

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

PRINTED: 11/18/2013
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
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NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769
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W 000	<p>INITIAL COMMENTS</p> <p>The following represents the findings of the California Department of Public Health during a full survey. The survey began on 9/16/13 and the date of exit was 9/26/13.</p> <p>Health Facilities Evaluator Nurses representing the Department: 09671 14552 14906 16553 18839 22069 22975</p> <p>Two representatives from the Centers for Medicare and Medicaid Services, CMS Consultant, and support staff participated in the survey.</p> <p>Census: 95 Core Sample size: 10</p> <p>Definitions:</p> <p>Gastrostomy - surgical formation of an artificial opening into the stomach from the skin surface of the abdominal wall used for feeding</p> <p>Enteral feeding - a mode of feeding that uses the gastrointestinal tract such as oral or tube feeding</p> <p>Jejunostomy - a surgical procedure performed to create an artificial opening to the jejunum (the middle of the three portions of the small intestines) through the abdominal wall used to</p>	W 000	<p>RECEIVED</p> <p>DEC 3 2013</p> <p>1:35pm</p> <p>MF</p>	

APOC
12/11/13
W

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl B...</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11-26-13</i>
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 administer feeding. Epilepsy- a group of neurological disorders characterized by recurrent episodes of seizures Core sample - Original randomly selected client sample. Focused client - Client added to the core sample. Decedent - same as deceased DTAC - Day Treatment Activities Center, activities/work site Pica - a craving to eat or ingest inedible (nonfood) substances or objects Hypercholesteremia- a condition in which greater than normal amounts of cholesterol are present in the blood Idiopathic cardiomyopathy - condition of the loss of elasticity of heart muscle causing enlargement or thickening of the heart MOD - On call physician GER - General Event Report IPP - Individual Program Plan, a treatment plan of care for clients QA - Quality Assurance SPT - Senior Psychiatric technician DDS - Department of Developmental Services	W 000	DEFINITIONS: *Comprehensive Functional Assessment: The IDTeam develops a comprehensive functional assessment that consists of an individualized, person-centered, prioritized and logical program plan that incorporates assessed preferences, strengths, needs and a discussion and decision about the recommendations (in order to identify the services and supports in which to meet the person's preferred future. In preparation for the Annual Individual Program Planning meeting, the IPC creates a draft Comprehensive Functional Assessment which is based on information from individualized, written assessments; interviews; observations; record reviews; etc. *Behavior Review Group (BRG): A monthly meeting during which behavior-related data and medication regiment is reviewed with the Psychologist, Physician, Pharmacist, Residence representative, and IPC; RN/HSS attends at least quarterly. Trends in behavior-related data is reviewed, any use of emergency restrictive intervention and overall status are evaluated for success as defined by the IDTeam.		

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W 000	Continued From page 2 HSS - Health Services Specialist Enhanced supervision - In line of sight, of staff member assigned to client. Float - Staff member reassigned from another unit. Comprehensive Functional Assessment- an assessment that includes the client's needs, abilities, skill deficits, choices and functional limitations. The following Entity Reported Events were investigated and substantiated: 333662, 344870, 345917, 347557, 347811, 363814, 365738, 368642, 363814, 367035 : SEE W249, W154 338571, 338925: SEE W127, W149, W150, W153, W154 360527, 363484: SEE: W 189 332312: SEE: W 127, W 150, W 154 The following complaints were investigated and substantiated: 357906, 361045, 361189: SEE W 104, W 127, W 149, W 150, W 153, W 154, W 189, W 196, W 249	W 000	(cont'd from page 2) *Enhanced Supervision (per AD 226): "Levels of supervision that fall outside of [General Supervision or On-campus Independence] will be justified by the IDT and specifically documented in the client's record." Thus, one client's "enhanced supervision" may be to have staff seated at the table during meals, while another may be to have staff within 3 feet (close enough to intervene) when antecedent behavior is observed. "Line of sight" is one other description of a type of Enhanced Supervision. *Dining Room Coordinator - Licensed staff, usually the Shift Supervisor present in the dining room during meal time to ensure client IPPs are implemented and the Dietary Safety Issues (DSI) is followed. Please note: Residence 15 was closed effective 10/31/13 and the beds placed into suspense. CDPH was notified of this action.		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS	W 100			

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W 100	Continued From page 3 "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation of Active Treatment Services: Findings: The facility did not meet the Condition of Participation (COP) in Active Treatment Services. The facility did not assure clients received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports. The facility failed to develop individual plans structured to promote consistent implementation of training programs to teach skills and increase independence. (See W 195).	W 100	W100 The Governing Body of Lanterman Developmental Center is committed to the health and well-being of the individuals served and in the implementation of systems to ensure that the Conditions of Participation for Client Protection and Active Treatment are met. The Governing Body will ensure that clients receive continuous active treatment programs that emphasize comprehensive and consistent implementation of formal and informal training programs and supports which promote independence and development of skills. See also W102, W104, W122, and W195.	9/26/13	
W 102	483.410 GOVERNING BODY AND MANAGEMENT	W 102	W102 1-3 a. The Governing Body of Lanterman Developmental Center is committed to the health and well-being of the individuals served and in the implementation of systems to ensure that the Conditions of Participation for are met. b. The Executive Committee (EC) is responsible for ensuring implementation of the plan of correction. This is being accomplished through the implementation of current policies and the development and implementation of new policies and/or	9/26/13 9/26/13	

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W 102	Continued From page 4 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews and record review, the facility did not meet the Condition of Participation in Governing Body and Management by the governing body's failure to take responsibility and action to identify and resolve systemic problems of serious and recurrent nature and by not meeting the requirements for the Condition of Participation of Client Protections and Active Treatment. The facility also failed to exercise, monitor and implement polices to ensure the health and safety of all clients residing at the facility. These failures affected 8 of ten core sampled and 13 focus sampled Clients and and potentially all 95 clients residing at the facility. (Clients 1, 13, 17, 29, 36, 37, 43, 47, 64, 69, 66, 77, 79, 89, 91, 92, 93, 94, 95, 97, 98) Findings: 1. The Condition of Participation, Governing Body was not met (See W-104) a. The Governing Body failed to ensure all alleged violations were reported immediately, investigated thoroughly and corrective actions were taken. Administrative Directive 124 dated April 15, 2011, titled Incident/Unusual Occurrence Reports was not implemented as written to ensure complete and thorough	W 102	W102 #1-3 cont. procedures. EC ensures staff knowledge of such policies and procedures through ongoing staff training. c. The Governing Body is ensuring compliance with the corrective actions and system implementation outlined in W104. d. To ensure the health and safety of all clients residing at the facility, the Governing Body is monitoring compliance with policy implementation as outlined in W104 and through processes which include: *scheduled and intermittent management direct observation by Governing Body/Executive Committee members of client service delivery; *a Quality Assurance committee process which promotes continuous quality improvement; and *rounds made by Shift Supervisors and Residence Managers. Observers will endeavor to make immediate correction of any non-compliance and follow up as needed. Issues and concerns noted in the monitoring process within this document will be elevated to the Governing Body (with recommendations if indicated) via the Center's management hierarchy or "chain of command" and integrated into the Quality Assurance committee process.	9/26/13 9/26/13

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	W102-2b,c,e; W122-1,2; W127-2; W150-1; W154-1			
	a. Client 98 was examined by the residence physician who determined that a possible sexual assault may have occurred. Office of Protective Services/Investigators were notified. Client 98 was escorted to [REDACTED] sexual assault response unit for further examination with familiar staff. Residence Psychologist and staff who care for Client 98 provided ongoing assessment to monitor for any adverse outcomes based on the injury.			11/6/12
	b. Program 2 Management increased NOC rounds for Res 21. A summary of the completed rounds was sent to the PD/CD for review.			11/6/12
	c. Program Management, Administrative staff and Quality Assurance staff initiated Protection from Harm rounds on all residences.			11/6/12
	d. The OPS Commander contacted the local DOJ - Elder Abuse Hotline office to report incident, via voicemail.			11/7/12
	e. The Office of Protective Services (OPS) Commander informed Executive staff that the CHP Investigative Unit would take the lead in the Criminal Investigation and OPS would conduct an Administrative Investigation concurrently.			11/7/12
	f. The Program's Health Services Specialist initiated a review (11/7/12) of all recently opened medical conditions related to the perineal area, such as rashes, impaired skin integrity, and urinary tract infections to determine any areas of concern. A summary indicating no abnormal findings were observed was provided to the PD/CD.			11/7/12
	g. QA Risk Manager completed an Incident Report review for all injuries occurring on Residence 21 for the previous 6 months.			11/21/12
	h. The Program 2 Program Assistant reviewed the Program Injury/Fall Log, identifying types of injuries that had been documented on this residence (11/7/12), which was distributed to members of the Daily Executive Risk Management Team (DERMT). Findings of no issues related to special medical conditions were discussed at the DERMT meeting and during the Program's Risk Management Meeting.			11/16/12
	i. Special Risk Management Meetings were held beginning 11/7/12 in all Programs to review AD 124: Incidents and Unusual Occurrence, AD 227: Alleged Abuse, Neglect or Exploitation, AD 225: Client Supervision and Personal Care, and Quality Assessment and Performance Improvement Plan for Special Medical Conditions.			11/20/12
	j. Acting Clinical Director conducted rounds on Res. 21, and met with CDPH SFU licensing surveyor.			11/7/12
	k. Executive Director made rounds on Res. 21.			11/30/12
	(continue on page 6b)			11/7/12
				11/8/12

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	(continued W102-2b,c; W122-1,2; W127-2; W150-1; W154-1)				
	I.Residence HSS and Physician completed physical examinations to rule out any further potential victims on all clients living on Residence 21. The Physicals were completed on the female clients first (11/8/12), followed by the male clients (11/15/12).			11/8/12 11/15/12	
	m.Memorandum from Acting Clinical Director to all Program Managers, Residence Managers and Shift Supervisors re: heightened awareness by all staff regarding Protection from Harm (PFH) measures (Steps b, c, k, n, and p) for all clients.			11/8/12	
	n.The OPS Commander instructed the OPS Sergeant to have Police Officers initiate daily rounds on residences at random times of the day. These are logged on the OPS Police Daily Activity Log as well as the residence 24-Hour Report.			11/8/12	
	o.The Director of Quality Assurance contacted the Sexual Assault Response Team (SART) Nurse from PVCH to inquire if there were any recommendations regarding protection from harm.			11/8/12	
	p.Program Management and Quality Assurance staff conducted rounds for the holiday weekend on each residence and each shift.			11/9/12	
	q.The Individual Program Coordinator and Program 2 Management reviewed Interdisciplinary Notes and Nursing Assessments for all clients living on Residence 21 for the previous 6 months, with no unusual findings reported to the Program Director and Clinical Director. (Female clients' record review completed on 11/9/12. Male clients record review completed on 11/16/12.)			11/9/12 11/16/12	
	r.Enhanced Rounds by all Program Managers and Supervisors and Quality Assurance staff to all residences and all shifts on an ongoing, weekly random schedule. Identified issues are reported and elevated to Executive Committee members if resolution is needed. Rounds data will be collected and presented to the Clinical Director for review at the Clinical Quality Management Committee Meetings and the Quality Management Council Meetings.			11/13/12	
	s.Client 98 received [REDACTED] which was personalized			11/13/12 11/14/12	
	to Client 98's wants and needs.				
	t.Senior Supervising Psychologist reviewed strategies to assist individuals in dealing with sexual assault with the DERMT members and Executive Committee.			11/16/12	
	u.A Special Team meeting was held to review Client 98's program plans and data collection, and modifications were implemented.			11/19/12 11/28/12	
	v.Center-wide training on Client Protection was led by OPS personnel and scheduled for all staff in 3 separate training sessions. Curriculum was developed in December, 2012 and two training sessions were held on 1/22/13 and 2/21/13.			1/22/13 2/21/13	

