

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W189 #3 cont.				
	d)The Shift Supervisor is responsible for reviewing the information on the document with any new staff or floating staff for the clients in their care each time the staff member floats to the residence.			9/25/13	
	e)The Shift Supervisor will provide any additional focused training throughout the shift and document via the Shift Supervisor Rounds sheets.			10/26/13	
	f)The Residence Manager will ensure a New Staff and Float Orientation sheet is completed for each new or float staff by reviewing the documents weekly.			10/26/13	
	g)Program management will complete a random check of the Orientation sheet when a float staff is working during routine management rounds at least monthly.			10/26/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 189	Continued From page 135 overtime and said, "I don't know the medical." 4. During an observation on 9/17/13 at 6:35 AM in group room 3 of Residence 29, six clients were observed with one staff. Five clients were noted sitting on the couch, including focus sample Client 2 who was rocking and yelling, focus sample Client 26 who was sitting in the corner screaming, and core sampled Client 64 was observed wearing white underwear only while pacing and jumping inside the group room with his index fingers in his ears. During an interview with the Psychiatric Technician (PT) of the night shift on the same day at 6:40 AM, she stated that she worked in the unit since 5/2012. She also stated that she's pretty familiar with the clients in the residence, although she didn't know the intervention on each one of them. When she was asked why core sampled Client 64 had his fingers in his ears, she stated, "I don't know why he does that." When she was asked if there was any training objective for it, she answered, "No, I don't know." When asked why core sampled Client 64 was only wearing his underwear, she replied, "Probably [focus sampled Client 43's name] took it off, he likes straightening things." 5. During an observation of the medication pass on 9/17/13 at 11 AM in Residence 29, a licensed staff was observed spoon feeding the medications to three focus sampled clients (2, 4, and 16.). During an interview with the licensed staff on the same day at 11:25 AM, he stated that he gives	W 189	W189 #4 a. The residence Psychologist provided training to all staff on duty on Client 2, 26, 73 and 64's Behavior Support plan and Approaches and Strategies. b. Residence Manager, IPC and Shift Supervisors will monitor and provide training to staff as needed. c. Shift Supervisors will ensure and provide support and coaching to staff during their daily rounds and document any barriers on their rounds sheet. d. The Residence Manager and Shift Supervisors provided staff training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation. e. IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted. (please see continuation page 136a) W189 #5 a. The Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation. b. The Residence Manager and Shift Supervisor will review and provide training to all staff on duty related to Self Administration of Medications.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W189 #4 cont.				
	f. The IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified during observations and record review, the IPC will elevate issues to the RM and Program Management for follow-up and document at least quarterly in the IPC note			10/25/13	
	h. The Rehabilitation Therapist will provide residential support in the living rooms focused on recreation and leisure activities.			10/25/13	
	i. Program Management to randomly monitor during monthly rounds and document on the 24 hour report.			10/25/13	
	j. Any identified action items found on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed at the monthly Risk Management Meeting.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 189	<p>Continued From page 136</p> <p>the medication to clients with pudding using a spoon. When asked if clients had trainings on self administration of medication, he stated, "None of them has medication management, not that I know of."</p> <p>The medical record for focus sampled Clients 2, 4, and 16 was reviewed on 9/20/13 at 9:50 AM. The Individual Program Plan (IPP) Narratives of the clients were reviewed in particular. The review indicated that all three clients had self-administration of medication formulated in the plan for continuous active treatment. The plan indicated that each client will respond to his name when called and approach the medication cart. Focus sampled client two required assistance in holding the cup in one hand and scooping the medication. Focus sampled Client 4 could hold the spoon scoop the medication. Focus sampled Client 16 was able to hold the liquid cup.</p> <div style="background-color: black; width: 100%; height: 40px; margin: 10px 0;"></div> <p>During an interview with the Individual Program Coordinator (IPC) on 9/24/13 at 3:30 PM, she stated that all three clients had trainings in self-administration of medications. She also acknowledged that she had observed the practice in the past and would bring it to the attention of the Supervising Psychiatric Technician or Residence Manager.</p> <p>6. During an observation on 9/24/13 at 9:15 AM in Residence 29, it was noted that clients were inside group room 1 and 3 with staff. The</p>	W 189	<p>W189 #5 cont.</p> <p>d. Shift Supervisors will randomly monitor medication passes to make sure staff are implementing Self Administration of Medication training to all clients, and especially identified Clients, 2, 4 and 16.</p> <p>e. The Residence Manager will monitor randomly during Medication Pass by Clinic Staff and document on the Residence Manager Rounds Sheet.</p> <p>f. The IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified during observations and record review, the IPC will elevate issues to the RM and Program Management for follow-up and document at least quarterly in the IPC note</p> <p>g. The Interdisciplinary Team evaluate each client's training plan and any identified issues as needed.</p> <p>h. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>i. Any identified action items from the Shift Supervisor and Residence Manager Report Sheets will be addressed during the monthly Risk Management Meetings.</p>	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769	
(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 189	<p>Continued From page 137</p> <p>surveyor was in the impression that clients were waiting to be escorted to Pine Vocational Center for their scheduled vocational training.</p> <p>During an interview with the Teachers Assistant (TA) on 9/24/13 at 9:40 AM in classroom 3 of Pine Vocational Center, he stated that he was waiting for clients from Residence 29 to arrive. Both classrooms (2 and 3) were observed empty, with the exception of the TA and focus sampled Client 43.</p> <p>During an interview with the Senior Psychiatric Technician (SPT) on 9/24/13 at 9:50 AM in Residence 29, she stated that the vocational training will be held in the residence. When she was asked, "Why?", she replied that their short staffed because one of the staffs had to leave due to an emergency. She also stated that a float staff from Residence 30 was in the residence to assist. When she was asked if the float was given any orientation in the residence, she replied, "Yes." According to the SPT, the staff float was given orientation to the location of areas, protocol for pica (ingestion of non-nutritive substances), building sweep, clients' and unit's routine, day treatment activities, assignments, staff and group leader introduction, and group introduction. After the orientation, the float staff will be brought to the nurses' station to sign the orientation log, acknowledging that the orientation was provided.</p> <p>Residence 29's Communication Log was reviewed on 9/24/13 at 10:20 AM. The log indicated that one staff was exchanged to Residence 15 and another staff went home. The log also indicated that on 9/24/13, Residence 29 acquired one staff (Psychiatric Technician</p>	W 189	<p>W189 #6</p> <p>a. Shift Supervisors will provide orientation staff as they float to 29 and document the training in the Orientation Float Book.</p> <p>b. The Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation throughout all of the Intermediate Care Facility.</p> <p>c. The Shift Supervisor will monitor the staff floating to 229 to evaluate competency and document all any findings on the Shift Supervisor Rounds Sheet.</p> <p>d. Residence Manager will monitor the Orientation folder randomly and provide training provide to the Shift Supervisors as warranted.</p> <p>e. The Residence Manager will monitor the Shift Supervisor Rounds Sheet and ensure any items are resolved immediately.</p> <p>f. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>g. Any identified action items from the Shift Supervisor and Residence Manager Rounds Sheet will be addressed in the monthly Risk Management Meeting.</p>	<p>09/27/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 189	<p>Continued From page 138 (PT)/staff float) from Residence 30 to assist in the residence.</p> <p>During an interview with the PT/staff float on 9/24/13 at 11 AM, he stated that he found out he was floating to Residence 29 when he came in that morning. He also stated that he previously worked once in the residence for overtime in the afternoon shift. When he was asked if he was familiar with the clients in Residence 29, he replied, "I'm not really familiar with the clients." When he was asked if he was provided orientation in the residence regarding client's behaviors and interventions, he stated that there was no formal orientation provided to him. When asked if he attended the huddle and how would he know his duties, he stated, "I didn't attend the huddle." He further stated that residence's SPT told him his duties. When asked, how he would intervene and apply the appropriate training methods and interventions when a behavior was observed? The PT/staff float gave a generalized answer of verbally redirecting the client, but verbalized that he would not know the training methods for clients. He further stated that he was not properly trained prior to assuming the responsibilities of taking care of clients in Residence 29.</p> <p>The facility policy and procedure titled "Client Services - 226: Client Supervision and Personal Care dated 6/6/08 reviewed on 9/26/13 at 9 a.m., indicated, "4. RESPONSIBILITY...4.5 Staff Assigned Responsibility For Any Client...4.5.4 Know each client's IPP (Individual Program Plan), including behavioral and medical considerations."</p> <p>7. On 9/20/13 at 10:30 AM, entity reported incidents were reviewed. The following indicated:</p>	W 189			

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 189	Continued From page 139 a. On 6/30/13 (ERI#360527) at 4PM, focused Client 92 during shower, attempted to stand up from the shower chair. Focused Client 92 lost his balance and fell. The staff providing care to focused Client 92 was standing at his side and was not able to prevent the fall. The staff was a float from Residence 15. b. On 7/20/13(ERI#363484) at 3:30 PM, focused Client 91 while being wheeled out of the bedroom, he fell out of the shower chair hitting the top of his head to the floor. The staff providing care was a float from residence 15. On 9/20/13 at 2PM, during an interview with the afternoon shift supervisor, he stated he had told the staff to seek assistance when providing shower and transfers to and from wheelchair or bed.	W 189	W189 #7 a 1. The Residence Manager will provide training to all staff on duty on Client 92's Approaches and Strategies. 2. The Shift Supervisor will provide orientation to all staff who float to Residence 23 and document in the Orientation Float Book. (please see continuation page 140a)	10/25/13 10/25/13	
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. 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 Services was met when individuals were not involved in activities which addressed their individualized priority needs. The facility did not assure Individuals had opportunities to practice new or existing skills and to make choices in their daily routines. The facility did not assure active treatment plans were implemented by trained staff, and objectives amended and revised by the qualified mental retardation professional (QMRP) / Individual Program Coordinator (IPC) as	W 195	W189 #7 b 1. Shift Supervisors will provide orientation staff as they float to 23 and document the training in the Orientation Float Book. 2. The Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation throughout all of the Intermediate Care Facility. 3. The Shift Supervisor will monitor the staff floating to 223 to evaluate competency and document all any findings on the Shift Supervisor Rounds Sheet. 4. Residence Manager will monitor the Orientation folder randomly and provide training provide to the Shift Supervisors as warranted. 5. The Residence Manager will monitor the Shift Supervisor Rounds Sheet and ensure any items are resolved immediately. (please see continuation page 140a)	09/17/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W189 #7 a cont.				
	3. The Shift Supervisor and Residence Manager will monitor staff during transferring, and provide coaching as warranted.			10/25/13	
	4. Observational findings will be documented on the Shift Supervisor Rounds Sheet.			10/25/13	
	5. The Residence Manager will monitor the Shift Supervisor Rounds Sheets to ensure that all identified issues have been resolved.			10/25/13	
	6. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	7. Shift Supervisor and Residence Manager Rounds Sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13	
	8. Any identified action items on the shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13	
	W189 #7 b cont.				
	6. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.			10/25/13	
	7. Any identified action items from the Shift Supervisor and Residence Manager Rounds Sheet will be addressed in the monthly Risk Management Meeting.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 195	Continued From page 140 individuals served failed to progress and or experienced significant events. The facility did not develop plans to address behavioral support needs that interfere with daily life. The facility did not assure that programs plans included measurable objectives and which data was collected in a manner that allowed determination of progress or lack of progress. Findings: 1. The facility failed to ensure each client received a continuous active treatment program, which included aggressive, consistent implementation of a program of training, treatment and or health services. Clients had regressed following consolidation (moves from closed residences) and were "retired" from active treatment, float staff did not know client programs, clients were served modified cafeteria style, pre-plated meals in an inconsistent dining environment with a lack of choice and staff over assisting. Clients were not allowed to participate in laundry activities. Activities designated to be community activities such as coffee socials provided no opportunity for clients to go to the bank (trust office) withdraw their own money, leave the facility and practice transitional community skills. This affected two of 10 core sampled and four focus clients. (Client 21, 63, 77, 79, 82, 89) SEE W196 2. The facility failed to develop a fully comprehensive functional assessment that identified specific needs, including behavioral	W 195	W195 #1 a) A special IDTeam meeting was held on 10/17/13 to evaluate Client 79's active treatment plan, including his training objectives. Client 79's active treatment plan has been modified to enhance training steps in current independence skills training in order to promote progress and implement a self-administration of medication training objective that promotes active involvement in his treatment. (Refer to W196, #6) b) On 10/24/13, a special IDTeam meeting was scheduled for 10/28/13 to address Client 89's active treatment plan, training objectives and increase in maladaptive behaviors and injuries. Client 89's active treatment plan has been modified to increase her participation in structured weekday activities, as well as active treatment activities on the residence. (Refer to W159, #1) c) All Day Training Activity Center (DTAC) classes in Program 2 will initiate the Orientation to DTAC Classroom form. (Refer to W189, #1) d) Client 63's medical needs were reviewed with the float staff on duty. (Refer to W189, #3) e) All clients active training plans and training objectives will be reviewed at their IPPs to ensure appropriate plans. Please see continuation page 141a	10/17/13	10/25/13
				10/25/13	09/19/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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
	W195 #1 cont.			
	f) The Dining Room Coordinator on residence 223 will monitor breakfast, lunch and dinner daily to ensure that clients' independence and training opportunities are provided. The Dining Room Coordinator will monitor for proper implementation of Dietary Safety Issues / Care Giver Feeding / Swallowing Guide at each meal. (Refer to W247, #6)			10/25/13
	g) The Interdisciplinary Team for individuals identified on residence 215 will identify and prioritize each person's needs for laundry training through comprehensive review of assessments, i.e. Independent Living Skills Assessment, staff interviews and monitoring of each individual's active treatment program. (Refer to W196, #4)			10/25/13
	h) The supervisor of residence 215's Rehabilitation Therapist (R.T.) reviewed AD 201: Client Rights with the residence R.T., especially as it relates to client social interaction / participation in community activities and managing their own money ensuring that the clients have opportunities to get their own money out of the Trust Office, then go purchase their desired items themselves. For each outing, an "On/Off Grounds Activity Trip Sheet" will be completed, with a dollar sign symbol next to each client's name who was able to participate in accessing / spending his own money. (Refer to W136, #3)			10/26/13
	i) The Individual Program Plan (IPP) describes the needs, preferences and choices of the person and his/her family. It is developed through a process of individualized needs determination and embodies an approach centered on the person and family, Administrative Directive (A.D.) 235: Individual Program Plan. All Residence Managers and Shift Supervisors will review and provide training in Administrative Directive 235: Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence.			10/25/13
	j) On July 11, 2013, the Executive Director and Clinical Director met with Program Management, Residence Managers, Shift Supervisors and Quality Assurance Staff to review expectations on active treatment programming on and off the residences and to solicit ideas for enhancing active treatment programs. The outcome of the meeting reinforced the Center's commitment to provide a client driven program for each client that is flexible in order to meet the clients' needs as their rhythm of life dictates.			07/11/13
	k) On August 1, 2013, the Executive Director and Clinical Director met with Program Management and Residence Managers/Designees to review active treatment expectations and protection from harm measures related to the delivery of client services.			08/01/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W195 #1 cont.				
	l) On October 16, 2013, the Clinical Director facilitated training to Program Management, Residence Managers, Shift Supervisors, Individual Program Coordinator, and Quality Assurance staff regarding active treatment: clients will receive a continuous active treatment program consisting of needed interventions to support the achievement of each client's Individual Program Plan; active treatment programs will be meaningful and staff will be able to explain how the activity promotes greater independence for each person involved in the activity; individuals are encouraged to make choices and decisions and to complete tasks with as much independence as possible; environments will be pleasant and conducive to learning; and appropriate materials and supplies will be available in order to effectively carry out active treatment programs based on the needs of the clients.			10/16/13	
	m) On October 17, 2013, the Clinical Director and Executive Director, along with consultants, reviewed active treatment strategies with Executive Committee Members, Program Management, Residence Managers and Quality Assurance staff; emphasizing active involvement with individuals who typically self-isolate, especially during transitional times during the day; restructuring environments to promote more effective group interactions; empowering staff with the tools they need to succeed; mentoring by Supervisors, Managers and Professional Level-of-Care staff; and modifying program plans when there is no progress or regression.			10/17/13	
	n) On October 22, 2013, an Active Treatment Workgroup was formed of creative staff who will share active treatment strategies for the benefit of all staff that have been known to be successful for highly resistive and more challenging individuals and will elevate clients' skill level.			10/22/13	
	o) Level of care staff on the residence and DTAC staff will ensure active treatment plans are implemented as developed by the IDTeams.			10/25/13	
	p) Each month, Level of care staff on the residence and DTAC staff document in the client's record the client's response to training objectives.				
	q) The Shift Supervisors and DTAC Coordinators will monitor during routine rounds to ensure staff deployment optimizes active treatment activities and active treatment plans as developed by each client's IDTeam are implemented on the residence and at the DTAC Sites, providing demonstration and coaching, as needed. Shift Supervisors and DTAC Coordinators will ensure re-training/instruction is given and corrective action taken, as needed.			10/25/13	
	r) The Shift Supervisor will identify issues and corrective actions (if any) on the Shift Supervisor Rounds Sheet, submitting to the RM weekly. The DTAC Coordinator will note on DTAC Classroom Rounds Sheet; any corrective actions will be documented in an email to the appropriate Program Manager.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W195 #1 cont.				
	s) The Residence Manager will monitor for effective active treatment program planning, provide coaching and identify corrective actions, when needed, during weekly rounds to ensure all clients' Individual Program Plans are being followed as developed by each client's IDTeam. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.			10/25/13	
	t) The Residence Manager will identify issues on the Residence Manager Rounds Sheet.			10/25/13	
	u) Any identified action items on the Shift Supervisor Rounds Sheet, DTAC Coordinators Rounds Report or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13	
	v) Program Director/Designee reviews the rounds forms by the SrPTs, DTAC Coordinators and RMs, resolves issues, as warranted, and elevates issues to the Governing Body if the rounds tool results show signs that the system is not working.			10/25/13	
	w) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/24/13	
	x) IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	y) IPC Supervisor will monitor for compliance via review of the IPC Notes. Any unresolved issues/ concerns will be brought forward to the CQM committee for resolution.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 195	Continued From page 141 management for one of 10 sampled clients (Client 77) and one focus client (Client 45). SEE W214 3. The facility failed to ensure objectives of the individual program plan were stated separately, in terms of a single behavioral outcome affecting two of 10 core sampled and two focus clients. (Client 37, 47, 61, 69) SEE W229 4. The facility failed to ensure for one of 10 core sampled clients (Client 77) vocational training that was consistent with his abilities. SEE W240 5. The facility failed to provide opportunities for client choice and self-management for two of 10 core sampled and five focus clients (Clients 1, 15, 18, 39, 65, 70 and 77). SEE W247 6. The facility failed to implement the clients' active treatment program for five of 10 core sampled clients and 13 focused sampled clients. (Clients 1, 2, 4, 6, 12, 15, 16, 26, 32, 43, 49, 52, 56, 64, 66, 76, 77, and 99) SEE W249 7. The facility failed to ensure data was collected accurately to serve as a performance measure and provide information to assist in program decisions, affecting one of 10 core sampled and five focus clients. (Clients 2, 26, 43, 49, 64, and 73) SEE W252 8. The facility failed to ensure the individual program plan was revised by the QMRP / IPC for one core sampled and one focused clients who were failing to progress toward identified objectives. Client 89 was "retired" and her active treatment program was not implemented. Client 47 was not progressing due to changes in Day Treatment Activities Center (DTAC) environment,	W 195	W195 #2 a) A special IDTeam meeting was held to review Client 77's comprehensive functional assessment (IPP Narrative), including an evaluation of the appropriateness of Client 77's current money management training objective, vocational training, self-administration of medication and continual and meaningful active treatment. The IDTeam implemented new training objectives in money management and self-administration of medication. Additionally, Client 77's vocational program has been enhanced to include more tasks in which he can actively participate. b) All clients comprehensive functional assessment (IPP Narrative), will be reviewed at their IPPs to ensure appropriate. please see continuation page 142a W195 #3 please see continuation page 142b W195 #4 please see continuation page 142c W195 #5 (Refer to tags W247 #1 - #6) W195 #6 (Refer to tags W249 #1 - #16) W195 #7 (Refer to tags W252 #1 - #6) W195 #8 (Refer to tags W257 #1 and #2)	10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
W195 #2	b) Shift Supervisors will ensure Client 77 is afforded weekly opportunities at Trust Office and Freedom Café.			10/25/13	
	c) The Rehabilitation Therapist will schedule community outings to provide Client 77 with opportunities and choices for shopping.			10/25/13	
	d) Residence Manager, Group Leader and IPC developed Client 77's training plans, and the IPC documented on the IPP listing, Approaches & Strategies and Daily Activity Schedule.			10/25/13	
	e) Client 45's IDTeam met and reviewed behavior data and agreed to include a behavior plan for pulling JT within Client 45's Behavior Support Plan.			10/23/13	
	f) Client 45's Psychologist will develop the plan and submit to Behavior Support Committee for approval.			10/23/13	
	g) Client 45's Psychologist and Residence Manager will provide service training on the plan and intervention steps to all staff upon approval.			10/23/13	
	h) Residence Manager and Shift Supervisor will monitor residence daily to ensure staff is knowledgeable with the plan and provide additional coaching, as needed.			10/23/13	
	i) The Shift Supervisor will complete daily rounds utilizing the Shift Supervisor Rounds Sheet and submit weekly to Residence Manager.			10/23/13	
	j) Program Management will conduct random rounds on a monthly basis and document on the 24 hour report.			10/23/13	
	k) Any identified action items from the Shift Supervisor or Residence Manager Rounds Sheet will be addressed in the monthly Risk Management Meetings.			10/25/13	
	l) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/24/13	
	m) IPCs will clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	n) IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W195 #3 cont.				
	a. On 10/16/13, a workgroup was formed to review the four sampled behavior support plans (clients 37, 47, 61 and 69) in regards to single behavioral outcomes. The workgroup is comprised of the Behavior Services Committee (BSC) Chairperson, two BSC member/reviewers, a Staff Psychologist, and the Senior Supervising Psychologist. On 10/28/13, members of the workgroup met and concurred in their understanding that behaviors that occur together as episodes and are difficult to separate, and that serve the same function, may be defined in terms of a cluster of behaviors and stated as a single behavioral outcome. The workgroup raised concerns related to separating out data for behaviors that occur concurrently (specifically, potential decrease in data accuracy and distortion of behavioral acuity resulting from much higher frequency counts than would result from counting episodes of concurrent behaviors).			10/28/13	
	b. The IDTeam will review the current behavior-plans of the four sampled clients (clients 37, 47, 61 and 69) and address the appropriateness of behavioral definitions.			10/31/13	
	c. The IDTeam will review all clients current behavior plans (IPP Narrative), at their IPPs to ensure appropriate and accurate.				
	d. All on-duty Psychologists will receive training in review of Title 42 pertinent to single behavioral outcomes.			10/30/13	
	e. Based on the IDTeam consensus, a behavior support plan will be modified to incorporate single behavioral outcomes, or justification will be provided if contraindicated. The Senior Supervising Psychologist will ensure that the Residence Psychologist notifies the BSC of changes made to the plan per the Behavior Services Manual (page 27), or, if indicated, submits the plan to the BSC, including all appropriate consents needed.			10/31/13	
	f. A review of behavior supports plans containing highly restrictive interventions will be initiated to identify behavior support plans containing multiple behavioral outcome objectives. The IDTeam will review the behavior plans and address the appropriateness of behavioral definition.			10/28/13	
	g. Based on the IDTeam consensus, a behavior support plan will be modified to incorporate single behavioral outcomes, or justification will be provided if contraindicated. The Senior Supervising Psychologist will ensure that the Residence Psychologist notifies the BSC of changes made to the plan per the Behavior Services Manual (page 27), or, if indicated, submits the plan to the BSC, including all appropriate consents needed.			10/31/13	
	h. Behavior plans containing highly restrictive interventions will be reviewed at the monthly Behavior Review Group meeting to ensure proper identification and definition of target behaviors.			10/29/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W195 #3 cont.				
	i. Individual Program Coordinator and Residence Manager will ensure that discussion and documentation are incorporated into Annual IPP meetings to determine and specify proper identification and definition of target behaviors.			10/29/13	
	j. The Quality Assurance IPP Audit is updated to include review for multiple behavioral outcomes.			10/29/13	
	k. At least annually, behavior support plans are reviewed by the Behavior Services Committee, Human Rights Committee and Therapeutic Review Committee each time a behavior support plan is submitted for review. These committees will monitor to ensure the inclusion of single behavior outcomes in each behavior support plan, or justification provided for any contraindication, prior to each behavior plan's approval and implementation. BSC Members will utilize the BSC Review Checklist (Appendix 12 of the BSC Manual), which stipulates that "Milestones are observable, measurable, specific and stated as a single outcome."			10/29/13	
	l. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documenting training objectives to provide clear directions to any staff person working with an individual about the type of data to record and the frequency which data is to be recorded. IPCs document monitoring and follow-up activities at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/24/13	
	m. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	n. IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	
	W195 #4 cont.				
	a) A special IDTeam meeting was held to review Client 77's comprehensive functional assessment (IPP Narrative), including an evaluation of the appropriateness of Client 77's current money management training objective, vocational training, self-administration of medication and continual and meaningful active treatment. The IDTeam implemented new training objectives in money management and self-administration of medication. Additionally, Client 77's vocational program has been enhanced to include more tasks in which he can actively participate. 10/25/2013				
	b) Shift Supervisors will ensure Client 77 is afforded weekly opportunities at Trust Office and Freedom Café. 10/25/2013				

