154, #2</p> <p>a. The Residence Physician conducted an examination of Client 76 and treatment was provided. A Dermatology consultation was also initiated.</p> <p>b. DCS conducted an assessment of all individuals on Client 76's residence for any observed injuries with findings provided to the Unit Supervisor for immediate follow-up.</p> <p>c. The Unit Supervisor/designee on Client 76's residence provided in-service training to staff who failed to report and document the event on Facility Policy 5-04-02 "Changes in Clients Medical Condition" and "The Physical Observation and Documentation Checklist" with emphasis on timely reporting to required disciplines and documentation requirements.</p>	<p>7/20/13</p> <p>8/8/13</p> <p>8/17/13</p>	

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{W 154}	<p>Continued From page 114</p> <p>kicked at staff. The GER indicated antecedents (pacing hallways) but failed to include what steps were taken during the implementation of the behavior plans prior to Client 17 being chemically and physically restrained.</p> <p>Residence 41</p> <p>8. GER # 13-07-66: On 7/29/13 at 9:20 a.m. Client 10 received a laceration requiring 15 sutures. The GER indicated while on the way to the training site, Client 10 got mad and kicked her leg against the wheelchair causing the laceration. The Office of Police Report indicated Client 10 was sitting on a chair turned and kicked her wheelchair three times causing the injury. The explanation of the injury is inconsistent.</p> <p>Residence 42</p> <p>9. GER # 13-07-70 On 7/23/13 at 12:01 p.m., the GER did not indicate what behavioral plan steps were implemented prior to Client 34 being placed into physical restraint and receiving a chemical restraint.</p> <p>Residence 28 - Client 114</p> <p>10. On 7/12/13, Client 114 was seen by staff on his residence at 7:50 p.m. At 8:00 p.m., staff was unable to locate the client, who had left the residence through an unlocked door. Two Office of Protective Services officers (OPS) found the client on campus and offered him a ride. The GER documented that the client "became resistive and started to run into the street." The street was the on-campus street with a posted speed limit of 25 miles per hour.</p>	{W 154}	<p>W154, #3</p> <p>a. The assessment of Client 76 performed by the residence physician provides the correct information regarding the injury.</p> <p>b. The US confirmed that Client 76 has a current tetanus shot (2/25/13).</p>	7/06/13	7/10/13*

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(W 154)	Continued From page 115 The General Event Report (GER), documented that Client 114 was returned to the residence 20 minutes after first being noticed as missing, having been handcuffed by OPS. When questioned upon his return to the residence, the client stated "[Client's first name] Walking." During an interview on 8/8/13 at 7:35 a.m., residence licensed staff stated that Client 114 would go walking on campus with his parents who visited regularly. Client 114 was observed on 8/8/13 between 7:35 a.m. and 8:05 a.m. actively walking around the day room on his residence. He would occasionally sit in a chair for a brief time then purposefully and repeatedly walk around the room. During an interview on 8/8/13 at 9:00 a.m., residence administrative staff stated that Client 114 was very comfortable walking on campus. He stated that the client may flail his arms which looks like fighting but is not. He stated Client 114 was not a confrontational person and was having no behavioral issues when he left the residence on 7/12/13. He stated the expectation would be for OPS to locate an client who is AWOL, keep him safe, then call the residence and wait for staff to arrive. He further stated, "OPS may have produced" the behavior. Facility policy and procedure (P&P) 6.9, Campus Safety and Security - Office of Protective Service (OPS) Police, documented the responsibilities of Police Officers included, "Assist in locating clients on unauthorized absences." The P&P further specified that "clinical staff responsible for the	(W 154)	W154, #4 a. An ERR was conducted for Client 60 and the incident that occurred on 7/29/13 was reviewed along with with sleep patterns correlating with behavioral outbursts and supervision will be modified. * b. A BPR meeting was held for Client 60 to discuss his behavioral issue of biting and the effectiveness of the modified behavior plan. * c. The Program Director is responsible for ensuring plans determined in the ERR and BPR meetings are implemented as agreed upon by the team. d. An ERR was conducted for Client 50 to review incident involving Client 60 to ensure protection plans were effective.* W154, #5 a. An ERR meeting was held for Clients 45 and the incident was reviewed.* b. A BPR meeting was held for Clients 45 to discuss his aggressive behavior. c. The treatment team for client 71 held an Acute Crisis Weekly Review. * d. The Level I and II Reviewers will utilize the template to ensure review of the census and staffing ratios.* e. The Program Director is responsible for ensuring plans determined in the ERR and BPR meetings are implemented as agreed upon by the team. W154, #6 a. An ERR meeting was held for Client 3. b. A BPR meeting was held for Client 3 to discuss her self-abusive behavior. c. The Level I and II Reviewers will utilize the template to ensure review of the census and staffing ratios, activity, client response and behavioral interventions.*	7/31/13 8/23/13 7/31/13 8/1/13 8/1/13 8/1/13 8/5/13* 8/25/13*
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{W 154}	<p>Continued From page.116 client... will make every reasonable and appropriate attempt to control the client's behavior without the use of any protective equipment."</p> <p>There was no documentation in the GER that residence clinical staff responsible for the client had been notified by OPS prior to the client being handcuffed or that OPS waited for clinical staff to arrive.</p> <p>During an interview on 7/31/13 at 7:55 a.m., facility administrative staff confirmed the client was doing nothing dangerous when OPS found him and that the client was not exhibiting any behaviors until OPS wanted him to get into their car. She further stated that residence staff had not been called to provide therapeutic communication before the client was handcuffed by OPS</p> <p>The OPS report, which was not attached to the GER, was requested. Facility administrative staff stated the OPS investigation report was not yet completed. On 8/8/13, the report was still not completed and the facility had not done a separate investigation or review of the actions of OPS during this incident.</p> <p>However, the "HRC [Human Rights Committee] Law Enforcement Review Record" was provided. This was dated 7/30/13 and signed by the HRC chair. The only thing reviewed by this record was the GER, which was not a completed investigation. In addition, only the committee chair was involved with the review, not the human rights committee. This was confirmed by administrative staff in an interview on 8/8/13 at 8:00 a.m.</p>	{W 154}	<p>d. The Program Director is responsible for ensuring plans determined in the ERR and BPR meetings are implemented as agreed upon by the team.</p> <p>W154, #7 a. An ERR meeting was held to review incident that occurred on 7/31/13 for Client 17.* 8/07/13* b. A BPR meeting was held for Client 17 to [REDACTED] 8/7/13* c. The Program Director is responsible for ensuring plans determined in the ERR and BPR meetings are implemented as agreed upon by the team. 8/25/13*</p> <p>W154, #8 a. An ERR meeting was held to review incident and cause of injury for Client 10. * 8/6/13 b. A BPR meeting was held for Client 10 to discuss her self-injurious behavior. 8/27/13 c. The Level I and II Reviewers will utilize the template to ensure reconciliation of actual cause of injury.*</p> <p>W154, #9 a. An ERR meeting was held to review incident of use of physical and chemical restraint for Client 34. 7/30/13 b. A BPR meeting was held for Client 34 to discuss her aggressive behavior, use of chemical and physical restraint and associated plan steps. 8/29/13 c. The Level I and II Reviewers will utilize the template to ensure plan steps are addressed.*</p>	

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(W 154)	Continued From page 117 There was no evidence that this incident of handcuffing a client on facility campus was thoroughly investigated. Residence 43 - Client 61 11. General Event Report (GER) 13-06-59 was reviewed on 7/31/13. The incident involved the observation by staff of multiple bruises of unknown origin on Client 61 on 6/29/13. When asked how he got the bruises, Client 61 stated a staff member had hit him. No OPS (Office of Protective Services) report was attached to the GER. During an interview on 7/31/13 at 12:45 p.m., facility administrative staff stated the investigation had been referred to SIU (Special Investigations Unit) and the report was not completed. She stated the expectation was for the report to be completed within 30 days of the incident. The investigation report for this allegation of abuse was again requested on 8/4/13 at 10:30 a.m. and again on 8/5/13. Administrative staff stated the report was still not completed. There was no evidence that a complete and thorough investigation was completed for an incident of alleged abuse of a client by a staff member. Residence 43 12. The investigation of a GER, dated 12/21/12, related to a fractured nose and other injuries which resulted from Client 48 being attacked by three other individuals served did not include an	(W 154)	W154, #10 a. A general event report (GER) is initiated by clinical staff, and thoroughly investigated by supervisors and managers any time OPS involvement is associated with a behavioral issue. b. OPS Officers generate a police report that is reviewed and approved by the Commander. c. The Governing Body reviews all instances of Law Enforcement Involvement (LEI) with the Commander/designee and makes recommendations as indicated. d. The HRC Committee criteria for reviewing LEI was revised to be more inclusive of clinical and OPS investigations. e. The Human Rights Committee (HRC) Manual was revised to include the process for those instances when LEI is involved in Behavior Emergencies. f. A collaborative workgroup consisting of representatives from OPS, Governing Body, Managerial, and Clinical areas was formed to discuss delineation of clinical and police responsibilities during behavioral events that endanger self or others. g. A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. [REDACTED] i. Shift Lead/designee will monitor throughout the shift to ensure that the environment is safe and secure.	9/9/13 9/9/13 9/9/13 9/9/13 7/13/13	

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(W 154)	Continued From page 118 evaluation of the effectiveness of the facility's response to the "behavior emergency" called when staff members were unable to keep Client 48 safe. The provider's failure to conduct a thorough investigation was included in the Statement of Deficiencies (Event ID Number 009N11). The provider's Plan of Correction related to the incident involving Client 48 documented, "...e. The SIU investigator has reopened the case to evaluate the facility's response to the behavioral emergency to determine effectiveness of alarm system and to rule out possible neglect by care providers. f. Additional findings from the re-opened investigation will be reviewed at Case Disposition meeting and action plans implemented as indicated." The Completion Date identified by the provider was 6/17/13. The Director of Agency Evaluation was interviewed on 8/1/13 at 9:41 AM. The Director of Agency Evaluation confirmed that the investigation had been re-opened and completed. However, once the investigative report was reviewed by the administrative personnel during "Case Disposition", the determination was made that the "re-investigation" was not thorough and the case was again returned to SIU for further investigation. The Program Director was interviewed at 11:05 AM on 8/1/13. She confirmed that on the evening of 12/21/12 when Client 48 was assaulted, she returned to campus. The Unit Manager confirmed she was the person who completed the GER, dated 12/21/12. The Unit Manager confirmed that a Behavior Emergency was initiated and that additional staff were called and responded once Client 48 was attacked. At 1:20 PM on 8/1/13, a copy of the "re-opened" investigation conducted by the Special	(W 154)	W154, #11 a. An ERR meeting was held to discuss incident that took place 6/29/13 for Client 61. b. The police report was completed on 8/13/13. The SIU report was completed on 8/14/13 and case disposition meeting was held on 8/27/13. c. The Executive Director is responsible for ensuring completion of the resolution determined in the case disposition. d. OPS Commander/designee monitors status and completion of OPS/SIU cases.* W154, #12 a. Case disposition meetings were held on 8/13/13 and 8/27/13. No staff were found to be negligent in their actions. An action plan was formulated at the case disposition meeting that a work group would be formed to evaluate the process for obtaining assistance when the PALS system is not working and for obtaining assistance on the night shift. b. Portable phones have been obtained for each residence to assist the staff in obtaining emergency assistance. c. Facility Procedure 5.6.3 "Obtaining Emergency Assistance" was revised to include instruction to staff to utilize whistles when the PAL system is non-operational and/or obtain immediate assistance.* d. US/Designee will provide training to DCS on Procedure 5.6.3 "Obtaining Emergency Assistance" with focus on obtaining assistance in the event of a PALS system failure.* e. Program Management will review each event for obtaining emergency assistance involving restrictive intervention and/or injury at the Management Debrief meeting to ensure policy was followed and effective.* W154, #13 (omitted)	7/5/13 8/27/13 8/27/13 9/09/13 2/20/13 10/10/13*	

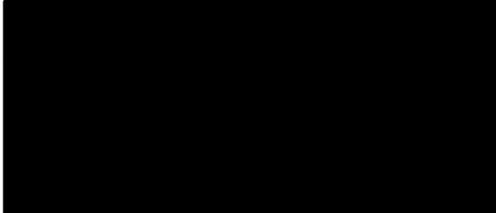
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{W 154}	Continued From page 119 Investigator was provided for review. The content of the "Supplemental Report," dated 6/13/13, is presented in entirety: "On 6/13/13 I was directed by [Name of Supervisor] to write a supplemental for case DS12-12-F-661. On 12/19/12, [Name of staff] sent an email to all FDC staff, stating that the PALS system was not working and they could call ext #77 for behaviors. On 12/20/12 Staff members on residence 44 were able to stop an incident (see DDS12-12-F-661-F) regarding clients. Staff members working on residence 44 witnessed the incident and immediately intervened and were able to separate all clients involved without utilizing their PALS or calling #77. Both staff members were interviewed. The statements of the clients involved and staff members were consistent to each other as to how the incident occurred. No evidence of neglect by any staff members found." The Director of Program Evaluation was interviewed at 3:45 PM on 8/1/13. The Director of Program Evaluation confirmed that the facility had failed to meet the Plan of Correction date of 6/17/13 to thoroughly investigate the facility's response to the behavior emergency called on 12/21/12. The Director of Agency Evaluation confirmed that the "re-opened" investigation failed to clarify the discrepancies between the information included in the Special Investigator's "Supplemental Report" and the original GER completed by the program director about whether or not a behavior emergency had been called. The Director of Agency Evaluation confirmed that the facility had yet to determine if/when the behavior response was called and which employees responded. The Director of Agency Evaluation confirmed the facility had not interviewed the employees who responded to the behavior emergency if/when it was initiated. The	{W 154}	W154, #14 a. A supplemental report was completed by the SIU investigator and the concerns related to witnesses not interviewed, a history of similar incidents, meal breaks and accounting of staff at the time of event were addressed. The findings continued to indicate insufficient evidence to substantiate neglect of Client 81. b. The results of the supplemental investigation were reviewed at Case Disposition Review and no further action was indicated.* c. The Executive Director is responsible for ensuring completion of the resolution determined in the case disposition. d. OPS Commander/designee monitors status and completion of OPS/SIU cases.* W154, #15  b. A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events. c. OPS continues to communicate with the Executive Director regarding the status of this case. d. Due to the complexity of the investigation, the internal investigation was closed to ensure that the external investigation could continue unimpeded. e. The Executive Director is responsible for ensuring completion of the resolution determined in the case disposition. f. OPS Commander/designee monitors status and completion of OPS/SIU cases.* g. Medical and nursing care provided to Client 12 will be reviewed via Case Disposition as part of revised policy for death review for clients who expire while on provisional placement related to a serious illness or significant injury.*	6/14/13 9/26/13* 8/08/13 9/9/13	

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{W 154}	Continued From page 120 Director of Agency Evaluation confirmed that if the behavior emergency was not called as indicated in the Special Investigator's report, there was no explanation about how the three clients who attacked Client 48 were able to kick and hit him repeatedly, (necessitating emergency room care and care in the on-campus medical unit) if the two staff on duty the night of 12/21/12 "immediately intervened and were able to separate all clients involved without utilizing their PALS or calling #77." Residence 44 14. Client 81 broke a window with a soiled linen cart and jumped to the ground from the second story Resident 44 building on 4/14/13. He was transported to a community hospital with a significant injury to his leg, ligament damage and tears. The Special Investigator substantiated policies were not followed as the three previous similar incidents of breaking windows to AWOL were not noted in his clinical record and there was no Interdisciplinary note in his clinical record until 5/21/13. The Client had broken and exited the 2nd story broken window on 4/14/13. Additional findings from the re-opened investigation, including witnesses and psychologist interviews and exact staff on duty by name and staffing conclusions were not yet completed as on 8/8/13. The action plan was waiting for supplemental information and had not been implemented as indicted in the 6/13/13 Plan of Correction. Residence 41 15. Review of the General Event Report dated 7/18/13, noted that Client 12 was monitored for weakness and complaint of back pain. A bruise, 4 cm (centimeters) x 2 cm and 4.1 cm x 5 cm very light purple was discovered on the client's lower	{W 154}	W157, #1-2 a. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS. The manual will be introduced at a general employee meeting and included on the Focus Calendar b. Facility Admission policy 1.9.1 Admission/Readmission was revised to address admission requirements. c. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness. d. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated and assess the individual's living arrangement to determine placement in the most appropriate setting, 9/09/13  g. AE Risk Manager reports on client to client abuse quarterly and annually to the AE Committee who formulates action plans as indicated.*	9/9/13 8/30/13 8/15/13 /12/13 /12/13	

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{W 154}	<p>Continued From page 121</p> <p>back at 12:30 a.m. The client was transferred to an outside acute care hospital to rule out spinal cord injury. CT scan of the lumbar spine and pelvis were taken and negative for fracture. The client returned to the facility.</p> <p>Review of the Level 1 Review by the Unit Supervisor done on 7/23/13, noted that the client had become less willing to move her lower extremities and complained of back pain on 7/17/13. X-rays done on 7/17/13 at the facility were negative for fracture of the cervical, lumbar, hips and pelvis areas. [REDACTED]</p> <p>The client's condition did not improve and the physician made the decision to send the client back to the outside acute care hospital to rule out spinal cord injury on 7/19/13. A CT scan was done at the hospital and the client had a fracture of the cervical spine (neck) C4 and C5 and taken to surgery.</p> <p>Statements (written) were obtained from staff regarding the client's condition two days prior to the discovery of her fracture. (Reviewed by the surveyor).</p> <p>During an interview with the Unit Supervisor on 8/9/13 at 11:00 a.m. she was asked if she interviewed and/or obtained statements from the client's day program staff. As of the time of the interview, she had not. Also, the Unit Supervisor stated that she had interviewed the client regarding the client's condition some time prior to her admission to the hospital; however, she was unable to provide documentation of the interview.</p>	{W 154}	<p>h. The Executive, Clinical, Quality Assurance and Program Director will monitor clients for behavioral trends and will make adjustments to living situations as indicated to provide a safe environment and protect other clients from harm.*</p> <p>i. Psychiatric Evaluation was completed and the IDT agreed to modify his medication regime.</p> <p>j. Psychologist continues to provide one to one therapy to address behavioral and psychological needs, with progress monitored weekly during the Emerging Risk Review Meetings.</p> <p>k. Training was initiated with DCS on modifications to Client 65's IPP, following each change.</p> <p>W159</p> <ul style="list-style-type: none"> The Behavior Support Committee initiated development of a process for a facility-wide data collection system that provides more immediate recording of behavioral data. The Senior Psychologist initiated development of accurate data collection methods with training to be provided. <p>W159, #1</p> <p>[REDACTED]</p> <p>b. Program Director met with the Social Worker, US and Psychologist to review FDC Policy 6.2.8 "Informed Consent", With emphasis on the expectation that packets for sleep medications will not be submitted to HRC until consent is received.</p> <p>c. HRC Chair will provide a status report to the Governing Body regarding sleep program approvals via AB Committee. Follow action plans will be initiated to ensure compliance*</p>	<p>8/15/13</p> <p>9/9/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>7/16/13</p> <p>9/09/13</p> <p>10/10/13</p>