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(continued W102-2b,c; W122-1,2; W127-2; W150-1; W154-1)					
	w. To improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective) and how those coincide with investigations by OPS by Disability Rights, California (DRC) Director, Investigations Unit and Senior Investigator.				2/14/13
	x. To further improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective).				5/1-2/13
	y. The DQA and QA Program Assistant have sent out a Template to Residence Managers and acting Residence Managers to assist in the completion of the Level 1 Review/investigation process.				12/26/12
	z) Standards Compliance Coordinator (SCC) provided training on 10/25/13 to the facility's Managers and Supervisors re: expectations to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations to the next level of management to ensure that active treatment programs and supervision are provided and/or needed revisions to plans are identified.				10/25/13
	aa) The Office of Quality Assurance will monitor all generated General Event Reports (GER) for complete and thorough investigations daily. Any issues will be brought up to Program Management and Exective Management at the Daily Executive Risk Management Team meeting (DERMT) for corrective action as warranted.				
	bb) The four staff who had worked on the night shift prior to the discovery of the injury were reassigned to non-client care duties pending the outcome of the investigation.				10/6/12
	cc) The Office of Protective Services administrative investigation was initiated in August 2013 upon receipt of the completed California Highway Patrol case. The OPS investigation included a review of historic information related to the alleged perpetrator's prior work assignments compared with incident data and was completed on October 17, 2013.				10/17/13
	dd) Supervising Investigator provided training to OPS Investigators re: expectations for requests of historical reviews of subjects identified in administrative investigations and weekly written updates from Investigators on administrative tasks completed on investigations while criminal investigations are conducted.				10/30/13
	ee) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an investigation so that it is included as part of the investigative process.				10/25/13

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	W102, W127, W104 #1, W122, W150, W154. W249			
	*The California Highway Patrol was notified by OPS and opened an investigation.			1/5/13
	*Involved staff was assigned to no client contact.			1/5/13
	*The Coroner was notified by the ACNS and responded to the facility.			1/5/13
	*The Medical Examiner completed an autopsy and concluded that the cause of death was natural.			2/12/13
	a. Lanterman Developmental Center's Administrative Directive 227: Alleged Neglect or Abuse, states that every staff member is responsible for the safety and well-being of the individuals served by the Center. Any neglect, abuse or exploitation by any person, whether staff, visitor, volunteer, family or other clients, is prohibited.			10/25/13
	b. To assist in assuring compliance with the above directive, classes on Client Protection, Clients Rights, and Behavior Management Training are included in training that is required for all staff. Additionally, all staff are trained annually, during the review of their Individual Development Plan, on Administrative Directive 227: Alleged Neglect and Abuse.			10/25/13
	c. The Clinical Director gave written direction to the Residence and Program Managers to: meet with all staff on duty and ensure that they understand that clients' supervision levels must be implemented per the client IPP; reevaluate staffing deployment immediately; and meet that day to review staffing levels with the Program Directors and Nursing Coordinators to ensure effective staff deployment.			09/23/13
	d. Program Managers reported to the Clinical Director that modification to deployment was not warranted at the time. Program Managers are responsible to assure that an adequate number of staff are on duty and that adjustments are made based on acuity level on a continuum.			09/23/13
	e. The CD reviews staffing minimums/ deployment with the PDs quarterly and as needed. Interim staffing changes are requested by the Program Director and approved by the Clinical Director. Temporary staffing changes can be approved by the Program Manager based on level of care staff input when acuity levels warrant an immediate change.			10/25/13
	f. The CD and Program 2 Director met to discuss and develop a Client Supervision Accountability System for level of care staff which includes: a Residence-specific reference tool which provides each client's name and their supervision level; a signed acknowledgement of the review and understanding of the client supervision levels.			09/23/13
	g. The Client Supervision Accountability System was implemented on Residence 31, including a review of the residence-specific reference tool and a signed acknowledgement of the review for all staff on duty			09/23/13
	h. A review of each residence-specific reference tool was conducted to ensure each client's supervision levels are clearly defined and consistent with the individual's IPP. The Residence Manager is responsible for the review of the reference tool. Any findings in need of improvement are referred to the ID Team for revision, for which the IPC is responsible for coordinating.			09/23/13

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	W102, W127, W104 #1, W122, W150, W154, W249 (continuation)				
	i. When an individual experiences a situation that requires short-term increased supervision, the level of supervision and the duration of the increase will be specified and documented as appropriate in the Clinical Record (Temporary Intervention Plan/ TIP, Short Term Nursing Observation/STNO, or Temporary Condition/TC, etc) and on the 24-hour Report. The information is communicated by Residence Manager/Shift Supervisors to level of care staff at intershift huddles. Huddle attendance is acknowledged on the 24-hour Report. All staff on the incoming shift will initial the 24-hour Report to verify receipt of the information. The Shift Supervisor will assure completion. The increase in supervision will be carried over to each 24-Hour Report log until concluded.			10/25/13	
	j. The Client Supervision Accountability System was implemented for all ICF residences. Residence Managers are responsible for accuracy and to ensure that all on-duty level of care staff have been trained on the supervision levels, and have signed an acknowledgement of the review and understanding of supervision levels. The Program Assistant will ensure this occurs for all the DTAC/worksite staff and Rehabilitation Therapists.			09/27/13	
	k. The acknowledgement for the client supervision accountability system and the Residence specific reference tool has been incorporated into new staff orientation and cross-training for staff transfers due to consolidation.			09/25/13	
	l. The "Orientation for Relief Staff Providing Client Services" was revised to ensure the review of client supervision is included. The Clinical Director coordinated the revision of the form, which is now titled, "New Staff and Float Orientation".			09/25/13	
	m. Use of the "New Staff and Float Orientation" has been implemented immediately following training to Residence Managers by the Clinical Director. Shift Supervisors are responsible for ensuring the review of supervision levels is completed for any/all relief/float staff and documented on the form.			09/25/13	
	n. Training on Administrative 226: Client Supervision and Personal Care was initiated on 9/23/13 with all level of care staff by Residence Managers. DTAC/worksite staff will be trained by the Program Assistant, initiated on 9/25/13.			09/27/13	
	o. An informational flyer describing definitions of level supervision was created at the direction of the Clinical Director and posted on each residence in the Nursing Station by Program Managers.			09/24/13	
	p. Program Assistants will ensure that the flyer is posted in DTAC/classroom/worksites.			09/25/13	
	q. The flyer will be posted on the facility Intranet and emailed to all staff.			09/25/13	
	r. Shift/Site Supervisors will review the information on the flyer at daily huddles on residences and DTAC/worksite effective immediately through 9/27/13.			09/27/13	
	s. The Clinical Director and ICF Program Directors met with Residence Managers, IPCs, and Quality Assurance staff to review client supervision expectations, and regarding IPP implementation to ensure protection from harm for clients. AD 226 was also reviewed with emphasis on Section 4.5.			09/24/13	

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	t. The Executive Director instructed Program and Residence Managers to conduct rounds on all ICF residences to assess staff knowledge and ability to implement supervision levels, and provide prompting and intervention where needed. Specific findings were relayed to the Residence Manager of the involved residence(s) for follow-up.				09/24/13
	u. A debrief of the 9/24/13 rounds was held to review overall findings of the staff knowledge and ability to implement supervision levels. Program and Residence Managers conduct rounds with random competency checks for staff knowledge of client supervision levels and implement. Outcomes were forwarded to the Executive and/or Clinical Director and on review, there were some instances in which staff was provided immediate feedback and coaching.				09/25/13
	v. The Clinical Director initiated the policy review/revision process for Administrative 226: Client Supervision and Personal Care to incorporate the Client Supervision Accountability System as well as any other revisions identified via the facility rounds. Additionally, definitions of commonly used descriptors pertaining to supervision levels will be added to the policy.				09/25/13
	w. On completion and approval of the revised Administrative 226: Client Supervision and Personal Care all level of care staff will be trained on the changes. Further orientation to the policy changes will be provided in employee meetings (such as Program meetings, and General Employee Meetings).				10/25/13
	x. The Individual Program Coordinator (IPC) will be responsible for updating the client supervision reference tool when any individual's supervision level is changed following any IPP meeting. The update 9/25 will be completed by close of business the day the supervision level is changed. Supervision change will be documented on the 24 Hour Report and incoming staff will initial for acknowledgement. The Program Assistant will review the changes/updates with DTAC/worksite staff and Rehabilitation Therapists which will be acknowledged by signing a Training Record.				09/25/13
	y. The Residence Manager/Program Assistants will ensure that the updated client supervision reference tool is promptly disseminated.				09/25/13
	aa. The IPC Supervisor will conduct a periodic audit to determine whether updates to the client supervision reference tools are completed on time for the first 90 days. Random audits will occur following IDTeam meetings in which the IPP documents indicate a change in level of supervision. Any findings in need of correction will be addressed with the IPC and involved residence immediately. The overall findings and recommendations will be submitted to the Executive Committee for review of compliance and of the process.				09/26/13
	bb. RM to ensure that copies of the current residence-specific reference tool are available to staff in the Group Book and an additional copy if desired to keep with them during the shift. A daily audit will be completed by the Residence Manager/designee to ensure compliance for 90 days. Findings will be documented as an entry on the 24-Hour Report. Program Directors will gather the findings and will report				10/25/13

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	out weekly at the Daily Executive Risk Management Team (DERMT) meeting (Fridays) with a review of findings and determination for ongoing monitoring needs.			10/25/13	
	cc. If a supervisor finds that supervision is not being implemented per plan, immediate corrective action will be taken by the site supervisor with notification to the Residence or Program Manager for appropriate follow up.			09/30/13	
	dd. A workgroup will be convened to develop a standardized Client Supervision Guide to identify the most effective residence-specific reference tool to use facility-wide. This workgroup will also be tasked with developing a standardized staff assignment sheet that will at a minimum identify staff "group" assignments and break times. The workgroup will consist of level of care staff, Shift Supervisor/s, IPC/s, and clinical managers. Membership will be determined at a DERMT meeting during the week of 9/30/13.			10/25/13	
	ee. The Shift Supervisor is responsible to assign relief staff as well as redeploy staff based on client need. Residence Manager will monitor for compliance and provide guidance and direction to ensure effective deployment.			10/25/13	
	ff. The standardized tool will be implemented facility-wide, including training to all IPCs, level of care staff, DTAC, shift supervisors and clinical managers. Training will be initiated within 30 days of the development of the form and will be ongoing for new and returning staff.			09/24/13	
	gg. Random competency checks of level of care staff on all ICF residences will be conducted during scheduled: Residence Manager rounds, Protection from Harm Rounds, Program Management rounds, IPC rounds and Executive rounds. Results of the competency checks will be submitted to Quality Assurance.			10/25/13	
	hh. Any/all findings of insufficient competency will be relayed to the Residence Manager of the involved staff for immediate attention.			09/24/13	
	ii. The Quality Assurance Department will review the results and report out at the Clinical Quality Management. Findings and recommendations forwarded to Governing Body members via the Quality Management Council meeting.			09/24/13	
	jj. The Director of Quality Assurance will monitor to assure completion of competency checks and review of the results for the first 90 days.			10/25/13	
	kk. Recommendations for continued monitoring will be submitted to the Executive Committee for consideration.			09/27/13	
	ll. All level of care (residence, DTAC, Rehab Therapists) staff will be provided a whistle to use when assistance is needed and other staff are not in the immediate vicinity. These will be distributed to on-duty staff on a continuum by Shift Supervisors. Residence Manager/Program Assistant will monitor for compliance. This system is in place on Residence 15			09/27/13	
	mm. An analysis of the number of clients who need enhanced or greater supervision in the various environments (dining room, living room, bathroom, worksite, etc.) on the staffing ratios in effect on each				

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	W102, W127, W104 #1, W122, W150, W154. W249 (continuation) residence. Staffing adjustments needs will be formally made as needed (such as higher ratio of individuals under enhanced supervision). nn. When one staff relieves another, endorsement with the receiving staff will occur providing any unusual/out of the ordinary behaviors or activities of the individuals to be supervised. If the time of the "relief" for staff to go on a break is different than was originally scheduled, the Staff Assignment Sheet will be updated by the Shift Supervisor. oo. At weekly staffing meetings and as needed, Residence Managers will report to Program Managers (Nursing Coordinator, Program Assistant, or Program Director) if any increased staffing is needed due to client activities, medical condition, or behaviors. pp. The Clinical Director reviewed the current client supervision reference tools and selected one to be the implemented ICF-wide until the workgroup develops an alternate. qq. The interim client supervision reference tool will be enacted by each Residence Manager. rr. The revision of AD 226 will include definitions of commonly used terms. Interim definitions will be "waking hours"- an individual's usual hours of being awake (a conscious or alert state- http://www.merriam-webster.com/dictionary/waking) in the rhythm of their day. "Napping" - to sleep briefly especially during the day (http://www.merriam-webster.com/dictionary/napping)			10/25/13 10/25/13 09/26/13 09/27/13 09/26/13	