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W195 #4 cont.				
	c) All clients comprehensive functional assessment (IPP Narrative), will be reviewed at their IPPs to ensure its appropriate.				
	d) The Rehabilitation Therapist will schedule community outings to provide Client 77 with opportunities and choices for shopping.			10/25/13	
	e) Residence Manager, Group Leader and IPC developed training plans, and the IPC documented on the IPP listing, Approaches & Strategies and Daily Activity Schedule.			10/25/13	
	f) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/24/13	
	g) IPC will monitor Client 77's progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	h) IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 195	Continued From page 142 i.e., increase in roster size, increase in overall noise level, increase in behaviors manifested by peers around him, changes in regular staffing level, and new instructors. (Clients 47 and 89) SEE W257	W 195			
W 196	The cumulative effect of these systemic problems resulted in the facilities inability to ensure that specific active treatment 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: (i) The acquisition of the behaviors necessary for 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 each client received a continuous active treatment program, which included aggressive, consistent implementation of a program of training, treatment and or health services. Clients had regressed following consolidation (moves from closed residences) and were "retired" from active treatment, float staff did not know client programs, clients were served modified cafeteria style, pre-plated meals in an inconsistent dining environment with a lack of choice and staff over	W 196			

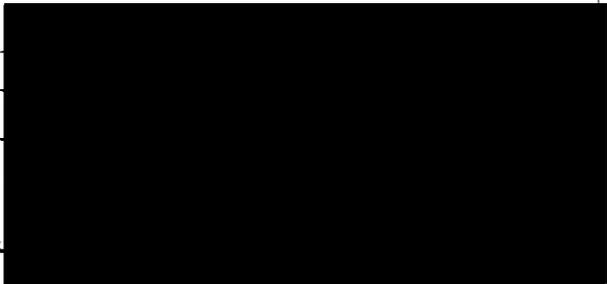
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	<p>Continued From page 143</p> <p>assisting. Clients were not allowed to participate in laundry activities and were not provided desensitization training as indicted. Activities designated to be community activities such as coffee socials provided no opportunity for clients to go to the bank (trust office) withdraw their own money, leave the facility and practice transitional community skills.</p> <p>This affected three of 10 core sampled and six focus clients. (Client 21, 37, 47, 63, 69, 77, 79, 82, 89)</p> <p>Findings:</p> <p>1. Observation on 9/24/13 at 9:30 AM, revealed Client 89 laying in bed fully clothed with the lights out [REDACTED]. The bedroom door was closed, curtains drawn and there was no stimulus in the room such as TV or music playing.</p>	W 196	<p>W196 #1</p> <p>a. Special team meeting was held to discuss and develop plans to revise client #89 Day Training Activity.</p> <p>b. The teacher for classroom #2 will develop a training objective for Client 89 to work on when she chooses to participate in class.</p> <p>c. All Residence Managers provided training to all staff on duty on Client Services - 235 Individual Program Plan Implementation.</p> <p>d. All Residence Managers and Shift Supervisors will continue to complete random rounds and document findings on the rounds sheets and provide additional training as necessary.</p> <p>e. Program Management will monitor the rounds sheets to ensure compliance and document on the 24 hour report.</p>	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	Continued From page 144  The IPP instructed staff to increase awareness of Client 89's whereabouts to protect her from harm, however, she was not receiving Enhanced supervision during the observation period. At 1:30 PM, the same day Client 89 was going thru a closed door onto the residence patio in a wheelchair alone. A special meeting dated 6/8/13 acknowledged Client 89's desire to attend DTAC and the team decided Client 89 could be "unretired" in order to get paid for any work she engages in at DTAC. The Individual Planning Coordinator (IPC) who recorded the special meeting indicated Client 89 would be included in the DTAC program effective June 2013. This program was not implemented for Client 89, as evident by the RM who indicated she was retired and no revision in her active treatment goals. Clinical record review confirmed no evidence of new assessment, revision and/or plan implementation to promote Client 89's physical wellness and fitness, socialization and tasks that stress maintaining coordination skills and reducing the rate of loss of skills that accompanies the physical aspects of the aging process. 2. Observation at the DTAC on 9/17/13 during the	W 196	W196 #1 cont. f. Shift Supervisor will complete daily rounds utilizing the Shift Supervisor Rounds Sheet and submit weekly to Residence Manager. g. Any identified action items from the Shift Supervisor or Residence Manager Rounds Sheets will be addressed in the monthly Risk Management Meeting.	10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 196	<p>Continued From page 145</p>  <p>Interview with the licensed staff member at 11:45 AM revealed he was a "float" working voluntary overtime and did not know the clients very well. The licensed staff member said he had worked "double shifts" for weeks but had not worked on Residence 15 because of a problem with a client - but the client had been recently discharged. The licensed staff member did not wish to elaborate on what the problem concerning a client was or speak further. A request thru Standards Compliance revealed there were no pending actions, however personnel records showed recent history of non-compliance with following the facility medication administration guidelines while being a overtime float.</p> <p>The "Teacher" in DTAC indicated in interview during the observation phase that he was also</p>	W 196	<p>W196 #2</p> <p>a. All Day Training Activity Center (DTAC) classes in Program 2 will initiate the Orientation to DTAC Classroom form.</p> <p>b. All staff new to the classroom, including residence staff, Senior Companions, volunteers, and college/vocational students, will be given orientation to the classroom and the clients in the classroom, and will sign the Orientation to DTAC Classroom form. If a lapse of a month passes that the person who signed the form is not in the class, the individual will be re-oriented to the classroom and the clients in the classroom, and sign the Orientation to DTAC Classroom form again.</p> <p>c. The Orientation to DTAC Classroom form will be kept in a binder in the classroom for a minimum of a month.</p> <p>d. The DTAC Coordinator will monitor form usage during weekly rounds and document on in DTAC Rounds Report.</p> <p>e. The DTAC Coordinator will maintain all Orientation to Classroom Rounds forms that are purged from the classroom binder for a year.</p> <p>f. All DTAC staff will sign a training sheet indicating they understand this process.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	Continued From page 146 new to the area and just getting to know the clients. The teacher indicated he was moved after residences consolidated and wasn't sure which staff were regular or floats. 3. Dining observations were completed on Residence 15 on 9/16/13 at 11:30 AM, 9/18/13 at 11:30 AM and 5:30 PM, and 9/24/13 at 7:30 AM. Clients were served modified cafeteria style, one client at a time picked up a tray and silverware, walked to the counter and received a pre-plated meal. Observations revealed an inconsistent dining environment organized to facilitate acquisition of skills, greater independence and choice opportunities. Staff over assisted clients for example; "waiter style", pouring drinks, walking around with a coffee pot and wiping their tables after eating. On one observation, Client 21 independently went to an cart with iced drink cartons and poured his glass of Silk perfectly. The next dining observation, staff instructed Client 21 to sit down and poured the Silk for him. During a lunch observation where sandwiches were on the menu, clients were not provided the opportunity to assemble their own sandwiches. This affected all clients residing on Residence 15. 4. On 9/16/13 at 3:30 PM on Residence 15, revealed the laundry room (washer and dryer) were off limits to the clients. Concurrent staff interview revealed no clients on the residence were allowed to do their personal laundry although some were "probably capable." Staff indicated they were told the water didn't get hot enough for the clothes to get clean. Staff indicated housekeeping staff sometimes use the washers for soft ties and other "things." When	W 196	W196 #3 a. The Senior Psychiatric Technician (SrPT)/Dining Room Coordinator at each meal will monitor and ensure compliance and implementation to identified independence levels and training in each IPP for client 21 and all clients who reside on residence. Re-training/ modeling is given and corrective action taken as needed. b. All RMs reviewed responsibilities of the dining room coordinator at all huddles. c. All SrPTs are responsible for ensuring a safe and therapeutic environment each shift. The routine of the dining room coordinator will be followed to compliance at each meal. d. All RMs will ensure compliance during daily routine rounds ensuring re-training/instruction is given and corrective action taken, if needed. W196 #4 a. The Interdisciplinary Team will identify and prioritize each persons needs for laundry training through comprehensive review of assessments, LSA, interview, and monitoring of each individual.	09/16/13 09/16/13 10/25/13 9/16/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 196	<p>Continued From page 147</p> <p>asked if the hot water issue would be fixed, she indicated "probably not" and if any of the eight clients awaiting placement practiced using the washer and dryer, she confirmed no.</p> <p>Interview with a second staff person on Residence 15 on 9/18/13 at 6 PM, indicated clients were capable of using the washer and dryer but had not been allowed to train or use them because detergent was not allowed on the residence, when asked what the soft tie restraints were washed with, he was unsure. The facility failed to address priority needs (doing laundry) formally and through activities which were relevant and responsive to eight clients on Residence 15 transitioning to the community.</p> <p>During an interview with the Chief of Plant Operations on 9/25/13 at 1 PM, he indicated there were no work orders pending for Residence 15 washers and to the best of his knowledge there was no a hot water issue.</p> <p>5. During an interview regarding client community activities on 9/18/13 at 6:30 PM, a licensed staff member indicated clients were involved in weekly community activities, for example, Starbucks Coffee Social. Further interviews with staff and clients revealed the recreational therapist and staff filled out a trust form for each client's account to be debited, went to Starbucks, picked up coffee and doughnuts, which were served to the clients on the residence. Although the clients indicated they enjoyed this activity, there was no opportunity for them to go to the bank (trust office) withdraw their own money, leave the facility, practice community skills, and practice choice by ordering their coffee and or dough nut and exchange</p>	W 196	<p>W196 #4 cont.</p> <p>b. The Residence Manager reviewed Administrative Directive 235: IPP implementation. The IDTeam will identify plans to enhance or acquire skills that can be incorporated into daily program plans. If at any time it is noted changes are needed to current IPP, the IPC/RM are notified immediately to determine need for a Special IPP meeting.</p> <p>c. The IPC/RM/SRPT/DTAC Coordinator will ensure compliance during daily routine rounds ensuring re-training/instruction is given.(please see continuation page 148a)</p> <p>W196 #5</p> <p>a. The supervisor of the rehabilitation therapist on Res.215, reviewed A.D. 236 Individual Program Plan with the R.T., especially as it relates to increasing our clients independence in managing their own finances by assisting the clients from Res. 215 to have opportunities to get their own money out of the Trust Office, then go purchase their desired items themselves. For each outing, an "On/Off Grounds Activity Trip Sheet" will be completed, with a dollar sign symbol next to each client's name who was able to participate in accessing / spending his own money.(please see continuation page 148a)</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/24/13</p>
-------	---	-------	--	---

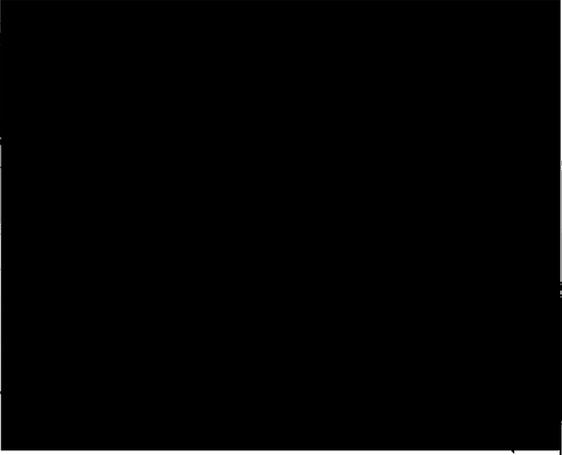
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W196 #4 cont. e. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.			9/16/13	
	W196 #5 cont. b. The supervisor of all of the rehabilitation therapists (Program Assistant) reviewed A.D. 235 Individual Program Plans with the R.T's, especially as it relates to increasing our clients' independence in managing their own finances to ensure that all clients who are able, have opportunities to access their own money at the Trust Office, and then go purchase their desired items themselves. For each outing, an "On/Off Grounds Activity Trip Sheet" will be completed, with a dollar sign symbol next to each client's name who was able to participate in accessing / spending his/her own money on a trip.			10/24/13	
	c. The Program Assistant will monitor the "On/Off Grounds Activity Trip Sheets daily to ensure that clients are given the opportunity to access / spend their own money.			10/24/13	
	d. The Rehabilitation Therapists will include a synopsis of each client's progress in the area of money management in their annual assessment for the client's IPP.			10/24/13	
	e. The P.A. will monitor each IPP for compliance.			10/24/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	Continued From page 148 money for a product. Staff indicated during the interview, we don't have enough staff to do that. 6. An interview was conducted with the IPC (Individual Program Coordinator) on 9/25/13 at 10:15 AM to ascertain information regarding Client 79's training plans.  Review of the Individual Program Coordinator review, dated 8/25/12, [sic] indicated: Independence skills training (# of times he is not resistive to fingernail training) denoted no progress for months, will refer to group leader possibly to modify the plan. Client's no progress in this area is possibly due to a lot of changes in his environment both at Day Program and the Residence (continuing/on going placement activities of clients in the residence, staff and peer changes as residences and Day Program classroom were closed or moved). 7. On 9/18/13 at 5:35 PM licensed staff was	W 196	W196 items #6-10 a) The Residence Manager (RM) reviewed the Individual Program Plan for client 79 including open training plans, Approaches and Strategies and Health Care Objectives and Plans with staff on duty. b) All Senior Psychiatric Technicians are responsible to ensure that orientation is provided to float and new staff, which includes review Individual Program Plan (IPP) information to assure staff, are familiar with each client via the revised New Staff, float and student orientation check sheet c) The Residence Managers and Rehabilitation Therapists meet at least weekly to review active treatment needs for the residence to ensure a adequate supply of materials are available to provide clients with a variety of options to choose from during waking hours. d) All Residence Managers obtained additional active treatment activities and supplies for the residence living rooms and activity areas and provided training on active treatment expectations based on the IPP. e) All Senior Psychiatric Technicians ensure that clients are engaged in meaningful activities per the IPP during daily rounds and documents on the Shift Supervisor Rounds Sheets.	10/25/13 09/25/13 10/26/13 10/26/13 10/26/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W196 items #6-10 cont. k. Any issues or barriers to compliance will be elevated to the Governing Body via the appropriate Quality Assurance committee. l. Any changes to the Active Treatment programs will be brought to the Governing Body's attention by the Program Director via the appropriate Quality Assurance process.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	Continued From page 150  Client 77's comprehensive functional assessment described his motor skills as, "No observable challenges when manipulating objects of varying size, shape or density". It did not describe his excellent fine motor skill that allowed him to tie his own shoe laces. Additionally his method of communication did not describe his ability to read lips. The recommendations were that his work situation, where he folded pieces of paper to be shredded by others, "continues to prove beneficial...". During an interview with Client 77's IPC (Individual Program Coordinator) on 9/24/13 at 2:35 PM she stated that Client 77 was very high functioning and agreed he could do more. When asked if there were more stimulating jobs more in line with his abilities, she said with the downsizing	W 196	W196 #10 A) A special team meeting was held to discuss Client 77's how to offer meaningful activities on the residence and at DTAC based on the client's IPP. B) Current DTAC program will be altered to include the labeling of grooming supplies and picking up empty medication cards. During times when Client 77 chooses not to work, he will be offered opportunities to participate in writing enhancement sessions. Also at break time he will be encouraged to make his own coffee staff will assist as needed. C) When going to clothing center staff will ensure that he picks out his own clothes and staff will assist as needed to ensure proper fit. Will continue with shopping trips with Rehabilitation Therapist to purchase clothing of his choice. D) Upon return from DTAC will continue to make positive choices in leisure activities for active treatment. E) Client 77's current program plan has been updated to include these additional program opportunities. F) All Residence Managers provided training to all staff on duty on Administrative Directive 235: Individual Program Plan implementation. G) Residence Manager and Shift Supervisors have provided staff training on the updated program plan for Client 77.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	<p>Continued From page 151 of the facility none were offered.</p> <p>Client 77's comprehensive functional assessment described his motor skills as, "No observable challenges when manipulating objects of varying size, shape or density". It did not describe his excellent fine motor skill that allowed him to tie his own shoe laces. Additionally his method of communication did not describe his ability to read lips.</p> <p>The recommendations were that his work situation, where he folded pieces of paper to be shredded by others, "continues to prove beneficial...".</p> <p>During an interview with Client 77's IPC (Individual Program Coordinator) on 9/24/13 at 2:35 PM she stated that Client 77 was very high functioning and agreed he could do more. When asked if there were more stimulating jobs more in line with his abilities, she said with the downsizing of the facility none were offered.</p> <p>Throughout the survey, facility staff performed functions for Client 77 rather than allowing him to perform them and reinforce his ability to do so [REDACTED]</p> <p>On 9/18/13 at 1:15 PM, Client 77 had just arrived at this DTAC (day training activity center) when staff asked him to perform his job of folding paper. He signed " no " and pointed towards his residence. Staff walked with him to his residence</p>	W 196	<p>W196 #10 cont.</p> <p>H) All Shift Supervisors to monitor daily and document observational findings on the Shift Supervisor Rounds Sheet.</p> <p>I) All Residence Managers will monitor during weekly rounds to ensure that program plan is being implemented as developed by the IDT.</p> <p>J) All ICF clients IPPs are reviewed monthly by the IPC and addressed with the ID Team where appropriate.</p> <p>K) Any Program changes will be elevated to the Governing body by the Program Director.</p>	10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 196	Continued From page 152  For a brief time period from 1:40 PM to 1:55 PM a staff member sat with the client while they played a card game, the client wrote words, drew a picture and performed simple arithmetic problems. Then instead of performing any form of active treatment in lieu of working he watched television, walked about the halls and sat in a hallway chair. This lack of activity continued from 2 PM until he and most of the clients on his residence went to Freedom Café at 4:05 PM for a coffee social. Upon his return to the residence he watched television, briefly looked a magazines, walked about and sat in the hall and group room until dinner at 5:30 PM. Following dinner at 5:45 PM, he went to a group to watch television by himself. On the morning 9/23/13 following breakfast at 8 AM, Client 77 sat down in the hallway chair. At 8:15 AM, staff asked him to come to the group room. He complied and was given a magazine which he looked at briefly then put it down. He sat and watched television until 8:30 AM when he got up and went to sit in the hallway chair. At 9:05 AM staff asked Client 77 is he wanted to go to work at his DTAC to fold paper and he signed "no". At 9:10 AM he was transported via van to a square dance that was held in a small auditorium. The square dance consisted of clients who were wheelchair bound clients that were propelled by staff to music that was played. Consequently Client 77 could only watch. At 10:30 he went back to the residence via van	W 196			

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

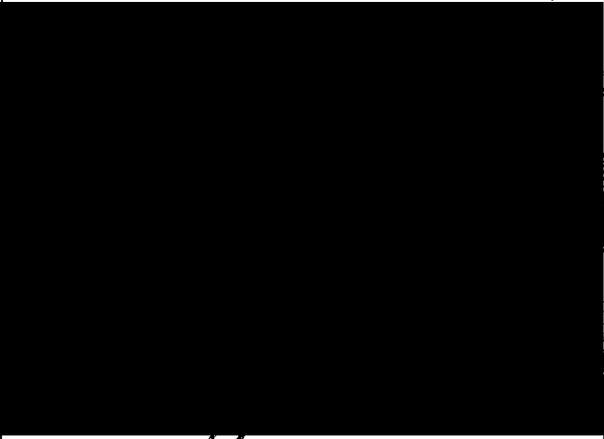
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769	
(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 196	Continued From page 153 transportation. After smoking on the patio he sat down in a hallway chair and walked about the nurses' station until lunch at 11:35 AM. At 1:05 PM he again refused to go to DTAC to fold paper. Staff did hand him a notebook and asked him if he wanted to write, he responded "no". For the next 45 minutes he alternated sitting in the hall and ambulating around the nurses' station and the group room. That same day at 1:45 PM staff was asked why Client 77 wasn't provided active treatment when he refused to go to work. They stated that he was provided with his choice of leisure activities. 11. Record reviews beginning on 9/18/13 for Client 37, 47, and 69 revealed nursing evaluations indicating desensitization training occurred on Residence 15. The nursing documentation indicated "Staff provide desensitization on the residence before medical/dental appointments..." interview 9/24/13 at 2 PM with RM, HSS, IPC confirmed no desensitization training occurring.	W 196	W196 #11 a. The Interdisciplinary Teams for clients 37, 47, 69, and all clients will identify and prioritize each persons needs for desensitization training through comprehensive review of assessments, ILSA, interview, and monitoring of each individual. b. All RMs reviewed Administrative Directive 235: IPP implementation. The IDTeam will identify plans to enhance or acquire skills that can be incorporated into daily program plans for all clients. The IPC will memorialize each step of the desensitization plan into the IPP. If at any time it is noted changes are needed to current IPP, the IPC/RM are notified immediately to determine need for a Special IPP meeting. c. All IPC/RM/SRPTs will ensure compliance during daily routine rounds ensuring re-training/instruction is given. d. All RMs will ensure compliance during daily routine rounds ensuring re-training/instruction is given and corrective action taken, if needed. e. Program Management will randomly monitor during monthly rounds and document on the 24 hour report. f. Program Management will address corrections made during rounds with the RM and the Governing Body	10/25/13 10/25/13 10/25/13
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, facility staff interview and clinical record review, the facility failed to develop a fully comprehensive functional assessment (an assessment of the clients strengths, preferences and abilities) that identified specific needs, of the	W 214		09/16/13 10/25/13 10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 214	<p>Continued From page 154</p> <p>clients, including behavioral management for one of 10 core sampled clients (Client 77) and one focus client (Client 45).</p> <p>Findings:</p>  <p>Client 77's comprehensive functional assessment described his motor skills as, "No observable challenges when manipulating objects of varying size, shape or density". It did not describe his excellent fine motor skill that allowed him to tie his own shoe laces. Additionally his method of communication did not describe his ability to read lips.</p> <p>The recommendations were that his work situation, where he folded pieces of paper to be shredded by others, "continues to prove beneficial ...".</p> <p>During an interview with Client 77's IPC (Individual program Coordinator) on 9/24/13 at 2:35 PM she stated that Client 77 was very high functioning and agreed he could do more. When</p>	W 214	<p>W196 #11 continuation the Clinical Quality Management Committee with recommendations/review/follow up discussion.</p> <p>W214 #1</p> <p>a. A special team meeting was held to discuss Client 77's current work program and activities offered throughout his day.</p> <p>b. Current DTAC program will be altered to include the labeling of grooming supplies and picking up empty medication cards. During times when Client 77 chooses not to work, he will be offered opportunities to participate in writing enhancement sessions. Also at break time he will be encouraged to make his own coffee staff will assist as needed.</p> <p>c. When going to clothing center staff will ensure that he is allowed to pick out his own clothes and staff will assist as needed to ensure proper fit. Will continue with shopping trips with Rehabilitation Therapist to purchase clothing of his choice.</p> <p>d. Upon return from DTAC will continue to make positive choices in leisure activities for active treatment throughout the day.</p> <p>e. Client 77's current program plan has been updated to include these additional program opportunities.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 214	<p>Continued From page 155</p> <p>asked if there were more stimulating jobs more in line with his abilities, she said with the downsizing of the facility none were offered.</p> <p>2. During observation of Client 45 conducted on 9/16/13 at 11 AM, client was observed in her room with a 1:1 supervision by licensed staff.</p> <div style="background-color: black; width: 100%; height: 150px; margin: 10px 0;"></div> <p>Interview with licensed nursing staff conducted on 9/18/13 at 10:50 AM revealed that they do not have program for the client's behavior of pulling her J-tube. She added, if the client is manic (extreme excitement and activity) and agitated, she reaches out and pulls out her j-tube.</p> <div style="background-color: black; width: 100%; height: 30px; margin: 10px 0;"></div>	W 214	<p>W214 #1 cont.</p> <p>f. The Residence Manager provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation. (please see continuation page 156a)</p> <p>W214 #2</p> <p>a. The team met and reviewed behavior data and agreed to include a behavior plan for pulling JT within client #45 Behavior Support Plan. All ICF clients with modified supervision have an attached plan that includes reduction.</p> <p>b. Psychologist will develop the plan and submit to Behavior Support Committee for approval. All ICF clients have scheduled reviews for modified supervision.</p> <p>c. Psychologist and Residence Manager, to provide service training on the plan and intervention steps to all staff upon approval.</p> <p>d. The Residence Manager and Shift Supervisor will monitor residence daily to ensure staff is knowledgeable with the plan and provide additional coaching as needed.</p> <p>e. The Shift Supervisor will complete daily rounds utilizing the Shift Supervisor Rounds Sheet and submit weekly to Residence Manager.</p> <p>f. Program Management will conduct random rounds on a monthly basis and document on the 24 hour report.</p>	<p>10/25/13</p> <p>10/23/13</p> <p>10/23/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