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{W 154}	Continued From page 122 The facility failed to complete a thorough investigation by not interviewing staff in other areas of the facility that the client was in contact with and not documenting that the client was interviewed in regards to her condition.	{W 154}	d. A QAPI is in place to keep Executive and Management staff apprised of current approvals and trends.		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview, record and facility document review the facility failed to take corrective actions when Client 65 physically assaulted one peer twice and two other peers on the residence in a ten week period. This placed all clients on the residence at risk for psychological and physical harm. (Unsampled Clients 65, 72, 75 and 82) Findings: 1. Beginning on 8/5/13 a review of the facility policy and procedure number 5-05-5 titled "General Event Reporting" (GER) and "Guidelines for Completing Level I and II Review" of the GER dated 6/13/13 was conducted. A GER is part of the facility system to initiate a collection of evidence, investigate and take corrective actions for unusual occurrences such as injury of unknown source, and allegations of mistreatment, neglect or abuse. A sample review from 42 GER's on Residences 28, 30, 41, 42, 44 and 45 dated 5/28/13 through 8/6/13 was completed.	W 157	W159 #2 a. The Behavior Support Committee initiated development of a process for a facility-wide data collection system that provides more immediate recording of behavioral data. b. The Senior Psychologist initiated development of accurate data collection methods with training to be provided. c. The NOC shift staff updated the Plus Program Data Collection Sheet to include all current milestones for each individual client that resides on residence 43 (including client 48, 49 and 53). d. The US trained DCS on Plus Program Data Collection Sheet, proper way to fill out the Plus Program Data Collection Sheet and the expectation of completing this daily. e. Shift Lead/designee will monitor daily to ensure staff has completed the Plus Program Data Collection Sheets. f. NOC shift staff will audit the Plus Program Data Collection Sheet each night and report to US/Designee of missing data information.	9/09/13 9/09/13 9/1/13 8/21/13	

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W 157	<p>Continued From page 123</p> <p>2. Beginning on 8/6/13 review of four GER's dated 7/18/13, 6/24/13, 6/6/13 and 5/10/13 revealed Client 65 physically assaulted one peer twice and three other peers on his residence.</p> <p>On 7/18/13 at 1:40 p.m. Client 65 hit Client 72:</p> <p>[REDACTED]</p> <p>On 6/24/13 at 11:59 a.m. Client 65 was walking out of the group area with a staff person and [REDACTED] punched Client 82 on the right side of his face. Client 82 received a reddened area to the right side of his head.</p> <p>On 6/6/13 at 4:30 p.m. [REDACTED]</p> <p>[REDACTED]</p> <p>Client 75 walked around the corner and was punched in the mouth by Client 65 - who was waiting there. There had been no antecedents or problems between Client 65 and 75. Client 72 received a painful split lip as a result of being punched in the face/ mouth.</p> <p>On 5/10/13 at 11:45 a.m. prior to getting into an elevator Client 65 turned and punched Client 82 in the eye [REDACTED] Client 82 received a laceration and black/blue/red left eye.</p> <p>[REDACTED]</p>	W 157	<p>g. Following Annual Conference / Specials (if applicable); the Chairperson will immediately update the current Plus Program Data Collection Sheet.</p> <p>h. US/Designee will monitor Plus Program Data Collection Sheets to ensure this is completed.</p> <p>i. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.</p> <p>j. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>k. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring.</p> <p>l. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.</p> <p>m. The AB SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AB Director and improvement plans will be initiated as indicated.</p>	9/1/13 9/1/13 9/01/13 9/06/13	

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W 157	Continued From page 124 On 8/8/13 review of the Individual Program Plan (IPP) dated 6/26/13 showed Client 65 assaulted or attempted to assault staff on 6/5, 6/12, 6/19, 6/20 and 6/25/13. On 6/8/13 he used a butter knife to try to cut his wrist. The behavior plan, approaches and strategies suggest Client 65 should be provided with frequent contact and positive reinforcement. Staff should be aware of peers intruding into his personal space and maintain it a greater than arms length. If Client 65 engages in antecedents ask him to place his hands in his pockets and request he distance himself from other clients and staff. If Client 65 engages in target behaviors (forcefully punches peers or staff potentially causing severe injury) get assistance and utilize restraints.	W 157	W159, #3 a. A Special Conference for Client 184 was held to discuss current medical status and adaptive equipment needs. d. Staff trained on Client 184's new milestone and translocation plan (to ride the bus). e. The US/designee trained DCS on all units including Res. 31 Staff on Section IV of "Protecting Human Rights" manual and Facility Policy 05.04.04 "Protective Devices" with emphasis on justification expectations and identifying criteria to discontinue use of restrictive interventions. * f. The US on 431 initiated a schedule to review restrictive protective documentation to ensure rationale and plan to discontinue criteria is current g. PD will monitor HRC documentation to ensure rationale and plan to discontinue criteria remain current* h. The IPCs will monitor for progress with the current program plans including restrictive interventions and will document their findings in the monthly note, along with follow-up corrective actions taken. i. Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings.	8/12/13 9/9/13 8/13/13 8/16/13 10/10/13 9/9/13

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W 157	Continued From page 125 Corrective actions have included keep Client 65 ten feet away from peers, [REDACTED]	W 157	j. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty. k. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring. l. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process. m. The AE SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.	9/1/13 9/1/13 9/6/13
(W 159)	Corrective actions to Client 65's active treatment program i.e. medication regimen, behavior program, change in routine and level of supervision have not resulted in a decrease or lessened severity of unpredictable physical assault and potentially affects the safety and security of all clients on the residence and staff providing care and services. Interview with the Unit Supervisor (US) and Program Assistant on 8/7/13 at 11 a.m. The US indicated the corrective actions have helped decrease episodes of aggression although the client remains unpredictable. Client 65 is receiving a staff enhancement of one staff to two clients due to his unpredictable behavior. The US indicated staff stay 10 feet away from Client 65 and encourage other clients to do the same. 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the active treatment programs for 9 clients were coordinated and monitored by the Qualified	(W 159)	W159, #4 a. Social Workers contacted the families of individuals on all residences including those residing on Res. 29 and 31, requesting family photos and other personal items to decorate client bedrooms and living areas. * b. PD provided training to US/designee on expectations that clients be assisted to obtain personal possessions which emphasize individuality and personal preferences.* c. Purchase Orders have been initiated, including 429 and 431, to personalize client living spaces and clients are involved in selecting items of interest. * d. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will monitor client living areas to ensure living areas reflect personal preferences, interests and likes during observations. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.*	10/10/13 10/10/13 10/10/13

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{W 159}	Continued From page 126 Mental Refardation Professional (QMRP)/Individual Program Coordinator (IPC) (Clients 32, 48, 49, 53, 63, 130, 157, 184, and 151.) Clients 48, 49, 53 did not have accurate data collection to assure their active treatments were being implemented. Client 32's vocational objective was not trained accurately and the IPC had not visited the worksite since February 2013. Client 63's increased behaviors and contributing factors were not addressed in the IPC documentation and money management training goals were not based on ability. Client 157 did not have a consent for a sleeping aide medication. Client 130 was not provided opportunities during dining observations. Client 184 was not able to self-release the seatbelt and the Individual Program Plan (IPP) did not define if its use was behavioral or medical. On Residence 29 and 31, the IPC did not assist clients in making choices of personal items reflective of each individual's unique interests and likes. The IPC on Residence 30 was not aware of the vocational assessment and recommendations for Client 151. Findings:	{W 159}	e. The IPCs will visit bedrooms during site visits and follow up with US when individuality and personalization does not meet the expected standard to work towards joint resolution. * f. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring. g. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.	9/01/13 9/1/13 9/6/13	

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{W 159}	Continued From page 127 Residence 30 1. On 8/9/13 review of GER 13-07-07 dated 7/2/13 at 4:45 p.m. revealed Client 157 had a special meeting on 3/6/13 to discuss her sleep medications. The team decided to initiate [REDACTED] and mailed a consent for treatment approval to the clients' representative. The medication was prescribed and started without the return of the consent. Client 157's program was not monitored by the IPC to assure approval was received before a new medication was started. 2. Review of documents entitled "IPP Desired Outcome and Milestone," "Milestone Progress Recording," and data collection documents for sampled Clients 53, 49, and 48, indicated inconsistent data collection. There were missing and incomplete data records, data collection records were not current, data was being collected for objectives that had been discontinued, and data for current milestone objectives did not reflect the data that was being collected. Data was not reported consistently in a quantifiable form. Numerous daily entries varied from using zeros to blank spaces. It was unclear if a blank space indicated that the client refused to participate, if no attempt was made at training, or if the client did not meet the objective. There was no legend specific to tracking data. There was insufficient data to determine progress or lack of progress. During an interview with the IPC on 8/7/13 at 2 p.m. the IPC stated that the Psychiatric Technicians (PTs) were responsible for collecting	{W 159}	W159, #5 a. Special conference held for Client 130 and a milestone was developed to serve self during meals. b. US trained DCS on Client 130's new dining milestone. c. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will monitor to ensure opportunities for dining independence are being promoted. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed. d. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty. e. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring. f. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process. g. The AB SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AB Director and improvement plans will be initiated as indicated. h. Director of Dietetics/designee trained all food service staff on "Dining Room Expectations" with an emphasis on promoting independence.* g. PA/Designee provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence. *	8/20/13 8/21/13 9/1/13 9/1/13 9/6/13 9/1/13 10/10/13 10/10/13

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(W 159)	<p>Continued From page 128 the data and plotting it on the graph on the Milestone Progress Record.</p> <p>The IPC stated that he did not review the data sheets but only reviewed the graphs on the "Milestone Progress Recording" record.</p> <p>The IPC acknowledged that the data was not always accurate. (See W 252) Residence 31</p> <p>3. On 7/30/13 at 9:15 a.m., Client 184 sat in a wheel chair and Licensed Staff secured a seat belt at his waist and then pushed the client's wheel chair about 5 minute walk to the client's day program in the Activity Center room 30. The client sat in the wheel chair, with the seatbelt still fastened and began to hit his hand on a table. After five minutes the Licensed Staff released the seatbelt and the client began to walk about the room. Staff verified that the client was not able to self-release the seatbelt.</p> <p>Review of the client's record on 8/6/13, and IPP indicated that Client 184 needed a wheelchair for off residence distance travel. The seatbelt which the client cannot apply or remove it, independently, was initiated in March 2013 to decrease attempts to exit the wheel chair during translocation. The IPP indicated that " plans to move to less restrictive will be discussed when [Client 184] has had no injuries from exacerbation of the bursitis for 2 consecutive years. There was no documentation of the date of the last exacerbation. The record referred to an orthopedic clinic appointment dated 1/4/95 that indicated the client's bursitis had resolved. A recent orthopedic consult was requested however none was forthcoming.</p>	(W 159)	<p>W159, #6</p> <p>a. A special conference was held for Client 32 to address her vocational training. The training milestone was changed to reflect her abilities and appropriateness for the classroom.</p> <p>b. Vocational Supervisor provided training to DCS on Client 32's new plan.</p> <p>c. PAs provided training to DCS on all units, including Client 32's residence, on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence.*</p> <p>d. Vocational Supervisor/designee will conduct rounds to ensure all clients vocational plans, including Client 32's plans, are being implemented as written and staff are providing continuous active treatment at the work site.</p> <p>e. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.</p> <p>f. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>g. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring.</p> <p>h. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.</p> <p>i. The AE SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.</p>	<p>8/9/13</p> <p>8/23/13</p> <p>10/10/13</p> <p>9/1/13</p> <p>9/1/13</p> <p>9/01/13</p> <p>9/06/13</p>	

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
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(W 159)	Continued From page 129 During an interview on 8/7/13, [REDACTED] The IPC stated that in the past the client had used a more restrictive pelvic restraint and the did have an order for the restraint due to a knee problem. The IPC was not able to show if the primary intended use of the restraint was behavioral or medical. Residence 29 and 31 4. Random observations of clients' personal space; bedrooms on these residences, revealed that the majority of the client's bedrooms failed to contain any personal decorative possessions, nor displayed anything of their individuality, preferences, or experiences. Bedrooms mostly shared with one to three other individuals could not be distinguished one from the other except for an individual's name on his/her wardrobe closet. There were no photos, bedspreads, evidence of interests that reflected the identity of an individual's personal space. During interviews on 8/1/13 and 8/7/13, Individual Program Coordinators on both residences acknowledged that the team could assist clients in making choices of personal items reflective of each individual's unique interests and likes. 5. On 7/29/13 at 12:45 p.m., on Residence 29 Client 130 sat down at a table to eat lunch. Shortly thereafter a dietary staff wheeled a table height cart to the clients table from which the client removed his cup, plates and utensils with one verbal prompt. The client then ate	(W 159)	W159, #7 a. US/designee to provide DCS on all units, including those on Client 63's residence, training on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to provide on-going activities that meet all individuals' person centered treatment plans to ensure they have opportunities to exercise greater independence.* b. US/designee to provide training to DCS on all units, including those on Client 63's residence, on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination* c. Shift lead/Designee will provide all new/float staff with orientation of residence clients to ensure client safety, continuity of care, and continuous active treatment.	9/9/13 9/9/13 9/9/13	

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{W 159}	<p>Continued From page 130.</p> <p>appropriately and independently took his dishes to the service window and left the dining room.</p> <p>During an interview on 8/1/13 at 10:30 a.m., the Individual Program Coordinator (IPC) [REDACTED] stated that he probably could serve himself family style from bowls.</p> <p>Review of the Independent Life Skills Assessment tool dated 7/15/13 under the section food prep the client was assessed as able to serve appropriate portions with verbal prompt. Residence 42</p> <p>6. Client 32 was observed at the Goodell School classroom on 7/30/13 at 10:10 a.m. She was sitting at a table placing business cards in a box, placing a small screen over each business card, then dapping glue onto the screen. The client's one to one staff from the residence was sitting next to her.</p> <p>During the visit, an interview was conducted with the job coach, a licensed staff. The job coach stated that the client's objective was not completed and it would take 30 days to complete for the teacher to complete. The teacher assigned to the class was not working that day. The job coach stated that the client was to write down the number of completed screens in each session, morning and afternoon class.</p> <p>At 11:00 a.m., the one to one staff counted boxes and told the client that she had completed 100. A few minutes later, the one to one staff told the client that she had completed 160. The client</p>	{W 159}	<p>d. Interdisciplinary team to meet to review current Individual Program Plan for appropriateness of training and behavioral supports to meet Client 63's current needs.</p> <p>e. US/Designee will train all level of care staff on any changes/modifications made to Client 63's plans.</p> <p>f. Facility Electrician lowered the Residence phone ringer volume.</p> <p>g. Facility purchased additional cordless phone handsets. A schedule has been established for installation on the residences.</p> <p>h. A signal expander has been ordered to ensure the phone can be utilized throughout the residence.</p> <p>i. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.</p>	9/9/13 9/9/13 9/9/13 9/9/13 9/9/13 9/1/13

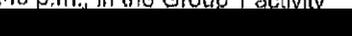
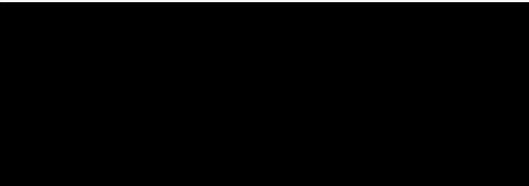
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{W 159}	<p>Continued From page 131</p> <p>then recorded that number in a log book. At no time did the one to one staff encourage the client to participate in counting the number of screens completed.</p> <p>During an interview with the one to one staff at 11:10 a.m., in regards to her counting for the client, she stated that she was not aware of the objective for the screens. During an interview with the client at that time, she stated that she could count to 30.</p> <p>During an interview with the classroom teacher on 7/31/13 at 10:35 a.m., she stated that the client was to count how many screens that she completed and write down that number. She stated that she had 30 days to complete the objective. The teacher was not sure when the client started the screen task; however, data was collected starting 7/15/13.</p> <p>The teacher stated that she completed the objective and presented a copy effective 8/1/13. The objective noted that effective, 8/1/13, the client was to record the number of screens she completed with 1 to 2 verbal prompts, 10 times per month. It was noted that the client was to count the number of screens she completed and write that number in the data collection sheet.</p> <p>During an interview with the IPC (Individual Program Coordinator) on 8/1/13 at 11:45 a.m., she stated that the objective was not what the team decided at a Special Conference held on 4/30/13.</p> <p>The IPC stated that she had not seen the client since the 4/30/13 conference and had not visited the classroom. She stated that it was her belief</p>	{W 159}	<p>j. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>k. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring.</p> <p>l. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.</p> <p>m. The AB SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AB Director and improvement plans will be initiated as indicated.</p>	<p>9/1/13</p> <p>9/6/13</p> <p>9/1/13</p>	

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{W 159}	Continued From page 132 that the client had been in the class since 6/3/13. Residence 44  On 7/29/13 at 5:45 p.m., in the Group 1 activity room, Client 63  placed a small black circular object in his mouth without direct care staff (DCS) intervention and stared. Monopoly was being played by some clients, led by a staff. Client 63's only activity besides a puzzle was when DCS placed a spinning wheel in front of the client once and asked him to spin the wheel and pick a letter.  On the morning of 7/30/13 at 6:40 a.m. there was a lot of noise and commotion as clients were directed or independently congregated in one of two group activity rooms. A phone in the nurses' station rang twice in five minutes and sent a loud, jarring noise down the hallway. Five minutes later, at 6:45 a.m. on 7/30/13, Client 63 walked into the Group 2 activity room. A direct	{W 159}	W159, #8 a. Interdisciplinary team meeting will be scheduled to discuss Client 63's money management training. b. The IDT will develop a new milestone to increase his independence in money management. c. Vocational Supervisor/Shift Lead will provide training to DCS regarding Client 63's money management milestones to ensure integration in all areas of his daily activities. d. US/designee and IPC will monitor during rounds to ensure all clients, including Client 63's, Individual Program Plan is being implemented as written. * e. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.	9/9/13 9/9/13 9/1/13

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{W 159}	<p>Continued From page 133</p> <p>care staff (DCS) asked what he had done the evening before to which Client 63 responded "bicycle with (Staff)." A DCS prompted him to go to his own group room. He stood up, began smacking his hands together, and eventually returned with an escort to the Group 1 activity room where he sat in a corner chair.</p> <p>This group activity room was a noisy, small, crowded room with multiple upholstered chairs, large and small tables and seven to eight clients seated or wandering into the room. Client 63 pieced a puzzle together while one staff stood at the blackboard and said, "What are your goals today?" Client 63 made no eye contact and did not engage in the discussion, repeated words others said, and repeatedly reached across the table towards another client with both hands and arms outstretched, at which point a staff, more than once, advised him not to touch. The discussion segued into sports with no engagement from Client 63 who reached out and touched a client who had just entered the room and who immediately struck back, missing, and said "Stop it!" Staff again, physically and verbally redirected Client 63 to stop the behavior. Staff did not engage Client 63 in any constructive one-to-one teaching while waiting to leave for the day program, did not provide a calm, quiet environment, nor did staff engage the client in any physical outdoor activities.</p> <p>On the morning of 7/31/13 at 9:17 a.m., in Group 1 activity room, a client was observed being restrained in a leather wrist-to-waist restraint and helmet. This distraction disrupted any planned activity as staff focused on managing that client's behavior and other clients became agitated and looked on.</p>	{W 159}	<p>f. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>g. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring.</p> <p>h. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.</p> <p>i. The AE SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.</p>	<p>9/1/13</p> <p>9/1/13</p> <p>9/6/13</p> <p>9/1/13</p>