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W 102	<p>Continued From page 6</p> <p>not take steps to prevent recurrence or implement their policies and procedures. (See W 122 and 149)</p> <p>b. The facility failed to protect two focus clients from harm (Clients 97 and 98). The facility failed to provide enhanced supervision to Client 97 who was found unresponsive and pronounced dead on 1/5/13. Client 98 was subjected to sexual assault. (See W 127).</p> <p>c. The facility failed to protect one client from sexual assault. (Client 98) (See W 150).</p> <p>d. The facility failed to ensure all allegations of abuse were reported immediately to California Department of Public Health, and facility Administrator. (See W 153).</p> <p>e. The facility failed to conduct a thorough investigation that addressed potential victims and areas worked by an alleged sexual perpetrator, and failed address a discrepancy between Office of Protective Services and the facility Generated Event Report findings. (See W 154).</p> <p>3. The facility did not meet the Condition of Participation (COP) in Active Treatment Services by its failure to ensure that each client received a continuous active treatment program, which included aggressive, consistent implementation of a program of training, treatment and or health services. The facility failed to ensure that individuals were involved in activities which addressed their individualized priority needs. The facility did not develop plans to address behavioral support needs documented to interfere with daily life. The facility did not assure that program plans included measurable objectives on</p>	W 102			

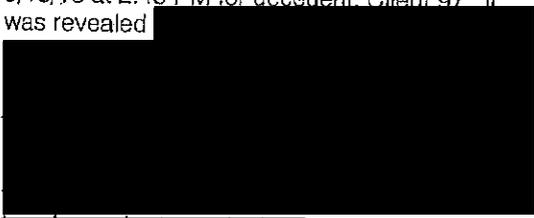
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W 102	Continued From page 7 which data was maintained in a manner that allowed determination of progress or lack of progress. (See 195, W 196, W 214, W 229, W240, W247, W 249, W 252)	W 102			
W 104	The cumulative effect of these systemic problems resulted in the facility failure to ensure the Governing Body was providing oversight and ensure the provision of safe healthcare and services. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interviews, clinical record reviews and facility document reviews, the governing body failed to exercise general policy and operating direction over the facility as follows: 1. The Condition of Participation, Governing Body was not met. (SEE W102) a. The Governing Body failed to ensure all alleged violations were reported immediately, investigated thoroughly and corrective actions were taken. Administrative Directive 124, dated April 15,2011 titled Incident/Unusual Occurrence Reports was not implemented as written to ensure complete and thorough investigations, analysis, corrective action, and notifications were conducted resulting in the Condition of Participation in Client Protections to be not met. ((SEE 104)	W 104			

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W 104	Continued From page 9 44, 56, 66, 89, 91, 92, 93, 94, 95, 97, 98. (SEE W122, W127, W149, W153, W154) a. During closed record review commencing 9/18/13 at 2:45 PM for decedent, Client 97, it was revealed  Bruises to the lower extremities were discovered the following day on 1/4/13 and Client 97 expired on 1/5/13. Two days after Client 97's expiration on 1/7/13 another client made an allegation Client 97 was hit in the stomach. All of the events were investigated and summarized in one investigative report. There was a hypothesis that the bruises discovered on 1/4/13 could reasonably be explained by events that occurred at the dental clinic. Per interview with the Medical Director on 9/20/13 commencing at 9:00 AM, it was revealed the Mortality Review (MR) minutes for Client 97 had not yet been summarized. On 9/23/13, typed minutes and handwritten notes were presented for review. Though the minutes documented an assertion that medical management was appropriate and the cause of death was due to underlying Idiopathic cardiomyopathy, the MR was absent of any discussion regarding the coroner's narrative and the issue identified regarding the nature of the lower limb bruising presumed to have occurred during recovery at the dental clinic. Even though a nexus was identified between the use of restraints and placement proximity to Client 97's upper hip bruises, there was no discussion in the MR regarding the efficacy of the	W 104	completing a comprehensive mortality review. d. The Quality Assurance Nurse Consultant I (also Fracture Risk Management Committee Chair) visited the Dentist office and interviewed the Dentist regarding the technique and use of Treatment Restraints as well as how they had been applied with Client 97 on 1/3/13. In a verbal report to the DQA, the NC-I opined that bruise pattern did not appear to correlate with the device and that the application appeared to be safe and was described as effective (as evidenced by there was no need to use the leg restraint during this appointment.) e. The Medical Director will ensure that the Mortality Review process incorporates the information/ components described in the training. Issues identified during the Mortality Review process will be elevated first to the Medical Executive Committee, and if indicated to the Governing Body via the Quality Management Council or Executive Committee. f. The Executive Director will monitor for compliance through observation and review within the above process.	10/31/13 10/25/13	

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	W102-2b,c,e; W122-1,2; W127-2; W150-1; W154-1				
	a. Client 98 was examined by the residence physician who determined that a possible sexual assault may have occurred. Office of Protective Services/Investigators were notified. Client 98 was escorted to [REDACTED] sexual assault response unit for further examination with familiar staff. Residence Psychologist and staff who care for Client 98 provided ongoing assessment to monitor for any adverse outcomes based on the injury.			11/6/12	
	b. Program 2 Management increased NOC rounds for Res 21. A summary of the completed rounds was sent to the PD/CD for review.			11/6/12	
	c. Program Management, Administrative staff and Quality Assurance staff initiated Protection from Harm rounds on all residences.			11/6/12	
	d. The OPS Commander contacted the local DOJ - Elder Abuse Hotline office to report incident, via voicemail.			11/7/12	
	e. The Office of Protective Services (OPS) Commander informed Executive staff that the CHP Investigative Unit would take the lead in the Criminal Investigation and OPS would conduct an Administrative Investigation concurrently.			11/7/12	
	f. The Program's Health Services Specialist initiated a review (11/7/12) of all recently opened medical conditions related to the perineal area, such as rashes, impaired skin integrity, and urinary tract infections to determine any areas of concern. A summary indicating no abnormal findings were observed was provided to the PD/CD.			11/7/12	
	g. QA Risk Manager completed an Incident Report review for all injuries occurring on Residence 21 for the previous 6 months.			11/21/12	
	h. The Program 2 Program Assistant reviewed the Program Injury/Fall Log, identifying types of injuries that had been documented on this residence (11/7/12), which was distributed to members of the Daily Executive Risk Management Team (DERMT). Findings of no issues related to special medical conditions were discussed at the DERMT meeting and during the Program's Risk Management Meeting.			11/7/12	
	i. Special Risk Management Meetings were held beginning 11/7/12 in all Programs to review AD 124: Incidents and Unusual Occurrence, AD 227: Alleged Abuse, Neglect or Exploitation, AD 225: Client Supervision and Personal Care, and Quality Assessment and Performance Improvement Plan for Special Medical Conditions.			11/16/12	
	j. Acting Clinical Director conducted rounds on Res. 21, and met with CDPH SFU licensing surveyor.			11/20/12	
	k. Executive Director made rounds on Res. 21.			11/7/12	
	(continue on page 6b)			11/8/12	

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	(continued W102-2b,c; W122-1,2; W127-2; W150-1; W154-1)				
	i. Residence HSS and Physician completed physical examinations to rule out any further potential victims on all clients living on Residence 21. The Physicals were completed on the female clients first (11/8/12), followed by the male clients (11/15/12).			11/8/12 11/15/12	
	m. Memorandum from Acting Clinical Director to all Program Managers, Residence Managers and Shift Supervisors re: heightened awareness by all staff regarding Protection from Harm (PFH) measures (Steps b, c, k, n, and p) for all clients.			11/8/12	
	n. The OPS Commander instructed the OPS Sergeant to have Police Officers initiate daily rounds on residences at random times of the day. These are logged on the OPS Police Daily Activity Log as well as the residence 24-Hour Report.			11/8/12	
	o. The Director of Quality Assurance contacted the Sexual Assault Response Team (SART) Nurse from PVCH to inquire if there were any recommendations regarding protection from harm.			11/8/12	
	p. Program Management and Quality Assurance staff conducted rounds for the holiday weekend on each residence and each shift.			11/9/12	
	q. The Individual Program Coordinator and Program 2 Management reviewed Interdisciplinary Notes and Nursing Assessments for all clients living on Residence 21 for the previous 6 months, with no unusual findings reported to the Program Director and Clinical Director. (Female clients' record review completed on 11/9/12. Male clients record review completed on 11/16/12.)			11/9/12 11/16/12	
	r. Enhanced Rounds by all Program Managers and Supervisors and Quality Assurance staff to all residences and all shifts on an ongoing, weekly random schedule. Identified issues are reported and elevated to Executive Committee members if resolution is needed. Rounds data will be collected and presented to the Clinical Director for review at the Clinical Quality Management Committee Meetings and the Quality Management Council Meetings.			11/13/12	
	s. Client 98 received one-to-one supervision for 24 hours to assess possible delayed response to alleged trauma. After Special IDTeam, IDTeam modified supervision level to "enhanced" which was personalized to Client 98's wants and needs.			11/13/12 11/14/12	
	t. Senior Supervising Psychologist reviewed strategies to assist individuals in dealing with sexual assault with the DERMT members and Executive Committee.			11/16/12	
	u. A Special Team meeting was held to review Client 98's program plans and data collection, and modifications were implemented.			11/19/12 11/28/12	
	v. Center-wide training on Client Protection was led by OPS personnel and scheduled for all staff in 3 separate training sessions. Curriculum was developed in December, 2012 and two training sessions were held on 1/22/13 and 2/21/13.			1/22/13 2/21/13	

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	w. To improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective) and how those coincide with investigations by OPS by Disability Rights, California (DRC) Director, Investigations Unit and Senior Investigator.			2/14/13	
	x. To further improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective).			5/1-2/13	
	y. The DQA and QA Program Assistant have sent out a Template to Residence Managers and acting Residence Managers to assist in the completion of the Level 1 Review/investigation process.			12/26/12	
	z) Standards Compliance Coordinator (SCC) provided training on 10/25/13 to the facility's Managers and Supervisors re: expectations to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations to the next level of management to ensure that active treatment programs and supervision are provided and/or needed revisions to plans are identified.			10/25/13	
	aa) The Office of Quality Assurance will monitor all generated General Event Reports (GER) for complete and thorough investigations daily. Any issues will be brought up to Program Management and Exective Management at the Daily Executive Risk Management Team meeting (DERMT) for corrective action as warranted.				
	bb) The four staff who had worked on the night shift prior to the discovery of the injury were reassigned to non-client care duties pending the outcome of the investigation.			10/6/12	
	cc) The Office of Protective Services administrative investigation was initiated in August 2013 upon receipt of the completed California Highway Patrol case. The OPS investigation included a review of historic information related to the alleged perpetrator's prior work assignments compared with incident data and was completed on October 17, 2013.			10/17/13	
	dd) Supervising Investigator provided training to OPS Investigators re: expectations for requests of historical reviews of subjects identified in administrative investigations and weekly written updates from Investigators on administrative tasks completed on investigations while criminal investigations are conducted.			10/30/13	
	ee) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an investigation so that it is included as part of the investigative process.			10/25/13	

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NAME OF PROVIDER OR SUPPLIER LANTERMAN DEVELOPMENTAL CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 POMONA BOULEVARD POMONA, CA 91769		
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	W102, W127, W104 #1, W122, W150, W154. W249 *The California Highway Patrol was notified by OPS and opened an investigation. *Involved staff was assigned to no client contact. *The Coroner was notified by the ACNS and responded to the facility. *The Medical Examiner completed an autopsy and concluded that the cause of death was natural.			1/5/13 1/5/13 1/5/13 2/12/13	
	a. Lanterman Developmental Center's Administrative Directive 227: Alleged Neglect or Abuse, states that every staff member is responsible for the safety and well-being of the individuals served by the Center. Any neglect, abuse or exploitation by any person, whether staff, visitor, volunteer, family or other clients, is prohibited.			10/25/13	
	b. To assist in assuring compliance with the above directive, classes on Client Protection, Clients Rights, and Behavior Management Training are included in training that is required for all staff. Additionally, all staff are trained annually, during the review of their Individual Development Plan, on Administrative Directive 227: Alleged Neglect and Abuse.			10/25/13	
	c. The Clinical Director gave written direction to the Residence and Program Managers to: meet with all staff on duty and ensure that they understand that clients' supervision levels must be implemented per the client IPP; reevaluate staffing deployment immediately; and meet that day to review staffing levels with the Program Directors and Nursing Coordinators to ensure effective staff deployment.			09/23/13	
	d. Program Managers reported to the Clinical Director that modification to deployment was not warranted at the time. Program Managers are responsible to assure that an adequate number of staff are on duty and that adjustments are made based on acuity level on a continuum.			09/23/13	
	e. The CD reviews staffing minimums/ deployment with the PDs quarterly and as needed. Interim staffing changes are requested by the Program Director and approved by the Clinical Director. Temporary staffing changes can be approved by the Program Manager based on level of care staff input when acuity levels warrant an immediate change.			10/25/13	
	f. The CD and Program 2 Director met to discuss and develop a Client Supervision Accountability System for level of care staff which includes: a Residence-specific reference tool which provides each client's name and their supervision level; a signed acknowledgement of the review and understanding of the client supervision levels.			09/23/13	
	g. The Client Supervision Accountability System was implemented on Residence 31, including a review of the residence-specific reference tool and a signed acknowledgement of the review for all staff on duty			09/23/13	
	h. A review of each residence-specific reference tool was conducted to ensure each client's supervision levels are clearly defined and consistent with the individual's IPP. The Residence Manager is responsible for the review of the reference tool. Any findings in need of improvement are referred to the ID Team for revision, for which the IPC is responsible for coordinating.			09/23/13	