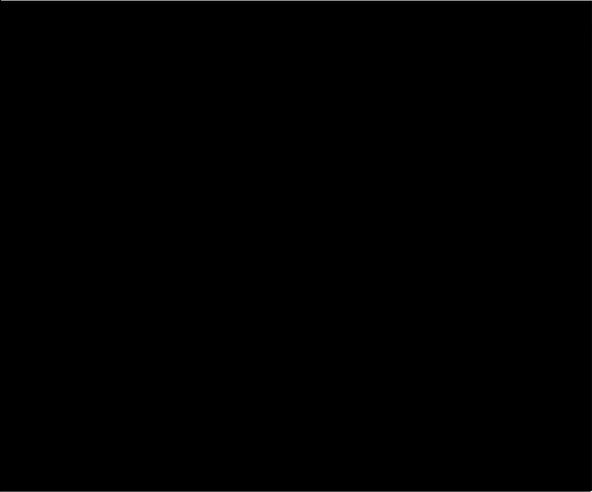
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W214 #1 cont: G) Residence Manager and Shift Supervisors have provided staff training on the updated program plan for Client 77.			10/25/13	
	H) Shift Supervisor to monitor daily and document observational findings on the Shift Supervisor Rounds Sheet.			10/25/13	
	I) The Residence Manager will monitor during weekly rounds to ensure that program plan is being implemented as developed by the IDT.			10/25/13	
	J) All ICF clients IPPs are reviewed monthly by the IPC and addressed with the ID Team where appropriate.			10/25/13	
	K) Any Program changes will be elevated to the Clinical Quality Management Committee by the Program Director.			10/25/13	
	W214 #2 cont. 				
	h. Any identified action items from the Shift Supervisor or Residence Manager Rounds Sheet will be addressed in the monthly Risk Management Meetings.			10/25/13	
	i. Any identified action items on the Shift Supervisor or Residence Manager Rounds Sheets & DTAC Rounds Report will be addressed during monthly Risk Management Meetings with any issues elevated to the Clinical Quality Management Committee with recommendations/review/follow up discussion.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

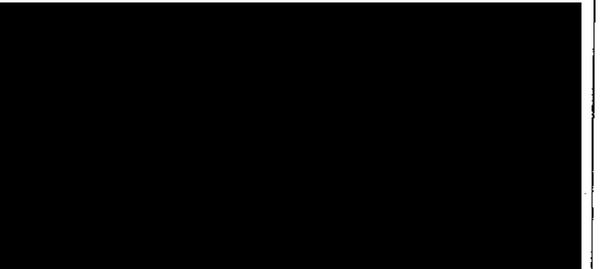
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	<p>Continued From page 156</p>  <p>In an interview with the licensed nursing staff conducted on 9/19/13 at 10:30 AM, she stated that the client was awake all night and was tired from attending last night's Dance Activity.</p> <p>During an interview with the night shift licensed nursing staff on 9/24/13 at 5:20 AM, she stated that the client was very hyperactive the night of 9/17/13 and accidentally pulled out her J - tube. The client was awake all night and they have to call the MOD to reinsert the J-tube.</p>  <p>A review of the facility's Nursing Procedure Manual dated 2/20/13, Number 9.4.1 for "Care of Clients with Jejunostomy Tube or Gastrojejunal Tubes " indicated the following:</p> <p>"Purpose: Jejunostomy Tube is used for enteral tube feeding that delivers nutrition, fluids, and/or medication into a section of small intestine known</p>	W 214		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 214	<p>Continued From page 157 as jejunum. It is a surgical insertion of a balloon tip jejunostomy tube or j-tube into the duodenum..."</p> <p>Further review of the procedure manual indicated that Roux- en - y jejunostomy was defined as "a surgical creation of a limb or pouch in the jejunum that is appropriate for the intermittent insertion of a feeding tube for a small bolus feeding. The type of j-tube placement for nutritional support that involves a creation of a short limb or pouch in the jejunum that is sutured to an opening in the abdominal wall to create a stoma. This type of procedure allows for the eventual use of a skin level device such as button feeding tube in place of a traditional tube. "</p>  <p>Review of the Interdisciplinary Notes (IDN) indicated that on 4/20/13, 4/26/13, 5/5/13, 5/8/13 and 5/9/13, the client made attempts to pull out her J- tube. Review of the Emergency Restraint Usage Report showed that on 5/10/13, the client was placed twice in soft tie restraints for attempting to pull her J- tube.</p> <p>Interview conducted with the Medical Director on 9/25/13 at 8:30 AM, revealed that the client had her J- tube for a long time and has a history of pulling her J-tube at least once or twice a month due to her behavior.</p>	W 214		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769	
(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 214	Continued From page 158 A review of Client 45's Individual Program Plan (IPP) conducted on 9/25/13, revealed that the client has an open behavioral training program of #B 1-1 -Self injurious behavior of [REDACTED] [REDACTED]) The client has an open behavioral training program for B4-1 - Inappropriate activity level of obsessive-compulsive behavior- [REDACTED] switches, moving-furnitures etc. There was no documentation in the medical record to reflect that a behavior training program for client's behavior of pulling her J-tube was addressed in her current IPP. In an interview with the Individual Program Coordinator (IPC) conducted on 9/25/13 at 11 AM, she stated that the client's behavior of pulling the J tube was not included in her IPP Desired Outcome and Milestone.	W 214		
W 229	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure objectives of the individual program plan were stated separately, in terms of a single behavioral outcome affecting two of 10 core sampled and two focus clients. (Client 37, 47, 61, 69)	W 229		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE .3530 POMONA BOULEVARD POMONA, CA 91769
--	---

(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 229	<p>Continued From page 159</p> <p>Findings:</p> <p>1. Record review beginning on 9/18/13 revealed Client 37 was prescribed psychotropic drugs for the control of aggressive behaviors. The Individual Program Plan (IPP) dated 5/22/13 indicated Client 37 displayed aggression [REDACTED]</p> <p>[REDACTED] The objective did not clearly state one expected learning result, such as Client 37 will reduce biting from x times to x times.</p> <p>The current status [REDACTED] was documented to be 122 episodes per month.</p> <p>[REDACTED]</p> <p>Data was to be collected daily per shift and at all locations. A review of the data being collected revealed there was no description of what behavior Client 37 displayed to reflect if he bit, pulled or grabbed.</p> <p>2. Record review beginning 9/23/13 revealed Client 37 had an objective B1-1 to decrease episodes [REDACTED] and B2-1 to reduce [REDACTED]. A review of the data showed no distinction between which behavior was observed and data collected.</p> <p>3. Record review beginning on 9/24/13 revealed</p>	W 229	<p>W229 #1-4</p> <p>a. On 10/16/13, a workgroup was formed to review the four sampled behavior support plans (clients 37, 47, 61 and 69) in regards to single behavioral outcomes. The workgroup is comprised of the Behavior Services Committee (BSC) Chairperson, two BSC member/reviewers, a Staff Psychologist, and the Senior Supervising Psychologist. On 10/28/13, members of the workgroup met and concurred in their understanding that behaviors that occur together as episodes and are difficult to separate, and that serve the same function, may be defined in terms of a cluster of behaviors and stated as a single behavioral outcome. The workgroup raised concerns related to separating out data for behaviors that occur concurrently (specifically, potential decrease in data accuracy and distortion of behavioral acuity resulting from much higher frequency counts than would result from counting episodes of concurrent behaviors).</p> <p>b. The IDTeam will review the current behavior plans of the four sampled clients (clients 37, 47, 61 and 69) and address the appropriateness of behavioral definitions</p> <p>c. The on-duty Psychologists will receive training in review of Title 42 pertinent to single behavioral outcomes</p>	<p>10/28/13</p> <p>10/31/13</p> <p>10/30/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W229 #1-4 cont.				
	G. Behavior plans containing highly restrictive interventions will be reviewed at the monthly Behavior Review Group meeting to ensure proper identification and definition of target behaviors.			10/29/13	
	H. Individual Program Coordinator and Residence Manager will ensure that discussion and documentation are incorporated into Annual IPP meetings to determine and specify proper identification and definition of target behaviors.			10/29/13	
	I. The Quality Assurance IPP Audit is updated to include review for multiple behavioral outcomes.			10/29/13	
	J. At least annually, behavior support plans are reviewed by the Behavior Services Committee, Human Rights Committee and Therapeutic Review Committee each time a behavior support plan is submitted for review. These committees will monitor to ensure the inclusion of single behavior outcomes in each behavior support plan, or justification provided for any contraindication, prior to each behavior plan's approval and implementation. BSC Members will utilize the BSC Review Checklist (Appendix 12 of the BSC Manual), which stipulates that "Milestones are observable, measurable, specific and stated as a single outcome."			10/29/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 240	Continued From page 161  Client 77's comprehensive functional assessment described his motor skills as, "No observable challenges when manipulating objects of varying size, shape or density". The recommendations were that his work situation, where he folded paper to be shredded by others, "continues to prove beneficial ...". During an interview with Client 77's IPC (Individual Program coordinator) on 9/24/13 at 2:35 PM she stated that Client 77 was very high functioning and agreed he could do more. When asked if there were more stimulating jobs more in line with his abilities, she said with the downsizing of the facility none were offered.	W 240	W240 a. A Special team meeting was held to discuss Client 77's functional skill level, preferred activities and opportunities for vocational training and growth. b. The jobs of labeling grooming supplies and delivering papers for shredding and medication cards to DTAC was added to Client 77's list of options for job he may choose to execute. c. DTAC staff will continue to assure Client 77 is regularly given options of increasing skills in reading and writing. d. The jobs of labeling the grooming supplies and delivering paper and medication cards will be documented on Client 77's time cards. e. The Teacher/mentor Teacher for the class will monitor Client 77's progress and document on the annual vocational assessment. f. The IPC will monitor Client 77's progress on a monthly basis and forward any lack of progress or participation to the Program Director for resolution. g. All ICF clients IPPs are reviewed monthly by the IPC and addressed with the ID Team where appropriate.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247	h. Any Program changes will be elevated to the Program Management by the Residence Manager.	10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 247	<p>Continued From page 162</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide opportunities for client choice and self-management to perform activities of daily living for two of 10 core sampled and five focus clients (Clients 1, 15, 18, 39, 65, 70 and 77).</p> <p>Findings: 1. During the breakfast observation conducted on 9/17/13, starting at 7:30 AM, facility staff was observed serving Client 1 with a breakfast tray. The facility staff dished up the client ' s food including the beverages and brought the entire tray to the client. There was no opportunity provided for client ' s choice of food. The client was able to feed herself without difficulty. After eating her breakfast, the volunteer staff gathered the client's dishes and brought the dishes to the cart. The client was not given an opportunity to bring her dishes to the cart.</p> <p>A lunch observation was also conducted for Client 1 on 9/17/13, starting at 11:30 AM. Client 1 was observed being assisted by a volunteer staff who was seated next to the client. The volunteer staff was observed to pour all of client' s beverages into the cup. The volunteer also assisted the client by holding the client' s fork and scooping the food into the spoon. There were no verbal prompts or hand over assistance. The volunteer held the client ' s fork the entire meal. After the meal was completed the volunteer was observed wiping the client ' s mouth with a napkin and the volunteer took the client' s dishes to the cart.</p> <p>An interview was conducted with the IPC (Individual Program Coordinator) on 9/24/13 at 10 AM. The IPC stated Client 1 is able to do a lot for herself and should have been given the opportunity to bring her dishes to the cart.</p>	W 247	<p>W247 #1</p> <p>a. The Residence Manager and the Dining Room Coordinators will review and provide training in client # 1 Desired Outcome, I5-5 with all staff members on duty.</p> <p>b. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence during meal time.</p> <p>c. The Shift Supervisor and Residence Manager will provide training to the assigned Senior Companion and all staff on duty to promote client independence during dining opportunities.</p> <p>d. The dining room coordinator will monitor breakfast, lunch and dinner daily to ensure that clients' independence/ training opportunities are being provided. The dining room coordinator will monitor for proper implementation of Dietary Safety issues / Care Giver Feeding / Swallowing Guide at each meal. Any identified issues will be elevated to Program Management.</p> <p>e. Observational findings will be documented on the Shift Supervisor Rounds Sheet.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 247	<p>Continued From page 163</p> <p>The record for Client 1 was reviewed on 9/24/13. The IPP (Individual Program Plan) dated 5/15/13, included the following objectives;</p> <p>a. "Will increase communication of her wants, needs and choices..." The training objective included for staff to, "Provide situations or opportunities for (Client 1) to make choices (between clothes, snacks, activities etc.)"</p> <p>b. "Will wipe her mouth with a napkin with 4-5 physical prompts..." The training method indicated, "While she is eating, remind her to lift the napkin to her lips when appropriate. With hand over hand guidance, clean her lips and area around her mouth, when appropriate, by gentle patting motions."</p> <p>2. During the lunch observation conducted on 9/17/13, starting at 12 PM, Client 18 was observed being assisted by staff. The staff was observed serving the client's meal from the tray line to her table where she sat. The staff was observed pouring the client's beverage to her cup. There was no hand over hand or verbal prompting to assist the client. The client was not given an opportunity to pour her own beverage to her cup.</p> <p>During a concurrent interview with facility staff, she stated the client was capable of feeding herself and should have been given an opportunity to pour her own beverage. The client was not given a choice of which beverage she would like to drink.</p> <p>The clinical record for Client 18 was reviewed on 9/24/13. The IPP dated 5/28/13, indicated the client was independent in tolerating/cooperating being fed and required verbal prompts to feed self, eat at a reasonable pace and use a spoon.</p> <p>3. During the dinner observation conducted on 9/18/13 starting at 5:40 PM, Client 39 was observed being assisted by staff. The staff was</p>	W 247	<p>W247 #1 cont.</p> <p>The Residence Manager, will randomly monitor mealtimes during weekly rounds for compliance to ensure all clients' IPPs are being followed for independence and training opportunities. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.</p> <p>g. Shift Supervisor and Residence manager rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.</p> <p>h. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.</p> <p>W247#2</p> <p>a. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure client 18 and all clients have the opportunity for training and independence. (please see continuation page 164a)</p> <p>W247 #3</p> <p>a. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 IPP with all staff on duty to ensure client 39 and all clients have the opportunities for training and independence. (please see continuation page 164a)</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W247#2 cont.				
	b. The Residence Manager and Shift Supervisors will provide training to all staff on duty to promote client independence during dining opportunities.				10/25/13
	c. The dining room coordinator will monitor breakfast; lunch and dinner daily to ensure that clients' independence and training opportunities are being provided. The dining room coordinator will monitor for proper implementation of Dietary Safety Issues / Care Giver Feeding / Swallowing Guide at each meal.				10/25/13
	d. Observational findings will be documented on the Shift Supervisor Rounds Sheet.				10/25/13
	e. The Residence Manager, will randomly monitor mealtimes for compliance to ensure all clients' Individual Program Plans are being followed for independence and training opportunities on a weekly basis. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.				10/25/13
	f. Observational findings will be documented on the Residence Manager Rounds Sheet.				10/25/13
	g. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.				10/25/13
	Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.				10/25/13
	i. Shift Supervisor and Residence manager rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.				10/25/13
	j. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.				10/25/13
	W247 #3 cont.				
	b. The Residence Manager and Shift Supervisors will provide training to all staff on duty to promote client independence during dining opportunities.				10/25/13
	c. The dining room coordinator will monitor breakfast; lunch and dinner daily to ensure that clients' independence and training opportunities are being provided. The dining room coordinator will monitor for proper implementation of Dietary Safety Issues / Care Giver Feeding / Swallowing Guide at each meal.				10/25/13
	d. Observational findings will be documented on the Shift Supervisor Rounds Sheet with any issues elevated to Program Management.				10/25/13
	e. The Residence Manager, will randomly monitor mealtimes for compliance to ensure all clients' Individual Program Plans are being followed for independence and training opportunities on a weekly basis. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.				10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W247 #3 cont.				
	f. Observational findings will be documented on the Residence Manager Rounds Sheet.			10/25/13	
	g. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	h. Observational finding will be documented on the Residence Manager Rounds Sheet.			10/25/13	
	i. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	j. Shift Supervisor and Residence manager rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13	
	k. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13	
	l. Any unresolved Monthly Risk issues will be elevated to the Clinical Quality Management Committee by Program Director with recommendations.			10/30/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

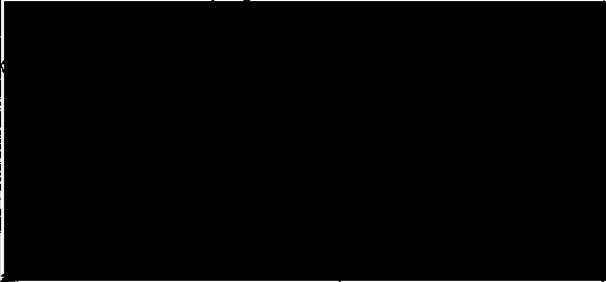
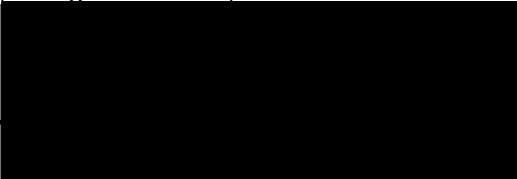
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	<p>Continued From page 164</p> <p>observed pouring the client's beverage for her. The client was not given an opportunity to pour or select her beverage of choice. After the meal, the staff gathered the client's dishes and brought them to the dish cart. The client was not given an opportunity to bring her own dishes to the to the dish cart.</p> <p>The record for Client 39 was reviewed on 9/24/13. The IPP dated 9/19/12, indicated the client was independent in showing awareness of meal time activities, tolerating meal time, and showing preference in dining room location. The IPP also indicated the client was "able to bus her dishes independently, however, she may require verbal prompt as a reminder to do so."</p> <p>4. During the day program observation conducted on 9/18/13 at 10:45 AM, Clients 15, 65 and 70, were escorted to the snack room. The client's teacher was observed serving the three clients with three small containers of apple sauce and two cans of soda. The clients were not given the opportunity to choose the snack of their choice. During a concurrent interview with the teacher, he stated the client were usually given what they have available. He stated the apple sauce and soda is what was available for the clients.</p> <p>On 9/24/13 at 10 AM, the IPC was interviewed. The IPC stated the clients should have choices for snacks unless there was a specific ordered snacks. She stated Clients 15, 65 and 70 did not have specific ordered snack and should have received other snacks besides apple sauce and soda.</p>	W 247	<p>W247 #4</p> <p>a. On a monthly basis, the DTAC Coordinator will distribute a snack order form to client 15, 65 and 70's classroom and all of the classrooms in Program 2 DTAC. DTAC will ensure a variety of snack choices for all clients.</p> <p>b. The Teacher/Teaching Assistant for each classroom will complete the form, ordering a variety of snacks, based on the likes and diet orders of the clients in that classroom.</p> <p>c. The snack order form will be turned into the DTAC Coordinator by the 10th of each month. The DTAC Coordinator will process the form and assure each classroom receives the snacks from Nutritional Services.</p> <p>d. The DTAC Coordinator will keep a copy of the order form for 6 months.</p> <p>e. All DTAC staff will sign a training sheet regarding providing snack choices indicating they understand this process.</p> <p>f. DTAC coordinator will evevate any concerns obtaining a variety of snacks to Program Management.</p> <p>g. Any systemic issue, Program Management to elevate any concerns to Clinical Quality Management.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 247	Continued From page 165 	W 247	W247 #5 a. A special team meeting was held to discuss Client 77's current work program and activities offered throughout his day. 	10/25/13
	Client 77's comprehensive functional assessment described his motor skills as, "No observable challenges when manipulating objects of varying size, shape or density". The recommendations were that his work situation, where he folded paper to be shredded by others, "continues to prove beneficial ...". During an interview with Client 77's IPC (Individual Program coordinator) on 9/24/13 at 2:35 PM she stated that Client 77 was very high functioning and agreed he could do more. When asked if there were more stimulating jobs more in line with his abilities, she said with the downsizing of the facility none were offered. Throughout the survey, facility staff performed functions for Client 77 rather than allowing him to perform them and reinforce his ability to do so as follows: staff scooped his meals to his plate at meal times, tied his shoes for him, threw away his cigarette for him, tested his blood sugar without his participation, poured his medication for him. Additionally staff went to the Fashion Center without him to obtain pants for him. 6. On 9/17/13 during breakfast and lunch observation in residence 23, the dietary staff		will be offered opportunities to participate in writing enhancement sessions. Also at break time he will be encouraged to make his own coffee staff will assist as needed. c. When going to clothing center staff will ensure that he is allowed to pick out his own clothes and staff will assist as needed to ensure proper fit. Will continue with shopping trips with Rehabilitation Therapist to purchase clothing of his choice. d. Upon return from DTAC will continue to make positive choices in leisure activities for active treatment throughout the day. (please see continuation page 167a)	10/25/13
			W247 #6 a. All Residence Managers and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence.	10/25/13