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(W 159)	Continued From page 134 On 8/5/13 from 5:55 p.m. until 7:40 p.m., approximately 1 3/4 hours, Client 63 was observed with a DCS who at 6:10 p.m. stated she had floated from Residence 43 to provide 1:1 for Client 63. During this time Client 63 was observed walking very quickly down the residence hall at 5:55 p.m. The client entered the Group 2 activity room and eventually returned to the Group 1 activity room. No active treatment was observed. When asked about Client 63's active treatment goals, the DCS said, "I don't know," since she was not regular staff. As the evening progressed, the client sat in various chairs and reached repeatedly towards other clients and repeatedly was verbally and physically redirected not to do so. At 7:05 p.m. DCS said, "No touching." The DCS repeated a few minutes later, "No, no touching," when the behavior continued. The client was engaged in no activity as he paid no attention to the movie running and continued the behavior of reaching out towards others intermittently and looking at the staff for a response. At approximately 7:25 p.m., the same DCS said, "No" to Client 63 again. Client 63 became restless, rocking in the chair. When the medication pass nurse came to get the client for his evening medications the assigned DCS said, "Maybe that calm him down." On 8/6/13 from 7:05 a.m. to 8:35 a.m., Client 63 engaged of the behavior of reaching his hands towards others and staff said, "No, no, no (Client 63.) Client 63 went to the group room and started a puzzle. DCS was discussing use of money, empathy and charity. When asked to respond to a question related to the topics, Client 63 said, "Four o'clock in the back yard ...four o'clock	(W 159)	W159, #9 a. IPP held to discuss Client 151's current program and training plans were revised and initiated to reflect her current interests, capabilities and needs. b. Training developed for Client 151 to rinse and rack dishes after meals. c. US conducted training with Res. 430 DCS on Client 151's dining plan. d. PAs provided training to DCS on all units, including Client 32's residence, on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence.* e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure that clients are provided opportunities for independence during rounds conducted on residence and through review of activity record. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. f. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress. g. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.	9/6/13 9/6/13 8/30/13 10/10/13 9/1/13 9/1/13

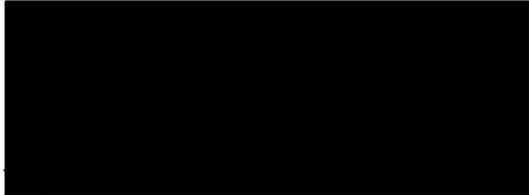
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{W 159}	Continued From page 135 bicycle ...four o'clock basketball," to which a DCS responded, "O.K. We're talking about charity (Client 63)." The group lesson continued. Client 63 continued the puzzle and again did not answer the DCS's question, this time about money. When asked, "What do you think (Client 63)?" he replied, "Backyard." No one-to-one teaching occurred; the unique needs of this client were not accommodated in this group activity. An alternative activity was not offered and no effort was made to take the client outside to ride a bicycle or play basketball, which the client continued to talk about.	{W 159}	h. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring. i. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process. j. The Agency Evaluation SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated. k. Active treatment coordinators have been designated in each program and are responsible for the development and implementation of active treatment projects to be integrated facility wide, with emphasis on promoting choices and independence in all environments.*	9/1/13 9/6/13 9/1/13 09/09/13	

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{W 159}	Continued From page 136   	{W.159}	W186, #1 a. Unit Supervisors/designee to provide all DCS including those assigned to Client 63's residence training on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to provide on-going activities that meet all individuals' person centered treatment plans to ensure they have opportunities to exercise greater independence.* b. Unit Supervisors/Designee to provide all DCS including those assigned to provide level of care staff on Client 63's residence training on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination.* c. Shift leads/Designee will provide all new/float staff with orientation of residence clients to ensure safety, continuity of care, and continuous active treatment.* d. Ongoing ID team to review current Individual Program Plan for appropriateness of training and behavioral supports to meet Client 63's current needs. e. The expectation for IPC site visits was revised by AE Director/Designee to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty. f. IPC documentation duties have been realigned by AE Director/Designee to promote more emphasis on program coordination, integration and monitoring. i. The AE SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.	9/9/13 9/9/13 9/9/13 9/9/13 09/01/13 09/01/13 9/01/13

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{W 159}	Continued From page 138  On 8/6/13 at 11 a.m., during interview of the IPC, when discussion about Client 63's ability to handle money was discussed, the IPC stated he did not know why Client 63 did not put money into the vending machine as a goal as the client was doing well with the current objective. The IPC stated he could bring it up at the next meeting, thought it was a good idea and stated this had not been tried before. When asked why not, the IPC responded, "I don't know." Residence 30 9. The Individual Program Coordinator (IPC), who serves as the Qualified Intellectual Disabilities Professional for Client 151, was interviewed at 9:00 AM on 8/8/13. The IPC was asked why Client 151 was not engaged in tasks and activities she was capable of performing. For example, The IPC was asked why Client 151 was not involved or included in folding the clothing protectors in the dining room. The IPC stated that Client 151 did not like to fold these cloths. Client 151's choice to not participate in capable activities was not identified in her IPP. The IPC had not identified choice and opportunities to practice capable skills as an active treatment training opportunity. When asked IPC appeared unaware of the 7/8/13 vocational assessment and recommendations for Client 151. Although asked, she provided no	{W 159}	W186, #5 a. USs and Program Management Team meet daily to review the staffing needs for the next 24 hours, including using available staff, return to work staff, limited duty assignments. Adjustments are made as needed. b. Nursing Coordinators review staffing assignments and deployments daily and make adjustments to meet residence acuity needs. c. Each Program utilizes an after-hours staffing residence to secure staffing resources as needed. Program Management remains on call to resolve after-hours staffing needs. d. Nursing Coordinators meet weekly to review facility staffing for the upcoming week and make plans for coverage as needed. e. A weekly staffing projection report is provided to the Program Directors and Clinical Director for monitoring to ensure minimum staffing guidelines are maintained. All requests to change minimum staffing guidelines must be approved by the CD/AOD and changes are provided to the governing body.* f. PDs review monthly residence schedules to ensure continuous balanced coverage. g. Clinical and Administrative services review undelivered staffing monthly to develop action plans for undelivered staff. h. Executive Director, Clinical Director, and Administrative Services Director review the staffing resources for the Center monthly to facilitate deployment of DCS. i. Clinical Director is developing a work group with DCS representatives from each area to review staffing deployment and make recommendations to ensure staffing levels are met within the center.	9/09/13

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(W 159)	Continued From page 139 Information as to how she would act on these recommendations and meet Client 151's Active Treatment Training needs with an appropriate day program.	(W 159)	j. The Program Directors will develop a protocol to provide a center wide staffing coordinator that will ensure scheduling of resources are effectively deployed to meet the minimum staffing guidelines and the acuity needs of the clients.		
W 186	Refer to W198 483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, interview, record review and review of facility documents, the facility failed to provide staffing in accordance with clients' needs for two of 20 core sampled and four unsampled clients; a. There was insufficient staff to remove Client 85 from a group activity room while restrained; b. one of 20 sampled clients (Client 63) did not have recreational/training needs met due to lack of sufficient staff; c. an unsampled client (Client 64) who asked to go outside could not be accommodated due to lack of sufficient staff; d. one of 20 sampled clients (Client 79) was told to wait to shower; e. an unsampled client (Client 77) was told to wait until a set smoking time to be allowed to smoke, so there would be a staff person available to accompany a group of clients to an outside area to have a cigarette, and also on Residence 31 when three male clients were in the same bathroom with one female client while her hair	W 186	k. A plan is being developed for Vocational Services to be restructured and redeployed to Central Program Services with staffing supports to provide continuity within each vocational site and enhance client's skills for job placement opportunities. l. A Quality Assurance performance (QAPI) was developed to review staffing concerns. The results of this report are reviewed at the AE committee and improvement plans are implemented as indicated.* m. Clinical Services is in the process of hiring DCS to fill vacant positions. n. The "Rounds Team" will monitor during rounds to ensure adequate staffing levels are provided based on client acuity. Rounds results will be calculated, analyzed by AE Analyst and presented to the Agency Evaluation Committee for action as indicated.	9/1/13 8/01/13 9/01/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
(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 186	Continued From page 140 was being combed due to needed supervision. (Clients 63, 64, 77, 79, 85 and 196) Residence 44 1. On 7/29/13 at 9:50 a.m., the Unit Supervisor (US) stated there were 23 clients on Residence 44. [REDACTED] [REDACTED] [REDACTED] On the morning of 7/31/13 at 9:17 a.m., in Group 1 activity room, another client, Client 85, was observed being restrained in a leather wrist-to-waist restraint and helmet. This distraction disrupted any planned activity as staff focused on managing that client's behavior and other clients became agitated and looked on.	W 186	W186, #6 a. Training was initiated for all DCS, including 431, on "Dignity In Care". * b. "Privacy" training was provided to Client 196's DCS [REDACTED] d. US identified gender specific restrooms on all co-ed residences including gender specific restrooms on Residence 431. * e. "Female" and "Male" signs were posted on gender specific restrooms on all co-ed residences including on designated bathroom doors on Residence 431. * f. All DCS received training on gender specific restrooms.* g. All DCS oriented clients to the gender specific restrooms.* h. All grooming supplies relocated to the correct gender specific restrooms.* i. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure to ensure privacy and dignity are maintained during ADLs. Results of findings will be calculated, analyzed by the AE Analyst and provided to the governing body via the AE Meeting and corrective action plans developed as warranted* j. Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings. k. US and Program Management Team meet daily to review the staffing needs for the next 24 hours, including using available staff, return to work staff, limited duty assignments. Adjustments are made as needed.	8/28/13 8/19/13 9/9/13 10/10/13 10/10/13 10/10/13 10/10/13 10/10/13 10/10/10	

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W 186	<p>Continued From page 141</p> <p>Client 63, who was seated, was visibly agitated, reaching out and not engaged in the puzzle in front of him. At 9:20 a.m., a direct care staff (DCS) stated there were over thirteen clients in the room and stated keeping Client 85 restrained in the presence of other clients was not expected procedure and the staff stated he did not know why the client was not removed from the room.</p> <p>Review on 7/31/13, of the "Daily Sign in Record," for the a.m. shift on Residence 44 (a behavioral unit), dated 7/31/13, showed that there were thirteen DCS (two floats and one mandatory overtime staff) for the day however, no staff was available on 7/31/13 to remove this restrained client from the group activity room, provide privacy to Client 85, and deescalate the tension in the room.</p> <p>On 8/6/13 from 7:05 a.m. to 8:35 a.m., Client 63 engaged in a behavior of reaching his hands towards others and staff said, "No, no, no (Client 63.) Client 63 went to the group room and started a puzzle. One upset client was seated on a couch crying, talking angrily saying, "F--- Y--- ...". This continued for 20 minutes until a staff intervened. A DCS was discussing use of money, empathy and charity. When asked to respond to a question related to the topics, Client 63 said, "Four o'clock in the back yard ...four o'clock bicycle ...four o'clock basketball," to which a DCS responded, "O.K. We're talking about charity (Client 63)." Client 63 repeatedly responded to the DCS's questions with comments about the backyard. When asked about money he replied, "Backyard." Although this client could communicate in simple language to staff, staff never offered to take Client 63 outside. There was not sufficient staff to engage the client in a</p>	W 186	<p>I. A Quality Assurance performance (QAP) was developed to review staffing concerns. The results of this report are reviewed at the AE committee and improvement plans are implemented as indicated.*</p> <p>W189.</p> <p>a. US to provide level of care staff on Client 63's residence training on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to provide on-going activities that meet all individuals' person centered-treatment plans to ensure they have opportunities to exercise greater independence.</p> <p>b. US to provide level of care staff on Client 63's residence training on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination.</p> <p>c. Shift lead/Designee will provide all float staff with orientation of residence clients to ensure continuity of client services.</p> <p>d. Interdisciplinary team will meet to review current Individual Program Plan for appropriateness of training and behavioral supports to meet his current needs.</p> <p>e. US/Designee will train all level of care staff on any changes/modifications made to Client 63's plans.</p> <p>f. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.</p> <p>g. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>h. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring.</p>	9/09/13 9/09/13 9/09/13 9/01/13 9/01/13 9/01/13	

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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 186	Continued From page 142 separate, appropriate activity, which might have included riding a bicycle or basketball therefore, the unique needs of this client were not accommodated.	W 186	i. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process. j. The Agency Evaluation SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.	9/6/13 9/1/13
		W191	a. US/designee to provide all DCS, including those assigned to Client 63's residence training on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to provide on-going activities that meet all individuals' person centered treatment plans to ensure they have opportunities to exercise greater independence.*	9/9/13
			b. US/Designee to provide all DCS including those assigned to provide level of care staff on Client 63's residence training on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination.*	9/9/13
			c. The facility Focus Calendar is discussed at daily intershift huddles and includes topics related to DCS role in Active Treatment implementation.*	
	2. On 8/5/13 at 7:25 p.m., Client 64, who was in a group activity room, asked to go outside. The			

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W 186	<p>Continued From page 143</p> <p>direct care staff (DCS) present told the client to ask another DCS. When that DCS entered the room and was asked, the response was, "We're going to start showers soon." The client then seated himself directly across from an autistic client and touched that client's feet which elicited an undesirable response from that client to which a 1:1 DCS said, "No." Client 64 stood up and began pacing around the room, back and forth. One of the DCS stated, "My partner, (DCS) went to shower another client so no one to take him outside."</p> <p>On 8/5/13 at 7:40 p.m., Client 64 was observed still pacing.</p> <p>3. On 8/5/13 at 6:55 p.m., Client 79, stood in a group activity room with two staff, one of whom came and went, and five to six clients. Client 79 asked the DCS if it would be possible to take a shower, the DCS, who was alone in the room with no other staff at the time responded, "It's too soon. One half hour, O.K.? No." The DCS looked to the surveyor for direction since there was no other staff present to accommodate this client. A short time later another staff returned to the group activity room at which point Client 79 was accommodated.</p> <p>4. On 8/6/13 at 6:45 a.m., Client 77 asked a DCS if he could go outside to smoke a cigarette. The DCS stated, "It's 6:45. Smoke break's at 7." Client 77 sat fidgeting for 15 minutes until 7 a.m. when the DCS came to the group activity room to take the client outside for a cigarette. Accompanied with three other clients, the DCS walked down the hall and unlocked a door leading down to an outdoor patio. As the DCS was unlocking the door another client began running</p>	W 186	<p>d. Shift lead/Designee will provide all new/float staff with orientation of residence clients to ensure safety of clients, continuity of care and continuous active treatment.</p> <p>e. Interdisciplinary team will meet to review current Individual Program Plan for appropriateness of training and behavioral supports to meet Client 63's current needs.</p> <p>f. US/Designee will train DCS for Client 63 on any changes/modifications made to his plans.</p> <p>g. Program Management will test competency of DCS on Client 63's program plan and will provide coaching as indicated.</p> <p>h. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress.</p> <p>i. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty.</p> <p>j. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process.</p> <p>k. The AE SCC will conduct quarterly audits to ensure IPC documentation meets expected standards. The results will be forwarded to the AE Director and improvement plans will be initiated as indicated.</p> <p>l. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment is being appropriately provided as scheduled. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*</p> <p>m. The US/designee will monitor during rounds that staff are aware of client plans and implement them consistently.</p>	9/1/13 9/9/13 9/1/13 9/1/13 9/6/13 9/1/13

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W 186	<p>Continued From page 144 down the hall yelling, "Wait for me. Wait for me!"</p>  <p>On 8/7/13 at 2:20 p.m., the Unit Supervisor (US) stated that presently, no clients had access to the patio without staff supervision. Therefore, none of the clients could smoke cigarettes without staff assistance. Due to limited staff availability, the residence had designated set smoking times and were not able on 8/6/13 to accommodate Client 77 when he asked to smoke 15 minutes before the designated smoking time.</p> <p>5. On 8/1/13 at 4:40 p.m. In the administrative building, a program director (PD) stated, "Given our resources we cannot maintain staffing ...the budget we are given for staffing would not be enough ...In the best of all possible worlds that would be wonderful."</p> <p>On 8/7/13, review of the Residence 44 facility, "Daily Sign In Record," from 8/18/13 through 8/6/13, showed that the facility met minimum daily requirements for staffing however relied on frequent mandatory overtime (MOT), voluntary overtime (VOT) and float staff who failed to meet the staffing needs of the clients. During this time period, mandatory OT reached as many as five staff on a given shift. Use of float staff and overtime staff potentially results in staff who do not implement active treatment effectively due to fatigue or lack of familiarity with clients.</p> <p>Review of the sign in records showed that during the a.m. shifts, from 8/18/13 through 8/6/13 there was MOT, VOT and float staff used as follows:</p>	W 186	<p>W193, #1</p> <p>a. Special Conference was scheduled for Client 180 to review the behavior demonstrated with the surveyor and develop training for appropriate greeting/communication.</p> <p>b. US/Designee will provide appropriate DCS training on significant changes made to the individual program plans.*</p> <p>c. US/designee will monitor during rounds to ensure that training is being implemented as written.</p> <p>d. IPC will monitor during site visits and will document training status on monthly note. Any concerns will be discussed with US for further action.</p> <p>e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment is being appropriately provided as scheduled. Results of findings will be calculated, analyzed by the AE Analyst and results will be reported to the Governing Body Via the AE Meeting. Corrective-action plans developed as needed.*</p> <p>f. US/Designee provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p> <p>g. Emerging and continuing behaviors are reviewed at behavior progress review meetings which includes the Psychologist and action plans are developed as indicated.*</p>	9/9/13	8/16/13

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
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W 186	Continued From page 145 MOT was used approximately 35% of the shifts, VOT approximately 22% and float staff were utilized approximately 22% of the shifts. For the p.m. shifts, for the same dates, MOT was used approximately 40% of the shifts, VOT approximately 65%, and floats were utilized approximately 40% of the shifts. For NOC shifts, the MOT was used approximately 39% of the shifts, VOT approximately 20%, and floats approximately 10% of shifts. The facility relied regularly on this practice to meet minimum staffing needs. 6. During observations on Residence 31 at 7:30 a.m., licensed staff was combing a female client's hair (non-sampled Client 196) in the women's bathroom (room 38) while three male clients observed. Client 196 was loudly vocalizing and biting her wrist. During an interview at 9 a.m., this Licensed Staff stated that two of the three male clients also needed close supervision and there was no other staff available at the time to assist.	W 186	W193, #2 a. US trained Residence 431 DCS on Client 193's behavior plans. b. DCS training has been developed and completed on the following topics: o FDC Policy 5.1 Clinical Standards of Care (Skin Integrity) o FDC Policy 5.4.2. Change of Condition o FDC Policy 5.5.5 General Event Reporting (Reporting/Documenting Minor Unknown Injuries) includes notification to ED/CDAB/PD o FDC Policy 5.5.5 Attachment A – Types of Incidents (Falls) o NP 11.01 Temporary Conditions o NP 11.02 Client Injury Assessment and Intervention o NP 11.04 Daily Care Flow Sheets/Daily Care Flow Sheet Form o Problem/Temporary Condition/Temporary Support Plan Log o Physical Observation and Documentation Checklist c. The US/designee will monitor to ensure all DCS received training in item b.* d. PD/PA/US/IPC/HSS will review and discuss changes in client condition at Management Debrief Meeting and follow up with action plan as indicated.* e. PDs/PAs will review 24 hour report and NOD Report daily for changes in client condition to ensure that changes are being adequately addressed. f. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment is being provided and injuries are identified, treated, and documented. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.*	9/06/13 9/09/13	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and facility document review, the facility failed to provide the Qualified Mental Retardation Specialist/Individual Program Coordinator (IPC) on Residence 44 with continuing training to	W 189			