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	i. When an individual experiences a situation that requires short-term increased supervision, the level of supervision and the duration of the increase will be specified and documented as appropriate in the Clinical Record (Temporary Intervention Plan/ TIP, Short Term Nursing Observation/STNO, or Temporary Condition/TC, etc) and on the 24-hour Report. The information is communicated by Residence Manager/Shift Supervisors to level of care staff at intershift huddles. Huddle attendance is acknowledged on the 24-hour Report. All staff on the incoming shift will initial the 24-hour Report to verify receipt of the information. The Shift Supervisor will assure completion. The increase in supervision will be carried over to each 24-Hour Report log until concluded.			10/25/13	
	j. The Client Supervision Accountability System was implemented for all ICF residences. Residence Managers are responsible for accuracy and to ensure that all on-duty level of care staff have been trained on the supervision levels, and have signed an acknowledgement of the review and understanding of supervision levels. The Program Assistant will ensure this occurs for all the DTAC/worksite staff and Rehabilitation Therapists.			09/27/13	
	k. The acknowledgement for the client supervision accountability system and the Residence specific reference tool has been incorporated into new staff orientation and cross-training for staff transfers due to consolidation.			09/25/13	
	l. The "Orientation for Relief Staff Providing Client Services" was revised to ensure the review of client supervision is included. The Clinical Director coordinated the revision of the form, which is now titled, "New Staff and Float Orientation".			09/25/13	
	m. Use of the "New Staff and Float Orientation" has been implemented immediately following training to Residence Managers by the Clinical Director. Shift Supervisors are responsible for ensuring the review of supervision levels is completed for any/all relief/float staff and documented on the form.			09/25/13	
	n. Training on Administrative 226: Client Supervision and Personal Care was initiated on 9/23/13 with all level of care staff by Residence Managers. DTAC/worksite staff will be trained by the Program Assistant, initiated on 9/25/13.			09/27/13	
	o. An informational flyer describing definitions of level supervision was created at the direction of the Clinical Director and posted on each residence in the Nursing Station by Program Managers.			09/24/13	
	p. Program Assistants will ensure that the flyer is posted in DTAC/classroom/worksites.			09/25/13	
	q. The flyer will be posted on the facility Intranet and emailed to all staff.			09/25/13	
	r. Shift/Site Supervisors will review the information on the flyer at daily huddles on residences and DTAC/worksite effective immediately through 9/27/13.			09/27/13	
	s. The Clinical Director and ICF Program Directors met with Residence Managers, IPCs, and Quality Assurance staff to review client supervision expectations, and regarding IPP implementation to ensure protection from harm for clients. AD 226 was also reviewed with emphasis on Section 4.5.			09/24/13	

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	t. The Executive Director instructed Program and Residence Managers to conduct rounds on all ICF residences to assess staff knowledge and ability to implement supervision levels, and provide prompting and intervention where needed. Specific findings were relayed to the Residence Manager of the involved residence(s) for follow-up.				09/24/13
	u. A debrief of the 9/24/13 rounds was held to review overall findings of the staff knowledge and ability to implement supervision levels. Program and Residence Managers conduct rounds with random competency checks for staff knowledge of client supervision levels and implement. Outcomes were forwarded to the Executive and/or Clinical Director and on review, there were some instances in which staff was provided immediate feedback and coaching.				09/25/13
	v. The Clinical Director initiated the policy review/revision process for Administrative 226: Client Supervision and Personal Care to incorporate the Client Supervision Accountability System as well as any other revisions identified via the facility rounds. Additionally, definitions of commonly used descriptors pertaining to supervision levels will be added to the policy.				09/25/13
	w. On completion and approval of the revised Administrative 226: Client Supervision and Personal Care all level of care staff will be trained on the changes. Further orientation to the policy changes will be provided in employee meetings (such as Program meetings, and General Employee Meetings).				10/25/13
	x. The Individual Program Coordinator (IPC) will be responsible for updating the client supervision reference tool when any individual's supervision level is changed following any IPP meeting. The update 9/25 will be completed by close of business the day the supervision level is changed. Supervision change will be documented on the 24 Hour Report and incoming staff will initial for acknowledgement. The Program Assistant will review the changes/updates with DTAC/worksite staff and Rehabilitation Therapists which will be acknowledged by signing a Training Record.				09/25/13
	y. The Residence Manager/Program Assistants will ensure that the updated client supervision reference tool is promptly disseminated.				09/25/13
	aa. The IPC Supervisor will conduct a periodic audit to determine whether updates to the client supervision reference tools are completed on time for the first 90 days. Random audits will occur following IDTeam meetings in which the IPP documents indicate a change in level of supervision. Any findings in need of correction will be addressed with the IPC and involved residence immediately. The overall findings and recommendations will be submitted to the Executive Committee for review of compliance and of the process.				09/26/13
	bb. RM to ensure that copies of the current residence-specific reference tool are available to staff in the Group Book and an additional copy if desired to keep with them during the shift. A daily audit will be completed by the Residence Manager/designee to ensure compliance for 90 days. Findings will be documented as an entry on the 24-Hour Report. Program Directors will gather the findings and will report.				10/25/13

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	out weekly at the Daily Executive Risk Management Team (DERMT) meeting (Fridays) with a review of findings and determination for ongoing monitoring needs.				10/25/13
	cc. If a supervisor finds that supervision is not being implemented per plan, immediate corrective action will be taken by the site supervisor with notification to the Residence or Program Manager for appropriate follow up.				09/30/13
	dd. A workgroup will be convened to develop a standardized Client Supervision Guide to identify the most effective residence-specific reference tool to use facility-wide. This workgroup will also be tasked with developing a standardized staff assignment sheet that will at a minimum identify staff "group" assignments and break times. The workgroup will consist of level of care staff, Shift Supervisor/s, IPC/s, and clinical managers. Membership will be determined at a DERMT meeting during the week of 9/30/13.				10/25/13
	ee. The Shift Supervisor is responsible to assign relief staff as well as redeploy staff based on client need. Residence Manager will monitor for compliance and provide guidance and direction to ensure effective deployment.				10/25/13
	ff. The standardized tool will be implemented facility-wide, including training to all IPCs, level of care staff, DTAC, shift supervisors and clinical managers. Training will be initiated within 30 days of the development of the form and will be ongoing for new and returning staff.				09/24/13
	gg. Random competency checks of level of care staff on all ICF residences will be conducted during scheduled: Residence Manager rounds, Protection from Harm Rounds, Program Management rounds, IPC rounds and Executive rounds. Results of the competency checks will be submitted to Quality Assurance.				10/25/13
	hh. Any/all findings of insufficient competency will be relayed to the Residence Manager of the involved staff for immediate attention.				09/24/13
	ii. The Quality Assurance Department will review the results and report out at the Clinical Quality Management. Findings and recommendations forwarded to Governing Body members via the Quality Management Council meeting.				09/24/13
	jj. The Director of Quality Assurance will monitor to assure completion of competency checks and review of the results for the first 90 days.				10/25/13
	kk. Recommendations for continued monitoring will be submitted to the Executive Committee for consideration.				09/27/13
	ll. All level of care (residence, DTAC, Rehab Therapists) staff will be provided a whistle to use when assistance is needed and other staff are not in the immediate vicinity. These will be distributed to on-duty staff on a continuum by Shift Supervisors. Residence Manager/Program Assistant will monitor for compliance. This system was already in place on Residence 15.				09/27/13
	mm. An analysis of the number of clients who need enhanced or greater supervision in the various environments (dining room, living room, bathroom, worksite, etc.) on the staffing ratios in effect on each				

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	residence. Staffing adjustments needs will be formally made as needed (such as higher ratio of individuals under enhanced supervision).			10/25/13	
	nn. When one staff relieves another, endorsement with the receiving staff will occur providing any unusual/out of the ordinary behaviors or activities of the individuals to be supervised. If the time of the "relief" for staff to go on a break is different than was originally scheduled, the Staff Assignment Sheet will be updated by the Shift Supervisor.			10/25/13	
	oo. At weekly staffing meetings and as needed, Residence Managers will report to Program Managers (Nursing Coordinator, Program Assistant, or Program Director) if any increased staffing is needed due to client activities, medical condition, or behaviors.			09/26/13	
	pp. The Clinical Director reviewed the current client supervision reference tools and selected one to be the implemented ICF-wide until the workgroup develops an alternate.			09/27/13	
	qq. The interim client supervision reference tool will be enacted by each Residence Manager.			09/26/13	
	rr. The revision of AD 226 will include definitions of commonly used terms. Interim definitions will be "waking hours"- an individual's usual hours of being awake (a conscious or alert state- http://www.merriam-webster.com/dictionary/waking) in the rhythm of their day. "Napping". - to sleep briefly especially during the day (http://www.merriam-webster.com/dictionary/napping)				

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W 104	Continued From page 10 use of restraints, the appropriateness of application used during the event as described and any other recommendations regarding client behavior and safety during a recovery period. In a follow-up interview with the Director of Quality Assurance (DQA) on 9/25/13, the DQA explained the issues raised regarding use of restraints and patient safety during recovery at the dental clinic would have been addressed at a separate incident review, but all three events were combined into one incident. 2. The facility failed to ensure the rights of clients to retain and use, personal possessions and failed to implement Clients' Personal Property policy and procedure which indicated clothing and personal property shall be safeguarded, itemized and posted to the Client's Personal Property Card, Form DS 5269. The policy directs that the Residence Manager shall ensure procedures are followed and a current personal property card shall be maintained for each client. Items shall be marked and the personal property card identifying the brand name, model, size and serial number. The policy did not indicate that changes of residence must be noted and the property inventoried per the legend on the Personal Property Card. The policy did not indicate staff are to document lost, stolen or destroyed property on the property card. Auditing procedures were not implemented to maintain the integrity of personal property and their records. This affected six of 10 sampled and four focused clients. (Clients 1, 29, 17, 37, 43, 47, 64, 69, 77, 79, 94) (SEE W137) 3. The facility failed to implement their policies and procedures titled Medication Regimen Review, dated August 2011 and Medication Safety Review dated 2013 which indicated the	W 104	W104-2 a. To ensure the rights of clients to retain and use personal possessions as well as to ensure accurate record keeping the Trust Audit Committee membership was defined and new members designated. by the Administrative Services Director (ASD). b. To ensure a uniform recordkeeping system, the ASD provided direction to Clinical Records staff and later Residence and Program Managers to initiate filing of all Property Cards along with the Purchase Orders in Section 3 of the Clinical Record. c. Residence Managers will ensure that records are submitted to Clinical Records staff for filing on an ongoing basis. d. The Residence Manager/designee will conduct a random audit of Property Cards for 50% of clients on each residence quarterly to check for compliance with the AD, document the audit, provide corrective action where necessary, and document any issues on the Residence Manager Rounds Sheet (RMRS). The Residence Manager will submit the RMRS to the Program Director weekly. e. The Program Director will review and ensure that any issues or concerns identified in the RMRS are addressed during the monthly Program Risk Management Meetings with recommendations for resolution of	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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	W104-2 (cont'd from page 11)				
	systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.				
	f. The Property Cards for all clients identified have been updated and corrected to reflect accurate information by the Residence Manager(s).			9/26/13 10/25/13	
	g. Residence Manager(s) provided training to staff on their duties related to Client Personal Property.			10/25/13	
	h. The Trust Audit Committee met, an audit schedule was initiated, with the first audits to include Clients 1, 29, 17, 37, 43, 47, 64, 69, 77, 79 and 94 as well as random audits of all ICF clients.			11/5/13	
	i. The Trust Audit process will be overseen by the Fiscal Services Officer; the first audit will be conducted during the 4th Quarter of 2013 and quarterly thereafter.			10/25/13	
	j. The Fiscal Services Officer will review audit findings and refer concerns and issues to the Administrative Quality Management Committee for review.			10/25/13	
	k. To clarify the process, the Administrative Directive 276: Client Personal Property was reviewed and changes were initiated by the Administrative Services Director.			10/25/13	