RECEIVED
DEC 8 2013
1:35 pm
ML

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W247 #5 cont.				
	e. Client 77's current program plan has been updated to include these additional program opportunities.			10/25/13	
	f. The Residence Manager provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.			10/25/13	
	g. Residence Manager and Shift Supervisors have provided staff training on the updated program plan for Client 77.			10/25/13	
	h. Shift Supervisor to monitor daily and document observational findings on the Shift Supervisor Rounds Sheet.			10/25/13	
	i. The Residence Manager will monitor during weekly rounds to ensure that program plan is being implemented as developed by the IDT.			10/25/13	
	j. All ICF clients IPPs are reviewed monthly by the IPC and addressed with the ID Team where appropriate.			10/25/13	
	k. Any Program changes will be elevated to the Clinical Quality Management by the Program Director.			10/25/13	
	47 #6 cont.				
	e. The Residence Manager, will randomly monitor mealtimes during weekly rounds for compliance to ensure all clients' Individual Program Plans are being followed for independence and training opportunities. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated. (please see continuation page)f. Observational finding will be documented on the Residence Manager Rounds Sheet.			10/25/13	
	g. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	h. Shift Supervisor and Residence manager rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13	
	i. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13	
	j. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/25/13	
	k. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	l. IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	<p>Continued From page 167</p> <p>provided light to the room. At 6:40 AM, the door to the group room was opened and lights turned on. The staff was observed playing guitar to Client 12 and the two more clients in the room. This continued till 6:55 AM.</p> <p>The Green group room 2320 had focused Clients 76 and 32. The door to the room was closed with lights off and television on. Client 32 was sleeping in her wheelchair. [REDACTED]</p> <p>[REDACTED] A staff came into the room and saw that Client 76 had no shirt on. He left the room and came back with a different colored shirt.</p> <p>The Red group room 2333 had a focused Client 6 sitting in a chair with both feet tucked under her. The room had no lights on but the television was on. The client was alone in the room with door closed. At 6:45 AM all the group rooms were opened and lights turned on.</p> <p>2. On 9/18/13 at 1:45 PM to 3:30 PM there were no active treatment observed being provided to Client 12. The staff in the room stated that Client 12 likes to play the "Connect 4" game. When asked if it is a training objective, he stated it is his leisure activity of choice. He further stated that Client 12's objective is to shred paper, but he has not been to DTAC for over a year. The afternoon supervisor had stated that he recommended to the team to start taking him back to DTAC as it is located next door versus the previous DTAC being located three to four blocks away from the residence. He further stated that he received no response from the team.</p> <p>At 3:30 PM a female staff came and read current news to three clients including Client 12 from an</p>	W 249	<p>W249 #1 and 2 cont.</p> <p>c. The Rehabilitation Therapist will purchase leisure items of choice and activity supplies on a routine basis to ensure clients have access to preferred leisure program materials.</p> <p>d. Shift Supervisors will monitor daily and documents observational findings on the Shift Supervisor Rounds Sheet.</p> <p>e. The Residence Manager will monitor the Shift Supervisor Rounds Sheets to ensure all items are resolved in a timely manner.</p> <p>f. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.</p> <p>g. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.</p> <p>h. Unresolved issues from monthly risk meeting will be elevated to Clinical Quality Management Committee with recommendations by Program Director.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 168</p> <p>iPad. There was no active participation to the current news. On the same day at 5:40 to 6:45 PM, a staff in the room was reading a book to the three clients without any signs of participation.</p> <p>[REDACTED]</p> <p>[REDACTED] At 6:40 PM, Client 12 went out of the room and sat on a chair by the nursing station.</p> <p>3. The clinical record for Client 12 was reviewed on 9/23/13 at 10:20 a.m. The narrative individual program plan indicated that Client 12 had training objective on self-administration of medication. The training consisted of,</p> <p>a. " Client 12 will be invited to the medication cart by [AM] morning and [PM] afternoon medication person.</p> <p>b. Staff will provide verbal explanation/prompts, guided assistance and gestures to assist him with learning to throw medication cup in correct container.</p> <p>c. If during</p> <p>d. Staff will fade assistance as skill is acquired. "</p> <p>During medication pass observation on 9/17/13 at 7:15 AM, it was noted that the medication person poured all the medication for Client 12 into the medication cup. She was observed to hand the medication cup to Client 12 and handed a glass of water, collected the empty cups and dump it on the side of the medication cart.</p> <p>4. Client 12 has a money management training which consist of:</p> <p>a. Inform [Client 12] that it is time for money</p>	W 249	<p>W249 #3 a-d</p> <p>a. The Residence Manager will provide training to all staff on duty on Client 12's and all clients Self-Administration of Medication training plan. 10/25/13</p> <p>b. All Residence Managers and Shift Supervisors will provide training on Administrative Directive 235: Individual Program Plan Implementation. 10/25/13</p> <p>c. Training on Client 12's Self Administration of Medication is conducted on a daily basis and data is collection 14 times a month. 10/25/13</p> <p>d. The Shift Supervisors will monitor the implementation of Self Administration of Medication training for Client 12 and all clients on a daily basis and document observational findings on the Shift Supervisor Rounds Sheet. 10/25/13</p> <p>e. The Residence Manager will monitor the Shift Supervisor Rounds Sheet to ensure all identified issues are resolved immediately. (please see continuation page 169a) 10/25/13</p>	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W249 #3 a-d cont.				
	f. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	g. Any identified action items on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed during the monthly Risk Management Meetings.			10/25/13	
	h. Unresolved issues from the monthly Program risk management meeting will be elevated to Clinical Quality Management Committee with recommendations			10/25/13	
	j. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/25/13	
	k. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	l. IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	
	l. Unresolved issues from monthly risk meeting will be elevated by Program Director/IPC supervisor to Clinical Quality Management Committee with recommendations.			10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 169 management.</p> <p>b. Put variety of money management materials on a table in front of him.</p> <p>c. Place materials in {Client 12} 's hand or give verbal prompt to pick the items so that he can explore the items while verbally explaining to him what the items are.</p> <p>d. Provide number of opportunities for him to touch ...</p> <p>e. ...compliance of given task.</p> <p>During observation in the group room on 9/17 and 9/18/13, staff did not provide money management training to the client.</p> <p>Further review of Client 12's clinical record revealed that the above training had not been met for over a year.</p> <p>5, On 9/18/13 at 1:15 PM, Client 77 had just arrived at this DTAC (day training activity center) when staff asked him to perform his job of folding paper. He signed " no " and pointed towards his residence.</p> <p>[REDACTED]</p> <p>[REDACTED] For a brief time period from 1:40 PM to 1:55 PM a staff member sat with the client while they played a card game, the client wrote words, drew a picture and performed simple arithmetic problems.</p> <p>Then instead of performing any form of active treatment in lieu of working he watched television, walked about the halls and sat in a hallway chair. This lack of activity continued from 2 PM until he and most of the clients on his residence went to Freedom Café at 4:05 PM for a coffee social. Upon his return to the residence he watched</p>	W 249	<p>W249 #4 a-e</p> <p>a. All Residence Managers provided training to all staff on duty on Active Treatment principles.</p> <p>b. All Residence Managers and Shift Supervisors provided training to all staff on duty on AD 235: Individual Program Plan Implementation.</p> <p>c. The DTAC Coordinator provided training on Client 12's money management training objective to all staff working in Client 12's classroom.</p> <p>d. The DTAC Coordinator will monitor to assure that program plans are implemented as outlined in Client 12's IPP in the classroom and document observational findings in the DTAC Coordinator Rounds Report.</p> <p>e. The IPC will monitor monthly and document progress which will be reviewed by the IPC Supervisor with concerns elevated to the Governing Body with recommendations.</p> <p>(Please see continuation sheet 171a)</p> <p>W249 #5</p> <p>a. A special team meeting was held to discuss Client 77's current work program and activities offered throughout his day.</p> <p>b. Current DTAC program will be altered</p> <p>[REDACTED]</p> <p>[REDACTED] During times when Client 77 chooses not to work, he will be offered opportunities to participate in writing enhancement sessions. Also at break time he will be encouraged to make his own coffee</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	Continued From page 170 television, briefly looked a magazines, walked about and sat in the hall and group room until dinner at 5:30 PM. Following dinner at 5:45 PM, he went to a group to watch television by himself. On the morning 9/23/13 following breakfast at 8 AM, Client 77 sat down in the hallway chair. At 8:15 AM, staff asked him to come to the group room. He complied and was given a magazine which he looked at briefly then put it down. He sat and watched television until 8:30 AM when he got up and went to sit in the hallway chair. At 9:05 AM staff asked Client 77 is he wanted to go to work at his DTAC to fold paper and he signed " no ". At 9:10 AM he was transported via van to a square dance that was held in a small auditorium. The square dance consisted of clients who were wheelchair bound clients that were propelled by staff to music that was played. Consequently Client 77 could only watch. At 10:30 he went back to the residence via van transportation. After smoking on the patio he sat down in a hallway chair and walked about the nurses' station until lunch at 11:35 AM. At 1:05 PM he again refused to go to DTAC to fold paper. Staff did hand him a notebook and asked him if he wanted to write, he responded "no". For the next 45 minutes he alternated sitting in the hall and ambulating around the nurses' station and the group room. That same day at 1:45 PM staff was asked why Client 77 wasn't provided active treatment when he refused to go to work. They stated that he was provided with his choice of leisure activities.	W 249	W249 #5 cont. c. When going to clothing center staff will ensure that he is allowed to pick out his own clothes and staff will assist as needed to ensure proper fit. Will continue with shopping trips with Rehabilitation Therapist to purchase clothing of his choice. d. Upon return from DTAC will continue to make positive choices in leisure activities for active treatment throughout the day. e. Client 77's current program plan has been updated to include these additional program opportunities. (please see continuation page 171a) W249 #6 a. The residence Psychologist provided training to all staff on duty on Client 2, 26, 73 and 64's Behavior Support plans and Approaches and Strategies. To ensure all clients recieve appropriate interventions designed to increase engagement and reduce socially stigmatizing or harmful behaviors. b. Residence Manager, IPC and Shift Supervisors will monitor and provide training to staff as needed. c. Shift Supervisors will ensure and provide support and coaching to staff during their daily rounds and document any barriers on their rounds sheet. (please see continuation page 171a)	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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
	W249 #4 a-e & #5 cont.			
	f. The Residence Manager provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.			10/25/13
	g. Residence Manager and Shift Supervisors have provided staff training on the updated program plan for Client 77 and all ICF clients.			10/25/13
	h. All Shift Supervisor to monitor daily and document observational findings on the Shift Supervisor Rounds Sheet.			10/25/13
	i. All Residence Manager will monitor during weekly rounds to ensure that program plan is being implemented as developed by the IDT.			10/25/13
	j. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/25/13
	k. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13
	l. IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13
	m. Unresolved issues from monthly risk meeting will be elevated by Program Director/IPC supervisor to Clinical Quality Management Committee with recommendations.			
	W249 #6 cont.			
	d. IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted.			10/25/13
	e. IPC to document the findings in the Monthly Summary notes.			10/25/13
	f. IPC Supervisor will monitor for compliance via review of the IPC Notes.			
	g. Unresolved issues from monthly risk meeting will be elevated by Program Director/IPC supervisor to Clinical Quality Management Committee with recommendations.			

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	<p>Continued From page 171</p> <p>6. During an initial observation on 9/16/13 at 11:10 AM in room 11 (group room 1) of Residence 29, four clients (focus sample Clients 2, 26, 73, and core sampled 64) were observed with one staff. [REDACTED]</p> <p>The staff continued to read to clients without any attempt to engage them in the activity. There were no appropriate interventions applied during the observation.</p> <p>7. During an observation on 9/17/13 at 6:10 AM. in Residence 29, focus sampled Client 43 was observed sitting on the chair by the nurses' station. [REDACTED]</p> <p>During the observation, the Supervising Psychiatric Technician (SPT) entered the unit with a cup on her right hand. She placed the cup with lid on top of the nurses' station counter while engaged in a conversation with the surveyor. Suddenly focus sampled Client 43 walked towards us as if he wanted something. The SPT intervened and redirected the client to sit back in the chair.</p> <p>During an interview with the Individual Program Coordinator (IPC) on the same day at 7:20 AM,</p>	W 249	<p>W249 #6 cont.</p> <p>f. Residence Psychologist to review the intervention plans with the staff members as needed during each shift.</p> <p>g. The Rehabilitation Therapist will provide residential support in the living rooms focused on preferred recreation and leisure activities.</p> <p>h. Program Management to randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>i. Any identified action items found on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed at the monthly Risk Management Meeting. Any issues will be elevated to the Clinical Management Committee by Program Director with recommendations.</p> <p>W249 #7</p> <p>a. The Residence Manager provided training to all staff on-duty related to unsecured liquids on the building.</p> <p>b. Shift Supervisors will monitor and alert visitors, floats and janitors on this protocol and document observational findings on the Shift Supervisor Rounds Sheets.</p> <p>c. The Residence Manager will monitor the Shift Supervisors Rounds Sheets and take corrective action when warranted.</p> <p>d. The Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	<p>Continued From page 172</p> <p>she stated that focus sampled Client 43 had a behavior of drinking any liquid. She also stated that the client will grab any container that could have liquid inside it and that staff should not have any type of container with liquids around him.</p> <p>The medical record for focus sampled Client 43 was reviewed on 9/24/13 at 2 PM. The Approaches and Strategies dated 8/6/13 indicated that he lacks safety awareness. It also indicated, "It is very important to maintain a safe environment around [core sampled client's name] at all times. No cans or drinks of any kind lying around in the group areas/van/patio/janitorial carts - He may jump over a counter to obtain a can or a drink if he sees it. Ensure all liquids are secured in a proper closed cabinet."</p> <p>8. During an observation on 9/17/13 at 6:35 AM in group room 3 of Residence 29, six clients were observed with one staff. Five clients were noted sitting on the couch, including focus sampled Client 2 [REDACTED]</p> <p>During an interview with the PT of the night shift on the same day at 6:40 AM, she stated that she worked in the unit since 5/2012. She also stated that she's pretty familiar with the clients in the residence, although she didn't know the intervention on each one of them. When she was asked why core sampled client 64 had his fingers in his ears, she stated, "I don't know why he does that." When she was asked if there was any training objective for it, she answered, "No, I don't</p>	W 249	<p>W249 #7 cont.</p> <p>e. The RM will ensure that all staff follows the client alerts as indicated on the Approaches and Strategies and document findings on the Residence Manager Rounds Sheet.</p> <p>f. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>g. Any identified action item from the Shift Supervisor and Residence Manager Rounds Sheets will be addressed during the monthly Risk Management Meetings. Any issues will be elevated to the Clinical Quality Management Committee with recommendations.</p> <p>W249 #8</p> <p>a. The residence Psychologist provided training to all staff on duty on Client 64's BSP and Approaches and Strategies.</p> <p>b. All RM, IPC and Shift Supervisors will monitor and provide training to staff as needed.</p> <p>c. Shift Supervisors will ensure and provide support and coaching to staff during their daily rounds and document any barriers on their rounds sheet.</p> <p>d. All IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted.</p> <p>e. All IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified IPC will elevate issues to the RM and Program Management.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 173</p> <p>know." When asked why core sampled client 64 was only wearing his underwear, she replied, "Probably [focus sampled Client 43's name] took it off, he likes straightening things." There were no appropriate interventions applied during the observation.</p> <p>9. During an observation of the medication pass on 9/17/13 at 11 a.m. in Residence 29, a licensed staff was observed approaching the clients (focus sampled clients 2, 4, and 16), one at a time and spoon fed their medications.</p> <p>During an interview with the licensed staff on the same day at 11:25 AM, he stated that he gives the medication to clients with pudding using a spoon. When asked if clients had trainings on self-administration of medication, he stated, "None of them has medication management, not that I know of."</p> <p>The medical record for focus sampled Clients 2, 4, and 16 was reviewed on 9/20/13 at 9:50 AM. The Individual Program Plan (IPP) Narratives of the clients were reviewed in particular. The review indicated that all three clients had self-administration of medication formulated in the plan for continuous active treatment. The plan indicated that each client will respond to his name when called and approach the medication cart. Focus sampled Client 2 required assistance in holding the cup in one hand and scooping the medication. Focus sampled Client 4 could hold the spoon scoop the medication. Focus sampled Client 16 was able to hold the liquid cup.</p> <p>During a meal observation in the dining area of Residence-29 on 9/17/13 at 12:05 PM and 9/18/13 at 5:35 PM and 6 PM, all three clients</p>	W 249	<p>W249 #8 Cont.</p> <p>f. Residence Psychologist to review the intervention plans with the staff members as needed during each shift.</p> <p>g. Program Management to randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>h. Any identified action items found on the Shift Supervisor or RM Rounds Sheet will be addressed at the monthly Risk Management Meeting.</p> <p>W249 #9</p> <p>a. The Residence Manager (RM) and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.</p> <p>b. The RM and Shift Supervisor will review and provide training to all staff on duty related to Self Administration of Medications.</p> <p>c. Shift Supervisors will randomly monitor medication passes to make sure staff are implementing each client's Self Administration of Medication training to all clients, especially identified Clients, 2, 4 & 16.</p> <p>d. The RM will monitor randomly during Medication Pass by Clinic Staff and document on the Residence Manager Rounds Sheet.</p> <p>e. The IPC will monitor progress monthly and document on the IPC Monthly Training Report and elevate issues to the RM and Program Management for follow-up.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 174</p> <p>were observed eating their meals using their hands.</p> <p>During an interview with the IPC on 9/24/13 at 3:30 PM, she stated that all three clients had trainings in self-administration of medications. She also acknowledged that she had observed the practice in the past and would bring it to the attention of the SPT or Residence Manager.</p> <p>10. a) During a meal observation in the dining area of Residence 29 on 9/16/13 at 11:35 AM, 9/17/13 at 11:59 AM, and 9/18/13 at 5:35 PM, staff were observed serving the clients their food, waiter style.</p> <p>During an interview with the Food Service I on 9/17/13 at 12:01 PM, he stated that they serve the food to the clients sitting on the table. He also stated that the staff will pick up the client's tray after they eat and dump the remaining content in the trash.</p> <p>There were no choices or opportunities for training provided for clients during these meals observations.</p> <p>b) During a meal observation in the dining area of Residence 29 on 9/16/13 at 11:35 AM, core sampled Client 64 was observed jumping while escorted by the Teacher out of the dining area.</p> <p>During an observation on 9/17/13 at 11:45 AM, in Residence 29, core sampled Client 64 was observed running and jumping in the hallway by the nurses' station. The SPT was in the area at the time, saw what the client was doing and stated, "[core sampled client 64]."</p>	W 249	<p>W249 #9 cont.</p> <p>f. The Interdisciplinary Team evaluate each client's training plan and any identified issues as needed.</p> <p>g. Program Management will randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>h. Any identified action items from the Shift Supervisor and Residence Manager Report Sheets will be addressed during the monthly Risk Management Meetings.</p> <p>W249 #10 a</p> <p>a. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence. (please see continuation page 175a)</p> <p>W249 #10b</p> <p>a. The residence Psychologist provided training to all staff on duty on Client 64's Behavior Support plan and Approaches and Strategies.</p> <p>b. Residence Manager, IPC and Shift Supervisors will monitor and provide training to staff as needed.</p> <p>c. Shift Supervisors will ensure and provide support and coaching to staff during their daily rounds and document any barriers on their rounds sheet. (please see continuation page 175a)</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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
--------------------	--	---------------	---	----------------------

	W249 #10 a cont.			
	b. The dining room coordinator will monitor breakfast; lunch and dinner daily to ensure that all clients' independence and training opportunities are being provided. The dining room coordinator will monitor for proper implementation of Dietary Safety Issues / Care Giver Feeding / Swallowing Guide at each meal.			10/25/13
	c. Observational findings will be documented on the Shift Supervisor Rounds Sheet.			10/25/13
	d. The Residence Manager will monitor the findings documented on the Shift Supervisor Rounds Sheet on a weekly basis to ensure all items identified have been corrected.			10/25/13
	e. The Residence Manager, will randomly monitor mealtimes weekly for compliance to ensure all clients' Individual Program Plans are being followed for independence and training opportunities. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.			10/25/13
	f. Observational findings will be documented on the Residence Manager Rounds Sheet.			10/25/13
	g. Shift Supervisor and Residence Manager Rounds Sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13
	h. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13
	i. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13
	W249 #10b cont.			
	d. The Residence Manager and Shift Supervisors provided staff training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.			10/25/13
	e. IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted.			10/25/13
	f. The IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified during observations and record review, the IPC will elevate issues to the RM and Program Management for follow-up and document at least quarterly in the IPC note			10/25/13
	g. Residence Psychologist to review the intervention plans with the staff members as needed during each shift.			10/25/13
	h. The Rehabilitation Therapist will provide residential support in the living rooms focused on recreation and leisure activities.			10/25/13
	i. Program Management to randomly monitor during monthly rounds and document on the 24 hour report.			10/25/13
	j. Any identified action items found on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed at the monthly Risk Management Meeting.			10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	<p>Continued From page 175</p> <p>During an observation on 9/24/13 at 9:55 AM outside Residence 29, core sampled Client 64 was observed jumping, escorted by staff while crossing the street. The client was observed behind the staff and was unaware of the client's behavior.</p> <p>The medical record for core sampled Client 64 was reviewed on 9/23/13 at 10:30 AM. The Approaches and Strategies dated 4/23/13 indicated that he lacks safety awareness and required enhanced supervision. It also indicated, "Translocation: Staff to walk besides him." The IPP Desired Outcome and Milestone indicated that there was a training method and intervention for his behavior of jumping (B5-1 Agitation). The review further indicated, "6. Intervention B5-1: staff are to intervene immediately to ensure safety and protection if behaviors are attempted/occurs. Indicate/gesture for [core sampled client 64's name] to stop the behavior/to relax."</p> <p>During an interview with the SPT on 9/24/13 at 10 AM, she stated that there was a plan for the client's behavior of running and hopping. According to her, staff who observed the behavior should ask the client to slow down and walk slowly, because it can cause injury.</p> <p>During an interview with the IPC on 9/24/13 at 2:50 PM, she stated that there was a plan for the client's behavior of running and hopping. According to her, when staff noticed the behavior, they should intervene and prompt the client to slow down and settle down, and that the intervention of prompting should be in a timely manner. She also stated, "The data should be collected and recorded as episodal."</p>	W 249		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 176</p> <p>11. a) During an observation in classroom 2 of Pine Vocational Center on 9/18/13 at 9:51 AM, focus sampled Client 49 was observed sitting by the radio and rocking. He was not observed engaged in any vocational activity. He suddenly got up and walked to the adjacent room (classroom 3) and sat on a chair. The client was observed walking back and forth between classrooms. At 10:20 AM, he was observed opening the cabinets in classroom 3 one by one. One of the staffs in classroom 3 observed his behavior and stated, "[focus sampled Client 49's name] are you making sure that everything is in place?" At 10:30 a.m., still without being engaged in any activities, he ran out of the room and left. The Teacher went after the client and came back with him, stating that he went home. At 10:40 AM, focus sampled client 49 was still observed just sitting, moving around, and not engaged in any activities.</p> <p>During an interview with the Teacher on the same day at 10: 38 AM, she stated, "He didn't want to do anything today, maybe because you're here.</p> <p>The medical record for focus sampled Client 49 was reviewed on 9/23/13 at 2 PM. The IPP Desired Outcome and Milestone dated 8/29/13 indicated that there was a plan and training method designed for the client while in the vocational training program to be implemented, even when he refused to work.</p> <p>b) During an observation in classroom 2 of Pine Vocational Center on 9/18/13 at 9:51 AM, focus sampled Client 2 was observed rocking while on the table with four other clients and a staff. He was observed not engaged in any vocational</p>	W 249	<p>W249 #11 a</p> <p>a. When IPPian packets are completed after clients' annual meeting, the DTAC Coordinator will send out the packet with a training sheet attached to the DTAC staff who work with that client. The DTAC staff who work with that client will review the packet, including the desired outcomes/ milestones for vocation, and sign the training sheet, indicating they understand the contents to ensure continuous active treatment for all clients.</p> <p>b. All DTAC Coordinators to collect and maintain the training sheets for at least one year.</p> <p>c. Staff will assure that supplies are set up and ready to be used by a client, prior to staff requesting the client to participate.</p> <p>d. The Teacher/Teaching Assistants will document progress in the classroom data for each client.</p> <p>e. The IPCs' will monitor progress and forward any lack of progress to the Program Director.</p> <p>f. The DTAC Coordinators will conduct weekly rounds and document observational findings on the DTAC rounds report.</p> <p>g. The Program Assistant will monitor the weekly rounds reports to ensure all action items are resolved.</p> <p>h. Any identified action items on the DTAC rounds reports will be addressed during monthly Risk Management Meetings with issues elevated to Clinical Quality Management Committee with recommendations.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 249	Continued From page 177 activity. He suddenly started hitting his face with his hand eight times. During an interview with the Teacher on 9/18/13 at 10:40 AM, she confirmed the self-injurious behavior of the client. She stated that she was aware of the client's behavior. When she was asked if the staff was tracking the self-injurious behavior of the client, she stated, "Yes." When she was asked how many times the client hit himself, she stated, "Ill averages it about 10." The medical record for focus sampled Client 2 was reviewed on 9/23/13 at 2:45 PM. The IPP Desired Outcome and Milestone dated 4/20/12 indicated that there was a training method and intervention for his behavior of hitting himself (B1-2 Self-injury). The review further indicated, "10. TRAINING METHOD - 1. Involve [focus sampled client 2's name] in scheduled activities..." No one was observed tracking or writing the self-injurious behavior and there were no appropriate interventions applied during the observation. c) During an observation in classroom 2 of Pine Vocational Center on 9/18/13 at 9:51 AM, focus sampled Client 43 was observed with the Teacher engaging him in an activity of placing stacks of paper on the table. The client was observed picking up a sheet of paper from on side of the table and placing it on the other side of the table while the teacher was counting from one to ten. When the client was finished stacking ten sheets of paper, the teacher stated, "You did it! Good job." The activity was done once and the client was given a small electronic piano afterwards.	W 249	W249 #11 b-c a. The DTAC Coordinator will provide training to the DTAC staff who work with Client 2 and 43 to review his behavior plan B1-2 for self-injurious behavior and sign a training sheet indicating they understand the plan. b. The Program Assistant and DTAC Coordinator met with the teaching staff for Client 2 and 43 to develop a reliable system for collecting behavioral data. (refer to W252 #6) c. The Teacher will keep a tablet on the Teacher's desk for the purpose of tracking Client 2 and 43's behaviors in the classroom. At the end of the session, the Teacher will document the accurate numbers in the behavior data. d. All clients behavior datas are turned in monthly to the residences and is monitored both in the monthly progress notes by residence staff and the IPCs Report. e. The DTAC Coordinators will do weekly spot checks to ensure the behavior datas tally sheet is being used throughout the day and document on the DTAC rounds report. f. The Program Assistant will monitor the DTAC rounds reports and ensure that any identified issue is resolved. g. Any identified action items on the DTAC rounds reports will be addressed during the monthly Risk Management Meetings. (please see continuation page 178a)	10/25/13	
				10/24/13	
				10/25/13	
				10/25/13	
				10/25/13	
				10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W249 #11 b-c cont.				
	h. The DTAC Coordinators will do weekly spot checks in all DTAC classrooms to ensure the behavior data tally sheet is being used throughout the day and document on the DTAC rounds report.				10/25/13
	i. The Program Assistant will monitor the DTAC rounds reports and ensure that any identified issue is resolved.				10/25/13
	j. Any identified action items on the DTAC rounds reports will be addressed during the monthly Risk Management Meetings and will be elevated to the Governing Body with recommendations.				10/25/13
	k. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.				10/25/13
	l. IPCs will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.				10/25/13
	m. IPC Supervisor will monitor for compliance via review of the IPC Notes.				10/25/13
	n. Unresolved issues from monthly risk meeting will be elevated by Program Director/IPC supervisor to Clinical Quality Management Committee with recommendations.				10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 178</p> <p>The medical record for focus sampled Client 43 was reviewed on 9/19/13 at 2:35 PM. The IPP Desired Outcome and Milestone dated 8/8/13 indicated that there was a plan and training method designed for the client while in the vocational training program. The review indicated, "Staff will model and verbally explain what we would like [focus sampled Client 43] to do in the process of counting 10 papers out for preparing work for shredding confidential paper. We would like [focus sampled Client 43] to use counting template to count out 10 sheets of paper, afterwards placing pile of 10 in a bin..."</p> <p>12. Client 1's clinical record was reviewed on 9/23/13. The annual IPP dated 5/15/13, included the following objectives: a. Will wipe her mouth with a napkin with 4-5 physical prompts... The training method indicated, "While she is eating, remind her to lift the napkin to her lips when appropriate. With hand over hand guidance, clean her lips and area around her mouth, when appropriate, by gentle patting motions." During the breakfast observation conducted on 9/17/13, starting at 7:30 AM, facility staff was observed serving Client 1 with a breakfast tray. The facility staff dished up the client's food including the beverages and brought the entire tray to the client. During the meal, there was no active treatment provided to the client regarding the use of a napkin. A lunch observation was also conducted for Client 1 on 9/17/13, starting at 11:30 AM. Client 1 was observed being assisted by a volunteer staff who was seated next to the client. The volunteer staff was observed to pour all of client's beverages into the cup. The volunteer also assisted the client by</p>	W 249	<p>W249 #12a-b a. The Residence Manager and the Dining Room Coordinators will review and provide training in client # 1's Desired Outcome, 15-5 with the assigned Senior Companion and all staff on duty to ensure all clients have the opportunities for training and independence during meal time. b. All Residence Managers and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence. c. All Residence Managers and Shift Supervisors will provide training to the assigned Senior Companion and all staff on duty to promote client independence during dining opportunities.</p>	<p>10/25/13 10/25/13 10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W249 #12a-b cont. i. Shift Supervisor and Residence Manager Rounds Sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13	
	j. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.			10/25/13	
	k. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings.			10/25/13	
	l. Unresolved issues from monthly risk meeting will be elevated by Program Director to Clinical Quality Management Committee with recommendations.			10/25/13	
	W249 #13 cont. (please see page 181 for b-g) h. Shift Supervisor and Residence Manager Rounds Sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution.			10/25/13	
	i. Any identified action items on the Shift Supervisor Rounds Sheets or Residence Managers Rounds Sheets will be addressed during the monthly Risk Management Meetings.			10/25/13	
	j. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/25/13	
	k. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	l. IPC Supervisor will monitor for compliance via review of the IPC Notes.			10/25/13	
	m. Unresolved issues from monthly risk meeting will be elevated by IPC supervisor to Clinical Quality Management Committee with recommendations.				