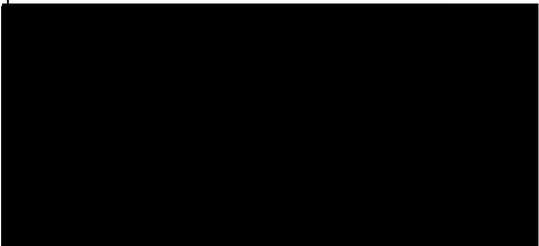
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W 189	<p>Continued From page 146</p> <p>enable the IPC to perform his duties effectively and competently, when training in autism was not provided to the IPC. The IPC, responsible for coordinating and monitoring provision of appropriate active treatment care to one of five autistic clients residing on Residence 44 (Client 63) failed to do so. The residence noise levels were often loud, environmental stimulation was often excessive, regular staff not consistent, and training not provided to meet the needs of the client.</p> <p>Findings:</p> <p>Residence 44</p>  <p>On 7/29/13 at 5:45 p.m., in the Group 1 activity room, Client 63 sat at a table rocking and flapping his hands, placed a small black circular object in his mouth without direct care staff (DCS) intervention and stared. Monopoly was being played by some clients, led by a staff. Client 63's only activity besides a puzzle was when DCS placed a spinning wheel in front of the client once and asked him to spin the wheel and pick a letter.</p> <p>On the morning of 7/30/13 at 6:40 a.m, there was a lot of noise and commotion as clients were directed or independently congregated in one of two group activity rooms. A phone in the nurses'</p>	W 189	<p>g. US/Designee provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.* 8/16/13</p> <p>h. Emerging and continuing behaviors are reviewed at behavior progress review meetings which includes the Psychologist and action plans are developed as indicated.*</p>	
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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
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W 189	<p>Continued From page 147</p> <p>station rang twice in five minutes and sent a loud, jarring noise down the hallway.</p> <p>Five minutes later, at 6:45 a.m. on 7/30/13, Client 63 walked into the Group 2 activity room. A direct care staff (DCS) asked what he had done the evening before to which Client 63 responded "bicycle with (Staff)." A DCS prompted him to go to his own group room. He stood up, began smacking his hands together, and eventually returned with an escort to the Group 1 activity room where he sat in a corner chair.</p> <p>This group activity room was a noisy, small, crowded room with multiple upholstered chairs, large and small tables and seven to eight clients seated or wandering into the room. Client 63 pieced a puzzle together while one staff stood at the blackboard and said, "What are your goals today?" Client 63 made no eye contact and did not engage in the discussion, repeated words others said, and repeatedly reached across the table towards another client with both hands and arms outstretched, at which point a staff, more than once, advised him not to touch. The discussion segued into sports with no engagement from Client 63 who reached out and touched a client who had just entered the room and who immediately struck back, missing, and said "Stop !!!" Staff again, physically and verbally redirected Client 63 to stop the behavior. Staff did not engage Client 63 in any constructive one-to-one teaching while waiting to leave for the day program, did not provide a calm, quiet environment, nor did staff engage the client in any physical outdoor activities.</p> <p>On the morning of 7/31/13 at 9:17 a.m., in Group 1 activity room, a client was observed being</p>	W 189	<p>W193, #3</p> <p>a. US trained Res. 431 DCS on Temporary Support Plans.</p> <p>b. US scheduled Client 196 for review at ERR meeting.</p> <p>c. Baseline data collection for Client 196 initiated for biting wrist.</p> <p>d. Special Conference scheduled for review of baseline data and to develop plans as appropriate.</p> <p>e. PDs/PAs/US/IPC/HSS will review and discuss changes in client condition including emergent behaviors at Management Debrief Meeting.</p> <p>f. PDs/PAs will review 24 hour report and NOD Report daily for changes in client condition to ensure that changes are being adequately and immediately addressed.</p> <p>g. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment is being provided and injuries are identified, treated, and documented. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.</p> <p>h. IPC will monitor completion of baseline data and initiation of training as indicated and document on monthly note.</p> <p>i. US/Designee provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p> <p>j. Emerging and continuing behaviors are reviewed at behavior progress review meetings which includes the Psychologist and action plans are developed as indicated.*</p>	9/9/13 9/9/13 9/9/13 9/9/13 8/16/13	

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W 189	<p>Continued From page 148</p> <p>restrained in a leather wrist-to-waist restraint and helmet. This distraction disrupted any planned activity as staff focused on managing that client's behavior and other clients became agitated and looked on. Client 63, who was seated, was visibly agitated, reaching out and not engaged in the puzzle in front of him. At 9:20 a.m., a direct care staff stated there were over thirteen clients in the room.</p> <p>On 8/5/13 from 5:55 p.m. until 7:40 p.m., approximately 1 3/4 hours, Client 63 was observed with a DCS who at 6:10 p.m. stated she had floated from Residence 43 to provide 1:1 for Client 63. During this time Client 63 was observed walking very quickly down the residence hall at 5:55 p.m. The client entered the Group 2 activity room and eventually returned to the Group 1 activity room. No active treatment was observed. When asked about Client 63's active treatment goals, the DCS said, "I don't know," and said she was not regular staff.</p> <p>As the evening progressed, the client sat in a chair and reached repeatedly towards other clients and repeatedly was verbally and physically redirected not to do so. At 7:05 p.m. DCS said repeatedly, "No ...No touching." The client was engaged in no activity as he paid no attention to the movie which was on and eventually, around 7:25 p.m. became restless, rocking in the chair. When the medication pass nurse came to get the client for his evening medications the assigned DCS said, "Maybe that calm him down."</p> <p>A DCS, on 8/5/13 at 6:45 p.m. commented that Client 63 did not sleep well at night.</p> <p>On 8/6/13 at 6:00 a.m., a direct care staff (DCS)</p>	W 189	<p>W193, #4</p> <p>a. US initiated training for DCS on Client 176's IPP with a focus on client likes/needs and communication style.</p> <p>b. USs/designees provided training to DCS including Residence 431 staff on:</p> <ul style="list-style-type: none"> o FDC Policy 5.1 Clinical Standards of Care (Skin Integrity) o FDC 5.4.2 Change of Condition o FDC 5.5.5 General Event Reporting (reporting/documenting Minor Unknown Injuries) including notification to ED/CD/AE/PD* o FDC Policy 5.5.5 Attachment A – Types of Incidents (Falls) o NP 11.01 Temporary Conditions o NP 11.02 Client Injury Assessment and Intervention o NP 11.04 Daily Care Flow Sheets/Daily Care Flow Sheet Form o Problem/Temporary Condition/Temporary Support Plan Log o Physical Observation and Documentation Checklist <p>c. The US/designee will monitor to ensure all DCS received training in item b.*</p> <p>d. PD/PA/US/IPC/HSS will review and discuss changes in client condition at Management Debrief Meeting and initiate action plans as indicated.*</p> <p>e. PD/PA will review 24 hour report and NOD Report daily for changes in client condition to ensure that changes are being adequately and immediately addressed.</p> <p>f. US/Designee provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p>	9/9/13 9/9/13 8/16/13	

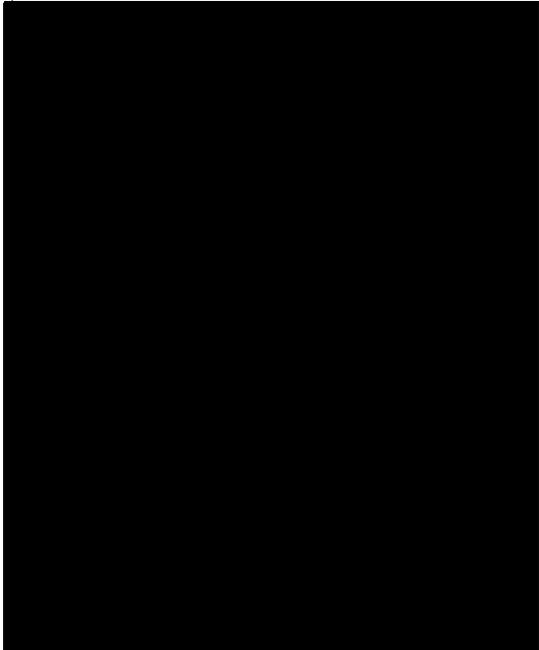
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W 189	<p>Continued From page 149</p> <p>stated the nurses' station phone bell could be turned down at night and stated it was the responsibility of the night shift but this was not an assigned task. The DCS stated some clients did not sleep well and the bell to the phone was "very loud and wakes up people." The DCS rolled her eyes and started laughing when asked if she had seen it wake up clients and said, "I wouldn't like that in my home."</p> <p>On 8/6/13 at 6:20 a.m., the hallways were dark, no clients were in the halls, it was quiet until the phone rang making a loud noise down the hallway. At 7:05 a.m. and 7:20 a.m. the phone rang again, first making a loud ringing noise five times, and then three times.</p> <p>On 8/6/13 from 7:05 a.m. to 8:35 a.m., Client 63 engaged in the behavior of reaching his hands towards others and staff said, "No, no, no (Client 63.) Client 63 went to the group room and started a puzzle. One upset client was seated on a couch crying, talking angrily saying, "F--- Y--- ...". Since the client received no attention from staff, this continued for 20 minutes until a staff intervened. A DCS was discussing use of money, empathy and charity. When asked to respond to a question related to the topics, Client 63 said, "Four o'clock in the back yard ...four o'clock bicycle ...four o'clock basketball," to which a DCS responded, "O.K. We're talking about charity (Client 63)." The group lesson continued. Client 63 continued the puzzle and again did not answer the DCS's question, this time about money. When asked, "What do you think (Client 63)?" he replied, "Backyard." No one-to-one teaching occurred; the unique needs of this client were not accommodated in this group activity. An alternative activity was not offered and no effort</p>	W 189	<p>g. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment is being provided and injuries are identified, treated, and documented. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.</p> <p>h. Emerging and continuing behaviors are reviewed at behavior progress review meetings which includes the Psychologist and action plans are developed as indicated.*</p>	

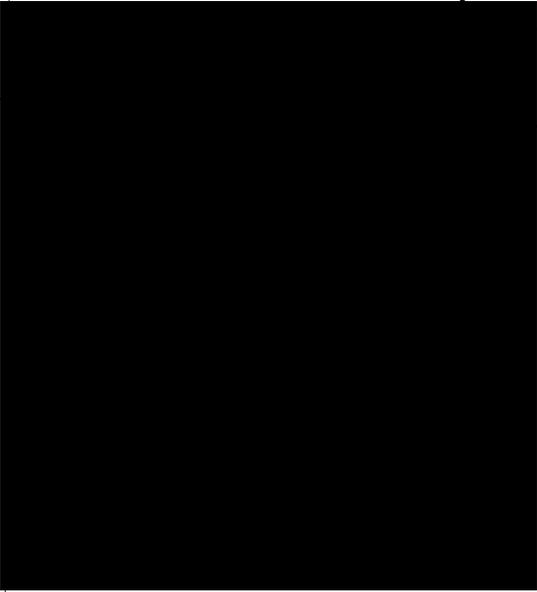
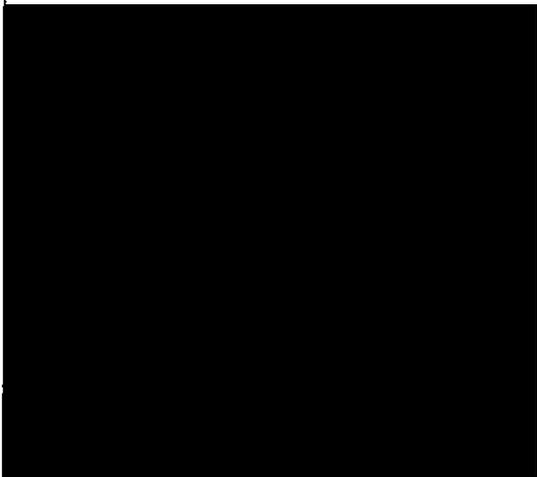
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W 189	Continued From page 150 was made to take the client outside to ride a bicycle or play basketball, which the client continued to talk about.   	W 189	W193, #5- a. US trained Residence 431 DCS on Client 189's behavior plans. b. An ERR meeting was held for Client 189 to discuss additional supports needed during his stressful times of the day. c. US initiated training for Residence 431 DCS on Client 189's communication milestone (replacement behavior for agitation) and additional supports d. Senior Psychologist initiated "Behavior Support Positive Practices" training for DCS on all units including 431 staff.* e. Staff Development provided "Respectful Interactions" training to all DCS including 431 staff.* f. Dining room coordinators will monitor dining rooms closely and make staffing adjustments to ensure active treatment implementation.* g. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure client protection and active treatment is provided during meals and report findings to the AB Committee. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.* h. Emerging and continuing behaviors are reviewed at behavior progress review meetings, which includes the Psychologist, and action plans are developed as indicated.*	9/3/13 7/31/13 9/4/13 9/3/13 9/6/13	

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W 189	Continued From page 151  	W 189	<p>W193, #6-8</p> <p>a. Special Conference held to discuss Client 184's dining needs.</p> <p>b. A follow-up conference was held to discuss progress and adaptations to adaptive equipment requested to assist client with dining process.</p> <p>c. New adaptive equipment (dycem mat, adapted spoon and plate) was obtained.</p> <p>d. US trained Residence 431 DCS on Client 184 dining plan and adaptive equipment.</p> <p>e. US trained Residence 431 DCS on how to request additional food from the kitchen and what options are available.</p> <p>f. Senior Psychologist provided "Behavior Support Positive Practices" to DCS including Residence 431. *</p> <p>g. Staff Development provided "Respectful Interactions" and "Dignity in Care" training to all DCS including staff on Residence 431.</p> <p>h. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure client protection and active treatment is provided during meals provide coaching as needed and report findings to the Agency Evaluation Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.</p> <p>i. IPC will monitor client use and progress of adaptive equipment and document in monthly notes.*</p> <p>j. USs/designees will provide training to appropriate DCS on changes to clients IPP including dining room plans.</p> <p>k. Dining room coordinators will monitor dining rooms closely and make staffing adjustments to ensure active treatment implementation.*</p>	<p>8/12/13</p> <p>9/9/13</p> <p>8/23/13</p> <p>8/30/13</p> <p>9/4/13</p> <p>9/3/13</p> <p>9/6/13</p>	

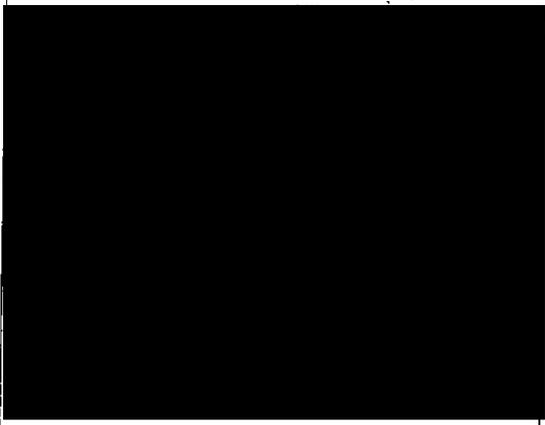
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W 189	<p>Continued From page 152</p>  <p>On 8/6/13 at approximately 11 a.m., the IPC stated that the IPC's had not receive the recent facility training in care of clients with autism and stated his knowledge stemmed from prior employment. The IPC stated he was not sure about Client 63's behavior of reaching out, said if staff did not know the client and did not allow him time to repeat his ritualistic behaviors the client would escalate.</p> <p>Review on 8/6/13 of the "Online Continuing Education" article dated 6/5/13, training material used by the facility to teach the facility psychologists how to meet the needs of autistic clients, presented multiple training approaches: "Some people with autism ...tend to be physically aggressive at times, making social relationships ...difficult. Some lose control, particularly when they're in a strange or overwhelming environment, or when angry and frustrated." It went on to describe sensory symptoms noting that, "Apparently, as a result of a brain malfunction, many ...with autism are highly</p>	W 189		
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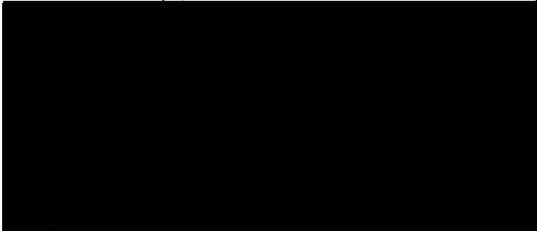
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W 189	Continued From page 153 attuned or even painfully sensitive to certain sounds ..." and can find noise to be "painful." The article showed that "Programs employing a developmental approach provide consistency and structure along with appropriate levels of stimulation." Some approaches cited focused on developing skills and replacing dysfunctional behaviors with more appropriate ones. Others recommended creating a stimulating learning environment tailored to the unique needs of the person. The article read, "Treatment programs that build on the (person's) interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the (person's) attention in highly structured activities and provide regular reinforcement of behavior, seem to produce the greatest gains." These included providing an environment that built on the person's skills and interests while accommodating their special needs. On 8/7/13 at 3:45 p.m. the Unit Supervisor (US) stated there were █ clients with the diagnosis of autism on Residence 44. The US stated she believed that the IPC's had been to the recent autism training.	W 189	W193, #9 a. Senior Psychologist initiated "Behavior Support Positive Practices" training for all DCS including staff on Residence 431* b. Staff Development provided "Respectful Interactions" and "Dignity in Care" training to all DCS including staff on Residence 431. c. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure respectful interactions and client dignity is maintained. Coaching and mentoring will be provided along with corrective active as warranted. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. W193, #10 a. Client 175's pillow was replaced and staff monitor daily to ensure that it's in good repair. b. An ERR was held to discuss Client 175's behavior of removing stuffing from pillows. c. Baseline was initiated for property destruction and removing items from peers' rooms. d. A follow-up meeting has been scheduled to discuss baseline results and develop plans as needed.	9/3/13 9/6/13	
W 191	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure that for employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. A direct care staff (DCS) providing 1:1 supervision did not provide	W 191	e. US provided Client 175 with alternate pillow coverings to prevent shredding of pillows. f. US is exploring options for different styles of pillows that the client will not destroy █ h. US/designee will monitor to ensure that residence is free of items that may be ingested.	8/15/13 8/17/13 9/9/13 8/9/13 8/9/13 9/9/13	

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W 191	Continued From page 154 Interventions as assessed; for one of twenty sampled clients (Client 63) as the DCS was not regular staff and did not know the client's active treatment plan. Findings: Residence 44  On 8/5/13 from 5:55 p.m. until 7:40 p.m., approximately 1 and 3/4 hours, Client 63 was observed with a DCS who at 6:10 p.m. stated she had floated from Residence 43 to provide 1:1 care for Client 63. During this time Client 63 was observed walking very quickly down the residence hall at 5:55 p.m. The client entered the Group 2 activity room and eventually returned to the Group 1 activity room. When the client did not engage in the movie that was being watched by others in the room, no other activity was offered. The DCS did not engage the client in any activity upon returning to the Group 1 activity room. When asked about Client 63's active treatment goals, the DCS said, "I don't know," and said she was not regular staff. As the evening progressed, the client sat in various chairs and reached repeatedly towards other clients and repeatedly was verbally and physically redirected not to do so. At 7:05 p.m.	W 191	i. The US/designee on all residences with individuals currently identified at risk for pica ensure that residences are free from items that may be ingested. j. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.* k. The Shift Leads/Designees will monitor during daily environmental rounds to ensure that the environment is free from hazards or items that may be ingested.* l. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure a safe environment is maintained. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.* W194, #1 a. USs/designees provided training to Shift Leads/Relief Shift Leads including Residence 431 on expectations for orienting float/new staff members with emphasis on providing client specific information. * b. PAs will insert client photos in all orientation books. * c. USs/designees will mentor and monitor float/new staff to ensure that they have all of the information and materials needed to provide services to the clients in their care and document on orientation form attached to 24 hour report. * d. PDs/designees reviews 24 hour report/orientation form for completion and provides follow up as needed.*	8/16/13	
				9/9/13	
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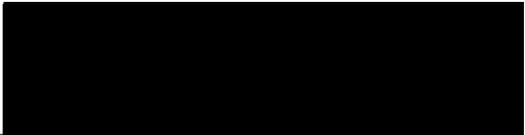
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W 191	Continued From page 155 DCS said, "No touching." The DCS repeated a few minutes later, "No, no touching." when the behavior continued. The client was engaged in no activity as he paid no attention to the movie running and continued the behavior of reaching out towards others intermittently and looking at the staff for a response. At approximately 7:25 p.m., the same DCS said, "No" to Client 63 again. Client 63 became restless, rocking in the chair. When the medication pass nurse came to get the client for his evening medications the assigned DCS said, "Maybe that calm him down."	W 191	<p>W194, #2</p> <p>a. US initiated training for Residence 431 DCS on Client 179's training plan for mouth mouthing-inedible objects.</p> <p>b. US initiated training with DCS on Client 179's Approaches and Strategies and Risk Assessment Summary with emphasis on mouthing-inedible objects.</p> <p>c. USs/designees will monitor during rounds to ensure clients are safe and treatment plans are followed.</p> <p>d. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p> <p>e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure a safe environment is maintained. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*</p> <p>W194, #3</p> <p>a. US trained DCS on Client 184's training plan to participate in meaningful active treatment activities.</p> <p>b. Active Treatment Coordinators have been designated on each Program and are responsible for the development and implementation of Active Treatment projects to be integrated facility-wide, with emphasis on promoting choices and independence in all environments.</p> <p>c. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure a safe environment is maintained. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*</p>	<p>9/9/13</p> <p>9/9/13</p> <p>9/09/13</p> <p>8/16/13</p> <p>9/9/13</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
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W 191	Continued From page 156 would continue to benefit from involvement in preferred recreational activities that involve physical activity, such as basketball. Such activities provide alternative outlets for aggression and frustration. 	W 191	d. The PA provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence and the expectations regarding staff knowledge of client training objectives and understanding of data collection components.* See insert for W195, #1 This POC includes Clients: 58, 63, 74, 105, 130, 180, 193, 151.		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that staff demonstrated the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients when: staff failed to promptly intervene when a client exhibited aggressive behavior (Client 180), failed to intervene with clients engaged in self injurious behavior (Clients 196 & 176), failed to provide activities and engagement to redirect from self injurious behavior, protect a client at the same table from an agitated peer (Client 189) and when staff frequently pulled on clients' hands, arms and bodies without sequential less intrusive verbal prompts and engagement, and when staff failed to remove a torn pillow after observing a client (Client 175) with the contents. Findings:	W 193			