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W 104	Continued From page 11 Pharmacist shall review drug regimens of all clients monthly, monitor and report irregularities in drug ordering, administration, documentation, and appropriateness of use based upon applicable State, and Federal regulations and standards. (SEE W314) 4. The facility failed to ensure rights of clients to be free from unnecessary drugs and provide active treatment to reduce dependency on drugs affecting one of 10 core sampled and two focus clients. (Clients 36, 47, and 69) (SEE W128) 5. The facility failed to ensure 11 clients living on Residence 15 were free from an unnecessary drug for which there was no substantiated use or active monitoring to support its use. (SEE W128) 6. The facility failed to ensure an "as needed drug" was not used in lieu of an active treatment program. This affected one focus client. (Client 69) (SEE W290) 7. 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. (SEE W312) 8. 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 affecting one of 10 sampled clients and two focus clients. (Clients 36, 47, 69) (SEE W314) 9. The facility failed to implement their policy titled	W 104	104-3 thru 104-8 a. The Governing Body is committed to ensuring *The monthly drug regimen review occurs in compliance with Center policies and procedures as well as applicable State and Federal regulations. *Clients are free from unnecessary medications/treatments. *Medications used for inappropriate behaviors are incorporated into the IPP. *Medications are not given in lieu of an active treatment program. b. See pages 12a-12d (See also W128, W290, W312, W314) W104-9 a. The Clinic person (per NP 4-13 - Emergency Equipment and Medical Supplies) on each residence will monitor daily and ensure compliance to necessary items on the Emergency cart. This will be documented on form ACNS 2069. Expired items were removed and replaced immediately. b. The Res. 15 SRPT will provide an itemized emergency cart review and check for expiration dates on a weekly basis. c. All Shift Supervisors will monitor to ensure that the Medication Cart and emergency supplies are clean and organized daily and take corrective action as needed. Rounds and any (Cont'd on Page 13)	9/26/13 09/16/13 09/16/13 10/25/13	

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W104-5, W128-1	The Nurse Consultant II investigated the sequence of events involved in this event and noted the following: a. After Community Industries staff was contacted by L.A. County Public Health Nurse about possible scabies exposure to LDC clients, the acting LDC Public Health Nurse consulted with the L.A. County Public Health concerning the exposure throughout this event. b. After receiving this information, Community Industries staff notified the Program Director and Residence 15's Residence Manager (There are clients from Res. 15 that worked in the same area). It was determined that the Physician would decide the course of action to be taken regarding the clients under their care. According to Public Health guidelines, "... exposed individual is potentially immediately infectious to others, even in the absence of symptoms. Cases are communicable from the time of infestation until mites and eggs are destroyed by treatment. (LDC Infection Control Manual Section 10 Protocol: Scabies) Definitive diagnosis requires microscopic identification of the mite and/or its eggs or fecal pellets or specimens collected by skin scraping, biopsy or other means. Properly performed skin scraping will almost always be positive in persons with crusted scabies but are generally negative in cases of typical scabies, even when performed by experienced operators. A negative skin scraping from a person with typical scabies does not conclusively rule out scabies infestation, mites are easily recovered, however, in skin scrapings from person with crusted scabies " [REDACTED]			11/18/13	
				8/20/13	
				8/22/13	
	c. Infection Control education on scabies was provided to staff on Res. 15 on 8/22/13 and in Community Industries on 8/23/13.			8/23/13	
	d. This event was reviewed at the Infection Control Committee meeting on 10/2/13. Any issues, concerns, or new information gathered from the above reports will be shared with the Infection Control Committee. Any recommendations following this will be forwarded to the Medical Executive Committee for follow-up.			10/2/13	
	e. The Medical Director directed physicians to: follow L.A. County Department of Public Health (or similar authority) guidelines for prophylactic treatments for scabies or other highly contagious/ communicable diseases or conditions. The Medical Director instructed all Physicians to raise any issues/concerns for discussion at the weekly physicians' rounds for recommendations and resolution.			10/29/13	
	f. Any Physician systemic issues/concerns will be elevated to Medical Quality Assurance and Improvement (MQA&I) with recommendations, for review and follow-up.			10/29/13	

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	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	
				10/25/13	
				9/27/13	
				10/25/13	
	f. The use of Restoril for Insomnia/Behavior was approved by the Therapeutic Review Committee on 10/24/13. 			10/25/13	
	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 eviws medication regimens and clinical record documentation of all ICF clients monthly, monitoring for irregularities in drug ordering,			11/1/13	

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	(cont'd W104-3,4,5,6,7,8; W128-1,3; W159-3; W290-1; W312-1; W314-1,2,3; W331-14)				
	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.				
	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 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.			10/30/13	
	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.			11/1/13	
	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.			9/26/13	

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	W111-10 (cont'd from page13) a recliner chair was placed in the living room [REDACTED] and documented on the Shift Supervisors Rounds Sheet. [REDACTED]				10/25/13
					10/26/13
	e. To ensure staff understanding regarding use of client's adaptive equipment, all Residence Managers provided training to residence staff on AD 265: Supportive/Protective Devices.				10/25/13
	f. The Shift Supervisor on each shift will monitor and ensure compliance during routine daily rounds ensuring all supportive/adaptive equipment are administered per physician's orders for all clients and documented on the Shift Supervisors Rounds Sheet, taking corrective action when needed. Rounds and any corrective actions or concerns will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.				10/25/13
	g. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that all supportive/adaptive equipment are administered per physicians orders 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 and submit to the Program Director weekly.				
	h. 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.				
	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.				

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W104-11	<p>1. All Program Management Teams meet on a weekly basis to identify the number of staff on duty and specific residential needs to assure that staff are evenly deployed throughout the program and that all services are supported.</p> <p>2. All Program Nursing Coordinators will assure staffing levels are met and evenly distributed on a daily basis. The Nursing Coordinators will arrange coverage behind any identified shortage of staff or emergency need during regular business hours.</p> <p>3. Each Program has established a system that ensures coordination of staff coverage on a 24-hour basis outside of regular business hours. The identified residence will arrange coverage behind any identified shortages of staff or emergency need outside of regular business hours.</p> <p>4. During the NOC/AM shift overlap, the NOC shift charge will coordinate any staffing issues and forward the information to the Nursing Coordinator for resolution if warranted.</p> <p>5. The Program Director will monitor staff deployment and coordination by attending weekly staffing meeting at least one time per month, to assure that staff coverage is equitable, consistent and is coordinated by the Nursing Coordinator with input from Residence Managers.</p> <p>6. Clinical Director ensures Quality Improvement process for staff deployment by receiving and reviewing weekly overtime reports as well as monthly schedules from each residence. Verbal recommendations are provided to Program Management by the Clinical Director when changes are needed to ensure ongoing quality improvement for staff coordination throughout the clinical areas.</p>			9/16/13	9/16/13
				9/16/13	9/16/13
				9/16/13	9/16/13
				10/25/13	10/25/13

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	W104-12				
	a. All Residence Managers/designees trained staff on Nursing Procedure 9.5, Enteral Feedings (Gastrostomy/Jejunostomy) with specific attention to Section II, # 3 Checking for residual.			10/25/13	
	b. The RN/HSS will monitor for compliance with this procedure by conducting a monthly Medication Pass Observation Audit on each residence. Corrective actions such as training will be taken as needed and documented on the audit form.			10/25/13	
	c. The RN/HSS will forward the results of the Medication Pass Observation Audit to the Program Director, Coordinator of Nursing Services, and Quality Assurance staff.				
	d. The Program Director will ensure that any issues or concerns identified in the audit 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.				
	W104-13				
	a) The water temperatures on Residence 20 were checked and adjusted by Plant Operations staff.			10/25/13	
	b) All residences water temperatures were checked and adjusted the maximum temperature to 110° F by Plant Operations staff.			11/1/13	
	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".			11/20/13	
	d) The Residence Managers/RN/HSS will provide training of the revised NPs to all supervisors and level of care staff.			11/30/13	
	e) Residence staff will perform monthly water temperatures checks and notify Plant Operations staff if it is out of range.			9/26/13	
	f) Plant Operations staff will perform monthly preventative maintenance which includes a water temperature check and will make adjustments as needed.			9/26/13	
	g) The Chief Engineer will monitor for compliance monthly. 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.				

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W104-14	a. The identified staff members from Residence 120 and 215 obtained their Identification Badges and are wearing them per facility policy.			9/18/13	
	b. The Residence Manager(s) for all ICF residences provided training to staff on duty on Administrative Directive 235, Employee Identification Badges.			9/20/13	
	c. The Shift Supervisor(s)/designee will check with each staff member on duty at the beginning of their shift to ensure that all staff are wearing their ID badges per the Administrative Directive. The shift supervisor will provide a temporary name badge for staff that report to work without their official ID badge to wear during that shift.			10/25/13	
	d. The Shift Supervisor/designee will follow up with corrective action for staff that do not have their badges when they report for work. Shift Supervisor will document compliance/corrections on the "Shift Supervisor Rounds" tool and submit to RM daily.			10/25/13	
	e. The Residence Manager will monitor for compliance during routine rounds as well as during review of "Shift Supervisor Rounds" tool daily.			10/25/13	
	f. Program Management will monitor for compliance with this AD during routine program management rounds at least weekly. Findings of management rounds as well as Shift Supervisor Rounds will be reviewed monthly at CQM meetings for a minimum of 90 days.			10/25/13	

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W 104	Continued From page 13 All staff, contract employees, volunteers and visitors are required to wear [facility name] issued identification badges (ID badges) in plain sight at all times while on campus. During observations on 9/17/13 at 11:15 AM, on Residence 20, three direct care staff were observed without identification badges. One staff stated that her badge was wet and two additional staff stated that their badges were in the car. On Residence 15, three additional staff were observed without identification name badges, on 9/16/13. One staff was a float from another residence, working overtime. 15. An exit door near room 27 on Unit 20 that was supposed to be locked was left unlocked. On 9/16/13 at 10:30 AM, the surveyor entered Unit 20 via an exit door. Two signs were noted on the inside of the door that read, "Please keep door locked at all times" and "Not self locking please lock manually." There were 5 steps leading up to the door that created a potential accident hazard for clients. During an interview with unit staff on 9/16/13 at 10:45 AM staff stated that, "the door should be locked." 16. During an interview with Motor Pool staff on 9/26/13 at 10 AM, staff stated that three to four vans used to transport clients were not in service due to air conditioning issues. Weather temperatures had been in the 100 degrees range. 17. The facility failed to ensure the client environment and kitchen was safe, sanitary and maintained for clients, staff and visitors as evidenced by the following;	W 104	W104-15 a. The identified door was locked by residence staff immediately once reported by the surveyor. b. Training was provided by the Residence Manager (RM) to the staff on duty on the Residence Access Plan that includes doors/rooms that are identified to be unlocked on the residence and those doors/rooms identified to be locked on the residence as well as ensuring staff follow posted information on doors/rooms. c. The Shift Supervisor will monitor for compliance with the Residence Access Plan and posted signs on the residence during the shift daily and document on the Shift Supervisor (SSRS) Rounds Form. d. The Residence Manager (RM) will monitor for compliance with the Residence Access Plan/posted signs, by reviewing the SSRS and making rounds weekly, taking 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 and submit to the Program Director weekly. 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	9/16/13 9/18/13 10/25/13 10/25/13 10/25/13	