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	Continued From page 180 objective to decrease frequency of episodes that she engages in self-injurious behavior (wets-skin by placing hand in mouth and twirling/rolling tongue with hand) ...The training method indicated, "If (Client 15) extends her tongue and attempts to twirl or roll it with her hands, verbally prompt her to stop and redirect her to ongoing activity. The IPP also documented the client having recurrent skin maceration to her hands and fingers due to, "constant exposure to saliva." During observations conducted on 9/17/13 and 9/18/13, Client 15 was observed numerous times engaging in behavior of twirling and rolling her tongue with her hand. There was no intervention from staff to prevent the client from twirling or rolling her tongue. On 9/24/13, at 10 AM, the IPC (Individual Program Coordinator) was interviewed. The IPC stated Client 15 had non-edible adaptive equipment "Chew Stix", for the behavior of twirling and rolling her tongue with her hand. She stated the equipment was a recommendation from the OT (Occupational Therapist). She stated staff should have utilized the adaptive equipment. A review of the OT evaluation dated 3/26/13, indicated a recommendation to, "...try non- food items that may be placed in the mouth... Some items to try might be drinking straws, swizzle sticks, or sensory mouthing items designed for chewing behaviors..." The adaptive equipment recommended by the OT was not observed during the observations conducted on 9/17/13 and 9/18/13. 14. The record for Client 56 was reviewed on	W 249	W249 #13 cont. b. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunities for training and independence. c. The Shift Supervisor will coach staff in the implementation of Client 15's Program Plan as warranted throughout the shift. d. Observational findings will be documented on the Shift Supervisor Rounds Sheet. e. The Residence Manager, will randomly monitor to ensure all clients' Individual Program Plans are being followed for independence and training opportunities on a weekly basis. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated. f. Observational findings will be documented on the Residence Manager Rounds Sheet. g. Program Management will randomly monitor for compliance during monthly rounds and document findings on the 24 hour report.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 249	<p>Continued From page 181</p> <p>9/24/13. The IPP dated 4/17/13 included an objective to place paper in shredder with verbal prompts for 3 minutes. The training method indicated, " 3. Staff will verbally prompt (Client 56) to begin working. 4. Staff will hand (Client 56) paper to shred and encourage her to continue working for as long as she will tolerate task."</p> <p>A day program observation was conducted on 9/18/13, from 9:10 AM to 11 AM. Client 56 was observed sitting next to staff without any participation. The client was observed pushing tray of papers away from her and not willing to participate. There was no intervention from staff to engage the client in the work activity. The staff supervising the client was observed folding the paper and stacking them next to the client. There was no attempt from the staff to verbally prompt the client to shred papers.</p> <p>During a concurrent interview with the staff, he stated the client's job was to fold the papers and stack them together.</p> <p>On 9/18/13, at 2:30 PM, a subsequent day program visit was made. Client 56 was again observed sitting next to staff. From 2:30 to 3 PM, the client sat next to staff without any participation. There was no attempt from staff to verbally prompt the client to shred papers.</p> <p>15. The clinical record for Client 52 was reviewed on 9/24/13. The IPP dated 1/23/13, indicated an objective, "Will increase the frequency of appropriate communicating wants/needs/choices by verbalizing... The training method indicated, " 1. Reinforce her throughout the day for appropriate behavior. Involve her in events/activities on/off residence. 4. Interact with</p>	W 249	<p>W249 #14</p> <p>a. The DTAC Coordinators will provide training to all DTAC staff who work with Client 56 & on the vocational desired outcome/milestones and sign a training sheet indicating they understand the contents.</p> <p>b. Teaching staff will ensure that the materials for Client 56's vocational activities and all clients are prepared and ready prior to requesting to participate in their vocational training.</p> <p>c. DTAC staff to document progress on time cards and data sheets.</p> <p>d. IPCs to monitor progress on IPC Report and forward any identified issues to the Program Director.</p> <p>e. DTAC Coordinators will conduct weekly rounds and document any identified action item on the DTAC rounds report and forward to the Program Assistant for resolution.</p> <p>f. Any identified action items on the DTAC rounds report will be addressed during the monthly Risk Management Meetings with any issues elevated to Clinical Quality Management committee with recommendations.</p> <p>W249 #15</p> <p>a. The Residence Manager and the Shift Supervisors will review and provide training in client # 52's Desired Outcome, S1-3 with all staff members on duty to ensure all clients receive continous training on appropriate communications skills.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 249	<p>Continued From page 182</p> <p>her as often as possible and provide her with an opportunity to communicate her feelings/thoughts.</p> <p>An observation was conducted on 9/17/13 starting at 12:30 PM. Client 52 was observed sitting in a reclining chair near the nurse's station. The client was observed sitting by herself [REDACTED]. The client sat on the reclining chair from 12:30 to 1:15 PM [REDACTED] without interaction from staff or peers. There was no intervention from staff to engage the client with active treatment activities. The client was not offered to communicate her wants, needs, or choices as stated in the above objective.</p> <p>During observations conducted on 9/18/13, at 3:30 PM, Client 52 was again observed sitting on the reclining chair with radio on, [REDACTED]. From 3:30 to 4:30 PM, the client sat in the reclining chair with no other activity other than sitting on the reclining chair [REDACTED]. There was no intervention from staff to engage the client with active treatment activities. The client was not offered to communicate her wants, needs, or choices as stated in the above objective.</p> <p>An interview was conducted with the PT on 9/18/13, at 4:35 PM. When asked about Client 52, she stated sometimes the client likes to go to the group and look at magazines.</p> <p>The client was not given to the opportunity to join the group or attend the patio activities.</p>	W 249	<p>W249 #15 cont.</p> <p>p. The Residence Manager and Shift Supervisors will review and provide training in Administrative Directive # 235 Individual Program Plan with all staff on duty to ensure all clients have the opportunity for training and independence.</p> <p>c. The Shift Supervisors will coach staff in the implementation of Client 52's Program Plan as warranted throughout the shift.</p> <p>d. Observational findings will be documented on the Shift Supervisor Rounds Sheet.</p> <p>e. The Residence Manager will monitor the findings documented on the Shift Supervisor Rounds Sheet on a weekly basis to ensure all items identified have been corrected.</p> <p>f. The Residence Manager, will randomly monitor to ensure all clients' Individual Program Plans are being followed for independence and training opportunities on a weekly basis. Re-training/instruction will be given as needed during observations and corrective action will be taken as indicated.</p> <p>g. Observational findings will be documented on the Residence Managers Weekly Audit.</p> <p>h. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 249	Continued From page 183 16. Review of a closed record beginning on 9/18/13 revealed Client 99 expired unexpectedly on 6/4/13 at 9 AM. Review of the Interdisciplinary Notes dated 6/3/13 at 2130 (9:30 PM) and 2230 (10:30 PM) and the NOC shift summary at 0600 AM revealed prior to Client 99's death had, she displayed agitation, running in hallways, kicking the doors, went outside to the patio, was making noises, defecating on the floor and awake until 0230 AM. The only description of therapeutic intervention was "difficult to redirect" and "taken to shower to clean." There is no written evidence of an enhancement of supervision, or behavior plan interventions utilized. In addition, Client 99 was reportedly on her menses and had been identified to suffer from moderate menses pain which benefited from prescribed pain relief and review of the medication record revealed pain relief was not assessed or provided to her. Behavior training methods described in the Individual Program Plan dated 11/8/12 defined Client 99 training priorities to include reduction of self injury, property destruction, aggressive behaviors and improve socially acceptable behaviors. The training plan included encouragement to participate and communicate by asking her point, gesture, take her hand etc. help her to communicate what she wants/needs, verbal reinforcement, making choices and accommodating needs. If Client 99 engaged in target behavior, staff should have directed her to stop, intervened immediately by directing her to a	W 249	W249 #15 cont. Shift Supervisor and Residence Manager rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution. j. Any identified action items on the Shift Supervisor Rounds Sheet or the Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings. Any unresolved issues elevated to the CQM committee with recommendations. W249 #16 a. Client #99 passed away on June 4, 2013. b. The Residence Manager and Shift Supervisors provided training to all staff on duty on specified levels of supervision identified in each individual's Individual Program Plan. c. Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 226: Client supervision levels. d. Residence Manager and Shift Supervisor provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation. e. Residence Manager to monitor residence daily to ensure client safety and that staff are knowledgeable and compliance with client supervision levels.	10/25/13 10/25/13 9/24/13 9/24/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 252	Continued From page 185 were no appropriate interventions applied and no data collected during the observation. 2. During an observation on 9/17/13 at 6:35 AM in group room 3 of Residence 29, six clients were observed with one staff. Five clients were noted sitting on the couch, including focus sampled Client 2 [REDACTED] During an interview with the PT of the night shift on the same day at 6:40 AM, she stated she worked in the unit since 5/2012. She also stated that she's pretty familiar with the clients in the residence, although she didn't know the intervention on each of them. When she was asked why core sampled Client 64 had his fingers in his ears, she stated, "I don't know why he does that". When she was asked if there was any training objective for it, she answered, "No, I don't know." When asked why core sampled client 64 was only wearing his underwear, she replied, "Probably [focus sampled client 43's name] took it off, he likes straightening things." There were no appropriate interventions applied and data collected during the observation. 3. During a meal observation in the dining area of Residence 29 on 9/16/13 at 11:35 AM, core sampled Client 64 was observed jumping while escorted by the Teacher out of the dining area. During an observation on 9/17/13 at 11:45 AM, in Residence 29, core sampled Client 64 was observed running and jumping in the hallway by	W 252	W252 #1 and 2 cont. d. IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted. e. IPC to document the findings in the Monthly Summary notes The IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified during observations and record review, the IPC will elevate issues to the RM and Program Management for follow-up and document at least quarterly in the IPC note f. All Residence Psychologists to review the intervention plans with the staff members as needed during each shift. g. Program Management to randomly monitor during monthly rounds and document on the 24 hour report. h. Any identified action items found on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed at the monthly Risk Management Meeting. W252 #3 a. The residence Psychologist provided training to all staff on duty on Client 64's Behavior Support plan and Approaches and Strategies. b. All Residence Managers, IPCs and Shift Supervisors will monitor and provide training to staff as needed.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 252	<p>Continued From page 186</p> <p>the nurses' station. The SPT was in the area at the time, saw what the client was doing and stated, "[core sampled client 64]."</p> <p>During an observation on 9/24/13 at 9:55 AM outside Residence 29, core sampled Client 64 was observed jumping, escorted by staff while crossing the street. The client was observed behind the staff and staff was unaware of the client's behavior.</p> <p>The medical record for core sampled Client 64 was reviewed on 9/23/13 at 10:30 AM. The Approaches and Strategies dated 4/23/13 indicated that he lacks safety awareness and required enhanced supervision. It also indicated, "Translocation: Staff to walk besides him." The IPP Desired Outcome and Milestone indicated that there was a training method and intervention for his behavior of jumping (B5-1 Agitation). The review further indicated, "6. Intervention B5-1: staff are to intervene immediately to ensure safety and protection if behaviors are attempted/occurs. Indicate/gesture for [core sampled client 64's name] to stop the behavior/to relax."</p> <p>During an interview with the SPT on 9/24/13 at 10 AM, she stated that there was a plan for the client's behavior of running and hopping. According to her, staff who observed the behavior should ask the client to slow down and walk slowly, because it can cause injury.</p> <p>During an interview with the IPC on 9/24/13 at 2:50 PM, she stated that there was a plan for the client's behavior of running and hopping. According to her, when staff noticed the behavior, they should intervene and prompt the client to</p>	W 252	<p>W252 #3 cont.</p> <p>c. Shift Supervisors will ensure and provide support and coaching to staff during their daily rounds and document any barriers on their rounds sheet.</p> <p>d. All Residence Managers and Shift Supervisors provided staff training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation. 5. IPC will monitor and reconvene a meeting to discuss any re-emerging behaviors or issues about the plan if warranted.</p> <p>e. IPC to document the findings in the Monthly Summary notes and on the report.</p> <p>f. Residence Psychologist to review the intervention plans with the staff members as needed during each shift.</p> <p>g. The Rehabilitation Therapist will provide residential support in the living rooms focused on recreation and leisure activities.</p> <p>h. Program Management to randomly monitor during monthly rounds and document on the 24 hour report.</p> <p>i. Any identified action items found on the Shift Supervisor or Residence Manager Rounds Sheet will be addressed at the monthly Risk Management Meeting.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 252	<p>Continued From page 187</p> <p>slow down and settle down, and that the intervention of prompting should be in a timely manner. She also stated, "The data should be collected and recorded as episodal." There were no appropriate interventions applied and data collected during the observation.</p> <p>4. a) During an observation in classroom 2 of Pine Vocational Center on 9/18/13 at 9:51 AM, focus sampled Client 49 was observed sitting by the radio and rocking. He was not observed engaged in any vocational activity. He suddenly got up and walked to the adjacent room (classroom 3) and sat on a chair. The client was observed walking back and forth between classrooms. At 10:20 AM, he was observed opening the cabinets in classroom 3 one by one. One of the staff in classroom 3 observed his behavior and stated, "[focus sampled Client 49's name] are you making sure that everything is in place?" At 10:30 AM, still without being engaged in any activities, he ran out of the room and left. The Teacher went after the client and came back with him, stating that the he went home. At 10:40 AM, focus sampled Client 49 was still observed just sitting, moving around, and not engaged in any activities.</p> <p>During an interview with the Teacher on the same day at 10: 38 AM, she stated, "He didn't want to do anything today, maybe because you're here.</p> <p>The medical record for focus sampled Client 49 was reviewed on 9/23/13 at 2 PM. The IPP Desired Outcome and Milestone dated 8/29/13 indicated that there was a plan and training method designed for the client while in the vocational training program to be implemented, even when he refused to work. There were no</p>	W 252	<p>W252 #4</p> <p>a. When IPPlan packets are completed after a client's annual meeting, the DTAC Coordinator will send out the packet with a training sheet attached to the DTAC staff who work with that client. The DTAC staff who work with that client will review the packet, including the desired outcomes/ milestones for vocation, and sign the training sheet, indicating they understand the contents to ensure clients recieved continous active treatment.</p> <p>b. The DTAC Coordinator to collect and maintain the training sheets for at least one year.</p> <p>c. Staff will assure that supplies are set up and ready to be used by a client, prior to staff requesting the client to participate.</p> <p>d. The Teacher/Teaching Assistant will document progress in the classroom data for each client.</p> <p>e. The IPC will monitor progress and forward any lack of progress to the Program Director.</p> <p>f. The DTAC Coordinator will conduct weekly rounds and document observational findings on the DTAC rounds report.</p> <p>g. The Program Assistant will monitor the weekly rounds reports to ensure all action items are resolved.</p>	<p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W252 #5 cont.				
	e. The DTAC Coordinator will do weekly spot checks in all classrooms to ensure the behavior data tally sheet is being used throughout the day and document on the DTAC rounds report and will elevate any issues to Program Management.			10/25/13	
	f. The Program Assistant will monitor the DTAC rounds reports and ensure that any identified issue is resolved. Any unresolved issues will be elevated to the Governing Body by the Program Director with recommendation.			10/25/13	
	g. Any identified action items on the DTAC rounds reports will be addressed during the monthly Risk Management Meetings.			10/25/13	
	h. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.			10/25/13	
	i. IPC will monitor clients' progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note.			10/25/13	
	j. IPC Supervisor will monitor for compliance via review of the IPC Notes.				

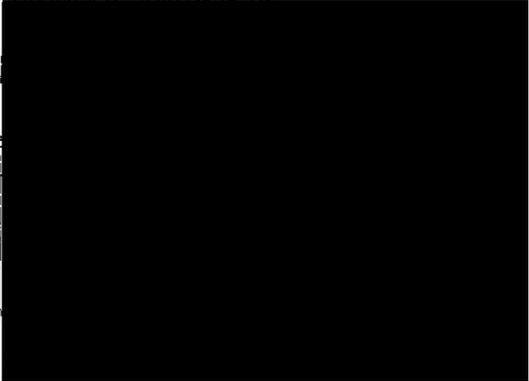
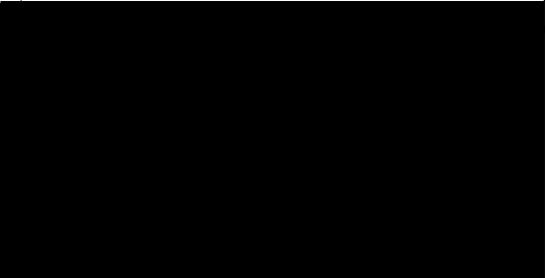
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 252	Continued From page 189 When the client was finished stacking ten sheets of paper, the teacher stated, "You did it! Good job." The activity was done once and the client was given a small electronic piano afterwards. The medical record for focus sampled Client 43 was reviewed on 9/19/13 at 2:35 PM. The IPP Desired Outcome and Milestone dated 8/8/13 indicated that there was a plan and training method designed for the client while in the vocational training program. The review indicated, "Staff will model and verbally explain what we would like [focus sampled Client 43] to do in the process of counting 10 papers out for preparing work for shredding confidential paper. We would like [focus sampled client 43] to use counting template to count out 10 sheets of paper, afterwards placing pile of 10 in a bin..." There were no data collected during the observation. During an interview with the IPC on 9/24/13 at 3:45 PM, she stated that there was a group book in each group that contained client's training plan, addressing the morning, afternoon, and night shift behaviors of clients. The group book also contained data sheets used to collect data for behaviors. According to her, staff wouldn't write the data right away, would write it at the end of the shift, and recollect the observed number of episodes. She also stated that many times there were concerns with the accuracy of data collections. The IPC also mentioned that many times, she went to staff and questioned the data collected, due to inaccuracy. She further stated, "When one or three clients were having behavioral episodal issues, without having enough staff to monitor the behavior, the data collection will be skewed."	W 252	W252 #6 cont. b. The Program Assistant and DTAC Coordinator met with the teaching staff for Client 43 to develop a reliable system for collecting behavioral data. c. The Teacher will keep a tablet on the desk for the purpose of tracking Client 43's behaviors in the classroom. At the end of the class session, the Teacher will document the accurate numbers in the behavior data. d. All behavior data is turned in monthly to the residence and is monitored both in the monthly progress notes by residence staff and tby he IPC Monthly note. The IPC Supervisor will review and elevate any issue to Governing Body with recommedations. e. Both DTAC Coordinators will do weekly spot checks in all classrooms to ensure the behavior data tally sheet is being used throughout the day and document on the DTAC rounds report to ensure all clients receive the proper IPP implementation. f. The Program Assistants will monitor the DTAC rounds reports and ensure that any identified issue is resolved. g. Any identified action items on the DTAC rounds reports will be addressed during the monthly Risk Management Meetings. Any unresolved issues will be elevated to the Governing Body by the Program Director with recommendations.	10/24/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

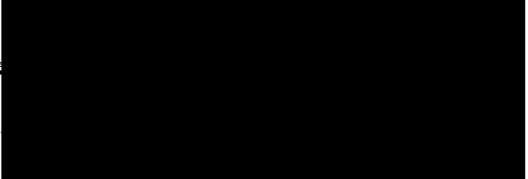
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 257	Continued From page 101  Review of the IPP dated 5/23/13, data collection and the Individual Planning Coordinator quarterly notes for the past year revealed Client 89 had failed to make progress toward her active treatment objectives and had an increase in maladaptive behavior and injuries. There was no indication of Client 89's plan was revised by the QMRP/ IPC after failing to progress toward all identified objectives for over a year. In an interview with the RM on 9/24/13 at 9:45 AM, he indicated the team was still getting to know Client 89 and had been assessing her. (SEE W196) 	W 257	W257 #1 cont. g. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client. h. IPC will monitor Client 89's progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note. i. IPC Supervisor will monitor for compliance via review of the IPC Notes. Any concerns/ unresolved issues will be elevated to CQM for resolution. W257 #2 a. Client 47 transferred to residence 233 on 10/16/13 when residence 215 consolidated. At that time, he was integrated into the weekday Senior Program. b. Senior Program instructors will ensure Client 47's active treatment plan is implemented as developed by his IDTeam. c. Each month, Senior Program instructors document in the client's record data re: the client's response to training objectives.	10/24/13 10/25/13 10/25/13 10/16/13 10/16/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 257	Continued From page 192 A review of the Individual Program Plan (IPP) dated 4/9/13, indicated an objective to increase time on task with verbal prompting. Data showed there had been a failure to progress due to changes in DTAC environment, examples included increase in roster size, increase in overall noise level, increase in behaviors manifested by peers around him, changes in regular staffing level, and new instructor. The goal was referral to a senior program, which had not occurred. There was no evidence Client 47's program needs were reviewed and revised following a recommendation in April 2013.	W 257	W257 #2 cont. d. The DTAC Coordinator will ensure active treatment plans as developed by each client's IDTeam are implemented at the Senior Program. The DTAC Coordinator will ensure re-training/instruction is given and corrective action taken, as needed.	10/25/13	
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure an "as needed drug" was not used in lieu of an active treatment program. This affected one of 10 focus client. (Client 69) Findings:  Restoril is a sedative-hypnotic (sleep) drug used	W 290	e. IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation at least quarterly in the IPC Note to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client. f. IPC will monitor all client's progress, and when areas of need or concerns are identified during observations and record review, the IPC will elevate issues to the Residence Manager and Program Management for follow-up and document at least quarterly in the IPC Note. g. IPC Supervisor will monitor for compliance via review of the IPC Notes. Any concerns/ unresolved issues will be elevated to CQM for resolution. W290 #1 a. TRC review paperwork sent on 10/10/13 with TRC review on 10/24/13 with TRC approval for 6 months. Special team held 10/25/13 determined that Restoril will be incorporated into BSP for review by BSC on 11/7/13. Consent was acquired on 10/25/13 for client 69.	10/24/13	10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 290	<p>Continued From page 193</p> <p>in adults for short term (7-10 days) treatment of a sleep problem. Restoril is a federally controlled substance (C-IV) because it can be abused and long term use leads to dependence. Side effects of Restoril can include memory loss, anxiety, severe allergic reactions and abnormal thoughts and behavior (confusion, agitation, hallucinations and worsening of depression).</p> <p>Medication record review revealed facility staff gave 30 mg of Restoril every night to Client 69 with the only rationale of "awake at 2200." Review of the available medication records showed the practice of giving a short term use drug had occurred routinely since at least April 2013. Interview with staff on 9/18/13 at 1 PM, revealed Client 69 had been on the "sleeping pill about a year, because he sits in the group area and will not go to sleep."</p> <p>A Psychiatric Consultation dated 1/10/13 indicated. [REDACTED]</p> <p>[REDACTED] NOC shift state he is awake until 1230 -1 AM. The order for Restoril was started on 12/28/12. [REDACTED]</p> <p>The health care plan and objective (HCOP) titled "insomnia, unspecified" opened on 12/28/12, set a goal for Client 69 to sleep 4-6 hours per night. The HCOP instructed if Client 69 becomes restless during the night rule out: need for restroom, hunger, thirst, comfort, toilet, offer light snack or juice. There is no document to support staff ruling out Client 69's needs for comfort etc. prior to giving the drug.</p>	W 290	<p>W290 #1 cont.</p> <p>b. TRC form 1204 for Regimen review and approval should Restoril PRN be order for longterm use.</p> <p>c. Physician/Pharmacist/Psychologist are responsible for ensuring a safe and therapeutic environment. Aforementioned disciplines will monitor by observations, chart review, Drug Regimen review, HCOP and monthly BRG review.</p> <p>d. HRC/BSC and TRC will monitor and ensure that administration of Restoril remains in compliance with the Center's policy ensuring re-training/instruction is given.</p> <p>e. Please refer to W331 #14.</p>	10/10/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

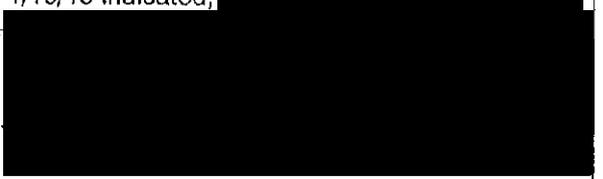
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 290	Continued From page 194 There was no written consent for the use of Restoril and no indication the Human Rights Committee reviewed its use. Review of the Drug Regimen Review for the preceding 12 months failed to address the use of an "as needed drug" on a long term routine basis.	W 290		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure drugs used for the control of inappropriate behavior were part of the Individual Program Plan (IPP) and used within an active treatment program targeted to eliminate the specific behaviors for which the drugs were prescribed. This affected one focus client. (Client 69) Findings: 	W 312	W312 #1 a. TRC review paperwork sent on 10/10/13 with TRC review on 10/24/13 with TRC approval for 6 months. Special team held 10/25/13 determined that Restoril will be incorporated into BSP for review by BSC on 11/7/13. Consent was acquired on 10/25/13 for	10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 312	<p>Continued From page 195 mg dose of Restoril.</p> <p>Restoril is a sedative-hypnotic (sleep) drug used in adults for short term (7-10 days) treatment of a sleep problem. Restoril is a federally controlled substance (C-IV) because it can be abused and long term use leads to dependence. Side effects of Restoril can include memory loss, anxiety, severe allergic reactions and abnormal thoughts and behavior (confusion, agitation, hallucinations and worsening of depression).</p> <p>Medication record review revealed facility staff gave 30 mg of Restoril every night to Client 69 with the only rationale of "awake at 2200." Review of the available medication records showed the practice of giving a short term use drug had occurred routinely since 12/28/12.</p> <p>Interview with staff on 9/18/13 at 1 PM, revealed Client 69 had been on the "sleeping pill about a year, because he sits in the group area and will not go to sleep." A Psychiatric Consultation dated 1/10/13 indicated, </p> <p>The health care plan and objective (HCOP) titled "Insomnia, unspecified" opened on 12/28/12, set a goal for Client 69 to sleep 4-6 hours per night. The HCOP instructed if Client 69 becomes restless during the night rule out: need for restroom, hunger, thirst, comfort, toilet, offer light snack or juice. There is no document to support staff ruling out Client 69's needs for comfort etc. prior to giving the drug.</p>	W 312	<p>W312 #1 cont.</p> <p>b. TRC form 1204 for Regimen review and approval should Restoril PRN be order for longterm use.</p> <p>c. The Physician/IPC/Pharmacist/Psychologist/HSS/RM are responsible for ensuring a safe and therapeutic environment. Aforementioned disciplines will monitor by observations, chart review, Drug Regimen review, HCOP and monthly BRG review for all clients.</p> <p>d. HRC/BSC and TRC will monitor and ensure that administration of Restoril remains in compliance with the Center's policy ensuring re-training/instruction is given.</p> <p>e. Please refer to W331 #14.</p>	<p>10/10/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