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			<p>g. The facility is also working closely with two consulting groups (H&W Independent Solutions and the Consortium for Innovative Practices) to identify system-wide issues at the root cause level and to partnership in the development of sustainable Active Treatment improvement plans.</p> <p>h. The IPC will monitor for progress with the current program plan and will document their findings in the monthly note, along with follow-up corrective actions taken.</p> <p>i. Follow-up/review for staff knowledge and awareness of active treatment standards will be incorporated into facility focus calendars for review at huddle/shift change meetings.</p> <p>j. A Quality Assurance Improvement Plan (QAPI) is in place related to Environmental Health and the results of this report, along with improvement plans, are presented at regular intervals to the Governing Body for follow-up action as indicated.</p> <p>k. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure implementation of program plan as written, safe environment and environmental sanitation. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed</p> <p>l. The PD provided training to Shift Leads on Environmental Guidelines initiated. *</p>		

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W 193	<p>Continued From page 157</p> <p>Residence 31</p> <p>1. On 7/29/13 at 6 p.m. in the day room, non-sampled Client 180 walked quickly toward and then grabbed and pulled on the blouse of the surveyor. Direct Care Staff present in the room at the time with three other clients, failed to observe and intervene until requested to do so by the surveyor. A concurrent focus review of the record revealed that the client had a frequent behavior of grabbing.</p> <p>2. On 7/29/13 at 7:15 p.m., non-sampled Client 193 appeared agitated and was observed biting her left wrist below the thumb. Staff was not observed to intervene. The client was not engaged with staff or in any activity. The skin of the wrist area was open with scant blood. [REDACTED]</p> <p>The following morning, at 7:25 a.m., the client's left wrist had an open area with some scab forming. The client had numerous areas of scarring on her arms.</p> <p>On 8/7/13 focus review of the client's record revealed a behavior plan for biting her hands and arms. An Interdisciplinary Note (IDN) dated 7/24/13 first documented the left wrist redness. On 7/25/13 the physician ordered antibiotics for "folliculitis" (Inflammation of a hair follicle).</p> <p>3. During observations on Residence 31 at 7:30 a.m., Licensed Staff was combing a female resident's hair (non-sampled Client 196). Client 196 was loudly vocalizing and biting her wrist. Staff did not intervene, and continued to fix the client's hair.</p>	W 193	<p>Client 58</p> <p>a. A Special conference was held for Client 58 and a training plan was developed to address licking non-nutritional substances.</p> <p>b. DCS received training on the training plan for decreasing licking non-nutritional substances.</p> <p>c. US trained DCS on Client 58's residence on environmental sanitation, with emphasis in cleaning active treatment items and preventing cross contamination.</p> <p>d. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p>	<p>8/26/13</p> <p>8/27/13</p> <p>8/21/13</p> <p>8/16/13</p>

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W 193	Continued From page 158 Observations at 9 a.m., revealed that the client had an open calloused area at the base of the left thumb. Licensed Staff interviewed on 8/6/13 at 9 a.m., stated that Client 196 "always vocalizes and gets agitated with any staff intervention." Staff stated about her hand, that "she doesn't really bite her skin because she doesn't have teeth." 4. Observations on 8/6/13 at 4:50 p.m. included non-sampled Client 176 frequently striking the right side of her head and ear area with her hand. The client was seated outside in the residence backyard near other clients and staff. The client was not engaged in any activity. The client's outer ear was red. Staff was not observed to intervene until the surveyor asked staff about it and pointed out that the client's ear was becoming reddened. 5. During dinner observations on 7/29/13 at 6:15 p.m., non-sampled Client 189, while waiting to receive his dinner, sat at the table and began yelling loudly, banged on the table with his elbows, stood up abruptly and sat down loudly, picked up his chair banged it down very hard on the floor and slapped the Licensed Staff two to three times, who stood nearby. Licensed staff stated to the client: "You cannot be like that" "That's not nice" and "be nice." The client's behavior continued intermittently, after the meal arrived. A peer sat quietly next to Client 189 throughout the client's aggressive agitation and then Client 189 took this peer's milk without staff observation. Client 189 then ran out of the dining room. There was no attempt by staff to protect the peer during the agitation of Client 189 nor were any staff seated at the table to intervene appropriately.	W 183	Client 63 a. IDT met to review Client 63's Individual Program Plan for appropriateness of training and behavioral supports. b. US/designee initiated training to DCS on changes/modifications made to Client 63's plans. c. Program Management will test competency of DCS on Client 63's program plan and will provide coaching as indicated. d. US provided training to DCS on Client 63's residence on FDC 1.3.1 "Mission and Values," with emphasis on staff responsibility to provide on-going activities that meet all individuals' person centered treatment plans, and to ensure clients have opportunities to exercise greater independence. e. US provided training to DCS on Client 63's residence on FDC 1.3.2 "Principles and Practices," with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination. f. Shift Lead/designee will provide float/new staff with orientation of clients assigned to their care to ensure continuity of care, client safety, and implementation of continuous active treatment services. Client 74 a. The US/designee for Client 74 scheduled a Special IDT Conference to discuss conditions at the time of the incident for contributing factors to the behavior exhibited and determine whether a formal program for Running Into/Throwing Self Against Objects is appropriate b. Nursing Coordinator monitors to ensure all staff have current training in Positive Behavioral Supports/emergency behavioral response.*	9/09/13 9/09/13 9/09/13 9/09/13 9/09/13 9/09/13	

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		TA 195	Client 193 a. The Unit Supervisor trained Residence 431 DCS on Client 193's behavior plan 	9/6/13
			Client 151 a. A Special Conference was held for Client 151 and training plans were updated to reflect her current abilities, interests and needs. b. Psychologist provided training to DCS on Client 151's behavior support plan, 	8/6/13 8/30/13
			c. Senior Psychologist provided "Behavior Support Positive Practices" training for DCS on Client 151's residence. d. The instructor updated the vocational assessment for Client 151.	9/4/13 9/6/13
			Client 76 a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly*.	9/01/13

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			b. US developed a Daily Clothing Inventory List for Client 76 to ensure that he has sufficient clothing in his wardrobe cabinet at all times.*	9/09/13	
			c. US/Designee provided training to DCS on the Daily Clothing Inventory List for Client 76.*	9/09/13	
			d. US assigned each DCS a caseload that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing.*	9/09/13	
			e. US/Designee trained DCS on the expectations of their client caseloads.*	9/09/13	
			f. US/Shift Lead/Designee will ensure client clothing is well fitted and clean during daily rounds and will set expectations and coach staff when they see ill-fitting or unclean clothing on clients.*		

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W 193	Continued From page 159 6. On 7/29/13 at 6 p.m., during dinner Client 184 ate with his hands and with much spillage on the table and floor. No staff sat at the table with him. There was no janitorial staff available to clean up the spillage on the floor that created a safety hazard. During breakfast observations on 7/30/13 at 8 a.m., Client 184 sat alone at a table. The client frequently ate with his hands and had a lot of spillage on the table and his clothing. No staff sat with the client. Licensed Staff periodically walked by and stated: "why are you doing that?" "Use your spoon." The client again put hands in the food and poured liquid in the dish. Staff returned took the plate away and stated "you're done," as the client grabbed onto the dish. Client 184 returned to the dining room at 8:15 a.m., sat at his place and began pounding on the table until the acting Unit Supervisor suggested offering him something to drink. 7. At 9:05 a.m., another Licensed Staff blocked Client 184 from re-entering the dining room by placing her hands on his chest.	W 193	c. The Psychologist/designee for Client 74 will schedule in-service training to level of care staff on Client 74's behavior plan with emphasis on identifying behavioral and environmental precursors including appropriate action steps. * d. A template for Facility Policy 5-05-5 Attach I - Guidelines For Completing Level 1 and 2 Review was developed and initiated to assist staff in identifying appropriate components of the General Event Report investigation, including identification of behavioral plan steps implemented during the event. e. Program Management for Client 74 will schedule a review of the behavioral intervention at the PRMR for appropriateness and correct implementation of the behavioral intervention. Client 105 a. US/designee trained DCS on Client 105's IPP, with a focus on his likes, dislikes, needs and modes of communication. b. US/designee will monitor during rounds to ensure that a variety of preferred leisure supplies are available to Client 105 during structured and unstructured activity times.	9/09/13 9/09/13 9/09/13	
	8. On 7/30/13 between 9:30 a.m., and 10:15 a.m., Licensed Staff was providing enhanced supervision to Client 184. The staff redirected the client using her hands on his arms and upper body to turn or to stop him. Staff pulled on the clients upper arms and wrist to redirect, placed her arms around the client's upper body to prevent his attempt to go out of a door. Staff continued to block the client from touching items in the room by grabbing him and pulling him by the arm. At 11:10 a.m., Client 184 went out of the back door onto a loading dock area then ran with a		c. Shift Lead/designee will monitor during rounds to ensure that DCS have ample and a variety supplies available in the assigned living room to ensure quality active treatment activities are implemented. d. Shift Lead/designee will provide float/new staff with orientation of clients assigned to their care to ensure continuity of care, client safety, and implementation of continuous active treatment services. e. The PA provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" on providing quality interaction and intervention.*	10/10/13	

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W 193	Continued From page 160 Licensed Staff in pursuit. Once near him the staff grabbed him by the arm as he tried to get away, until the client sat down on the ground. A few minutes later other staff happened to walk by and assisted staff. 9. On 7/30/13 at 8:00 a.m., a Licensed Staff placed her hands on the upper and lower arms of a client and then grabbed the client about the waist from behind, and placed her hands on the client's chest as he tried to leave the day room area. At 9:10 a.m., the staff was pulling non-sampled Client 183 by the arms and [REDACTED] 10. On 7/29/13 at 6:45 p.m., non-sampled Client 175 walked about the residence with a piece of material (similar to a cotton ball) behind her left ear. During a concurrent interview Licensed Staff was unaware of what it was or where it came from. When the client went to her room there was a ripped pillow on the bed. The Licensed Staff stated: "so this is where you are getting this from." The staff tried to remove the pillow however the client grabbed it and after a short tussle the staff let go. The following morning on 7/30/13 at 8:30 a.m., the same ripped pillow was observed on Client 175's bed. During interviews, on 8/1/13 and 8/6/13 at 3 p.m., observations were shared with the Individual Program Coordinator (IPC's) and Residence Psychologist who had not previously heard of this particular behavior by Client 175. [REDACTED]	W 193	Client 130 a. A Special conference was held for Client 130 and the IDT developed training to encourage independence in the dining room by serving himself during meals. b. DCS on Client 130's residence received training on new dining plan. c. Training was initiated for DCS on 429 on "Dignity in Care". d. US/designee will monitor to ensure opportunities for independence are being promoted during mealtime and that Client 130's training plan is implemented. e. DCS for Client 130 received training related to toileting privacy including prompts to close the stall door. f. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.* Client 180 a. A Special Conference was scheduled for Client 180 to review the behavior of touching/grabbing other people's clothing and a new training plan was initiated for appropriate greeting/communication. b. US/designee provided training to DCS on Client 180's new training plan. c. US/designee will monitor during rounds to ensure that training is being implemented as written. d. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*	8/20/13 8/21/13 8/28/13 9/09/13 8/16/13 9/9/13 9/9/13

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W 193	Continued From page 161 [REDACTED]	W 193	Client 193 a. US trained Residence 431 DCS on Client 193's behavior plan related to biting her hands and arms, with emphasis on intervention, documentation, and nursing care as indicated when the behavior occurs. b. DCS training has been developed and completed on the following topics:*	9/06/13	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure that staff demonstrated skills and techniques necessary to implement individual's program plans when new staff were not provided adequate orientation to client's needs and risks (Client 184), when staff failed to intervene in clients with known mouthing behavior of inebbles (Client 179), and when staff failed to provide engagement and opportunities for leisure activities when a client demonstrated inappropriate behavior (Client 184). Findings: Residence 31 1. During an interview on 7/30/13 at 7:50 a.m. a Licensed Staff stated that it was the first time she had worked on this residence. The staff stated she had received orientation regarding the client group to which she was assigned. The staff was unable to recall the names of the clients. The staff stated: "They told me just to watch and help	W 194	o FDC Policy 5.1 Clinical Standards of Care (Skin Integrity) o FDC 5.4.2 Change of Condition o FDC 5.5.5 General Event Reporting (reporting/documenting Minor Unknown Injuries) o NP 11.01 Temporary Conditions o NP 11.02 Client Injury Assessment and Intervention o Problem/Temporary Condition/Temporary Support Plan Log o Physical Observation and Documentation Checklist o Behavior Support Positive Practices o FDC 5.3.1, 5.3.2, 5.3.3 Behavior Principles and Techniques and Interventions c. US will monitor to ensure DCS received the above training. d. PD/PA/US/IPC/HSS will review and discuss changes in clients' conditions at Management Debrief Meetings.* e. PD/PA will review 24 hour report and NOD Report daily for changes in client condition to ensure that physical and behavioral concerns are adequately addressed and documented.* f. US/designee will monitor during daily rounds to ensure DCS are assessing clients in their care for injury during naturally occurring times throughout the day.* g. A QAPI log was established to monitor adherence to assessment and documentation protocols. CNS presents findings to AB Committee for follow up action plans.*	8/01/13	

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W 194	Continued From page 162 with what they (the clients) needed." Client 184 was in the group and the staff was not aware of the need to watch him closely due to [REDACTED]. At 9:05 a.m., Client 184 was alone in the day room lying on a sofa. There was blue plastic material (disposable undergarment) on the floor next to him. A regular Licensed Staff then entered, picked up the blue plastic from the floor and stated: "[Client name] what are you doing? That's not nice [client name]." [REDACTED] 2. On 7/29/13 at 7 p.m., non-sampled Client 179 was seated in his wheel chair on the lawn in the back yard. The client had a leaf in his mouth. This observation was immediately reported to staff. The staff removed the item and walked away. The client then leaned over and picked up some grass. [REDACTED]	W 194	Client 151 a. A Special Conference was held for Client 151 and training plans were updated to reflect her current abilities, interests and needs. b. Psychologist provided training to DCS on Client 151's behavior support plan, with emphasis on identifying antecedent behavior, intervention strategies when she hits herself, and preventative techniques. c. Senior Psychologist provided "Behavior Support Positive Practices" training for DCS on Client 151's residence. d. The instructor updated the vocational assessment for Client 151. e. Vocational Supervisor will provide training to DCS on any changes made to Client 151's vocational plans and location change. f. A follow-up Special Conference was held and a new dining room objective was developed for Client 151. g. Training was initiated for Residence 430 DCS on Client 151's current program plan. h. New facility policies 5.3.1 Behavior Support Principles (and Glossary), 5.3.2 Behavior Support Programs, and 5.3.3 Behavior Techniques and Interventions were developed and distributed. Policy 5.3.3 specifically addresses the expectation for applying restraints in a manner that protects clients' privacy and dignity. i. A summary of new and key items from the new facility behavior policies were distributed to DCS, emphasizing positive behavioral approaches.	8/6/13 8/30/13 9/4/13 9/6/13 9/01/13	
W 195	3. On 8/6/13 at 4:30 p.m. Client 184 while in the backyard, threw a cup, pounded on the aluminum table, dropped to the ground, then pulled down one of the metal poles of a canopy, while staff continually told him no in response without providing any activities or engagement. 483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met.	W 195			

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W 195	Continued From page 163 This CONDITION is not met as evidenced by: Based on observations, interview, record and document reviews, the facility failed to ensure the Condition of Participation, Active Treatment was met when individuals were not involved in activities which addressed their individualized priority needs, individuals did not have opportunities to practice skills and to make choices in their environment, individual functional abilities have not improved and the facility did not identify barriers and implement a plan to minimize or overcome barriers. Findings: 1. The facility failed to ensure nine clients received a continuous implemented active treatment program consisting of supports and services which met their needs. (Clients 58, 63, 74, 76, 105, 130, 180, 193, and 151) (See W196) 2. The facility failed to ensure Client 94 had an Independent Living Skills Assessment (ILSA) that recognized his full abilities at his present level to include washing his own laundry. (See W224) 3. The facility failed to ensure staff were knowledgeable of the steps necessary for Client 32 to complete an objective. (See W227) 4. The facility failed to ensure the Individual Program Plan included opportunities for choice and self management for one of 20 sampled clients (Client 184), one unsampled Client 42 and clients residing on Residences 29 and 31, the majority of the client's bedrooms failed to contain any personal decorative possessions, nor displayed anything of their individuality.	W 195	j. Vocational Supervisor/designee will conduct rounds to ensure Client 151's program plan is being implemented as written and staff are providing quality active treatment services at the work site. k. US/designee will monitor during rounds to ensure that Client 151's program plan is implemented, including positive behavioral techniques l. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.* W195, #2 a. A Special Conference was held for Client 94 to discuss his independent laundry skills and a training plan was developed to complete the sequence for washing his clothes to reflect his current abilities. b. The Acting US provided training to DCS on Client 94's updated milestone for washing his clothes. c. US/designee on 428 will monitor during rounds to ensure training plans are implemented as written and provide follow up as indicated. d. PA provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence and the expectations regarding staff knowledge of client training objectives, understanding of data collection components.* e. US/designee will monitor during rounds to ensure Active Treatment programs are initiated correctly and consistently.* f. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed	8/16/13 8/14/13 8/15/13 10/10/13