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	W104-15 (cont'd from page 14) to the Shift Supervisor or Residence Manager for documentation on the Rounds Sheet. 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.			10/25/13	
	W104-16 a. No client activities were cancelled due to the in-operation of air conditioning in the 3-4 vans, however all efforts will be made to ensure that vehicles are in good repair and available to provide transportation for client activities.			10/25/13	
	b. The General Services Administrator I (GSA I) will monitor to ensure availability of adequate vehicles in good operating condition to support all client activities.			10/25/13	
	c. Any concerns identified by the General Services Administrator I will be brought to the attention of the Administrative Services Director for resolution.			10/25/13	
	d. The Shift Supervisors and DTAC Coordinators will monitor during routine rounds to ensure activities occur as planned and will make note if availability of vans/transportation are impacting planned activities (or impacting scheduling of future activities). 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	
	e. The Residence Manager or Program Manager will elevate any transportation-related issues on an as needed basis. The mode of communication will depend on the complexity of the issue- may be resolved via phone call to GSA I; system concerns may be brought to attention of Clinical Director or Administrative Services Director. Issue resolutions (if any) will be discussed and documented at Administrative Services Quality Management Committee (AQMC).			10/25/13	

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W 104	Continued From page 14 a. On the morning of 9/18/13 at the Northwest corner of the intersection of Crescent and Diamond Bar Streets near Residence 20 a large branch of the pine tree was observed to have partially fractured. Approximately 5 to 6 feet beyond the fracture the branch had been removed. On 9/19/13, the survey team received a complaint about a fallen tree branch that was so large that it had damaged a number of cars in the adjacent parking lot. Subsequent facility staff interview confirmed that this did occur in the back yard and parking lot of Residence 54 on 9/16/13. Facility administrative staff stated this incident had not been reported to the California Department of Public Health because it didn't meet their requirements to do so. Observation of the backyard of Residence 54 revealed a number of extremely large Ficus trees. The one closest to the parking lot had been removed leaving a very large stump. Damage to the corner of the patio roof nearest the parking was observed. Driving through the facility, a very large number of extremely tall and full branched trees were observed. On the morning of 9/25/13 at 8:05 AM, at the Southwest corner of the intersection of Crescent and Diamond Bar Streets in the backyard of the Program 2 Vocational Center, a large branch of a Pine Tree there had fractured to where one end had fallen to the sidewalk. This branch was approximately 15 yards long and could have severely injured any individual if they had been walking there.	W 104	#17 a a. The tree branch near Residence 20 was removed from the area by Grounds staff. b. To ensure that the client environment is safe and maintained for clients, staff, and visitors, the campus will be checked for downed tree branches on a daily basis by Grounds staff. c. The Supervisor of Grounds will monitor trees on a weekly basis to ensure all tree branches are attached and/or picked up. d. A tree trimming contract has been developed and is scheduled to begin. The Chief of Plant Operations will monitor for completion. e. The Chief of Plant Operations will ensure that corrective actions are taken when indicated and will elevate to the Administrative Services committee for unresolved or systemic concerns. To ensure that the client environment continues to be safe, sanitary and maintained for clients, staff, and visitors, the Chief of Plant Operations may develop or extend other outside contracts.	09/23/13 10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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	W104-17b-g;				
	a. The Residence Manager/designee on Res. 15 gave instruction to staff, both immediately and during Huddle to ensure: 1)all debris/cigarette butts/broken furniture are removed surrounding the residence by all staff; 2) all debris is removed from the HRI room on the residence by all staff.			9/20/13	
	b. Housekeeping staff picked up litter and cleaned area surrounding Residence 15.			9/20/13	
	c. The torn baseboard strip on Residence 15 was repaired by Plant Operations staff.			10/25/13	
	d. The shovel and the debris on the patio were removed immediately by Residence staff.			9/16/13	
	e. All flies and gnats were eradicated on Residence 20 by pest control staff.			9/27/13	
	f. The Program Assistant contacted the Supervisor of Vocational Services via e-mail requesting routine patio cleaning at least weekly for Residence 120.			10/23/13	
	g. Housekeeping Department staff did a thorough cleaning of the residence, including all kitchen drains and all furniture.			9/21/13	
	h. Housekeeping Department staff thoroughly clean all sink, floor, kitchen and shower drains on a weekly basis and have increased the number of staff assigned to clean Residence 20.			9/23/13	
	i. The Pest Control Technician and contractor continued to provide regular inspections and treatments to the residence.			11/1/13	
	j. The General Services Administrator I will monitor for compliance and ensure that the pest control contractor will be requested to provide a weekly service call where each residence is inspected for insects. Concerns will be addressed as appropriate, and elevated to the Administrative Services Director if needed.			10/25/13	
	k. To ensure that the client environment is safe, sanitary and maintained for clients, staff, and visitors: *The Chief of Plant Operations III will monitor work orders to ensure they are responded to in a timely manner. *Housekeeping staff will check area surrounding residences on a daily basis to ensure that the outside area surrounding the residence is litter free. *Supervising Housekeeper I will conduct periodic inspections of the outside areas of the residence and take corrective actions if needed. Findings and concerns will be included in their reports. *All Shift Supervisors will monitor during daily rounds to ensure that the client environment is safe, sanitary and maintained for clients, staff, and visitors, and take corrective action as needed. Environmental Rounds are documented on the 24-Hour Report. Other rounds and any corrective actions (such as removal/disposal of debris/cigarette butts/broken furniture) will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.			10/25/13	

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W 104	Continued From page 15 On the afternoon of 9/25/13, two facility groundskeepers were observed looking at trees on the facility campus. When interviewed at 3:20 PM one of the grounds keepers said they were making a list of trees to be trimmed. He said, "For three years there was no money to trim trees. Now all of a sudden there is money." He also stated that there must be about 3,500 trees on the facility grounds. On the morning of 9/26/13, the issue of lack of operating direction related to inadequate tree maintenance was discussed with administrative staff. The most recent record of tree trimming was requested and received. An invoice for a tree service was issued 4/11/12 for tree service performed in March 2012 was produced. However, the scope of that service was grossly inadequate as evidence by the large number of untrimmed trees and active falling branches.	W 104	W104-17b-g (continued from pg 15a) l. Housekeeping Supervisors will include information regarding the cleanliness of the outside areas of the residences in the monthly staff meetings; concerns (if any) will be elevated to Administrative Services Quality Management Committee if necessary. m. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that to ensure that the client environment is safe, sanitary and maintained for clients, staff, and visitors, 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 and submit to the Program Director weekly.	10/25/13	10/25/13
	b. Observations beginning on 9/16/13 at 11:30 AM, revealed the entry to Residence 15 was littered with two plastic disposable gloves, cigarette butts, paper trash and fallen foliage from surrounding trees and bushes. There was a wicker desk outside the front door with several neglected dried plants. This area was observed unchanged through 9/16, 9/17, 9/18 and 9/19/13 until brought to the attention of staff after the surveyor discovered [REDACTED] Interview with staff on 9/19/13 at 11:30 AM confirmed no clients smoked cigarettes on the residence and the butts must have been left by		n. The DTAC Coordinator will monitor during rounds to ensure that the client environment is safe, sanitary and maintained for clients, staff, and visitors, at least weekly and take corrective action as needed. Rounds will be noted on DTAC Classroom Rounds Sheet; any corrective actions will be documented in an email to the appropriate Program Manager. o. Program Management will randomly monitor during rounds at least monthly and document on the 24-Hour Report. Corrective actions will be taken as	10/25/13	10/25/13

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W 104	Continued From page 16 staff. The Residence Manager indicated environmental rounds should be conducted every shift, but there was no documentation to show rounds were conducted. Interview with the facility staff indicated the environmental rounds should be completed by the senior staff each shift or their designee however performing staffing duties and assignments can keep them occupied c. Observation on 9/16/13 at noon on Residence 15 revealed a bedroom with soft tie restraints set up on a bed. Soiled clothes, plastic bags and sheets were laying on the floor. Pieces of PVC pipe were leaning against a wall and on top of the wardrobe closet. A music magazine was laying on the bed. A privacy screen leaning against a wall was soiled and broken. In the open wardrobe was a grey glove and restraint mittens. The room smelled strongly of urine.	W 104	needed and reported to the Shift Supervisor or Residence Manager for documentation on the Rounds Sheet. p. 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.	10/25/13	
	Concurrent interview with the Residence Manager revealed 8/15/13 was the last time the restraint room was used [REDACTED], indicating the room had possibly been used or left in an unsanitary condition for over a month. The Residence Manager indicated environmental rounds should be conducted every shift, but there was no documentation to show who and if these rounds were conducted. Interview with the facility staff indicated the environmental rounds should be completed by the senior staff each shift or their designee however performing staffing duties and assignments can keep them occupied. Review of the facility wide restraint log report provided by Standards Compliance department failed to show that any restraint usage was				

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W 104	Continued From page 17 reported for the month of August 2013, despite evidence to the contrary. Additionally, the facility indicated in opening statements during the entrance Executive and Management teams had been making rounds on the residences but the environment and restraint room had gone unnoticed. d. Observation on 9/24/13 at 7 AM in in group living area on Residence 15 revealed a torn baseboard strip pulled several feet off a wall presenting a danger to clients and staff. Observation of the fenced patio, Residence 15 on 9/23/13 revealed broken wood chairs in the middle of the patio and two office chairs on wheels which potentially placed clients, staff and visitors at risk for injury. e. On 9/16/13 at 11 AM, during an observation of the outside patio on Unit 20, debris, paper wrappers, and a shovel were noted on the ground.	W 104	W104-18 a. The swamp cooler was relocated in a position to not be in the direction of food preparation by the Supervising Cook II (SCII) b. The swamp cooler was thoroughly cleaned by the SCII. c. The swamp cooler will be routinely cleaned by the Cook Specialist II bi-monthly. d. The SCII will monitor for compliance monthly by completing monthly rounds. e. The plastic panel was thoroughly cleaned by the SCII. f. The plastic panels will be cleaned on a routine basis and as needed. g. The plastic panels will be checked monthly by the SCII. h. The water was mopped by a Food Service Technician. i. Plant Operations repaired the condenser. j. The SCII will check the condenser on a routine basis to ensure it is operational during rounds. k. The Director of Dietetics will monitor for compliance monthly during rounds. l. The frozen pork was dated by the SCII. m. The bags of bread crumbs and thickener were immediately discarded by the SCII. n. The staff was trained to not store	9/18/13 9/18/13 10/25/13 10/25/13 9/19/13 10/25/13 10/25/13 9/18/13 10/25/13 10/25/13 10/25/13 9/18/13 9/19/13 10/24/13	
	f. During a lunch observation on 9/17/13 at 12 PM, flies were noted in the dining room on Residence 20. A level of care staff was seated next to a client at the dining table assisting her with her meal and was observed waving her hand to keep the fly away from the client's food. g. Gnat type insects were noted in Unit 20's nursing station on multiple days of the survey. 18. Accompanied by the Director of Dietetics on 9/18/13, commencing at 11:10 AM, the following observations were made in the main kitchen. a. In the main production area, a swamp cooler was observed blowing air in the immediate vicinity				

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W 104	Continued From page 18 of a large tiered rack of baked apples. The tubing of the swamp cooler, where the cool area exited, had a large amount of visible black debris coating the inside of the tube. The survey staff was able to wipe the debris off with a paper towel. b Hanging plastic panels, located at the entrance of a walk in freezer in the distribution area, were observed with a large amount of black debris, resembling mildew. c. A condenser had malfunctioned and water was observed on the floor beneath it.	W 104	food (i.e., breadcrumbs) on that shelf by SCII o. The SCII will monitor dates on products during routine kitchen inspections and take corrective action where warranted. p. The Director of Dietetics will monitor for compliance monthly during rounds. q. One tilting skillet was repaired by Plant Operations. r. It was concluded by the SCII that the other skillet and steamer was not needed. s. The SCII will monitor equipment for working order during routine kitchen inspections. t. Water and ice were removed from all refrigerators / freezers by the SCII. u. Plant Operations checked the refrigeration / freezer units involved.	10/25/13 10/25/13 10/25/13 10/24/13 10/25/13 9/18/13 9/29/13	
	d. In freezer 20 B, frozen pork was undated. e. Two 20.5 ounce plastic bags of bread crumbs and two 20.5 ounce plastic bags of thickener were observed stored on a low shelf in the kitchen area. The bags were wet. Staff present stated, "They should have been picked up before washing the floor." f. Two tilting skillets and a steamer were out of order. Staff present stated that the parts were ordered approximately two months ago. g. Water was observed on the floor in Refrigerator 21. Multiple refrigerators/freezers were out of order, icicles were observed hanging down from freezers and multiple freezers had protruding blocks of ice on the floor creating a		v. The SCII will monitor equipment for working order during monthly routine kitchen inspections. w. The rubber ring was cleaned by a Cook Specialist II. x. The SCII will monitor the rubber rings for cleanliness on a monthly basis. y. The Director of Dietetics will monitor for compliance monthly by completing rounds. z. The disposal company was contacted to replace the bin without a lid by the Material and Stores Specialist. aa. The new bin arrived on and was	10/25/13 9/18/13 10/25/13 10/25/13 9/18/13 9/20/13	