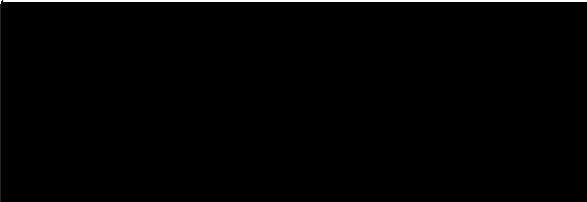
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 196 There was no written consent for the use of Restoril and no indication the Human Rights Committee reviewed its use. Review of the Drug Regimen Review for the preceding 12 months failed to address the use of standing order, "as needed drug" used on a long term routine basis. The facility failed to assess, develop and implement effective non-drug interventions that addressed Client 69's long term usage of Restoril. (Reference: National Institutes of Health www.NIH.gov)	W 312		
W 314	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely in conjunction with the physician and the drug regimen review requirement at §483.460(j). This STANDARD is not met as evidenced by: Based on record reviews and interview the facility failed to ensure drugs used for the control of inappropriate behavior were monitored closely in conjunction with the physician and the drug regimen review requirement. This affected one of 10 sampled clients and two focused clients. (Clients 36, 47, 69) Findings: Drug regimen review is an on-going evaluation of medications promoting positive outcomes, identifying, reporting, resolving problems and	W 314		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 314	<p>Continued From page 197 irregularities with accepted approaches.</p>  <p>Restoril is a sedative-hypnotic (sleep) drug used in adults for short term (7-10 days) treatment of a sleep problem. Restoril is a federally controlled substance (C-IV) because it can be abused and long term use leads to dependence. Side effects of Restoril can include memory loss, anxiety, severe allergic reactions and abnormal thoughts and behavior (confusion, agitation, hallucinations and worsening of depression).</p> <p>Medication record review revealed facility staff gave 30 mg of Restoril every night to Client 69 with the only rationale of "awake at 2200." Review of the available medication records showed the practice of giving a short term use drug had occurred routinely since 12/28/12. Interview with staff on 9/18/13 at 1 PM, revealed Client 69 had been on the "sleeping pill about a year, because he sits in the group area and will not go to sleep."</p> <p>There was no written consent for the use of Restoril and no indication the Human Rights Committee reviewed its use. Review of the Drug Regimen for the preceding 12 months failed to address the use of standing order, "as needed drug" used on a long term routine basis.</p>	W 314	W314 #1-3 a. Please see pages 198a & b.	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W104-3,4,5,6,7,8; W128-2,3,4; W159-3; W290-1; W312-1; W314-1,2,3; W331-14 a. The Pharmacist documented a medication regimen irregularity and recommendation record for Clients 36, 47 and 69.			10/3/13	
	b. The Medical Director shared with Physicians the need to ensure that if the Pharmacist identifies a drug regimen irregularity indicating that a medication (such as Restoril, Atarax) is prescribed for a medical condition, but appears to be primarily in use for behavior-modifying effect or there is frequent use of an "as needed" medication, the use should be reviewed by the Physician, and an IDTeam meeting held if warranted.			10/29/13	
	[REDACTED]			10/25/13	
	d. The Residence Manager for Client 47, conducted a chart review noted currently receiving Atarax, [REDACTED]			9/27/13	
	[REDACTED] Conservator was contacted on 7/2/13 in regards to Atarax and didn't recall this medication as part of the Regimen. A follow up call was made to the conservator on 7/5/13, by the Physician, Sr. PT, PT/Med Person (refer to IDN at 1220 for full information). The use of the medication and Risk vs Risk vs Benefit was re-explained/reviewed/discussed and agreed with the continuation use of Atarax. [REDACTED]			10/25/13	
	e. A Special meeting was held to discuss Client 47's Atarax use. [REDACTED]			10/25/13	
	[REDACTED] After review, the Physician discontinued the order for Hydroxyzine (Atarax). [REDACTED]			10/25/13	
	f. The use of Restoril for Insomnia/Behavior was approved by the Therapeutic Review Committee on 10/24/13. A Special team was held for Client 69, and it was determined that [REDACTED]			10/25/13	
	[REDACTED]			11/1/13	
	g. The Pharmacy Services Manager instructed all Pharmacists to review current Pharmaceutical Policy and Procedure, "Medication Regimen Review", specifically focusing on Section II. A. Therapeutic Monitoring that describes the process in which the Pharmacist reviews medication regimens and clinical record documentation of all ICF clients monthly, monitoring for irregularities in drug ordering, administration, documentation, and appropriateness of use. Pharmacists ensure that the Medication Regimen Review (MRR) includes at least the following elements:				

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	(cont'd W104-3,4,5,6,7,8; W128-1,3; W159-3; W290-1; W312-1; W314-1,2,3; W331-14)				
	<p>1.The clients' drug therapy must fit the diagnosis. 2.The potential for adverse reaction to a medication must be minimal. 3. Medication used to treat any physical or behavioral condition must not unnecessarily interfere with the activities of daily living and minimize potential for any adverse reactions. 4.All laboratory tests needed monitor for the effects of a medication must be ordered at the required intervals. 5.If any irregularities are noted or there are recommendations to be made, the Medication Regimen Irregularity and Recommendation Record (PH 2089) is completed by the Pharmacist and forwarded to the physician for review, and response, The physician makes any necessary comments, signs and returns to the reviewing Pharmacist within 10 working days. All Pharmacists signed a Training and Development Sheet after completion of the review.</p> <p>h. The Pharmacy Services Manager instructed all Pharmacists to review Policy & Procedure "Psychotherapeutic Medications", specifically, Sedatives and Hypnotics use - Insomnia. Pharmacists signed a Training and Development sheet after completion of the review.</p> <p>i. The Pharmacy Services Manager forwarded to the P&T Committee the following recommended change to the current P&P "Psychotherapeutic Medications", Sedatives and Hypnotics-Insomnia: A step will be added so that after an initial trial period for the PRN hypnotic, if the hypnotic is continued, the Pharmacist will forward a Medication Regimen Review and Recommendation Record to the Physician so that the use of the PRN hypnotic will reassess the continued need for the medication.</p> <p>j. To ensure compliance with the medication regimen review process, the Medication Regimen Irregularity and Recommendation Records will be reviewed at least quarterly during Pharmacy and Therapeutics Committee (P&T) meetings. Concerns and recommendations will be forwarded to the Medical Executive Committee; those concerns or recommendations which warrant Governing Body attention via the Quality Management Council.</p> <p>k. To ensure the IDTeam is notified of decisions made related to the Medication Regimen Review and Recommendation Record process, the Pharmacist will forward a copy of the completed form to the Residence Manager. The RM will convene an IDTeam meeting; the review of the Medication Regimen Irregularity and Recommendation Record and Physician's comments will be documented in the clinical record by the IPC.</p>				10/30/13 10/30/13 11/1/13 9/26/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 314	<p>Continued From page 198</p> <p>2. Review of Client 47's Physician orders revealed he received Hydroxyzine 50 mg (Atarax) four times day for the past year for a problem defined as unspecific allergy, itching or irritation of left eye which was closed in September 2012.</p> <p>Hydroxyzine is an antihistamine drug with anticholinergic (drying of mucus membranes) and sedative properties used for symptomatic relief of anxiety and tension and management of pruritus due to allergic conditions. The effectiveness of Hydroxyzine for long term use, (more than four months) has not been assessed by clinical studies. Side effects of Hydroxyzine can include drowsiness, sedation, involuntary motor activity, confusion, constipation, drying and thickening of oral and respiratory secretions.</p> <p>Review of the Drug Regimen for the past year, revealed no evidence of a review for Hydroxyzine for its effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use. An Interdisciplinary note dated 7/2/13, indicated the conservator was aware of the use of Hydroxyzine. There was no written consent for the use of Restoril and no indication the Human Rights Committee reviewed its use.</p> <p>In an interview with the Residence Manager, Individual Planning Coordinator and Health Services Specialist on 9/25/13 at 2 PM revealed the facility staff, not the physician had notified the conservator via telephone concerning the use of the Hydroxyzine but did not document it.</p> <p>3. Review of the Drug Regimen dated 8/14/13 for Client 36 revealed, the Pharmacist identified the long term usage of Hydroxyzine 50 mg (Atarax)</p>	W 314		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 314	Continued From page 199 four times day since 2/26/13 for dermatitis (itchy skin disorder). The Pharmacist (and Dermatology) suggested to avoid the use of hydroxyzine as it is a highly anticholinergic (drying) drug and could cause a greater risk of confusion to Client 36. The review also suggested the dosage was above the maximum daily dosage of 25 mg three or four times daily. The physician response was indicative of the actual use of hydroxyzine: " Zyprexa already approved. Just waiting for conservator permission to start. If started we can D/C hydroxyzine. Hydroxyzine has an added anxiolytic effect.."	W 314		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that clients received follow-up examinations or evaluations and treatments for three core sampled clients. (Client 64, Client 77, Client 25) and two focus sampled clients (Client 96, Client 44). Findings: 	W 322	W322 #1 a. The Residence Physician ordered symptomatic treatment for the client's cough and fever. b. The Residence Physician stated that the client Complete Blood Count (CBC) result was normal and the infiltration	1/10/2/13 1/11/13

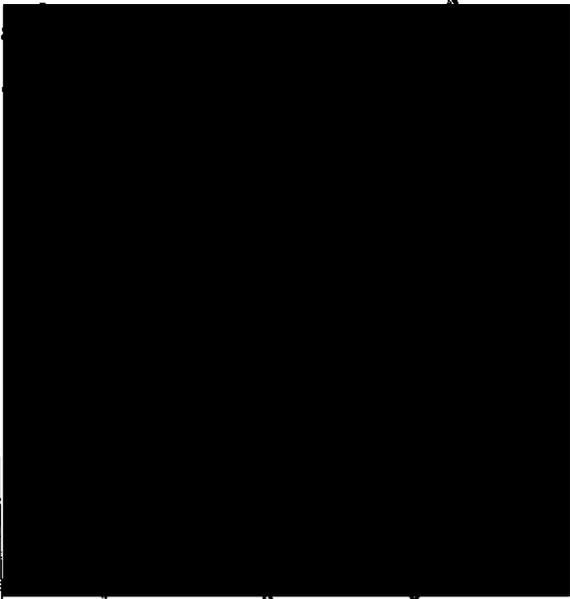
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 322	Continued From page 200  The Physician's Progress Notes dated 1/10/13 at 9:15 AM. indicated that core sampled Client 64 was evaluated by a physician due to an increase in temperature. He was seen again by the physician on 1/11/13 at 9:45 AM due to a fluctuating temperature. There was no other symptom noted by the physician during examination, but an order for acetaminophen (medication for fever) and x-ray was documented. The radiology result dated 1/11/13 indicated that a single view of core sampled Client 64's anterior and posterior chest was x-rayed. The result indicated, "IMPRESSION: Minimal right infrahilar infiltrate (abnormal substance that accumulates in the lungs) suggesting a small pneumonia (infection)."	W 322	W322 #1 cont. per X-ray was minimal or the affected area was very small that further treatment was not necessary. c. After the client was treated symptomatically, the symptoms were cleared and there were no new clinical symptoms observed or presented. d. The Residence Physician felt that the client responded to the treatment and no further treatment needed. e. The Program Management instructed all clinic staff working closely with the Physicians to communicate concerns/issues/follow up by writing on the Physician communication log that is available on all residences. f. The Medical Director met with physicians to review survey findings and provided direction on follow-up actions to ensure compliance. g. The Medical Director directed physicians to ensure proper documentation in the Physician's Progress Notes following a clinical test or evaluation, especially when there are positive or significant findings. h. The Medical Director instructed all Physicians to raise any issues/concerns for discussions at the weekly physicians' rounds for recommendations and resolution. i. Any systemic issues/concerns will be elevated to Medical Quality Assurance and Improvement (MQA&I) with recommendation, review and follow up.	11/27/13 10/29/13 10/29/13 10/29/13
-------	--	-------	--	--

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	<p>Continued From page 201</p> <p>There were no documentations found in the medical record of core sampled Client 64 to indicate that a follow-up, evaluation, assessment, and treatment was provided for him when the x-ray revealed that he had pneumonia.</p> <p>During an interview with the Individual Program Coordinator (IPC) of Residence 29 on 9/24/13 at 2:55 PM, she reviewed the medical record of core sampled Client 64 and confirmed that there were no follow-up evaluations and treatments provided for the client when he acquired the pneumonia</p> <p>2. The physician's orders for the treatment of type 1 diabetes mellitus for sampled Client 77 and Focused Sampled Client 96 did not meet the current standards of practice.</p> <p>Type 1 and Type 2 diabetes mellitus are two separate diseases. They are similar only in that they affect blood sugar. With Type 2 diabetes the body still produces insulin but is somewhat insensitive to it. Type 1 diabetes mellitus is an auto immune disease in which the body has killed its own islet cells that produce insulin. Insulin is required for cellular uptake of glucose and protein from the blood. If blood glucose is chronically high it may cause numerous complications such as blindness, kidney disease and nerve damage. If blood glucose is acutely low it can cause neurological damage, seizures and even death. The goal of treatment is to keep blood glucose as close to normal as possible. This normal range would be between 70 to 125 milligrams per deciliter.</p> <p>The individual with type 1 diabetes mellitus requires dosages of long acting insulin for basal rate and fast acting insulin for carbohydrate</p>	W 322	<p>W322 #2</p> <p>a. A comprehensive review of diabetic client (#77) was done by primary care physician to include discussion with dietician for diet change and endocrinology consultation.</p> <p>b. The client was seen by an endocrinologist consultant with recommendations and have been carried out by Residence Physician.</p> <p>c. The Program Management instructed all clinic staff working closely with the Physicians to communicate concerns/issues/follow up by writing on the Physician communication log that is available on all residences.</p> <p>d. The Medical Director instructed physicians to ensure proper documentation in the Physician's Progress Notes following a clinical test or evaluation, especially when there are positive or significant findings.</p>	<p>10/25/13</p> <p>11/12/13</p> <p>11/20/13</p> <p>10/29/13</p>	

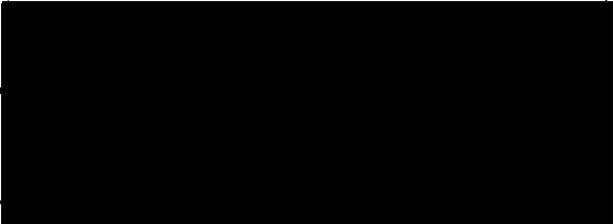
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	Continued From page 202 ingestion and any correction dose needed to come close to normal blood glucose levels. The basal dosage is geared to the level of glucose the liver continuously secretes to the blood stream that with insulin the cells uptake for energy. The dosage for ingested carbohydrates also supplies the cells with energy to function but also allows additional carbohydrates to be taken from the blood stream and stored in the liver for usage later. A correction dosage, on a sliding scale, may be needed to facilitate this delicate balance of basal and carbohydrate ingestion doses to approach normal blood glucose levels. Client 77 had diagnoses that included type 1 diabetes mellitus. These orders omitted any insulin administration for ingested carbohydrates and consequently did not provide for the avoidance of wide variations of blood glucose levels, especially high blood glucose levels.	W 322	W322 #2 e. The Medical Director will provide training and to review Type 1 Diabetes Treatment Guidelines to all Physicians. f. The Medical Director will add the Type 1 Diabetes Treatment Guidelines to LDC's Medical Guidelines. g. The Medical Director met with physicians to review survey findings and provided direction on follow-up actions to ensure compliance. h. The Medical Director instructed all Physicians to raise any issues/concerns for discussions at the weekly physicians' rounds for recommendations and resolution. i. Any systemic issues/concerns will be elevated to Medical Quality Assurance and Improvement (MQA&I) with recommendation, review and follow up.	11/27/13 11/27/13 10/29/13 10/29/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	Continued From page 203  On the afternoon of 9/25/13, a dietary department staff member was interviewed regarding the Consistent Carbohydrate Diet. She said that it was a little lower in carbohydrates than the other diets but was consistent only in total from day to day at approximately 200 total carbohydrates. The surveyor asked her to calculate the Consistent Carbohydrate House Diet for the Tuesday Week 2 menu. Her Calculations were Breakfast 72 carbohydrates, Lunch 57 carbohydrates, Dinner 38 carbohydrates and a late evening snack of 30 carbohydrates. When asked why she thought the doctor hadn't ordered carbohydrate coverage with insulin, she said she wasn't sure. When asked what advantage this diet had when there no insulin administered based on the number of carbohydrates consumed each meal. She said it was of little value other than being a little lower in carbohydrates. She said she had been a diabetic educator at an outside acute care hospital where they always taught diabetic patients to use a personalized insulin to carbohydrate ratio for food ingestion. Focused Client 96 had a very similar diabetes mellitus treatment regime without any insulin orders for ingested carbohydrates. Client 77's physician was on vacation, so the medical director was interviewed in his place on	W 322			

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 322	<p>Continued From page 204</p> <p>9/26/13 at 9:35 AM. After being apprised of the situation, he said he would talk to the physician when he returned from vacation and have an endocrinologist consult.</p> <p>3. During observation conducted on 9/24/13 at 7:35 AM, Client 25 was observed to have a red discoloration on her left upper cheek and left eyebrow.</p> <p>Interview with the Senior Psychiatric Technician conducted on 9/24/13 at 7:40 AM, revealed that the client fell while walking during off-campus activity over the weekend.</p> <p>Review of Client 25's medical record conducted on 9/25/13 indicated that Client 25 has an open health care objective for ataxia (P 16-6) . Further review of the Approaches and Strategies dated 6/20/13 indicated "Walks slowly with a rocking motion, stopping at curbs and sidewalks and verbal prompts. When walking, staff to assist as needed to help prevent accidental falls (i.e., verbal reminders to watch where she is walking, physical guidance on uneven surface, unfamiliar areas, surfaces/areas of poor color contrast, and when crossing street with blended curbs) ."</p> <p>Review of the Interdisciplinary Notes dated 9/22/13 at 3:40 PM indicated " Client was returning from the activity @ (at) Rustic Camp while walking through Richardson Park under the shelter, she tripped on a crack in the cement and fell forward sustaining an abrasion to her left upper cheek bone, left elbow and left knee."</p>	W 322	<p>W322 #3</p> <p>a. A special team meeting was held for client 25 and the team agreed to initiate a referral to PM&R clinic for follow-up. Referral to address recent falls, gait safety evaluation and recommendation. 10/25/13</p> <p>b. The RN/HSS will review client #25 Health Care Plan and Objective (P.16.6) and make/update any changes as needed. HSS provided service training to all staff on client #25 HCPO (P16.6) and and all ICF level of care staff on NP 1.20 Fall Assessment of Risk, Causes and Care. 10/25/13</p> <p>c. The Shift Supervisor and IPC will monitor Monthly Summary Notes to ensure summary note reflects interventions implemented to prevent client falls. 10/25/13</p> <p>d. The Residence Manager and Program Assistant provided training to ancillary staff e.g. R.T., Job Coach, Teachers Assistance, on providing assistance off the residence. 10/25/13</p> <p>e. The Residence Manager to monitor residence daily and DTAC randomly to ensure client safety and that staff are knowledgeable and compliance with client #25 HCPO and NP 1.20. 10/25/13</p>	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	Continued From page 205 Further review of the medical record indicated that the client had episodes of falls on 5/19/13, 6/2/13, 6/8/13, 7/31/13 and 9/22/13. The client's Nursing Fall Risk Assessment dated 5/23/13 indicated a score of 9, which is indicative of moderate risk for falls. There was no current Nursing Fall Risk Assessment completed despite the client's episodes of falls in June, July and September 2013. Review of the Licensed Monthly Summary Notes for the months of May, June, July 2013 did not reflect that the client had falls and did not reflect interventions implemented to prevent client's falls when addressing P- 16-6 - Ataxia. The above Licensed Monthly Notes indicated "Ataxia -unspecified- No problems noted this month." Review of the Nursing Procedures Manual, Number 1.20 dated 6/26/13, entitled "Fall Assessment of Risk, Causes and Care" indicated	W 322	W22 #3 cont. f. The Shift Supervisor will complete daily rounds utilizing the Shift Supervisor Rounds Sheet provide additional coaching as needed and submit weekly to Residence Manager. g. Any identified action items on the Shift Supervisor or Residence Manager Rounds Sheets will be addressed at monthly Risk Management Meetings. Any issues or concerns not resolved will be elevated to the Clinical Quality Management Committee by the Program Management with recommendations/discussions and follow up. h. The Program Management instructed all clinic staff working closely with the Physicians to communicate concerns/issues/follow up by writing on the Physician communication log that is available on all residences. i) The Medical Director met with physicians to review survey findings and provided direction on follow-up actions to ensure compliance. j) The Medical Director directed physicians to ensure proper documentation in the Physician's Progress Notes following a clinical test or evaluation, especially when there are positive or significant findings.	10/25/13 10/25/13 11/20/13 10/29/13 10/29/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	<p>Continued From page 206</p> <p>under section VII - Examples of Falls Prevention and Interventions included "... Interdisciplinary Team Conference" - " Discuss "at risk" level in team conference; formulate goals addressing safety; identify specific strategies for fall prevention in the care plan; communicate level of risk to other staff."</p> <p>There was no documentation that the Interdisciplinary Team discussed the client's need for a reassessment for her risk for falls and need for referrals to prevent falls. Further review of the record conducted on 9/25/13 indicated that the attending physician was notified of the client's fall on 9/22/13.</p> <p>4. A review of the medical record for Client 44 revealed that she is receiving Nitrofurantoin (an antibacterial agent used to treat urinary tract infections)</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] The consultation report further indicated that a rare but reported possible side effect of long term use of Nitrofurantoin is pulmonary fibrosis. A Chest X-ray has been obtained for the client every 6 months and result is negative. Interview with the Individual Program Coordinator (IPC) conducted on 9/25/13 at 11 A.M., revealed that the Nitrofurantoin was discontinued in 2/2013</p>	W 322	<p>W322 #4</p> <p>a. Follow up order for chest x-ray of client #44 by the physician was done. 10/15/13</p> <p>b. The team has reviewed the side effects of pulmonary Fibrosis with the physician. 10/15/13</p> <p>c. All teams review side effect when starting a new medication per center policy. 10/15/13</p> <p>d. IPC monitors that the ID team has reviewed the side effects when starting a new medications per center policy. 10/15/13</p> <p>e. IPC supervisor will review IPC notes and will elevate any concerns to the QA Director with recommendations. 10/15/13</p> <p>f. The Program Management instructed all clinic staff working closely with the Physicians to communicate concerns/issues/follow up by writing on the Physician communication log that is available on all residences. 11/20/13</p>		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 322	Continued From page 207 per the Urologist's recommendation in 1/2013. In 8/2013, the attending physician gave an order to administer Nitrofurantoin to the client per family's request. There was no documentation in the medical record to reflect that an order for follow-up chest X-ray was requested as of 9/24/13. Client 44's last chest x-ray was done on 1/8/13.	W 322	W322 #4 cont. g. The Medical Director met with physicians to review survey findings and provided direction on follow-up actions to ensure compliance.	10/29/13	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that clients were provided nursing services in accordance with their needs. There were missing Health Care Plans for acute illnesses, Health Care Plans were not updated, Health Care Plans did not reflect clients' current conditions, physician's orders were not implemented, splints were not removed as ordered, the facility policy was not implemented for verifying gastric tube placement, a gastric tube was not changed per physician's order, the policy was not implemented for obtaining vital signs for a change in condition, and there was lack of evidence of a Health Services Specialist note for a client with an infection. The facility also failed to provide nursing services in accordance with facility policy titled Client Services - 265: Supportive and Protective Devices and desensitization training prior to appointments. This affected three of 10 sampled and two focus clients (Clients 37, 47, 69, 79 and 94).	W 331	h. The Medical Director directed physicians to ensure proper documentation in the Physician's Progress Notes following a clinical test or evaluation, especially when there are positive or significant findings. i. The Medical Director instructed all Physicians to raise any issues/concerns for discussions at the weekly physicians' rounds for recommendations and resolution. j. Any systemic issues/concerns will be elevated to Medical Quality Assurance and Improvement (MQA&I) with recommendation, review and follow up.	10/29/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 331	<p>Continued From page 208</p> <p>Findings:</p> <p>1. Record review on 9/24/13 indicated that Client 79 had numerous Health Care Plans that had not been updated for multiple conditions. [REDACTED]</p> <p>2. On 9/24/13 review of Client 79's Individual Program Plan, dated 5/30/13, [REDACTED] Documentation indicated that Client 79 was on "strict nothing by mouth" at all times.</p> <p>Client 79's care plan [REDACTED] included the following entry: Provide small frequent meals as ordered by the physician. Client 79's care plan did not reflect his current condition for NPO (nothing by mouth) status.</p> <p>3. Client 79 had current physician's orders, dated 9/2013, that indicated the following: Gastrostomy tube change every three (3) months on 3rd Saturday of the month. The Nursing Care Plan for "Gastrostomy Status" was not consistent with the physician's orders as it indicated, "Change G-T (gastrostomy tube) monthly."</p> <p>4. Review of Client 79's treatment record indicated that his gastric tube was to be changed on 9/21/13 (the 3rd Saturday of the month).</p>	W 331	<p>W331 #1-13</p> <p>a. The Health Services Specialist corrected the inaccurate Health Care Objective and Plan(s) for client 79 immediately. (Items 1,2,3)</p> <p>b. Both Program Directors instructed all Health Services Specialists to check each clinical record for all clients on ICF residences to ensure there was a current, accurate Health Care Objective and Plan for each identified open medical condition.</p> <p>c. All missing Health Care Objective and Plans were placed in the clinical record (s) for both Client 79 and 94.</p> <p>d. The Health Care Objective and Plan for Client 94, Hypothyroid was corrected immediately by the Health Services Specialist.</p> <p>e. The gastrostomy tube for Client 79 was changed on 9/24/13. The Residence Manager provided training to all staff on both the corrected Health Care Objective and Plan for Client 79 as it relates to the frequency of his gastrostomy tube change.</p> <p>f. All RMs trained staff on Nursing Procedure 9.5, Enteral Feedings (Gastrostomy/Jejunostomy) with specific attention to Section II, # 3 Checking for residual.</p> <p>g. Residence Managers provided training to staff who work on the other two residences where individuals receive enteral feedings on Nursing Procedure 9.5, Enteral Feedings (Gastrostomy/Jejunostomy) with specific attention to Section II, # 3</p>	<p>9/25/13</p> <p>10/22/13</p> <p>10/24/13</p> <p>9/25/13</p> <p>10/26/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 331	<p>Continued From page 209</p> <p>Review of Client 79's treatment record on 9/23/13, indicated that the record lacked documented evidence that the gastric tube was changed on 9/21/13, per physician's order.</p> <p>On 9/24/13 at 6:40 AM, the RM (Resident Manager) was interviewed and confirmed that the gastric tube had not been changed on Saturday, 9/21/13.</p> <p>5. The Nursing Procedure #9.5 for "Enteral Feedings (Gastrostomy/Jejunostomy)," revised on 7/21/11, included the following entry: To verify the gastrostomy tube placement and patency: a. Check the tube length/markings is the same distance from the stoma as it has been. b. Attach a 60cc syringe and aspirate the stomach contents, note the amount of residual (the amount of remaining stomach contents).</p> <p>During observations of two medication administration passes, on 9/18/13 at 9:15 AM and at 4:50 PM, two licensed staff failed to implement the policy for verifying gastric tube placement. Both staff verified residual by aspirating /withdrawing gastric contents with a syringe but neither staff checked the tube length/markings.</p> <p>Staff stated that the amount of residual was not routinely documented but if the residual was over 100ccs it would be documented on the MTR (Medication / Treatment Record) and the physician would be notified.</p> <p>6. On 9/18/13, review of Physician's Progress Notes, dated 9/17/13, indicated that [REDACTED]</p>	W 331	<p>W331 1-13 cont.</p> <p>Checking for residual.</p> <p>n. The Residence Manager provided training on Client # 79 Health Care Objective and Plans for his adaptive equipment, his physicians orders, Approaches and Strategies and his Individual Program Plan related to the use of his orthotic devices with staff on duty immediately and continued to provide training to additional staff.</p> <p>i. Adaptive Equipment will be monitored each shift by all Shift Supervisors and documented on the Shift Supervisor Rounds Sheets. The Shift Supervisor Rounds Sheets were modified on 10/25/13 and trained to all RM/ SPTs on 10/28/13.</p> <p>j. The Residence Manager will monitor for compliance with ensuring staff adhere to the physicians orders for each client as well as observing the use of personal adaptive equipment during routine rounds and document on the Residence Manager Rounds Sheets.</p> <p>k. Program Management will monitor for compliance with use of personal adaptive equipment, that staff are following established Nursing Procedures and are implementing the Individual Program Plan during routine management rounds at least monthly and document on the 24-hour report.</p> <p>l. Training was provided to staff on duty by all Residence Managers on Administrative Directive 235, Individual Program Plan and Nursing Procedure 13.0, Physicians Orders and Nursing Procedure 1.18 Vital Signs.</p>	<p>10/25/13</p> <p>10/26/13</p> <p>10/26/13</p> <p>10/26/13</p> <p>10/24/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013	
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 331	<p>Continued From page 210</p> <p>████████████████████</p> <p>A chest x-ray was obtained and the radiology report summary indicated: Mild chronic infiltrate-scarring is identified in the left lower lobe. The medical record lacked evidence of a Health Care Plan for this newly diagnosed condition.</p> <p>7. Client 79's physician's monthly orders for 9/2013 included the following: ██████████</p> <p>████████████████████ Splint-EO (Elbow/orthotic) twice daily, left and right elbow, on 1 hour in morning and 1 hour in evening at 8 AM and 8 PM.</p> <p>During an observation of Client 79 at the day program, on 9/19/13 at 10:30 AM, Client 79 was observed with his elbow orthotics in place. The teacher said that the orthotics felt tight. Shortly after, Client 79 was returned to the unit at 11:10 AM with the orthotics still in place.</p> <p>The client was observed with a long sleeve shirt that had been pulled over the orthotics, creating a snug fit.</p> <p>At 11:10 AM, when the RM (Resident Manager) removed the orthotics, Client 79's arms were noted with numerous reddened areas. The orthotics had remained on for over 3 hours instead of 1 hour as the physician's order indicated.</p> <p>During an interview with the RM at that time, the RM stated that the staff who initially applied the orthotics in the morning had to leave the unit and failed to communicate to other staff that the orthotics were still in place and had not been removed.</p> <p>The Medication / Treatment Record did not have a specific area designated for documenting when</p>	W 331	<p>W331 1-13 cont:</p> <p>m. The Program Director will ensure that any issues or concerns identified are addressed during the monthly Program Risk Management Meetings with recommendations for any resolution of systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.</p>	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