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W 195	Continued From page 164 preferences, or experiences. (See W247) 5. The facility failed to ensure consistent implementation of individual program plans for four of 20 sampled clients and one additional client. Clients 1, 63, 130, 184 and 189. (See W249) 6. The facility failed to ensure that data collection was accurately documented. Data records were missing and / or incomplete, data collection records were not current, data was collected for objectives which had been discontinued, and data for current milestone objectives did not reflect the data that was being collected for four of 20 sampled clients (Clients 48, 49, 53, and 130). (See W252) 7. The facility failed to ensure one of 20 sampled client's (Client 63) individual program plan was reviewed and revised to meet the needs of the client. Client 63's money management objective was set below the client's assessed skill level. (See W255)	W 195	g. The IPC will monitor for progress with the current program plan and will document their findings in the monthly note, along with follow-up corrective actions taken. h. Follow-up/review for staff knowledge and awareness of active treatment standards will be incorporated into facility focus calendars for review at huddle/shift change meetings. W195, #3 a. A Special Conference was held for Client 32 to address her vocational training needs. The training milestone was changed to reflect her abilities and appropriateness for the classroom. b. The Vocational Supervisor provided training to DCS on Client 32's new plan, c. The Program Assistant provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence and the expectations regarding staff knowledge of client training objectives and understanding of data collection components. d. The Vocational Supervisor/designee will conduct rounds to ensure Client 32's plans are being implemented as written and staff are providing continuous active treatment at the work site. e. A protocol was initiated for the Vocational Supervisor to review and approve all vocational assessments prior to submission. f. Supervisor of Vocational Services will monitor Vocational Assessments to ensure that they meet the documentation standards. g. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure active treatment. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed	8/09/13 8/23/13 9/09/13	
W 196	The cumulative effect of these systemic problems resulted in the facility failure to ensure that specific active treatment services requirements were met. 483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (1) The acquisition of the behaviors necessary for	W 196		9/01/13	

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W 196	Continued From page 165 the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nine clients received a continuous implemented active treatment program consisting of supports and services which met their needs. (Clients 58, 63, 74, 76, 105, 130, 180, 193, and 151) Findings: 1. Beginning on 8/6/13 review of General Event Report (GER) 13-06-50, dated 7/23/13 at 5:30 p.m. revealed Client 74, [REDACTED] was discovered with a fracture of the 7 th distal rib following a restrictive intervention. The GER is part of the facility system to initiate a collection of evidence, investigate and plan corrective actions for an unusual occurrence such as an injury of unknown source, and allegations of mistreatment, neglect and abuse. The GER indicated Client 74 was participating in group activities when "suddenly" became agitated, yell and swear at staff. Client 74 was described as frantically running around the room and running into tables, chairs and attempted to aggress staff. The GER indicated staff attempted to "de-escalate" and "behavior plans were implemented," but Client 74 was placed in emergency manual sitting containment restraint and held there by four staff. Client 74 was later discovered to have suffered a fractured	W 196	W195, #4 Client 74 a. The US/designee for Client 74 scheduled a Special IDT Conference to discuss conditions at the time of the incident for contributing factors to the behavior exhibited and determine whether a formal program for Running Into/Throwing Self Against Objects is appropriate b. Nursing Coordinator monitors to ensure all staff have current training in Positive Behavioral Supports/emergency behavioral response.* c. The Psychologist/designee for Client 74 will schedule in-service training to level of care staff on Client 74's behavior plan with emphasis on identifying behavioral and environmental precursors including appropriate action steps. * d. A template for Facility Policy 5-05-5 Attach 1 - Guidelines For Completing Level 1 and 2 Review was developed and initiated to assist staff in identifying appropriate components of the General Event Report investigation, including identification of behavioral plan steps implemented during the event. e. Program Management for Client 74 will schedule a review of the behavioral intervention at the PRMR for appropriateness and correct implementation of the behavioral intervention.	9/09/13 9/09/13 9/09/13 9/09/13	

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W 196	Continued From page 166 rib. On 8/8/13 review of the Individual Program Plan (IPP) dated 9/6/12 indicated [REDACTED] [REDACTED] If Client 74 appeared agitated, staff should distract or prompt in a calm and playful manner to use relaxation techniques such as deep breathing. Staff should encourage Client 74 to express his needs. If Client 74 was at risk for harming himself or others, direct other clients away, request assistance from other staff and ask him to go to his room to calm down. The GER failed to document any of the approved behavior interventions above that were tried and Client 74's response to the interventions. There was no indication Client 74's written IPP active treatment program was implemented before he was placed in emergency manual sitting restraint and held there by four staff. Client 74 was discovered after the restrictive interventions were concluded to be in pain and discovered to have a fracture of the 7 th distal rib. 2. Beginning on 8/6/13 review of the GER's revealed Client 63 bit two clients, Client 72 and 76 when staff failed to consistently implement his active treatment program to ensure assigned staff maintained visual observation within 3 feet. A GER dated 7/6/13 at 8:20 p.m. revealed Client 63 left his group area unsupervised and went into Client 76's room and bit him twice of the left arm.	W 196	WI95, #5 Client 1 a. US trained DCS on Client 1's handwashing objective, with emphasis on the training method that includes utilizing soap, having her rub her hands together, rinsing and drying. b. US met with the staff who failed to complete the training or engage in the activity and provided corrective action. c. US/designee will monitor during rounds to ensure Client 1's training plan is implemented as written. Client 63 a. US provided training to DCS on Client 63's residence on FDC 1.3.1 "Mission and Values" with emphasis on staff responsibility to provide on-going activities that meet all individuals' person centered treatment plans to ensure they have opportunities to exercise greater independence. b. US provided training to DCS on Client 63's residence on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination. c. Shift Lead/designee will provide all new/float staff with orientation of residence clients to ensure client safety, continuity of care, and continuous active treatment. d. IDT met to review Client 63's Individual Program Plan for appropriateness of training and behavioral supports. e. US/designee initiated training to DCS on changes/modifications made to Client 63's plans. f. Program Management will test competency of DCS on Client 63's program plan and will provide coaching as indicated.	8/09/13 8/09/13 9/09/13 9/09/13 9/01/13 9/09/13 9/09/13 9/09/13

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W 196	<p>Continued From page 167</p> <p>A GER dated 8/25/13 at 6:56 a.m., revealed during morning rounds staff heard wrestling noises coming from the music room. When staff entered the room, staff observed Client 63 biting Client 78 on the right forearm.</p> <p>Review of the Approaches and Strategies section of the Individual Program Plan (IPP) updated 6/21/13, revealed [REDACTED]</p> <p>[REDACTED] The facility failed to assure assigned staff maintained visual observation within three feet of Client 63.</p> <p>Interview with facility staff on 8/7/13 at 11 a.m. revealed the clients behavior programs had been implemented but there was no documentation, plan details or what the clients response was and agreed it had not been documented.</p> <p>3. On 7/30/13 at 11:30 a.m., Client 105 was observed in a day room, after he returned from his day program. There were 7 other clients in the day room. Some clients in the day room were sitting and some were standing or talking with staff. The room was located next to the dining area and the group was the second group to eat. There were 1 to 2 staff members providing various activities. One direct care staff member was discussing the food pyramid; another was reading the paper informing clients about current events. Client 105 made no attempt to interact with the direct care staff or other clients. At times he stood up and walked around the day room at times he sat down. Staff was observed redirecting the client or offering assistance. After 30 minutes client 105 remained in the</p>	W 196			

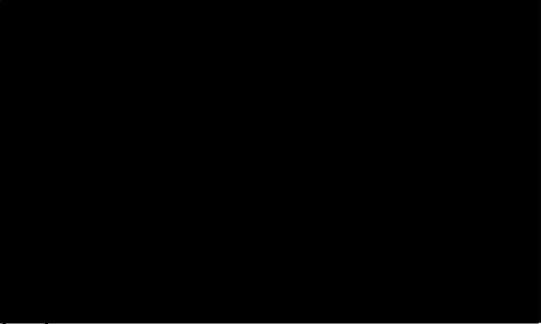
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W 196	Continued From page 188 dayroom with the other clients and continued to walk around the day room or sit down. Almost one hour later at 12:20 p.m., Client 105 was observed sitting then standing rocking back and forth making a moaning sound. One hour had passed before the client when to the dining area to eat. On 8/1/13 at 8:15 a.m., Client 105 was observed in the day room located next to the dining room. There were 5 to 8 clients in the day room and two direct care staff. One staff was standing just outside the door and one was in the room. There was no active treatment provided by either staff. An interview was conducted with a direct care staff at 8:30 a.m., she explained, that both the direct care staff assigned to the day room were floated from another residence, however she had an understanding of working the residence and had an orientation. The direct care staff was asked what her responsibilities were for being with the clients in the day room. She replied, "Safety I am to make sure no one gets hurt, that is job one".	W 196	Client 130 a. DTAC Coordinator trained DCS for Client 130 on his training objective for greeting staff with a handshake. b. DTAC Coordinator trained classroom staff on documentation guidelines/expectation for completing documentation in a timely and complete manner. c. PA/DTAC Coordinator will review documentation in the classroom during rounds to ensure quality and timeliness. d. Training was initiated for DCS on "Dignity In Care". e. "Privacy" training was provided to Client 130's DCS.	9/09/13 9/09/13 8/28/13 8/28/13 8/19/13 9/09/13	

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W 196	Continued From page 169  4. During an observation on Residence 43 on 7/30/13 at approximately 12 p.m., Client 58 was observed sitting at a table in an activity room with other clients present. Client 58 continuously picked up multiple red items resembling checkers, licked them one by one, and placed them back down on the table. Staff present did not intervene or redirect the client. On 7/31/13 at 12 p.m., Client 58 was again observed sitting at a table in the activity room with a large pile of small pictures in front of him. He was observed continually picking up the pictures and licking them, one by one, and placing them back on the table. Staff present did not redirect the client. On 8/7/13 at 4:45 p.m., Client 58 was again observed in the activity room continually picking up puzzle pieces and licking them, one by one. Two staff were present in the room. One staff was giving a client a haircut while the other staff was conversing with him (the staff member). There was no staff intervention until the surveyor brought it to the attention of the staff at which time, staff redirected the client to another area.	W 196	Client 184 a. Special Conference held to discuss Client 184's dining needs and revisions to the program plan were identified and implemented. b. New adaptive equipment  were obtained for Client 184. c. The Unit Supervisor trained Residence 431 DCS on Client 184's dining plan and adaptive equipment. d. A follow-up conference was held to discuss progress and adaptations to the new adaptive equipment to assist Client 184 with the dining process. e. The Unit Supervisor trained Residence 431 DCS on how to request additional food from the kitchen and what options are available. f. Senior Psychologist initiated "Behavior Support Positive Practices" training for LOC staff. g. Staff Development provided "Respectful Interactions" and "Dignity in Care" training to DCS on Residence 431.	8/12/13 8/23/13 8/30/13 9/09/13 9/04/13 9/03/13 9/06/13	

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W 196	Continued From page 170. 5. On 7/29/13 at 12:45 p.m., Client 130 sat down at a table to eat lunch. Shortly thereafter a dietary staff wheeled a table height cart to the clients' table from which the client removed his cup, plates and utensils with one verbal prompt. The client then ate appropriately and independently took his dishes to the service window and left the dining room. [REDACTED] the client was assessed as able to serve appropriate portions with verbal prompt. [REDACTED] [REDACTED] Staff was not observed to sit at the client's table to provide needed prompts and reminders. When the client independently brought his dishes to the service window staff was not available to prompt or provide an opportunity for the client to put scraps in trash or related tasks although his assessment noted he was able to do so with a verbal prompt.	W 196	Client 185 Client 189 is in error. Should be Client 185. a. A Work Order was submitted and key card for Client 185 was reprogrammed. b. The Program Assistant provided an updated approval list of all client key card zones to Plant Operations, Unit Supervisor, and Social Workers. c. Unit Supervisor/designee will monitor to ensure Client 185 has his key card and access per his plan. d. The Program Director/designee will monitor during rounds to ensure program plans are implemented as written and client access rights are provided.	8/06/13 8/21/13	
	6. On 7/30/13 at 8:45 a.m., Client 130 entered the bathroom on Residence 29 with staff. The client used the commode without closing the stall door or being prompted to do so by staff. Staff left and returned and still did not provide assistance to the client. The client left the bathroom without hand washing. [REDACTED]				

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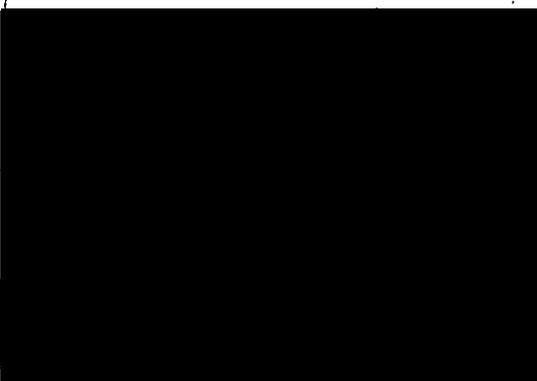
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W 196	Continued From page 171 Residence 31 7. On 7/29/13 at 6 p.m. in the day room, non-sampled Client 180 walked quickly toward and then grabbed and pulled on the blouse of the surveyor. Direct Care Staff present with two other clients was not engaged with clients or providing any activity. The staff failed to observe and intervene until requested to do so by the surveyor. A concurrent focus review of the record revealed that the client had a frequent behavior of grabbing. 8. On 7/29/13 at 7:15 p.m., non-sampled Client 193 appeared agitated and was observed biting her left wrist below the thumb. Staff was not observed to intervene. The client was not engaged with staff or in any activity. The skin of the wrist area was open with scant blood. The client was not able to answer questions verbally. The following morning, at 7:25 a.m., the client's left wrist had an open area with some scab forming. The client had numerous areas of scarring on her arms. On 8/7/13 focus review of the client's record revealed a behavior plan for biting her hands and arms. Residence 30 Client 151 9. Observations from 2:00-2:20 on 7/29/13, from 9:00-10:15 on 7/30/13 and again on 7/31/2012. Client 151 was observed sitting in front of work	W 196			

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
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W 196	Continued From page 172. table not-engaged in work or any other activity. Client 151 was observed sitting on her cross legs, rocking and slapping her face. When asked at 10:00 a.m. on 7/30/13, the instructor stated that Client 151: "does not like to work." The instructor stated that Client 151 rarely processed more than 2 pounds of paper per day. According to the Instructor, Client 151 had not even processed 1/2 pound of paper during the 9:00-10:15 surveyor observations on 7/30/2013. The vocational instructor told the surveyor Client 151: "needs a DTAC setting to work on communication skills and motor skills." The instructor went on to say that Client 151: "needs lots of prompts to keep working and rarely opens even a small amount of newspaper."  The Residence 30 psychologist was interviewed on 8/6/13 at 3:15 P.M. When asked, Client 151's psychologist stated that she was not aware of this vocational assessment and recommendations. If she had known about this 7/8/13 vocational assessment,	W 196			

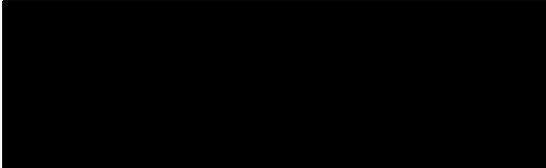
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W 196	<p>Continued From page 173</p> <p>the team would have met and the Director of DTAC would have acted on these recommendations and met Client 151's Active Treatment needs with an appropriate day program.</p> <p>Client 151 was observed on 7/29/13, 7/30/13, 7/31/13 and 8/5 over multiple times sitting with her legs under her back not engaged in any activities.</p> <p>Survey observations beginning at 12:06 p.m. on 7/29/13 and from 6:30 a.m. - 8:40 a.m. on 7/30/13 and 7:00-9:00 a.m. on 7/31/13 in the Group Room on Residence 30, written interventions required to eliminate or minimize risks for Client 151 harm to self when hitting herself were not implemented when Client 151 began to display antecedent behaviors including psychomotor agitation, pacing, and rocking before hitting herself.</p> <p>The survey observations revealed Client 151 hitting herself. Client 151 was not observed in any structured leisure activity. Staff were not engaging her in preferred activities, especially those that involved the use of her hands as stated in her 10/4/12 IPP training method.</p> <p>When asked, direct support staff were unable to tell the surveyor what Client 151's structured leisure activities were. They stated at times, before breakfast, they would offer her a ball or any object from the arts and crafts supplies in the group room.</p> <p>The Residence 30 psychologist was interviewed on 8/6/13 at 3:15 P.M. Client 151's psychologist stated that direct support staff should be giving</p>	W 196	<p>W195, #6</p> <p>Clients 48, 49 and 53</p> <p>a. The Plus Program Data Collection Sheets were updated to include all current milestones for Residence 43 clients, including client 48, 49 and 53. 9/01/13</p> <p>b. The Unit Supervisor trained DCS on the Plus Program Data Collection Sheet, the proper way to fill out the Plus Program Data Collection Sheet and the expectation for completing this task daily. 8/21/13</p> <p>c. Shift Lead/Designee will monitor daily to ensure DCS completes the Plus Program Data Collection Sheets.</p> <p>d. Plus Program Data Collection Sheets will be audited daily for accuracy and completeness. Results will be reported to Unit Supervisor/designee for follow up. 8/29/13</p> <p>e. Following Annual Conference/Specials, the Chairperson will update the Plus Program Data Collection Sheet.</p> <p>f. Unit Supervisor / Designee will monitor Plus Program Data Collection Sheets reflect current training plans.</p> <p>g. The Behavior Support Committee is developing a process for a facility-wide data collection system that provides more immediate recording of behavioral data.</p> <p>h. The Senior Psychologist will develop and provide training to DCS on accurate data collection.</p> <p>i. Psychologist will monitor behavioral data and will review the results with other IDT members during Behavioral Progress Review meeting for all clients including Clients 48, 49, and 53 and reconcile any inaccuracies.*</p> <p>j. IPCs will monitor data collection sheets during rounds on the residences and in day programs and will work in partnership with the US and CPS staff to take corrective actions as indicated.*</p>		

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W 196	Continued From page 174 her soft objects that she could manipulate and hold in her hands. The psychologist went on to recommend that Client 151 needs to be in a more quiet environment and proceeded to change her group room. Surveyor observed that Client 151 had been moved to another Group room when the surveyor arrived at 7:00 a.m. on 8/7/13.  Active Treatment was not consistently implemented for Client 151. Client 151's training plan written by the licensed psychologist was not consistently followed. On 7/30/13 at 8:40 a.m. DTAC staff were observed putting on the shoes and socks for Client 151. Client 151 Independent Life Skills Assessment signed as completed on 7/25/13 assessed as independent in: "putting on socks." Client 151 Independent Life Skills Assessment signed as completed on 7/25/13. Assessed her as requiring a verbal prompt when rinses dishes; dries dishes; dusts furniture; operates washer and operates dryer. When asked direct support staff verified that Client 151 was not given opportunities to practice these skills on a regular basis. Throughout the survey, there were no opportunities at any meals observed including breakfast, lunch and dinners to rinses dishes or	W 196			

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W.196	<p>Continued From page 175</p> <p>dries dishes. Staff, who had worked with Client 151 for both 7 and 10 years, stated that Client 151 was very capable of performing above tasks, verified that Client 151 is not offered any informal training opportunities to dust furniture. Direct support staff stated: "we need to train her."</p> <p>Record Review on 8/1/13 revealed, Client 151's 10/04/12 IPP states she has the ability to fold towels and linens and she likes to wipe and dust tables.</p> <p>A paid facility staff member was observed folding the clothing protectors in the dining room during the breakfast meal on 7/30/2013.</p> <p>When asked direct care staff who worked with and know Client 151 for 7 years and another direct care staff person that had worked with her 10 years stated that Client 151 does not dust furniture on Residence 30.</p> <p>The Individual Program Coordinator (IPC), who serves as the Qualified Intellectual Disabilities Professional for Client 151, was interviewed at 9:00 AM on 8/8/13. When asked why Client 151 was not folding the clothing protectors in the dining room, the IPC stated that Client 151 did not like to fold these cloths. The IPC had not identified choice and opportunities to practice capable skills as a training opportunity. Refer to W159, W249</p> <p>Residence 44</p> <p>10. During survey beginning on 7/29/13 review of</p>	W 196		