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W 104	Continued From page 19 potential accident hazard for staff. h. The rubber rings at the base of the steam kettles had black debris embedded in the rubber. i. One outside debris disposal bin was observed uncovered with no lid. 19. During initial observation on 9/16/13 at 10:50 AM in Residence 29's patio, the following was noted: a. Three bikes were not properly maintained. All three had flat tires and seats were torn and dirty exposing its padding. b. Dried leaves were all over the patio area and water fountain. The water drainage for the gutter was stuffed and covered with dried leaves. c. One blue dirty shirt was found lying on the ground. d. A dead dried plant on the gutter. e. Dirty umbrella and mat.	W 104	put in place. bb. The SCII will monitor to ensure the bin is closed during routine kitchen inspection. cc. The Director of Dietetics is responsible to ensure monitoring occurs and that corrective action is taken when indicated. Any systemic issues will be elevated to the Administrative Services Quality Management Committee (AQMC)	10/25/13	
	During an interview with the Residence Manager (RM) on the same day at 10:55 AM, he stated that there was no work order submitted to repair the bikes. He also stated that the cleaning crew from Community Industries comes in once a week to clean their patio. 20. During observation on the same day at 11:10 AM inside Residence 29, the following was noted: a. Multiple cans of Mountain Dew inside a box were found inside room 21 (Fire Room Panel). b. Water fountains had old water deposits on the sink part. c. No toilet paper inside the bathroom (room 31). During an interview with the Residence Manager (RM) on the same day at 11:15 AM, he stated that		W104-19, 20 a. The three bikes and one dirty blue shirt were removed immediately by residence staff. b. The case of soda was immediately removed upon discovery by residence staff. The RM reminded staff to store food in the breakroom. c. Toilet paper was placed in the dispenser by housekeeping staff. d. Housekeeping staff cleaned the water fountain on Residence 29 and removed the water deposits on the sink part.	9/16/13 9/16/13 9/16/13	

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W 104	Continued From page 20 he didn't know who the drinks belong to. He stated that there's a break room for staff and the drinks could have been left over from the patio party. During an interview with the Psychiatric Technician (PT) of the night shift on 9/17/13 at 6:25 AM, he stated that most of the clients in the residence [REDACTED] and all had access to the patio. 21. During observations conducted on 9/17/13, at 11:30 AM, the following was noted: a. In Room 3160, the toilet seat cover dispenser was empty. In addition, the toilet seat was noted to be wobbly. b. In Room 3152, a client's family photo frame was observed on the floor. During a concurrent interview with staff, he stated a work order had been submitted on 9/9/13, but no one had come to hang the frame. 22. During observations conducted on 9/24/13, at 10:40 AM, the following was noted: a. A large rack of chairs were observed in the patio area. The chairs were noted stained, rusted and broken down. There were also broken plastic chairs stacked at the corner of the patio. During a concurrent interview with the IPC (Individual Program Coordinator), she stated she was not sure how long the chairs had been stored there. She stated the clients were no longer using the chairs and should have been removed from the patio. 23. During observations conducted in Residence 23 on 9/24/13 at 11:30 AM, Room 2340 hand washing sink had large amount of black stain around the rim of the sink. 24. During an interview with the Benefit Insurance	W 104	e. Community Industries was contacted to clean the patio per contract. f. A work order was submitted to clean the gutters and remove all extraneous debris from the patio and entryway of 229. g. Housekeeping staff (Custodian) will clean water fountain on a daily basis and ensure toilet paper is available in all bathrooms. Housekeeping staff will leave extra toilet paper on the Custodian cart in case toilet paper runs out after hours. h. Housekeeping Supervisors will inspect the water fountain sink and check for adequate toilet paper supply weekly to ensure compliance and take corrective action as warranted. i. All Shift Supervisors will monitor during daily rounds to ensure the residence environment is safe, repairs are identified, work orders submitted, and items are properly stored, and take corrective action as needed. Environmental Rounds are documented on the 24-Hour Report. Other rounds and any corrective actions (such as removal/disposal of debris/cigarette butts/broken furniture) will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly. j. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure	9/16/13 9/17/13 10/25/13 10/25/13 10/25/13 10/25/13	

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W 104	Continued From page 21 Officer on 9/25/13 at 11:42 AM, she stated that the original receipts of cash purchases were sent to the trust office for filing. The residence kept copies of the receipts. a. The property card of Client 12 was reviewed on 9/25/13 at 1:45 PM. The review indicated one Connect Four game was listed on the property card. The purchase receipt showed that two Connect Four games were purchased. b. On the same day, the trust account file for Client 12 indicated that an amount of \$44.88 was requested and approved. There was no receipt to indicate what the amount was used for. c. Focused Client 92 had a cash request of \$44.88. There was no receipt to indicate what the amount was used for. d. Client 93 had a request for \$44.88 and was approved. There was no receipt to indicate the what amount that was used for. On 9/26/13 at 8:10 AM review of the policy titled, "Client's Personal Property dated 10/25/07, 2.1 Residence Manager; 2.1.5 Maintain a current personal property card for each client; Item such as... 2.1.6. Keep the purchase order copy on file for a minimum of 2 years to..."	W 104	that the client environment is safe, sanitary and maintained for clients, staff, and visitors, and take corrective action if needed. Rounds and any corrective actions will be documented on the RM Rounds Sheet (RMRS). The RM will submit the SSRS and RMRS and submit to the Program Director weekly. k. The DTAC Coordinator will monitor during rounds to ensure that the client environment is safe, sanitary and maintained for clients, staff, and visitors, at least weekly and take corrective action as needed. Rounds will be noted on DTAC Classroom Rounds Sheet; any corrective actions will be documented in an email to the appropriate Program Manager. l. Program Management will randomly monitor during rounds at least monthly and document on the 24-Hour Report.	10/25/13	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain an accurate record keeping system for one focus sampled clients. (Client 69)	W 111	Corrective actions will be taken as needed and reported to the Shift Supervisor or RM for documentation on the Rounds Sheet. m. 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.	10/25/13	

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W104-21, 22	a. Toilet seat covers were placed in the dispenser by Housekeeping staff. b. The wobbly toilet seat in Room 3160 of Residence 31 was repaired by Plant Operations staff. c. Housekeeping staff (custodian) will check dispensers frequently to ensure that toilet seat covers are always in dispenser. Housekeeping staff will leave extra toilet seat covers on the Custodian cart in case toilet seat covers are needed after hours. d. Housekeeping Supervisors will monitor dispensers to ensure availability of toilet seat covers on a weekly basis e. It was determined that the family picture found on the floor in room 3152 was recently taken down from the wall in preparation for the client's pending placement. (client # 51 was placed into the community). In the future, personal items will be stored in a box or travel case until the client is ready to move. f. Additionally, the Residence Manager and Shift Supervisors will review and provide training with all staff on duty on Administrative Directive # 276 Clients' Personal Property. g. Upon receiving personal items on the residence, the Residence Manager/ Shift Supervisors after being notified via the 24 Hour Report, will send a Work Order to Plant Operations to hang personal items appropriately in clients' room. h. The Residence Manager will follow up on work orders that have not been completed in a timely manner to ensure clients have their personal items to enjoy.			09/16/13 10/25/13 10/25/13 10/25/13 10/3/13 10/25/13 10/25/13 10/25/13	
	i. The rack of rusted chairs and stack of broken plastic chairs were immediately removed from the patio and condemned. j. The Residence Manager/Shift Supervisors completed a Property Move Request for Property to pick up broken chairs or furniture for repair or condemning. k. The Residence Manager and the Shift Supervisors will review and provide training with all staff regarding equipment storage. The Residence Manager or Shift Supervisor will ensure that any broken chairs or furniture to be condemned are stored in a non-client area until Property picks them up. l. All Shift Supervisors will monitor during daily rounds to ensure the residence environment is safe, repairs are identified, work orders submitted, and items are properly stored, and take corrective action as needed. Environmental Rounds are documented on the 24-Hour Report. Other rounds and any corrective actions (such as removal/disposal of debris/cigarette butts/broken furniture) will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.			9/24/13 10/25/13 10/25/13 10/25/13 10/25/13	

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	(cont'd from page 22a)				
	m. All Residence Managers will monitor for compliance through review of the SSRS and during weekly rounds. Rounds and any corrective actions will be documented on the RM Rounds Sheet (RMRS). The RM will submit the SSRS and RMRS and submit to the Program Director weekly.				10/25/13
	n. 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 RM for documentation on the Rounds Sheet.				10/25/13
	o. The Program Director will ensure that any issues or concerns identified in the SSRS 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.				10/25/13
	W104-23				
	a. Housekeeping staff (Custodian) cleaned the hand washing sink and removed the black stain surrounding the rim of the sink .				10/1/13
	b. Housekeeping staff (Custodian) will clean sink on a daily basis to ensure that it does not develop any residue causing it to become stained.				10/25/13
	c. Housekeeping Supervisors will monitor the hand washing sink weekly to ensure the sink is clean and take corrective action if needed.				10/25/13
	l. All Shift Supervisors will monitor during daily rounds to ensure the residence environment is safe, repairs are identified, work orders submitted, and items are properly stored, and take corrective action as needed. Environmental Rounds are documented on the 24-Hour Report. Other rounds and any corrective actions (such as removal/disposal of debris/cigarette butts/broken furniture) will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly.				10/25/13
	m. All Residence Managers will monitor for compliance through review of the SSRS and during weekly rounds. Rounds and any corrective actions will be documented on the RM Rounds Sheet (RMRS). The RM will submit the SSRS and RMRS and submit to the Program Director weekly.				10/25/13
	n. 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 RM for documentation on the Rounds Sheet.				10/25/13

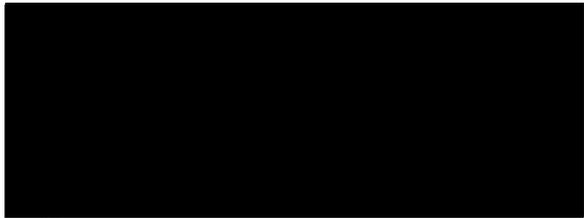
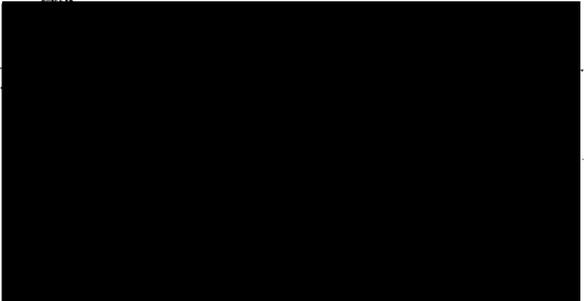
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	o. The Program Director will ensure that any issues or concerns identified in the SSRS or RMRS are addressed during the monthly Program Risk Management Meetings with recommendations for any resolution of systemic issues (if any) elevated to the Clinical Quality Management Committee for review/follow up discussion.			10/25/13	
	W104 #24 a-d				
	a. Trust Office contacted Vendor and requested a duplicate copy of the receipt for the items purchased in July 2013.			10/25/13	
	b. New procedure has been established to have the vendor provide a receipt for any future purchases.			10/25/13	
	c. Trust Officer will monitor purchases from vendor to ensure that a receipt is provided at the time of purchase.			10/25/13	
	d. For further monitoring, auditing, compliance steps, please see W104-2 beginning on page 11.				