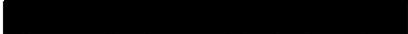
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 211 the orthotics were removed (after 1 hour).</p> <p>8. Client 79 had an additional physician's monthly order for [REDACTED] and included the following: Wear sheepskin boot on top of high top sneakers.</p> <p>An Occupational Therapy Referral, dated 12/1/12, indicated that Client 79 hooks the back of his heel on the front underside of the wheelchair footplate.</p> <p>During observation of Client 79 on 9/18/13 at 4 PM, Client 79 did not have sheepskin boots on. On 9/18/13 at 4:50 p.m., the RM stated that she found an old pair of sheepskin boots and that she would order him a new pair.</p> <p>9. Client 79's physician's monthly orders for 9/2013 included the following: [REDACTED] Staff please properly tighten and position the "thigh placed lap belt" when seating in his wheelchair and check the tightness of the lap belt hourly. Make sure it is not placed on the abdomen.</p> <p>During an observation of Client 79 on 9/18/13 at 4:25 p.m., the client was observed having slid down in his wheelchair with the lap belt positioned on his abdomen. Staff were observed in the immediate area with the client with no intervention. The client was repositioned after the surveyor brought it to their attention.</p> <p>10. Observations on 9/18/13 at 10:10 AM, 6:40 PM, and throughout the survey, Client 79 was observed on multiple occasions slouched down in his wheelchair with his head leaning toward the left, unsupported. On numerous occasions, there was no staff</p>	W 331		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 331	<p>Continued From page 212 intervention to reposition the client or his head until requested the surveyor.</p>  <p>11. Client 79's physician's monthly orders for 9/2013 included the following:   Elevate lower extremities while in bed and wheelchair. During an observation of Client 79 on 9/18/13 at 4:25 PM, Client 79's lower extremities were not elevated while in the wheelchair.</p> <p>12. Client 94 was diagnosed with a UTI (urinary tract infection)   The medical record lacked evidence of a Health Care Plan for this newly diagnosed condition/infection.</p> <p>During an interview with the HSS (Health Services Specialist) on 9/25/13 at 11 AM, the HSS stated that she completed a Health Care Plan for a UTI but she did not put the care plan in Client 94's record, but put it in a wall rack in the physician's office. The HSS acknowledged that the Health Care Plan was not in the client's record.</p> <p>Upon further record review, Client 94's record lacked evidence of a nursing note / assessment by the HSS. The HSS stated, "I usually write a note at the</p>	W 331		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 331	<p>Continued From page 213</p> <p>onset but I don't think I did it at that time." The HSS further stated that there should be an initial HSS note. The HSS stated that she followed up on a daily basis and asked staff if the client had a fever.</p> <p>A request by the surveyor was made to review Client 94's vital signs. Record review indicated that there was no documentation of vital signs (temperature, pulse, respiration, blood pressure) during Client 94's treatment for his UTI. The HSS was asked to provide any information she had relating to documentation of vital signs, i.e. flow sheets/graphs. The facility was unable to provide any evidence/documentation of Client 94's vital signs during this time.</p> <p>On 9/25/13 at 2:30 PM, Quality Assurance staff confirmed that vital signs records/ flow sheets were not available.</p> <p>The Nursing policy #1.18 for Vital Signs, revised 6/26/13, included the following entry: Vital signs are taken according to the physician's order, client service routines, or any change in condition.</p> <div style="background-color: black; width: 100%; height: 40px; margin: 5px 0;"></div> <p>The Nursing Care Plan was not consistent with Client 94's diagnosis of hypothyroid.</p> <p>14. Observation on 9/16/13 at 11:30 AM revealed Client 69 wore a hard helmet with face guard and chin strap. During lunch observation on 9/16/13</p>	W 331		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 331	<p>Continued From page 214</p> <p>at 12:15 AM, Client 69 removed the helmet and placed it on a shelf. The inside protective foam of the helmet was noted to be torn, worn and soiled. The exterior of the helmet appeared scratched and soiled. [REDACTED]</p> <p>During each observation period Client 69 was not wearing Ted Hose (compression stocking) and was not encouraged to elevate his legs or provided equipment to do so.</p> <p>Observation of Client 69's room and personal wardrobe closet on 9/17/13 revealed no Ted Hose in his personal wardrobe or available for use in his room. Client 69 had a low bed, there was no mat on the floor in his room and the bed did not have supports such as a wedge or blocks to facilitate elevation of his legs. There was a soft helmet observed laying on the floor of the wardrobe closet.</p> <p>On 9/18/13 a review of the Individual Program Plan (IPP) Approaches and Strategies dated 4/9/13, indicated the team had determined during the assessment phase Client 69 required a hard helmet with face shield and chin strap during the day, soft helmet at night, mat on the floor next to bed in case of falls from seizure activity at night and a lowered long bed. There was no evidence in the IPP who would monitor and assure these supports were in place, how it would be documented, who, how often, and with what to clean the equipment. There was no evidence of a teaching component to help Client 69 make good</p>	W 331	<p>W331 #14</p> <p>a. The Helmet for client 69 was sent for repair on 9/17/13 and a back-up helmet was ordered and received.</p> <p>b. All RMs reviewed all adaptive equipment and its use at huddles. All Senior Psychiatric Technician (SrPT) on each shift will monitor and ensure compliance per AD 265 Supportive and Protective Devices during routine daily rounds ensuring re-training/instruction is given and corrective action taken as needed.</p> <p>c. The Physician, HSS, SRPT, RM and Father discussed the Risk vs Benefit of the bedside mat for client 69 next to the low bed. It was determined that risk of fall while entering/exiting low bed with a bedside mat outweighed the benefit. A recliner chair was placed in the living room, TED Hose were offered at a higher frequency (he demonstrates the ability to remove and apply independently) and a wedge was placed at the foot of the bed to ensure legs are elevated to tolerance during hours of sleep.</p> <p>d. All IDTeams will identify and prioritize each persons needs for supportive device training through comprehensive review of assessments, ILSA, interview, and monitoring of each individual.</p> <p>e. Dietician/Physician review of current diet notes it is appropriate</p>	<p>9/17/13</p> <p>9/20/13</p> <p>9/16/13</p> <p>10/25/13</p> <p>9/17/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013	
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 331	<p>Continued From page 215 choices regarding his equipment.</p> <p>The physician orders for August 2013 directed Client 69 was to elevate his legs as tolerated and wear above the knee Ted Hose daily due to swelling of the limbs caused by venous insufficiency. The Medication and Treatment records showed that each AM and PM shift documented Client 69 was wearing the Ted Hose as prescribed, despite observations showing he did not have them on or had removed them.</p> <p>The most recent nursing assessment dated 11/18/12 indicated Client 69 used Ted hose stockings bilaterally during the day and elevated his legs when sleeping as tolerated. The health care plan and objective indicated equipment was checked daily to assure in clean and dry, however there was no documentation to support it had been done. The last time the helmet was replaced was in June 2012 and a second hard helmet was not available for use during cleaning.</p> <p>A review of the facility policy titled Client Services - 265: Supportive and Protective Devices, was completed. The policy defined postural and or mechanical supports (splints, braces, wedges, wheelchair adaptations etc.) and devices to prevent injury (helmets, side rails) shall be ordered by the physician, reasons for their use documented, reviewed and included in the Individual Program Plan (IPP), health care plan, medication/treatment record, and have consents for their use reviewed by the Human Rights Committee (HRC). The client shall be monitored for response and effectiveness of treatment and it shall be documented. The policy indicated the Health Services Specialist (HSS/RN), Individual Program Coordinator (IPC) and residence staff</p>	W 331	<p>f. The instruction was given immediately and during Huddle to ensure all supports/adaptive equipment are administered per physicians orders by all staff.</p> <p>g. The mat was removed from the bedside, HCO&P and A&S. Training provided at huddles by Shift Supervisors.</p> <p>h. All IDTeams will identify plans to enhance/ acquire skills that can be incorporated into daily program plans. If changes are needed to current IPP, the IPC/RM/ Dietitian/Physician are notified immediately to determine need for a Special IPP meeting</p> <p>i All Shift Supervisors will monitor to ensure that all supports/adaptive equipment are administered per physicians orders during rounds daily and should the client not tolerate supports/adaptive equipment, SRPT will ensure appropriate documentation and notification to HSS/Physician/IPC. Rounds and any corrective actions will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.</p> <p>j. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that all supports/adaptive equipment are administered per physicians orders and take corrective action if needed. Rounds and any corrective actions will be documented on the Residence</p>	<p>9/16/13 9/20/13 9/20/13 10/03/13 10/25/13 10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 331	<p>Continued From page 216</p> <p>shall ensure the devices are in clean good working condition, used appropriately and according to the IPP. Client 69's equipment was not monitored by the licensed nurse.</p> <p>Review of the Individual Program Plan dated 12/13/12 for Client 69 also indicated he received five small meals a day with snacks and had a tendency to seek food after meal time and when returning from day treatment program in the afternoon. [REDACTED]</p> <p>The most recent nursing evaluation dated 11/12 showed Client 69 was receiving large regular portion meals. Dining observations completed on Residence 15 on 9/16/13 at 11:30 AM, 9/18/13 at 11:30 AM and 5:30 PM, and 9/24/13 at 7:30 AM showed Client 15 was provided three meals a day, low fat house portions eating 100% each time. Snacks included a half of a prepared sandwich at 10 AM and a jello cup at 3 PM. Weights indicated a progressive weight loss since January 1/13= 244 lbs through 7/13 = 227. There was a lack of evidence Client 69 was monitored by the licensed nurse for adequacy of meals and referral to dietitian for assessment.</p> <p>In an interview with the HSS, IPC and Residence Manager on 9/25/13 at 2 PM, Client 69's helmets, mat, Ted Hose, elevation of legs and dietary concerns were discussed. There was confirmation the current helmet had been in use for 15 months with no documented maintenance or cleaning schedule, Ted Hose documentation was not accurate and there was no mat for Client 69's use by the bedside. There was agreement concerning a lack of training for the staff concerning clients equipment. There was also</p>	W 331	<p>W331-14 (cont'd)</p> <p>Manager Rounds Sheet (RMRS). The Residence Manager will submit the SSRS and RMRS and submit to the Program Director weekly. The shift supervisor rounds sheets were modified on 10/25/13 and training was conducted on 10/28/13.</p> <p>k. Program Management will randomly monitor during rounds at least monthly and document on the 24-Hour Report. Corrective actions will be taken as needed and reported to the Shift Supervisor or Residence Manager for documentation on the Rounds Sheet.</p> <p>i. The Program Director will ensure that any issues or concerns identified in the SMRS or RMRS are addressed during the monthly Program Risk Management Meetings with recommendations for any resolution of systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.</p> <p>See page 217a-b for further corrective actions.</p>	<p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
W331-14	a. The Pharmacist documented a medication regimen irregularity and recommendation record for Client 69.			10/3/13	
	b. The Medical Director shared with Physicians the need to ensure that if the Pharmacist identifies a drug regimen irregularity indicating that a medication (such as Restoril, Atarax) is prescribed for a medical condition, but appears to be primarily in use for behavior-modifying effect or there is frequent use of an "as needed" medication, the use should be reviewed by the Physician, and an IDTeam meeting held if warranted.			10/29/13	
	c. The use of Restoril for Insomnia/Behavior was approved by the Therapeutic Review Committee on 10/24/13. A Special team was held for Client 69, and it was determined that Restoril would be incorporated into a Behavior Support Plan and submitted for review and approval by BSC/TRC/HRC on 11/7/13. Consent was acquired on 10/25/13.			10/25/13	
	d. The Pharmacy Services Manager instructed all Pharmacists to review current Pharmaceutical Policy and Procedure, "Medication Regimen Review", specifically focusing on Section II. A. Therapeutic Monitoring that describes the process in which the Pharmacist reviews medication regimens and clinical record documentation of all ICF clients monthly, monitoring for irregularities in drug ordering, administration, documentation, and appropriateness of use. Pharmacists ensure that the Medication Regimen Review (MRR) includes at least the following elements: 1. The clients' drug therapy must fit the diagnosis. 2. The potential for adverse reaction to a medication must be minimal. 3. Medication used to treat any physical or behavioral condition must not unnecessarily interfere with the activities of daily living and minimize potential for any adverse reactions. 4. All laboratory tests needed monitor for the effects of a medication must be ordered at the required intervals. 5. If any irregularities are noted or there are recommendations to be made, the Medication Regimen Irregularity and Recommendation Record (PH 2089) is completed by the Pharmacist and forwarded to the physician for review, and response, The physician makes any necessary comments, signs and returns to the reviewing Pharmacist within 10 working days. All Pharmacists signed a Training and Development Sheet after completion of the review.			11/1/13	
	h. The Pharmacy Services Manager instructed all Pharmacists to review Policy & Procedure "Psychotherapeutic Medications", specifically, Sedatives and Hypnotics use - Insomnia. Pharmacists signed a Training and Development sheet after completion of the review.			10/30/13	
	i. The Pharmacy Services Manager forwarded to the P&T Committee the following recommended change			10/30/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	(cont'd W331-14) to the current P&P "Psychotherapeutic Medications", Sedatives and Hypnotics-Insomnia: A step will be added so that after an initial trial period for the PRN hypnotic, if the hypnotic is continued, the Pharmacist will forward a Medication Regimen Review and Recommendation Record so that the Physician will reassess the continued need for the use of a PRN hypnotic. j. To ensure compliance with the medication regimen review process, the Medication Regimen Irregularity and Recommendation Records will be reviewed at least quarterly during Pharmacy and Therapeutics Committee (P&T) meetings. Concerns and recommendations will be forwarded to the Medical Executive Committee; those concerns or recommendations which warrant Governing Body attention via the Quality Management Council. k. To ensure the IDTeam is notified of decisions made related to the Medication Regimen Review and Recommendation Record process, the Pharmacist will forward a copy of the completed form to the Residence Manager. The RM will convene an IDTeam meeting; the review of the Medication Regimen Irregularity and Recommendation Record and Physician's comments will be documented in the clinical record by the IPC.			11/1/13	9/26/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 331	<p>Continued From page 217</p> <p>discussion that Client 69 had experienced swelling of his legs, been to a clinic recently for this concern and no review of the plan or use of the adaptive equipment completed. The team indicated the five small meals with snacks was incorrect, agreed the client seeks food and had been losing weight.</p> <p>Client 69 also had a health care plan and objective (HCOP) [REDACTED]</p> <p>[REDACTED] The HCOP instructed if Client 69 becomes restless during the night rule out: need for restroom, hunger, thirst, comfort, toilet, offer light snack or juice. There is no document to support staff ruling out Client 69's needs for comfort etc. prior to giving a as needed drug on a routine basis. [REDACTED]</p> <p>[REDACTED]</p> <p>Restoril is a sedative-hypnotic (sleep) drug used in adults for short term (7-10 days) treatment of a sleep problem. Restoril is a federally controlled substance (C-IV) because it can be abused and long term use leads to dependence. Side effects of Restoril can include memory loss, anxiety, severe allergic reactions and abnormal thoughts and behavior (confusion, agitation, hallucinations and worsening of depression).</p> <p>Medication record review revealed facility staff gave 30 mg of Restoril every night to Client 69 with the only rationale of "awake at 2200." Review of the available medication records</p>	W 331		

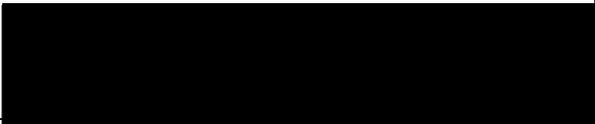
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 331	Continued From page 218 showed the practice of giving a short term use drug had occurred routinely since 12/28/12. In an interview with the Health Services Specialist, Individual Program Coordinator and Residence Manager on 9/25/13 at 2 PM, revealed the only documented intervention was a sleep log kept by the NOC shift. Interviews confirmed they were unaware of Restoril's short term use and dependency concerns.	W 331	W331 #15 a. The IDTeam will identify and prioritize each persons needs for desensitization training through comprehensive review of assessments, ILSA, interview, and monitoring of each individual. b. All RMs reviewed Administrative Directive 235: IPP implementation. All IDTeams will identify plans to enhance or acquire skills that can be incorporated into daily program plans. The IPC will memorialize each step of the desensitization plan into the IPP. If changes are needed to current IPP, the IPC/RM are notified immediately to determine need for a Special IPP meeting.	10/25/13	
	15. Record reviews beginning on 9/18/13 for Client 37, 47, and 69. revealed nursing evaluations indicating desensitization training occurred on Residence 15. The nursing documentation indicated "Staff provide desensitization on the residence before medical/dental appointments..." Interview 9/24/13 at 2 PM with RM, HSS, IPC confirmed no desensitization training occurring.		c. Training was conduct with staff on client 37, 47 and 69's IPPs with staff. d. The IPC/RM/SRPT/RM will ensure compliance during daily routine rounds ensuring re-training/instruction is given with any issues elevated CQM Committee with recommendations /review/follow up discussion.	11/21/13	
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on record review and staff the facility failed to provide care as ordered by the physician in one of 10 core sampled clients. (Client 93). Findings: The clinical record for Client 93 was reviewed on 9/24/13 at 9:15 AM. [REDACTED]	W 339	W339 [REDACTED] b. All Residence Managers and Shift Supervisors provided training to all staff on duty on appropriate documentation of treatment services NP 1.12. c. The Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.	10/25/13	
				10/16/13	
				10/25/13	
				10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769	
(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 339	Continued From page 219 	W 339	W339 cont. d. Shift Supervisors will monitor daily the implementation and documentation of treatment modalities and document observational findings on the Shift Supervisor Rounds Sheet.	10/25/13
	During an interview with the morning Supervisor and Residence Manager on the same date at 11:30 AM, both stated that there was no documentation to prove that the orders were followed to ambulate and provide standing exercise to Client 93. The Supervisor and Residence Manager were not able to give reasons why it was not documented.		e. The Residence Managers will monitor the Shift Supervisor Rounds Sheets weekly and ensure all items are resolved immediately.	10/25/13
W 340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to provide clients with training in proper hygiene methods for one of 10 core sampled clients (Client 77) and two focus sampled client. (Clients 31 and 53) Findings: On 9/18/13 at 11:35 AM, Focused Sample Client 53 was observed to get up from the breakfast table and take a napkin to a trashcan in the dining room. He lifted the lid by hand, thus contaminating it, then returned to eat more of his breakfast. It wasn't until the surveyor brought this to staff attention that Focused Sample 53 was	W 340	f. Program Management will randomly monitor for compliance during monthly rounds and document on the 24 hour report. g. Any identified action items on the Shift Supervisor or Residence Manager Rounds Sheets will be addressed during monthly Risk Management Meetings with any issues elevated to the Clinical Quality Management Committee with recommendations/review/follow up discussion. W340 a. The Residence Manager reviewed with all staff on duty during huddle the Infection Control 6.22 Hand Washing/Hand Hygiene Program Procedure and training sheets were signed to ensure all staff can assist clients with the concept of clean and dirty and good hygiene.	10/25/13
			b. The DTAC Coordinator reviewed Nursing Procedure 6.22 Hand Washing/Hand Hygiene Program Procedure with the teaching staff who work with Client 77.	10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