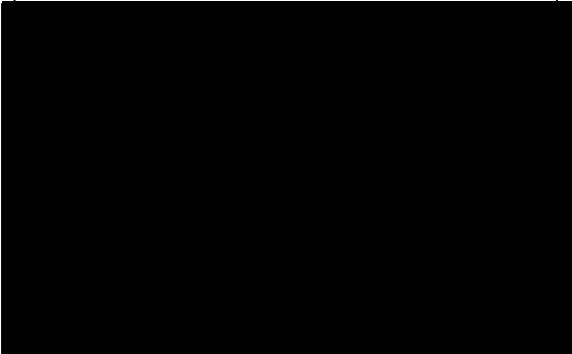
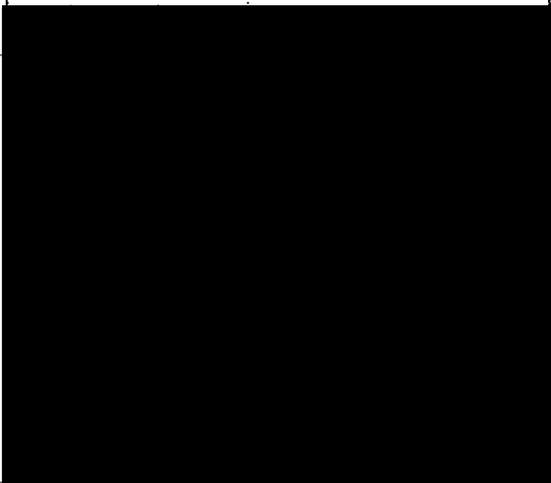
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W 196	Continued From page 176  On 8/5/13 from 5:55 p.m. until 7:40 p.m., approximately 1 3/4 hours, Client 63 was observed with a DCS who at 6:10 p.m. stated she had floated from Residence 43 to provide 1:1 care for Client 63. During this time Client 63 was observed walking very quickly down the residence hall at 5:55 p.m. The client entered the Group 2 activity room and eventually returned to the Group 1 activity room. When the client did not engage in the movie that was being watched by others in the room, no other activity was offered. The DCS did not engage the client in any activity upon returning to the Group 1 activity room. When asked about Client 63's active treatment goals, the DCS said, "I don't know," and said she was not regular staff.	W 196	Client 130 a. DTAC Coordinator trained DCS in Client 130's classroom on his training objective to greet staff with a handshake. b. DTAC Coordinator trained DCS on documentation guideline expectations for completing data collection in a timely and complete manner. c. PA/DTAC Coordinator will review documentation in the classroom during rounds to ensure implementation of training plans and completion of data collection.	9/09/13 9/09/13	
	As the evening progressed, the client sat in various chairs and reached repeatedly towards other clients and repeatedly was verbally and physically redirected not to do so. At 7:05 p.m. DCS said, "No touching." The DCS repeated a few minutes later, "No, no touching," when the behavior continued. The client was engaged in no activity as he paid no attention to the movie running and continued the behavior of reaching out towards others intermittently and looking at the staff for a response. At approximately 7:25 p.m., the same DCS said, "No" to Client 63 again. Client 63 became restless, rocking in the chair. When the medication pass nurse came to get the				

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W 196	Continued From page 177 client for his evening medications the assigned DCS said, "Maybe that calm him down."   	W 196			

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W 196 (W 224)	Continued From page 178 repeated intervention being utilized by the DCS was contrary to what was recommended in the assessments as a method of decreasing undesirable behaviors and promoting active treatment. (W 224) 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one unsampled client Client 94 had an Independent Living Skills Assessment (ILSA) that recognized his full abilities at his present level to include washing his own laundry. Findings: Residence 28	W 196 (W 224)			
	On 7/29/13 at 10:45 a.m., an interview was conducted on unit 28 with the Residence Manager. He stated that no clients currently do their own laundry however he felt that some of the clients may be able to if given the training. He added, that the facility may do some informal training on the weekends but there was no formal training On July 29, 30 and 31, 2013, during observations on Residence 28 and throughout the grounds of the facility, client 94 was observed performing activities of daily living and functioned at his work				

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{W 224}	Continued From page 179 site independently with some supervision. A second interview conducted with the Residence Manager on 8/6/13 he explained that client 94 could probably do his own laundry if he was shown. However, Client 94's mother currently did his laundry and he had not approached her with the idea. He added that they could consider the client doing half of his laundry for a start. On 8/6/13 at 1:30 p.m., an interview was conducted with unsampled Client 94. He stated he felt like he would be willing to try and do his own laundry if someone shows him how. A review of the ILSA Independent living Skills Assessment for Client 94 indicated that he is able to function independently with makes bed, picks up personal items, hangs own cloths, washes dishes, and puts away own clothing. The ILSA indicated that the client is total dependence for operating a washer/dryer.	{W 224}	W195, # 7 a. Interdisciplinary team met to discuss Client 63's money management training and developed new milestones to increase his independence in money management consistent with his current functioning level. b. Vocational Supervisor/designee will provide training to DCS on Client 63's money management milestone to ensure his plan is being integrated in all areas of his life. c. US/designee and Individual Program Coordinator will monitor during rounds to ensure Client 63's Individual Program Plan is being implemented as written.	9/09/13	
{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 observation, interview and record review, the facility failed to ensure the Day Program had timely completed an objective for one of 20 sampled clients (Client 32), in order to ensure that staff were knowledgeable about the steps necessary for the client to complete the	{W 227}			

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{W 227}	Continued From page 180 task. Findings: Residence 42 Client 32 was observed at the Goodell School classroom on 7/30/13 at 10:10 a.m. She was sitting at a table placing business cards in a box, placing a small screen over each business card, then dapping glue onto the screen. The client's one to one staff from the residence was sitting next to her. During the visit, an interview was conducted with the job coach, a licensed staff. The job coach stated that the client's objective was not completed and it would take 30 days for the teacher to complete. The teacher assigned to the class was not working that day. The job coach stated that the client was to write down the number of completed screens in each session, morning and afternoon class.	{W 227}			
	At 11:00 a.m., the one to one staff counted boxes and told the client that she had completed 100. A few minutes later, the one to one staff told the client that she had completed 160. The client then recorded that number in a log book. At no time did the one to one staff encourage the client to participate in counting the number of screens completed. During an interview with the one to one staff at 11:10 a.m., in regards to her counting for the client, she stated that she was not aware of the objective for the screens. During an interview with the client at that time, she stated that she could count to 30.				

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{W 227}	Continued From page 181 During an interview with the classroom teacher on 7/31/13 at 10:35 a.m., she stated that the client was to count how many screens that she completed and write down that number. She stated that she had 30 days to complete the objective. The teacher was not sure when the client started the screen task; however, data was collected starting 7/15/13. The teacher stated that she completed the objective and presented a copy effective 8/1/13. The objective noted that effective, 8/1/13, the client was to record the number of screens she completed with 1 to 2 verbal prompts, 10 times per month. It was noted that the client was to count the number of screens she completed and write that number in the data collection sheet. Review of the client's Independent Living Skills Assessment dated 2/2013, noted that the client understood number values and could count by rote.	{W 227}			
{W 247}	4B3.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview, and record	{W 247}			

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			<p>W196, #1 This POC includes Clients: 58, 63, 74, 76, 105, 130, 180, 193, 151.</p> <p>a. Active Treatment Coordinators have been designated on each Program and are responsible for the development and implementation of Active Treatment projects to be integrated facility-wide, with emphasis on promoting choices and independence in all environments. *</p> <p>b. Active Treatment projects will be presented to the Governing Body who will make recommendations for facility-wide implementation.</p> <p>c. PA provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" with emphasis on promoting independence and the expectations regarding staff knowledge of client training objectives, understanding of data collection components. *</p> <p>d. US/designee will monitor during rounds to ensure Active Treatment programs are initiated correctly and consistently. *</p> <p>e. The PD/designee will review General Event Reports Level I documentation for required components and appropriate emergency behavioral intervention implementation during completion of the Level II Review.</p> <p>f. QA Director/designee will monitor General Event Report Level I and II investigations for accuracy, completeness and consistency with other event information</p>	<p>9/09/13</p> <p>9/09/13</p> <p>10/10/13</p>

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			<p>g. The facility is also working closely with two consulting groups (H&W Independent Solutions and the Consortium for Innovative Practices) to identify system-wide issues at the root cause level and to partnership in the development of sustainable Active Treatment improvement plans.</p> <p>h. The IPC will monitor for progress with the current program plan and will document their findings in the monthly note, along with follow-up corrective actions taken.</p> <p>i. Follow-up/review for staff knowledge and awareness of active treatment standards will be incorporated into facility focus calendars for review at huddle/shift change meetings.</p> <p>j. A Quality Assurance Improvement Plan (QAPI) is in place related to Environmental Health and the results of this report, along with improvement plans, are presented at regular intervals to the Governing Body for follow-up action as indicated.</p> <p>k. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure implementation of program plan as written, safe environment and environmental sanitation. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed</p> <p>l. The PD provided training to Shift Leads on Environmental Guidelines initiated. *</p>		

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{W 247}	<p>Continued From page 182</p> <p>review, the facility failed to include opportunities for client choice and self-management: for a clients with clothing that was ill-fitting and in disrepair (Clients 42 and 151); for clients who were not allowed choice in food items (Clients 64 and 82. In addition, 23 clients residing on Residence 43 also had the potential to be affected); for a client who was not allowed to choose a preferred activity (Client 184); and for clients residing on Residences 29 and 31 who were not allowed the opportunity for self-expression (this had the potential to affect 53 clients); for a client who was not provided the opportunity to practice self-care and housekeeping skills (Client 151); for clients who were not allowed to leave the group room (Clients 151 and 162); and for a client who was not provided the opportunity to eat in a regular dining chair (Client 162.)</p> <p>Findings:</p> <p>1. During an observation on Residence 43 on 8/8/13 at 9:12 a.m. Client 42 was observed ambulating in the hallway wearing ill-fitting black pants. The pants were falling down from his hip area as he ambulated and his upper buttock area was exposed. Staff present stated that he would get Client 42 a belt.</p> <p>2. During an observation of the breakfast meal on Residence 43 on 7/30/13 at 8:20 a.m., level of care staff asked the FST (Food Service Technician) for additional eggs for the clients' breakfast. The surveyor overheard the FST inform the level of care staff that there were no more eggs. The surveyor then spoke to the FST to inquire further.</p> <p>During an interview with the FST on 7/30/13 at</p>	{W 247}	<p>W196, #1</p> <p>a. The US/designee for Client 74 scheduled a Special IDT Conference to discuss conditions at the time of the incident for contributing factors to the behavior exhibited and determine whether a formal program for Running Into/Throwing Self Against Objects is appropriate.* 9/09/13</p> <p>b. Nursing Coordinator monitors to ensure all staff have current training in Positive Behavioral Supports/emergency behavioral response.*9/09/13</p> <p>c. The Psychologist/designee for Client 74 will schedule in-service training to level of care staff on Client 74's behavior plan with emphasis on identifying behavioral and environmental precursors including appropriate action steps. *9/09/13</p> <p>d. A template for Facility Policy 5-05-5 Attach I - Guidelines For Completing Level 1 and 2 Review was developed and initiated to assist staff in identifying appropriate components of the General Event Report investigation, including identification of behavioral plan steps implemented during the event. *9/09/13</p> <p>e. Program Management for Client 74 will schedule a review of the behavioral intervention at the PRMR for appropriateness and correct implementation of the behavioral intervention.* 9/09/13</p>		

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{W 247}	<p>Continued From page 183</p> <p>8:30 a.m., the FST stated that there were enough eggs for a serving plus a little extra but if someone took too much, they ran out. She further stated that, "They love eggs."</p> <p>The FST then told the surveyor that she would check for more eggs in the Residence 44 kitchen, which adjoined the Residence 43 kitchen.</p> <p>Shortly after, two additional containers of eggs were provided and were brought out to the dining room for the clients' meal.</p> <p>Residence 44</p> <p>3. On 7/29/13 at 12:15 p.m., Client 64 was seated at a dining room table eating. Client 64 asked the registered dietician (RD) for cottage cheese to which the RD replied, "I have to have a reason to give you more. Tomorrow." Client 64 then asked, "If I lose weight I can have cottage cheese?" The RD replied, "August 1st they are going to weigh everybody. Then we see, O.K.?" The RD then stated to the surveyor that she had difficulty getting clients to not over eat. The dietician did not support the client in attempting to make a healthy food choice by discussing with the client how this food choice could be incorporated into his diet through food substitution nor did the RD discuss a low sodium cottage cheese option as a healthy choice for the client.</p> <p>Review of a "Client Face Sheet," and "Monthly Orders" for 8/13 showed that Client 64 was on a 2000 - 2500 calorie "house diet," with no added salt and low sodium foods such as fruits and vegetables were to be encouraged. [REDACTED]</p>	{W 247}			

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{W 247}	Continued From page 184 [REDACTED] On 8/8/13 review of the annual IPP (Individualized Program Plan/assessment tool) dated 1/8/13 [REDACTED] [REDACTED] During an interview on 8/9/13 at 11:45 a.m., the RD stated that cottage cheese was a food that would be recommended for a diet. The RD stated that if someone was on a low sodium diet, there was low sodium cottage cheese available. Residence 44	{W 247}			

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{W 247}	<p>Continued From page 186</p> <p>4. On 7/29/13 at 12:15 p.m., in the dining room, Client 82 ate lunch at a table with a direct care staff (DCS) seated directly across and a registered dietician (RD) standing to his left. Client 82 stated he wanted more fish. The RD responded that the client should eat carrots and Client 82 said, "I don't like carrots," to which the RD replied, "That's what you need." The RD walked over to a food cart in the middle of the room and dished out some fish nuggets, rice, and carrots which were given to Client 82. An equivalent substitute for carrots was not offered to the client as an alternative. The DCS seated at the table never said a word regarding Client 82's statement about not liking carrots and did not suggest an alternative vegetable be offered.</p> <div style="background-color: black; width: 100%; height: 100px; margin: 10px 0;"></div> <p>Residence 31</p> <p>5. On 8/6/13 at 4:30 p.m. Client 184 while in the backyard, threw a cup, pounded on the aluminum table, dropped to the ground, then pulled down one of the metal polls of a canopy, while staff continually told him no in response without providing any activities or engagement.</p> <p>During a concurrent interview Licensed Staff was asked if there were activities he enjoyed. The staff described certain types of objects that the</p>	{W 247}	<p>W196, #2</p> <p>a. IDT met to review Client 63's Individual Program Plan for appropriateness of training and behavioral supports.</p> <p>b. US/designee initiated training to DCS on changes/modifications made to Client 63's plans.</p> <p>c. Program Management will test competency of DCS on Client 63's program plan and will provide coaching as indicated.</p> <p>d. US provided training to all DCS, including DCS on Client 63's residence, on FDC 1.3.1 "Mission and Values," with emphasis on staff responsibility to provide on-going activities that meet all individuals' person centered treatment plans, and to ensure clients have opportunities to exercise greater independence.</p> <p>e. US provided training to all DCS including DCS on Client 63's residence on FDC 1.3.2 "Principles and Practices," with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination.</p> <p>f. Shift Leads/designees will provide float/new staff with orientation of clients assigned to their care to ensure continuity of care, client safety, and implementation of continuous active treatment services.</p>	<p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p>

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{W}247	<p>Continued From page 186</p> <p>client preferred. Staff failed to initiate providing such activities until further questioned by the surveyor.</p> <p>Residences 29 and 31</p> <p>6. Random observations of clients' personal space; bedrooms on these residences, revealed that the majority of the client's bedrooms failed to contain any personal decorative possessions, nor displayed anything of their individuality, preferences, or experiences.</p> <p>Bedrooms mostly shared with one to three other individuals could not be distinguished one from the other except for an individual's name on his/her wardrobe closet. There were no photos, bedspreads, evidence of interests that reflected the identity of an individual's personal space.</p> <p>During interviews on 8/1/13 and 8/7/13, individual Program Coordinators on both residences acknowledged that the team could assist clients in making choices of personal items reflective of each individual's unique interests and likes.</p>	{W}247		
	<p>Residence 30 Client 151</p> <p>7. Client 151 Independent Life Skills Assessment signed as completed on 7/25/13 assessed as independent in: "putting on socks." DTAC staff was observed putting on Client 15's socks in the Group Room at 8:40 a.m. on 7/30/13.</p> <p>Client 151 Independent Life Skills Assessment signed as completed on 7/25/13 Assessed her as requiring a verbal prompt when</p>			

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{W 247}	<p>Continued From page 187</p> <p>rinses dishes; dries dishes; dusts furniture; operates washer and operates dryer. When asked direct support staff verified that Client 151 was not given opportunities to practice these skills on a regular basis.</p> <p>Throughout the survey, there were no opportunities at any meals observed including breakfast, lunch and dinners to rinses dishes or dries dishes. Staff, who had worked with Client 151 for both 7 and 10 years, stated that Client 151 was very capable of performing above tasks, verified that Client 151 is not offered any informal training opportunities to dust furniture. Direct support staff stated: "we need to train her."</p> <p>Client 151</p> <p>8. On 7/30/13 at 7:15 a.m, DTAC staff stated that the torn leather shoe observed on Client 151 was unacceptable. The DTAC staff person stated that she went to the Fashion Center and obtained a pair of white Velcro shoes size 5 and put these shoes on Client 151. Client 151 surveyor observations revealed Client 151 putting on and taking off her own shoes independently. When asked, staff stated that she helped Client 151 and put on Client 151's shoes because the shoes were new. Staff stated that she obtained Velcro shoes because Client 151 could not tie her own shoes. Client 151 was not given an opportunity to go shopping and choose her own shoes (Refer to W136 Client 151 had not been taken to the community shopping)</p> <p>Client 162 and 151</p> <p>9. Based on observations from 6:30 - 7:30 on 7/30/13 and 7/08 - 7:30 on 7/31/13 and interview, sample Client 162 and 151 had no opportunity for</p>	{W 247}		

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{W 247}	Continued From page 188 choice and were mandated to stay in the Group Room before going to the dining room to eat breakfast. Staff were overheard saying to the individuals: "You have to wait in this room;" "Would you please stay here?" "Have a seat here and wait" When Client 151 left the Group Room was specifically told by direct care staff: "Would you go in there and wait please?" "Go in and wait; Sit down, you just have to wait; Sit down, we're going to breakfast in a minute" "Would you please stay here and watch TV?" Record review of the 7/3/13 update to Client 151's annual psychological evaluation of 9/19/12, the licensed clinical psychologist listed the following management strategy: "Allow the client to move to a quiet area if the environment is uncomfortably loud." When asked staff stated that this group of 10 women had to wait in this Group Room "for their own safety."	{W 247}	W196, #3 Client 105 a. US/designee trained DCS on Client 105's IPP, with a focus on his likes, dislikes, needs and modes of communication. b. US/designee will monitor during rounds to ensure that a variety of preferred leisure supplies are available to Client 105 during structured and unstructured activity times. c. Shift Lead/designee will monitor during rounds to ensure that DCS have ample and a variety supplies available in the assigned living room to ensure quality active treatment activities are implemented. d. Shift Lead/designee will provide float/new staff with orientation of clients assigned to their care to ensure continuity of care, client safety, and implementation of continuous active treatment services. e. The PA provided training to DCS on Policy 5.1.2 "Continuous Active Treatment" on providing quality interaction and intervention.*	9/09/13 10/10/13	
	Client 162 10. At 5:30 pm on 7/29/13 Client 162 was observed being transported to the dining room via the Residence 30 wheelchair. From 5:40-6:00 pm Client 162 was observed eating her entire evening meal while sitting in this wheelchair. Client 162 was not given a choice to sit in a regular chair and eat her evening meal. Throughout the survey all breakfast and lunch meals observed, Client 162 sat in a regular chair at the dining table and ate her meals. Record review revealed Client 162's most				