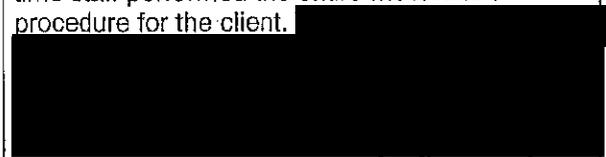
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 371	<p>Continued From page 221</p>  <p>There was no assessment based on the data collected from the tool nor was there a training plan for SAM.</p> <p>For clarification, an interview was conducted with the IPC (Individual Program Coordinator) on 9/25/13 at 10:15 AM. The IPC stated that the group leader and medication person assess all clients for the trainings they might need for the every day activities of daily living. The IPC further stated that the psychologist did behavioral training and the Occupational Therapist would assess for sensory training.</p> <p>The IPC stated that there was no formal assessment for self-administration of medications. She stated that she would ask the group leader and medication person, "What would be a good training?"</p> <p>The IPC stated that all training plans were written by the group leaders, Senior Psychiatric Technicians, and Resident Manager and that the IPC never wrote training plans. The IPC stated, "We monitor and coordinate. The evidence of the assessment is through the training plan."</p> <p>When asked about the training for SAM, the IPC stated that the training that related to SAM was that Client 79 would make eye contact when his name was called while staff applied his elbow orthotic. The IPC further stated that the SAM objective could be anything related to the client's medical treatment specific to his needs.</p>	W 371	<p>W371 #1 cont.</p> <p>b. The Residence Manager (RM) in conjunction with the Individual Program Coordinator(s) (IPC) conducted an audit of the clinical records for the individuals living on Residence 120 to ensure there is an assessment and milestone for Self-Administration of Medication (SAM) for all clients living on the residence.</p> <p>c. The Residence Manager and IPC's will ensure that each client has an assessment and when determined to be appropriate by the ID team that has training for SAM discussed and developed at the Individual Program Plan (IPP) meeting.</p> <p>d. The Program Director will review the Individual Program Plan to ensure SAMs discussed at each IPP.</p> <p>e. All residence managers initiated SAM training for their residents to all medication administration staff and medication administration relief staff.</p>	<p>10/26/13</p> <p>10/26/13</p> <p>10/26/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013	
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 371	<p>Continued From page 222</p>  <p>He exhibited excellent fine motor skills when he was observed to tie his own shoe laces.</p> <p>He had  physician orders for blood glucose checks before every meal and insulin administration.</p> <p>This procedure was observed on 9/18/14 at 11:30 AM; 5:30 PM and on 9/23/13 at 11:30 AM. Each time staff performed the entire medication procedure for the client. </p> <p> All of this was performed without any client participation or prompting by staff.</p> <p>On 9/23/13 at 11:35AM staff was observed to take a bubble pack, punch out a vitamin pill into a medication cup and handed it to Client 77. The client's ability to read along with his manual</p>	W 371	<p>W371 #2</p> <p>a. A special team meeting was held to evaluate Client 77's Self Administration of Medication Objectives and to determine if a new objective would be appropriate. It was determined a change would be appropriate; </p> <p></p> <p>b. The Residence Manager will provide training to the AM and PM clinic personnel including relief clinic personnel on the new training objective. 10/25/13</p> <p>c. All residence managers initiated SAM training for thier residents to all medication administration staff and medication adminstration relief staff. 10/25/13</p> <p>d. The clinic personnel will ensure that Client 77 receives the opportunity for training as specified in the new training objective and data be collected. 10/25/13</p> <p>e. The Client Training Index, A& S and all pertinent documentation will be updated to reflect the new training objective. 10/25/13</p> <p>f. The IPC will monitor progress monthly and document on the IPC Monthly Training Report. When areas of need/concerns are identified during observations and record review, the IPC will elevate issues to the RM and Program Management for follow-up and document at least quarterly in the PC note. 10/25/13</p>	10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 419	<p>Continued From page 225</p> <p>During observations beginning on 9/16/13 at 11:30 AM revealed a bed in the restraint room covered with a torn white blanket, concurrent interview with the residence manager indicated the blanket should have been discarded.</p> <p>Further observations conducted on 9/17/13 thru 9/19/13 revealed clients had only a thin white worn blanket on beds. There was no evidence of colorful, decorative, weather appropriate bedspread or comforters available for use for all 11 of 11 clients residing on the residence.</p> <p>Interview with facility staff on 9/23/13 at 11:30 AM revealed all the client's bedding had been sent to the prison industry laundry and the turn around time could be up to two weeks. Staff indicated the entire residence had been treated for scabies (mite that burrows under the skin) on 8/21/13 and the residence had been striped of personal and bedding items. Observations conducted 9/25/13 verified bedding had not been returned for four and half weeks.</p>	W 419	<p>W419 continuation bedspread and appropriate linens available at all times. Laundry will be contacted immediately if insufficient clean linen is available.</p> <p>c. The SrPTs are responsible for ensuring a safe and therapeutic environment each shift. The SRPT will monitor each bed/bedroom for appropriate linens each shift.</p> <p>d. The RM will ensure compliance during daily routine rounds ensuring re-training/instruction is given and corrective action taken, if needed. Rounds and any corrective actions will be documented on the Residence Manager Rounds Sheet (RMRS). The Residence Manager will submit the SSRS and RMRS and submit to the Program Director weekly.</p> <p>e. Program Management will randomly monitor during rounds at least monthly and document on the 24-Hour Report. Corrective actions will be taken as needed and reported to the Shift Supervisor or Residence Manager for documentation on the Rounds Sheet.</p>	09/16/13 09/16/13
W 426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, review of facility policies, and review of temperature logs, the facility failed to ensure that the water temperature did not exceed 110 degrees</p>	W 426	<p>f. The Program Director will ensure that any issues or concerns identified in the SMRS or RMRS are addressed during the monthly Program Risk Management Meetings with recommendations for any resolution of systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.</p>	10/25/13 10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 426	<p>Continued From page 226</p> <p>Fahrenheit (F) in multiple client areas on Unit 20. The facility policy was not consistent with the ICF/IID regulation.</p> <p>Findings:</p> <p>On 9/18/13 at 6 p.m., the hot water log for 9/2013 was reviewed on Unit 20. The log indicated that the water temperature in room 12 was 112 degrees F. The RM (Resident Manager) stated that she did not believe that any of the clients that resided on the unit were able to self regulate the water temperature.</p> <p>Accompanied by the RM and Plant Operations staff, water temperatures were conducted in multiple client areas on Unit 20, as follows: Room 15- Water from the sink was 111.3 degrees F. Room 3- Water from the sink was 111.3 degrees F and water from the shower was 103.9 degrees F. Room 6- Water from the sink was 113.5 degrees F. Room 39- Water from the sink was 113 degrees F.</p> <p>The facility policy for #16.5 entitled "Personal Care," revised on 2/15/12, included the following entry: Shower water temperature should not be lower than 105 degrees F ...</p> <p>The facility's Nursing Procedure # 14.3 entitled "Hot Water Temperature Checks in Client Accessible Areas," revised on 2/20/13, included the following entry: Hot water temperature control shall be maintained to automatically regulate the temperature of hot water delivered to plumbing fixtures used by clients to attain a hot water</p>	W 426	<p>W426</p> <p>a) The water temperatures on Residence 20 were checked and adjusted by Plant Operations staff.</p> <p>b) All residences water temperatures were checked and adjusted the maximum temperature to 110° F by Plant Operations staff.</p> <p>c) The Nursing Procedures (NP)# 14.3: Hot Water Temperature Checks in Client Accessible Areas and 16.5: Bath will be revised by NP Committee to reflect the new maximum water temperature "not to exceed 110° F".</p> <p>d) The Residence Managers/RN/HSS will provide training of the revised NPs to all supervisors and level of care staff.</p> <p>e) Residence staff will perform monthly water temperatures checks and notify Plant Operations staff if it is out of range.</p> <p>f) Plant Operations staff will perform monthly preventative maintenance which includes a water temperature check and will make adjustments as needed.</p> <p>g) The Chief Engineer will monitor for compliance monthly.</p> <p>h) Any system issues will be brought to the attention of the Chief of Plant Operations, (CPO) and when indicated, elevated to the Administrative Services Committee for review/follow up discussion.</p>	<p>10/25/13</p> <p>11/1/13</p> <p>11/20/13</p> <p>11/30/13</p> <p>9/26/13</p> <p>9/26/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 426	Continued From page 227 temperature not less than 105 degrees F and not more than 120 degrees F.	W 426	W436 #1 a) Helmet for Client #69 was sent for repair on 9/17/13, and a back-up helmet was ordered on 9/24/13 and received on 10/1/13. A recliner chair was placed in the living room, TED Hose were offered at a higher frequency (he demonstrates the ability to remove and apply independently) and a wedge was placed at the foot of his bed to ensure his legs are elevated to tolerance during hours of sleep. (9/16/13) The Physician, HSS, SrPT, RM and Father discussed the risk vs benefit of the bedside mat next to his low bed. It was determined that the risk of falling while entering/exiting his low bed with a bedside mat outweighed the benefit. (Last noted seizure 9/25/11) The mat was removed from the bedside, and the Health Care Objective and Plans and Approaches & Strategies were modified.	10/03/13
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to furnish and maintain adaptive equipment for one of 10 core sampled and one focus client as defined by facility policy titled Client Services - 265: Supportive and Protective Devices. (Client 69, 94) Findings: Observation on 9/16/13 at 11:30 AM revealed Client 69 wore a hard helmet with face guard and chin strap. During lunch observation on 9/16/13 at 12:15 AM, Client 69 removed the helmet and placed it on a shelf. The inside protective foam of the helmet was noted to be torn, worn and soiled. The exterior of the helmet appeared scratched and soiled. [REDACTED] [REDACTED] Further observations occurred on 9/16/13 thru 9/18/13 at varied times during the end of NOC shift, AM and PM shift of Client 69 in the dining room, day treatment center and in residence group areas.. During each observation period Client 69 was not	W 436	b) RM reviewed with residence staff all adaptive equipment and its use at Huddle. c) Level of care staff on the residence ensure that supportive and protective devices are in place, clean and in good repair and apply supportive and protective devices following NP 19.1: Restraints, Mechanical Supports, and Adaptive Devices: Nursing Care of Clients, ensuring that Health Care Objectives and Plans are implemented as developed by the IDTeam and ordered by the Physician.	09/20/13 10/25/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 436	<p>Continued From page 228</p> <p>wearing Ted Hose (compression stocking) and was not encouraged to elevate his legs or provided equipment to do so.</p> <p>Observation of Client 69's room and personal wardrobe closet on 9/17/13 revealed no Ted Hose in his personal wardrobe or available for use in his room. Client 69 had a low bed, there was no mat on the floor in his room and the bed did not have supports such as a wedge or blocks to facilitate elevation of his legs. There was a soft helmet observed laying on the floor of the wardrobe closet.</p> <p>On 9/18/13 a review of the Individual Program Plan (IPP) Approaches and Strategies dated 4/9/13, indicated the team had determined during the assessment phase Client 69 required a hard helmet with face shield and chin strap during the day, soft helmet at night; mat on the floor next to bed in case of falls from seizure activity at night and a lowered long bed. There was no evidence in the IPP who would monitor and assure these supports were in place, how it would be documented, who, how often, and with what to clean the equipment. There was no evidence of a teaching component to help Client 69 make good choices regarding his equipment.</p> <p>The physician orders for August 2013 directed Client 69 was to elevate his legs as tolerated and wear above the knee Ted Hose daily due to swelling of the limbs caused by venous insufficiency. The Medication and Treatment records showed that each AM and PM shift documented Client 69 was wearing the Ted Hose as prescribed, despite observations showing he did not have them on or had removed them.</p>	W 436	<p>W436 #1cont.</p> <p>d) RMs & Shift Supervisors provided training to all staff of NP19.1 to ensure that all adaptive equipment are in place and in good repair.</p> <p>e) All clients adaptive equipments were assessed via the Shift Supervisor Rounds Sheet.</p> <p>f) Each month, level of care staff on the residence document in the client's record in an IDNote Monthly Summary the client's response and effectiveness of the protective devices and the condition of the equipment.</p> <p>g) The Health Care Objective and Plans have been modified to include the cleaning/maintenance schedule and steps for Client #69 to use and care for his supportive and protective devices to the extent of his capabilities.</p> <p>h) Senior Psychiatric Technicians (SrPTs) are responsible for ensuring a safe and therapeutic environment each shift. The SrPTs will ensure all supports/adaptive equipment are administered per Physician's orders on each shift will monitor and ensure compliance per AD 265: Supportive and Protective Devices and NP 19.1: Restraints, Mechanical Supports and Adaptive Devices: Nursing Care of Clients during routine daily rounds. Additionally, SrPTs monitor for staff compliance via IDNote Monthly Summary audit. SrPT will ensure re-training/instruction is given and corrective action taken, as needed.</p>	<p>11/30/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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 436	Continued From page 229 The most recent nursing assessment dated 11/18/12 indicated Client 69 used Ted hose stockings bilaterally during the day and elevated his legs when sleeping as tolerated. The health care plan and objective indicated equipment was checked daily to assure in clean and dry, however there was no documentation to support it had been done. The last time the helmet was replaced was in June 2012 and a second hard helmet was not available for use during cleaning. Individual Planning Coordinator notes, most recent dated April 2013 was unclear what equipment was in place and indicated "all adaptive equipment is available, in good working condition and in use during observation." A review of the facility policy titled Client Services - 265: Supportive and Protective Devices, was completed. The policy defined postural and or mechanical supports (splints, braces, wedges, wheelchair adaptations etc.) and devices to prevent injury (helmets, side rails) shall be ordered by the physician, reasons for their use documented, reviewed and included in the Individual Program Plan (IPP), health care plan, medication/treatment record, and have consents for their use reviewed by the Human Rights Committee (HRC). The client shall be monitored for response and effectiveness of treatment and it shall be documented. The Health Services Specialist (HSS/RN), Individual Program Coordinator (IPC) and residence staff shall ensure the devices are in clean good working condition, used appropriately and according to the IPP. In an interview with the HSS, IPC and Residence Manager on 9/25/13 at 2 PM, Client 69's helmets,	W 436	W436 #1cont. Should the client not tolerate supports/adaptive equipment, the SrPTs will ensure appropriate documentation in the client's clinical record and notify the Physician, HSS and IPC. i) Residence Manager (RM) will ensure compliance during daily routine rounds, ensuring re-training/instruction is given and corrective action taken, if needed. j) Individual Program Coordinator (IPC) Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC required monthly documentation to ensure supportive and protective devices continue to meet the needs of each client. k) All IPC will monitor clients response to and effectiveness of the supportive and protective devices and the condition of the equipment and document findings on the IPC monthly documentation. l) The Program Directors (PD) and RMs will continue to review the IPC monthly required documentation to ensure all issues are resolved. m) IPC Supervisor will monitor for compliance via review of the IPC monthly documentation. Any concerns/ unresolved issues will be elevated to CQM for resolution.	10/25/13 10/24/13 10/25/13 10/25/13 10/25/13	

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 093B-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769	
(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 436	<p>Continued From page 230</p> <p>mat, Ted Hose, and elevation of legs were discussed. There was confirmation the current helmet had been in use for 15 months with no documented maintenance or cleaning schedule, Ted Hose documentation was not accurate and there was no mat for Client 69's use by the bedside. There was agreement concerning a lack of training for the staff concerning clients equipment. There was also discussion that Client 69 had experienced swelling of his legs, been to a clinic recently for this concern and no review of the plan or use of the Ted Hose had been completed.</p> <p>2. Review of Client 94's IPP, dated 8/19/13, indicated that Client 94 utilized bilateral arm splints to protect his face and head from soft tissue injuries due [REDACTED]</p> <p>[REDACTED] Documentation indicated, "It is possible that the arm splints are providing a comforting pressure for him ..."</p> <p>Review of an IPP Special Meeting, dated 8/22/13, indicated that Client 94's team would "move forward with introducing the leg and arm wrap (pressure orthosis items). It is suggested that two sets of leg and arm wraps be ordered so that one is available when another is being laundered, thereby contributing to the continuity of care." The plan was to order the pressure orthosis items.</p> <p>During an interview with the RM (Resident Manager) on 9/25/13 at 10:15 AM, the RM stated</p>	W 436	<p>W436 #2</p> <p>a) Client 94's Interdisciplinary Team met on 10/25/13 to review the delay in obtaining the items identified in the Special Team of 8/22/13.</p> <p>b) The clothing (pressure orthosis items) have been purchased by the RM and are being used by client 94.</p> <p>c) The RM and IPC have reviewed Administrative Directive (AD) 235, Individual Program Plan and AD 236 Individual Program Coordination.</p> <p>d) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including monthly documentation requirements to ensure supportive and protective devices continue to meet the needs of each client.</p> <p>e) All IPCs will monitor clients response to and effectiveness of the protective devices and the condition of the equipment and document findings on the IPC required monthly documentation.</p> <p>f) The PD and RM will continue to review the IPC monthly documentation to ensure all issues are resolved.</p> <p>g) IPC Supervisor will monitor for compliance via review of the IPC monthly documentation.</p>	<p>10/25/13</p> <p>10/26/13</p> <p>10/25/13</p> <p>10/24/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 436	Continued From page 231 that the client did not have the items and that she could not provide any evidence that there had been any action on this request since 8/22/13.	W 436	W454 a) The Residence Manager provided training to all staff on duty on Infection Control Procedure 6.22,	09/20/13
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure a sanitary environment to avoid transmission of infections when staff was observed opening a bathroom doorknob with a gloved hand immediately after providing incontinence care to a client. Findings: On 9/17/13 at 12:25 PM, the surveyor entered room [REDACTED] on Unit 20, [REDACTED] After the care had been provided, the staff member opened the bathroom doorknob with her gloved hand that she had just used while providing incontinence care. Staff did not remove her gloves nor did she wash / sanitize her hands before making contact with the doorknob to enter the bathroom.	W 454	Handwashing/ Hand Hygiene Program. b) The Residence Manager obtained additional posters for Hand Hygiene for the residence as a reminder for staff. c) The Residence Manager, Shift Supervisor and HSS will monitor for proper hand hygiene when observing or assisting staff in provision of client care. d) Hand Hygiene procedures will be reviewed and documented in the monthly Program Risk Management Meetings under the section for reviewing staff illness, injuries to ensure staff remain diligent in preventing the spread of organisms. e) To ensure staff knowledge on proper use of gloves all Res. staff are provided training annually and as needed by Public Health Nurse or designee.	10/26/13 10/25/13 10/25/13
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by:	W 460	W460 #1 a) The Residence Manager reviewed the Dietary Safety Information (DSI) for Client 48 with the staff member responsible for his care. The incorrect diet provided for client 48 was pureed, as is his preference, a lower texture than his ground diet therefore he was	09/17/13

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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 460	<p>Continued From page 232</p> <p>Based on observation, staff interview, and record review the facility failed to ensure that one sampled and one focused client (Client 48) received a specially prescribed diet including snacks. (Clients 48 ,77).</p> <p>Findings:</p> <p>1. Current physician's monthly orders, dated 9/2013, indicated that Client 48 had a diet order for a ground textured diet.</p> <p>During an observation of a lunch meal on 9/17/13 at 12 PM, Client 48 was observed with a pureed textured lunch.</p> <p>During an interview with a food service staff member at this time, the food service staff stated, "I made a mistake." Upon further interview with another food service staff present, staff stated that both staff on duty were floats.</p> <p>2. On 9/18/13 at 10:30 AM at his DTAC, all the clients there were offered and consumed snacks except Client 77.</p> <p>That same morning at 11:15 AM, the DTAC staff members were asked why all the clients except Client 77 had received snacks. They responded that he had diabetes and they didn't have an appropriate snack for him.</p>	W 460	<p>W460 #1 cont.</p> <p>able to tolerate this texture without incident.</p> <p>b) An Occupational Therapy Evaluation was completed for client 48 as his preference is for a pureed texture diet. His diet order has been changed to indicate that he can have a choice of diets, either ground or pureed.</p> <p>c) All Residence Managers reviewed the DSI's for all clients on their residences with staff on duty to ensure all clients receive a diet as indicated in their IPP.</p> <p>d) The Residence Manager reviewed Nursing Procedure 13.1 Physicians Orders, Documentation, Transcription and Tracking of, with all staff on duty.</p> <p>e) The Shift Supervisors will monitor for compliance with the DSI for each client at mealtime, ensuring that all clients receive the correct diet as ordered and document on the Shift Supervisor Rounds sheets. (please see continuation page 233a)</p> <p>W460 #2</p> <p>a) A Special Team was held to discuss a plan for ensuring that Client 77 has preferred snacks that meet his dietary and medical needs.</p> <p>b) The Dietician ordered appropriate snack/drink for consumption in the DTAC classroom, based on Client 77's diet. (please see continuation page 233a)</p>	<p>10/29/13</p> <p>11/4/13</p> <p>10/26/13</p> <p>10/25/13</p> <p>10/26/13</p> <p>10/25/13</p> <p>10/25/13</p>
W 484	<p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs,</p>	W 484		

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
(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	
	W460 #1 cont.				
	f) The Dining Room Coordinators will oversee diet serves to ensure that the prescribed diets are serve correctly. Any issues will be reported to Residence Managers with recommendation.			11/21/13	
	g) All Residence Managers will monitor compliance by reviewing the Shift Supervisor Rounds Sheets as well as during rounds at least weekly during mealtime and document on the Residence Manager Rounds Sheets.			10/25/13	
	h) Program Managements will monitor for compliance during routine rounds at least monthly and document on the 24-hour report.			10/25/13	
	i) The FST who served the incorrect food was re-trained on how to read and follow the CMP and menu.			10/08/13	
	j) The FSSI will observe for compliance during routine meal observations two times per month.			10/25/13	
	k) The FSSII will monitor for compliance monthly and will report to the Director of Dietetics.			10/25/13	
	l) Any systemic issues elevated to Clinical/Administrative Services committee by the Director of Dietetics with recommendations/discussions and follow-up.				
	W460 #2 cont.				
	c) DTAC Coordinator to provide training to DTAC staff on Administrative Directive 235: Individual Program Plan Implementation.			10/25/13	
	d) DTAC Coordinator to monitor during weekly rounds to assure a snack/drink is available to Client 77 and all DTAC clients with Diabetes, and will be documented on DTAC rounds report.			10/25/13	
	e) Program Assistant to monitor the DTAC Rounds reports to ensure that all identified action items found on the DTAC rounds report are resolved.			10/25/13	
	f) All clients diagnosed with diabetes, their diet will be audited by HSSs for an order of nourishments. Findings will be communicated to DTAC Coordinators and PAs to ensure that the appropriate snack is available in DTAC areas.			11/13/13	
	g) Any identified action items/issues on the DTAC rounds report will be addressed during monthly Risk Management Meetings with recommendation/discussion/follow up.			10/25/13	
	h) Any systemic issues being elevated by the Program Director with recommendations/follow up via the Clinical Quality Management Committee.				

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
---	--

(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 484	<p>Continued From page 233</p> <p>eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that clients were equipped with adaptive equipment and furniture to meet their developmental needs for 2 focused clients (Clients 48 and 9).</p> <p>Findings:</p> <p>1. Current physician's monthly orders, dated 9/2013, indicated that Client 48's dining/seating orders included the use of a dining chair with arms.</p> <p>During an observation of a lunch meal on 9/17/13 at 12 PM, Client 48 was seated at the dining table in a regular chair with no arms.</p> <p>2. Current physician's monthly orders, dated 9/2013, indicated Client 9 had an order to utilize a cloth napkin during dining. During an observation of a lunch meal on 9/17/13 at 12 PM, Client 9 had a paper napkin next to her plate during dining.</p> <p>During an interview with level of care staff at this time, staff stated that Client 9 could wipe her mouth herself and it was cleaner for her to use a cloth napkin.</p>	W 484	<p>W484 #1 and 2</p> <p>a) The Residence Manager reviewed the Dietary Safety Information (DSI) for Client 48 and client 9 with the staff member(s) responsible for their care.</p> <p>b) All Residence Managers reviewed the DSI's for all clients on the residence with staff on duty to ensure all client will utilize adaptive dining equipment to eat as independently as possible.</p> <p>c) The Residence Manager reviewed Nursing Procedure 13.1 Physicians Orders, Documentation, Transcription and Tracking of, with all staff on duty.</p> <p>d) All Shift Supervisors will monitor for compliance with the DSI for each client at mealtime, ensuring all adaptive equipment is utilized as ordered daily and take corrective action as needed. Rounds and any corrective actions will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.</p> <p>e) All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure compliance and take corrective action if needed. Rounds and any corrective actions will be documented on the Residence Manager Rounds Sheet (RMRS). The Residence Manager will submit the SSRS and RMRS to the Program Director weekly.</p>	<p>09/17/13</p> <p>10/26/13</p> <p>10/26/13</p> <p>10/26/13</p> <p>10/25/13</p>

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

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>3) Program Management will randomly monitor during rounds at least monthly and document on the 24-Hour Report. Corrective actions will be taken as needed and reported to the Shift Supervisor or Residence Manager for documentation on the Rounds Sheet.</p> <p>4) The Program Director will ensure that any issues or concerns identified in the SMRS or RMRS are addressed during the monthly Program Risk Management Meetings with recommendations for any resolution of systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.</p>			<p>10/25/13</p> <p>10/25/13</p>
--	--	--	--	---------------------------------