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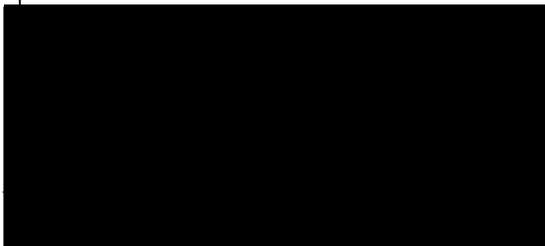
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{W 247}	Continued From page 189 current IPP dated 8/16/12 read: "Client 162 ambulates independently. Client 162 utilizes a wheelchair when trans locating to work, on campus, and in the community due to an unsteady gait."	{W 247}		
{W 249}	<p>Refer to W488 483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement the Plan of Correction to ensure clients received consistently implemented services designed to teach skills leading to greater independence as identified by comprehensive functional assessment data. (Clients 189, 63, 64, 79, 130, 184, and 1.)</p> <p>Findings: 1. As observed on 5/7/13, and 5/8/13, Client 189 had a key card for access to doors on Residence 31, for which the client had a signed consent, interdisciplinary team (IDT) approval, and Human Rights Committee (HRC) approval. However, the key card had never been activated and did not open the doors on the residence.</p>	{W 249}		

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{W 249}	<p>Continued From page 190</p> <p>The facility's plan of correction related to this situation was to hold a special IDT meeting to discuss the client's access program, to submit the program to the HRC for approval, and to activate the client's key card. Documentation indicated Client 189 was to have access by key card from 9:00 a.m. to 4:30 p.m. every day.</p> <p>During an interview on 8/7/13 at 11:00 a.m., administrative staff provided documentation that Client 189's key card had been activated to allow access to residence doors only Monday through Friday, although his plan indicated he was to have access daily. She was unable to explain why the client was denied access to the locked doors on the weekends.</p> <p>Residence 44</p>  <p>Beginning on 7/29/13, review of client activity information showed that prior to a day program, in the mornings, Client 63 typically was scheduled from 6:45 a.m. to 7:30 a.m. to get dressed and go to the group activity room where various topics related to daily living were to be discussed prior to breakfast which was around 8 a.m. Around 9:15 a.m. - 11:45 a.m. and 1:15 p.m. - 3:45 p.m. the client attended a day program.</p>	{W 249}		

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{W 249}	<p>Continued From page 191</p> <p>On 7/29/13 at 5:45 p.m., in the Group 1 activity room, Client 63 sat at a table rocking and flapping his hands, placed a small black circular object in his mouth without direct care staff (DCS) intervention and stared. Monopoly was being played by some clients, led by a staff. Client 63's only activity besides a puzzle was when DCS placed a spinning wheel in front of the client once and asked him to spin the wheel and pick a letter.</p> <p>On 7/29/13 at 6:05 p.m., in the dining room, Client 63 was observed communicating using single words, short phrases and gestures. During dinner, Client 63 ambulated without use of assistive devices or staff assistance and the client ate with verbal prompts.</p> <p>On the morning of 7/30/13 at 6:40 a.m. there was a lot of noise and commotion as clients were directed or independently congregated in one of two group activity rooms. A phone in the nurses' station rang twice in five minutes and sent a loud, jarring noise down the hallway.</p> <p>Five minutes later, at 6:45 a.m. on 7/30/13, Client 63 walked into the Group 2 activity room. A direct care staff (DCS) asked what he had done the evening before to which Client 63 responded, "bicycle with (Staff)." A DCS prompted him to go to his own group room. He stood up, began smacking his hands together, and eventually returned with an escort to the Group 1 activity room where he sat in a corner chair.</p> <p>This group activity room was a noisy, small, crowded room with multiple upholstered chairs, large and small tables and seven to eight clients seated or wandering into the room. Client 63 pieced a puzzle together while one staff stood at</p>	{W 249}	<p>W196, #4 Client 58</p> <p>a. A Special conference was held for Client 58 and a training plan was developed to address licking non-nutritional substances.</p> <p>b. DCS received training on the training plan for decreasing licking non-nutritional substances.</p> <p>c. US trained DCS on Client 58's residence on environmental sanitation, with emphasis in cleaning active treatment items and preventing cross contamination.</p> <p>d. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p>	8/26/13 8/27/13 8/21/13 8/16/13	

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{W 249}	<p>Continued From page 192</p> <p>the blackboard and said, "What are your goals today?" Client 63 made no eye contact and did not engage in the discussion, repeated words others said, and repeatedly reached across the table towards another client with both hands and arms outstretched, at which point a staff, more than once, advised him not to touch. The discussion segued into sports with no engagement from Client 63 who reached out and touched a client who had just entered the room and who immediately struck back, missing, and said "Stop!!!" Staff again, physically and verbally redirected Client 63 to stop the behavior. Staff did not engage Client 63 in any constructive one-to-one teaching while waiting to leave for the day program, did not provide a calm, quiet environment, nor did staff engage the client in any physical outdoor activities.</p> <p>On the morning of 7/31/13 at 9:17 a.m., in Group 1 activity room, a client was observed being restrained in a leather wrist-to-waist restraint and helmet. This distraction disrupted any planned activity as staff focused on managing that client's behavior and other clients became agitated and looked on. Client 63, who was seated, was visibly agitated, reaching out and not engaged in the puzzle in front of him. At 9:20 a.m., a direct care staff stated there were over thirteen clients in the room.</p> <p>On 8/5/13 from 5:55 p.m. until 7:40 p.m., approximately 1 3/4 hours, Client 63 was observed with a DCS who at 6:10 p.m. stated she had floated from Residence 43 to provide 1:1 for Client 63. During this time Client 63 was observed walking very quickly down the residence hall at 5:55 p.m. The client entered the Group 2 activity room and eventually returned to</p>	{W 249}			

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
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{W 249}	<p>Continued From page 193</p> <p>The Group 1 activity room. No active treatment was observed. When asked about Client 63's active treatment goals, the DCS said, "I don't know," and said she was not regular staff.</p> <p>As the evening progressed, the client sat in a chair and reached repeatedly towards other clients and repeatedly was verbally and physically redirected not to do so. At 7:05 p.m. DCS said repeatedly, "No ...No touching." The client was engaged in no activity as he paid no attention to the movie which was on and eventually, around 7:25 p.m. became restless, rocking in the chair. When the medication pass nurse came to get the client for his evening medications the assigned DCS said, "Maybe that calm him down."</p> <p>A DCS, on 8/5/13 at 6:45 p.m. commented that Client 63 did not sleep well at night.</p> <p>On 8/6/13 at 6:00 a.m., a direct care staff (DCS) stated the nurses' station phone bell could be turned down at night and stated it was the responsibility of the night shift but this was not an assigned task. The DCS stated some clients did not sleep well and the bell to the phone was "very loud and wakes up people." The DCS rolled her eyes and started laughing when asked if she had seen it wake up clients and said, "I wouldn't like that in my home."</p> <p>On 8/6/13 at 6:20 a.m., the hallways were dark, no clients were in the halls, it was quiet until the phone rang making a loud noise down the hallway. At 7:05 a.m. and 7:20 a.m. the phone rang again, first making a loud ringing noise five times, and then three times.</p> <p>On 8/6/13 from 7:05 a.m. to 8:35 a.m., Client 63</p>	{W 249}			

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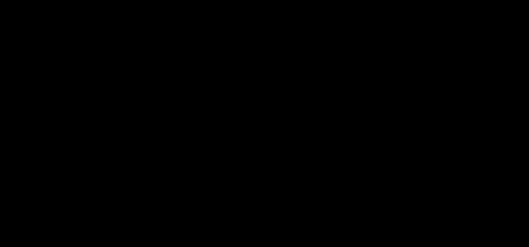
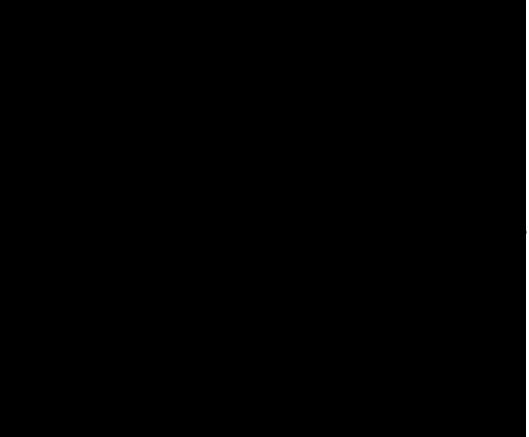
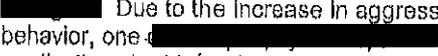
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
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{W 249}	Continued From page 194 engaged in the behavior of reaching his hands towards others and staff said, "No, no, no (Client 63.) Client 63 went to the group room and started a puzzle. One upset client was seated on a couch crying, talking angrily saying, "F--- Y--- ...". Since the client received no attention from staff, this continued for 20 minutes until a staff intervened. A DCS was discussing use of money, empathy and charity. When asked to respond to a question related to the topics, Client 63 said, "Four o'clock in the back yard ...four o'clock bicycle ...four o'clock basketball," to which a DCS responded, "O.K. We're talking about charity (Client 63)." The group lesson continued. Client 63 continued the puzzle and again did not answer the DCS's question, this time about money. When asked, "What do you think (Client 63)?" he replied, "Backyard." No one-to-one teaching occurred; the unique needs of this client were not accommodated in this group activity. An alternative activity was not offered and no effort was made to take the client outside to ride a bicycle or play basketball, which the client continued to talk about.	{W 249}	W196, #5-6 Client 130 a. A Special conference was held for Client 130 and the IDT developed training to encourage independence in the dining room by serving himself during meals. b. DCS on Client 130's residence received training on new dining plan. c. Training was initiated for DCS on 429 on "Dignity In Care". d. US/designee will monitor to ensure opportunities for independence are being promoted during mealtime and that Client 130's training plan is implemented. e. DCS for Client 130 received training related to toileting privacy including prompts to close the stall door. f. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*	8/20/13 8/21/13 8/28/13 9/09/13 8/16/13

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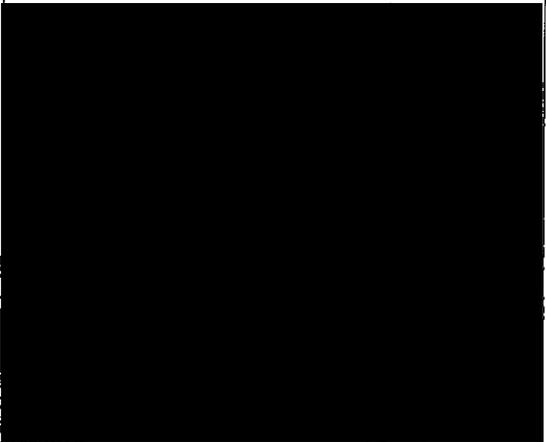
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
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{W 249}	Continued From page 195    Due to the increase in aggressive behavior, one  medications had been increased. Various forms of interventions/restraints were being used including physical escort, use of a helmet to prevent biting, a wrist-to-waist restraint, and a	{W 249}			

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{W 249}	<p>Continued From page 196</p> <p>5-point restraint/mobile chair restraint which secured each limb as well as the waist to the mobile chair or table.</p>   <p>On 8/6/13 at approximately 11 a.m., the IPC, stated the IPCs had not receive the recent facility training in care of clients with autism and stated</p>	{W 249}		

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{W 249}	<p>Continued From page 197</p> <p>his knowledge stemmed from prior employment. The IPC stated he was not sure about Client 63's behavior of reaching out, said if staff did not know the client and did not allow him time to repeat his ritualistic behaviors the client would escalate. The IPC also stated [REDACTED] medications recently were increased due to an increase in undesirable behaviors.</p> <p>Review on 8/6/13 of the "Online Continuing Education" article dated 6/5/13, training material used by the facility to teach the facility psychologists how to meet the needs of autistic clients, presented multiple training approaches: "Some people with autism ...tend to be physically aggressive at times, making social relationships ...difficult. Some lose control, particularly when they're in a strange or overwhelming environment, or when angry and frustrated." It went on to describe sensory symptoms noting that, "Apparently, as a result of a brain malfunction, many ...with autism are highly attuned or even painfully sensitive to certain sounds ..." and can find noise to be "painful." The article showed that "Programs employing a developmental approach provide consistency and structure along with appropriate levels of stimulation." Some approaches cited focused on developing skills and replacing dysfunctional behaviors with more appropriate ones. Others recommended creating a stimulating learning environment tailored to the unique needs of the person. The article read, "Treatment programs that build on the (person's) interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the (person's) attention in highly structured activities and provide regular reinforcement of behavior, seem to produce the greatest gains." These included</p>	{W 249}		

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{W 249}	<p>Continued From page 198</p> <p>providing an environment that built on the person's skills and interests while accommodating their special needs.</p> <p>On 8/7/13 at 3:45 p.m. the Unit Supervisor (US) stated there were autistic clients on Residence 44. The US stated she believed that the IPC's had been to the recent autism training and stated that to accommodate the needs of autistic clients the facility might change wall colors, lighting, provide structured activities and only when suggested did she agreed that a calm environment and consistent staff were a good ideas. She said, "...sensory is very important."</p> <p>3. On 7/29/13 at 12:15 p.m., Client 64 was seated at a dining room table eating across from a direct care staff (DCS). Client 64 asked the registered dietician (RD), who stood next to the client, for cottage cheese to which the RD replied, "I have to have a reason to give you more. Tomorrow." Client 64 then asked, "If I lose weight I can have cottage cheese?" The RD replied, "August 1st they are going to weigh everybody. Then we see, O.K.?" The dietician did not take this teaching opportunity to discuss with Client 64 how his desire for cottage cheese could be incorporated into his prescribed diet through food substitution to not exceed caloric needs and meet his dietary restrictions nor did she discuss low sodium cottage cheese versus regular cottage cheese as an option with the client. The DCS seated at the table also did not take this opportunity to teach Client 64 about the client's diet. Away from the table, the RD stated to the surveyor that she had difficulty getting clients to not over eat.</p> <p>Review of a "Client Face Sheet," and "Monthly</p>	{W 249}	<p>W196, #7 Client 180</p> <p>a. A Special Conference was scheduled for Client 180 to review the behavior of touching/grabbing other people's clothing and a new training plan was initiated for appropriate greeting/communication.</p> <p>b. US/designee provided training to DCS on Client 180's new training plan.</p> <p>c. US/designee will monitor during rounds to ensure that training is being implemented as written.</p> <p>d. USs/Designees provided training to all DCS on Policy 5.1.1 "Standards of Care" with emphasis on supervision and assisting clients in socially acceptable behaviors leading to independence.*</p>	<p>9/9/13</p> <p>9/9/13</p>

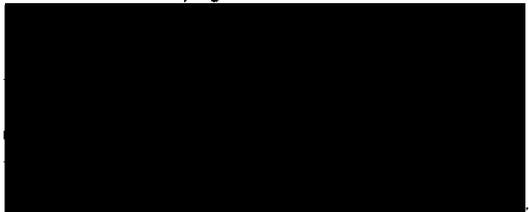
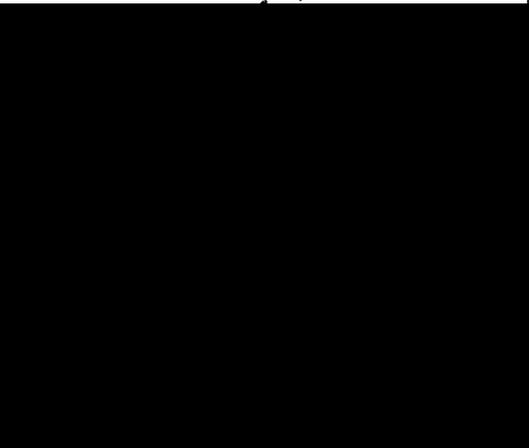
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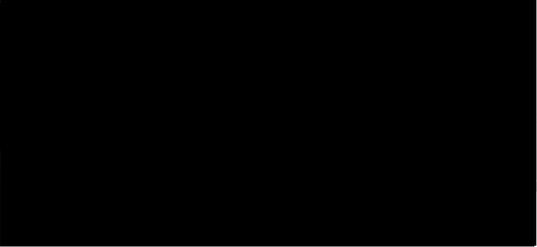
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{W 249}	Continued From page 199.   	{W 249}		
	During an interview on 8/9/13 at 11:45 a.m., the RD stated that cottage cheese was a food that			

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(W 249)	Continued From page 200 would be recommended for a diet. Additionally, the RD stated that if someone was on a low sodium diet, there was low sodium cottage cheese available.  On 7/29/13 at 10:20 a.m., Client 79 was observed in the day program school, Room 13, sorting paper. At 10:23 a.m. the Client stopped. Day Program Staff asked Client 79, "You want to do more?" Client 79 declined and went to sit on a couch where the client engaged in no meaningful activity. Client 79 sat and watched others work. Over 20 minutes later, at 10:45 a.m. Client 79 was still sitting doing no activity. Staff did not approach Client 79 on the couch during those twenty minutes and focused on other clients. Client 79 did not return to any activity until 10:50 a.m. On 7/30/13 at 9:50 a.m., at the day program, Client 79 stopped sorting papers, walked to an area of the room with a couch and chairs, weighed some papers and stated "Four pounds," then sat down and put on headphones to listen to music. At 10:05 a.m. the client's head slumped to the table top between his crossed arms. Day program staff prompted the client to "wake up." After approximately one minute the client's head slumped into his arms again. When asked about the client's lack of engagement, the staff had no	(W 249)	Client 193 #8 a. US trained Residence 431 DCS on Client 193's behavior plan related to biting her hands and arms, with emphasis on intervention, documentation, and nursing care as indicated when the behavior occurs. * 9/06/13 b. DCS training has been developed and completed on the following topics:* o FDC Policy 5.1 Clinical Standards of Care (Skin Integrity) o FDC 5.4.2 Change of Condition o FDC 5.5.5 General Event Reporting (reporting/documenting Minor Unknown Injuries) o NP 11.01 Temporary Conditions o NP 11.02 Client Injury Assessment and Intervention o Problem/Temporary Condition/Temporary Support Plan Log. o Physical Observation and Documentation Checklist o Behavior Support Positive Practices o FDC 5.3.1, 5.3.2, 5.3.3 Behavior Principles and Techniques and Interventions c. US will monitor to ensure DCS received the above training. d. PD/PA/US/IPC/HSS will review and discuss changes in clients' conditions at Management Debrief Meetings.* e. PD/PA will review 24 hour report and NOD Report daily for changes in client condition to ensure that physical and behavioral concerns are adequately addressed and documented.* f. US/designee will monitor during daily rounds to ensure DCS are assessing clients in their care for injury during naturally occurring times throughout the day.* g. A QAPI log was established to monitor adherence to assessment and documentation protocols. CNS presents findings to AE Committee for follow up action plans.*8/01/13		

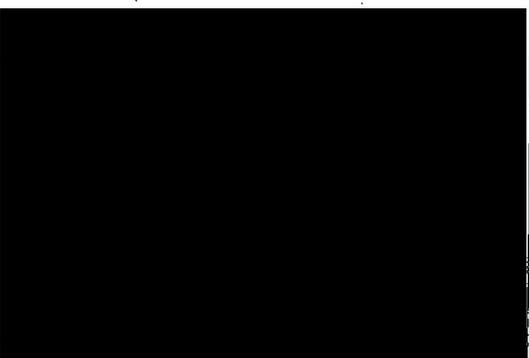
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(W 249)	<p>Continued From page 201 reason for the client 's behavior and stated, "I'm not here all the time."</p> <p>On 7/30/13 at 10:25 a.m., Day Program Staff stated that Client 79 had a short attention span, and thought the client could do something more challenging. The staff stated that Client 79 did something for five minutes and then lost concentration, "so we just let him do what he wants to." There was no explanation how having Client 79 sit for extended periods of time functioned to supported the client towards Independence.</p> <p>On 8/5/13 at 10:35 a.m. a day program staff asked Client 79 how many pounds the client measured had been batched and when asked, Client 79 stated he had written down the amount. From 10:45 a.m. until 11:15 a.m. Client 79 sat on a couch engaged in no activity other than watching others work.</p>  <p>Residence 29</p> <p>5. On 7/30/13 at 9:30 a.m., Client 130 entered the</p>	(W 249)		
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