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W 111	Continued From page 22. Findings: During observations of Client 69 on 9/16/13 thru 9/18/13 at varied times (end of NOC shift, AM and PM shift in the dining room, day treatment center, and in residence group areas), he was observed not wearing Ted Hose (compression stocking) and was not encouraged to elevate his legs or provided equipment to do so.	W 111	W111 a. The Shift Supervisor/Residence Manager instructed staff immediately and during Huddle to ensure all supportive/adaptive equipment are administered per physicians orders for all clients by all staff. b. The Shift Supervisor ensured that a recliner chair was placed in the living room for Client 69 and documented on the Shift Supervisors Rounds Sheet. A wedge was placed at the foot of the bed to ensure legs are elevated to tolerance. c. To ensure staff understanding regarding use of client's adaptive equipment, all Residence Managers provided training to residence staff on AD 265: Supportive/Protective Devices. d. The Shift Supervisor on each shift will monitor and ensure compliance during routine daily rounds ensuring all supportive/adaptive equipment are administered per physician's orders for all clients and documented on the Shift Supervisors Rounds Sheet, taking corrective action when needed. Rounds and any corrective actions will be documented on the Shift Supervisors Rounds Sheet (SSRS) and submitted to the Residence Manager weekly. e. The Shift Supervisor will ensure that the HSS/Physician/IPC are notified if the client does not tolerate the supportive /adaptive equipment, and that the appropriate documentation is completed. f. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that all supportive/adaptive equipment are administered per physicians orders and take corrective action if needed. Rounds	09/20/13 09/16/13 11/1/13 10/25/13	
W 112	  In an interview with the Health Services Specialist, Individual Program Coordinator and Residence Manager on 9/25/13 at 2 PM, Client 69's Ted Hose and elevation of legs were discussed. There was confirmation the Ted Hose documentation was not accurate and a staff training issue was identified regarding the elevation of Client 69's legs. (SEE W436) 483.410(c)(2) CLIENT RECORDS	W 112		09/16/13 10/25/13	

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W 112	Continued From page 23 The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to protect confidential information from being photographed by its outside consultants. This affected two clients outside the core sample, Clients 76 and 100. Findings: Upon arrival at the facility on 9/17/13 at 10:30 AM a metal sign posted near a stop sign at the facility's entrance requested visitors respect the privacy of individuals. The notice also prohibited photographing and videotaping without the authorization of the facility director.	W 112	W111 continuation 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. g. 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. h. 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.	10/25/13 10/25/13
	During review of facility incident reports on 9/18/13 commencing at 8:15 AM it was revealed the facility completed two General Event Reports (GERs) for Clients 76 and 100 both from Residence 21. The description under "Event Information" stated for both clients, "In the process of investigating a report of a consultant taking a picture of a client's document at LDC with her personal smart phone, it was discovered that there were additional pictures taken by the same person of two other client's documents." In a concurrent interview with the Director of Quality Assurance (DDQA) about the incident, the DQA explained that the consultant was actually a provider who had been previously informed that scanning documents with her phone was		W112 a. Contractor is long-standing in provision of services at LDC. LRP Director has discussed LDC policy and protocol for obtaining copies of client documents with said company and associates over the past several years on several different occasions. b. The LRP Director followed up the situation with the CEO of consultant firm. The company CEO confirmed that she knew the requirements in obtaining documents that the staff member should have not taken the pictures. c. The specific consultant wrote a letter that she had errantly assumed that access to the client's document also	05/08/13 5/8/13

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W 112 W 122	Continued From page 24 prohibited. 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview, record and document review, the facility failed to ensure that appropriate systems were in place that would prohibit the neglect of clients in the facility. The facility failed to ensure that clients were not subjected to sexual abuse. The facility failed to implement a center-wide accountability system to ensure clients received enhanced supervision in accord with individual plans. The facility failed to take steps to prevent recurrence or implement their policies and procedures related to Client Supervision, Client Services - Alleged Abuse, Neglect or Exploitation, and Incident/Unusual Occurrence Reports. The lack of systems caused the Condition of Participation, Client Protections, to be not met. Findings: 1. The facility failed to protect two focused clients from harm. (Clients 97 and 98). The facility failed to provide enhanced supervision for Client 97 who was found unresponsive and pronounced dead on 1/5/13. Client 98 was subjected to a sexual assault. (See W 127 and 149). 2. The facility failed to protect one client from sexual assault (Client 98) . (See W 150).	W 112 W 122	W112 continuation meant that she had access to photograph. Pictures of documents taken with consultant's smart phone were deleted. d. CEO of consultant firm trained all contractors in HIPAA Regulations and LDC AD 152Confidentiality..... e. The LRP director added HIPAA requirements as a specific topic for all provider/consultant/contractors orientations in addition to LDC AD 152 Confidentiality: Access to Clients and to observe the metal posted signs on Lanterman campus entrance about respecting the privacy of individuals served and prohibits the videotaping and photography without the authorization of the director. f. All client assessments are scheduled and will continue to be scheduled through the Lanterman Regional Project (LRP). LRP staff will continue to remind contractors to follow LDC's P & P regarding access to records, including requesting copies through the Clinical Records Department if needed. g. Future reviews of clinical records by consultants will be supervised by LRP or LDC staff to ensure compliance with policy. h. In service training will continue to be given during HIPAA block training and Documentation training that addresses the LDC policies. i. The LRP Director will monitor for compliance & take corrective actions. j. Findings will be referred to AQM for reviews. k. Result of findings reviews will be referred to QMC for review and recommendation if needed.	05/31/13 5/31/13 10/25/13 5/31/13 5/31/13 11/22/13 monthly

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W 122	Continued From page 25 3. The facility failed to ensure all allegations of abuse were reported immediately to California Department of Public Health, and facility Administrator. (See W 153). 4. The facility failed to conduct a thorough investigation that addressed potential victims and areas worked by a sexual perpetrator, and failed address a discrepancy between Office of Protective Services and the facility Generated Event Report findings. (See W 154). The cumulative effect of these systemic problems resulted in the developmental center's inability to ensure that specific client protections requirements were met.	W 122	W122 # 1 & 2 please see pages 6a-6d W122 #3 a. Administrative Directive 124: Incident/Unusual Occurrence Reporting was revised and changes approved by the Executive Committee on behalf of the Governing Body. The policy now includes the requirement for notification to CDPH within 24 hours of the incident for: injuries of unknown origin that meet CDPH reporting criteria and all allegations of abuse and/or neglect. (please see cont. pages 6a-6h & 26a)	10/25/13	
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.	W 126	W122 #4 a) It is the expectation that all staff to be vigilant and constantly alert to ensure that each person's physical and emotional well-being is not endangered in any way and that protection from harm measures are incorporated into every area of our service delivery activities. (Administrative Directive 227: Alleged Abuse, Neglect or Exploitation)	10/25/13	
	This STANDARD is not met as evidenced by: Based on observation, facility staff interview and clinical record review, the facility failed to allow and 1 of 10 core sampled clients (Client 77) to manage his financial affairs and teach him to do so to the extent of his abilities. Findings: Observation of Client 77 revealed he could write his name, and words such as coffee and car. He also drew a picture of a car and labeled it as such. He was observed to point to the correct day		b) Each employee reviews and acknowledges training in AD227: Alleged Abuse, Neglect or Exploitation at least annually, which includes expectations regarding the investigative process. c) The Office of Protective Services administrative investigation (for Client 98) was initiated in August 2013 upon receipt of the completed California Highway Patrol case and was completed on October 17, 2013. (please see cont. pages 6a-6h & 26a)	10/17/13	

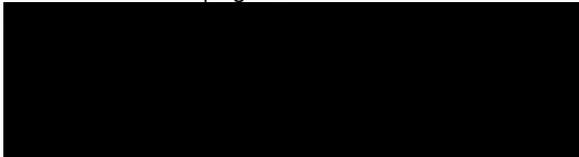
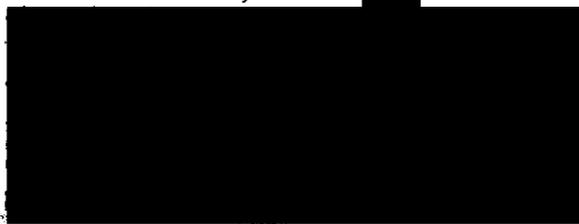
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	W122 #3 cont. <input type="checkbox"/>		Program Directors will notify the Director of Quality Assurance or designee by phone of the incident. The Director of Quality Assurance/designee will provide preliminary notification to CDPH via email- providing information about the incident. The Standards Compliance Coordinator will ensure that CDPH is notified on the next working day by sending an Event Summary Notification or equivalent. This procedure has been in effect for allegations of abuse and neglect since February, 2011. The preliminary notification (date, time, who made the notification) will be logged into the Therap system by Quality Assurance staff. The DQA will ensure this system occurs with a monthly audit of timely notifications completed by the QA Risk Manager and reviewed at the Daily Executive Risk Management Team (DERMT) meeting by the 10th of the following month <input type="checkbox"/>	10/25/13	
	W122 #4 cont. <input type="checkbox"/>		d) The Commander of the Office of Protective Services (OPS Commander) will ensure that all allegations and/or suspected sexual assault are reported to outside law enforcement. <input type="checkbox"/> e) The OPS Commander will ensure that Investigators assigned to administrative investigations handled criminally by outside law enforcement agencies will complete as much of the administrative investigation as possible while the criminal investigation is being conducted so that the investigative results are available for facility disposition and corrective action. <input type="checkbox"/> f) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an administrative investigation so that it is included as part of the investigative process. <input type="checkbox"/> g) Supervising Investigator provided training to OPS Investigators re: expectations for requests of historical reviews of subjects identified in administrative investigations and weekly written updates from Investigators on administrative tasks completed on investigations while criminal investigations are conducted. <input type="checkbox"/> h) Standards Compliance Coordinator provided training on 10/25/13 to Managers and Supervisor re: expectations to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations to the next level of management to ensure that active treatment programs and supervision are provided and/or needed revisions to plans are identified. <input type="checkbox"/>	10/30/13 10/30/13 10/30/13 10/30/13 10/25/13	

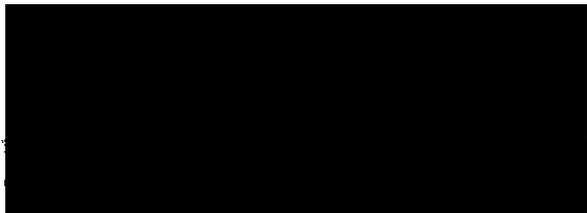
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W 126	Continued From page 26  Although he was deaf, he read lips well. When he tried to read the surveyor's notes the surveyor said, "Your penmanship is better than mine" the client smiled and shook the surveyors hand.  The money handling objective for Client 77 was to maintain fifty cents in his possession that he received on Saturdays to spend on items of his choice at the canteen.	W 126	W126 a. A special team meeting was held to evaluate the appropriateness of Client 77's current money management training objective. It was determined to close 19.1 and open 19.2" Will withdraw money from Trust office to utilize to make purchases at Freedom café or store of his choice in community" will be implemented. b. Shift Supervisors will ensure Client 77 is afforded weekly opportunities at Trust Office and Freedom Café. c. All clients training objectives will be reviewed at their individual IPP meetings. d. The Rehabilitation Therapist will schedule community outings to allow for choices of shopping. e. Training plans will be established accordingly and will be reflected in the IPP listing, A&S and Daily Activity Schedule. f. IPC will monitor Client 77's progress on an ongoing basis and document findings on the IPC Quarterly Report.	10/25/13 10/25/13 10/25/13 10/25/13	
W 127	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. On 9/24/13 at 2:50 PM during an interview with the psychologist that worked with Client 77, she stated that he is, "Smart and arrogant. He knows he is smarter than the others". 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or	W 127	g. IPC Supervisor will monitor for compliance via review of the IPC Quarterly Reports. h. Any unresolved issues from monthly risk meeting will be elevated by Program Director/IPC supervisor to Clinical Quality Management Committee with recommendations. W127 #1 *The Office of Protective Services was notified and an investigation was initiated. *The California Highway Patrol was notified by OPS and opened an investigation. *Involved staff was assigned to no client contact.	10/25/13 10/25/13 01/15/13 01/5/13 01/5/13	

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W 127	Continued From page 27 psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that enhanced supervision was provided to the clients with identified needs and behavior problems. The facility failed to implement corrective actions to ensure that clients were not subjected to neglect (Clients 56, 91, 92, and 97) and sexual abuse (Client 98). This affected five focused clients. (Clients 56, 91, 92 97, and 98). The facility's failure to implement a center-wide accountability system to ensure clients receive enhanced supervision in accord with individual plans resulted in an Immediate Jeopardy situation that was declared on 9/24/13 at 10:30 AM. Findings:	W 127	W127 #1 *The Coroner was notified by the ACNS and responded to the facility. *The Medical Examiner completed an autopsy and concluded that the cause of death was natural. a. Lanterman Developmental Center's Administrative Directive 227: Alleged Neglect or Abuse, states that every staff member is responsible for the safety and well-being of the individuals served by the Center. Any neglect, abuse or exploitation by any person, whether staff, visitor, volunteer, family or other clients, is prohibited. b. To assist in assuring compliance with the above directive, classes on Client Protection, Clients Rights, and Behavior Management Training are included in training that is required for all staff. Additionally, all staff are trained annually, during the review of their Individual Development Plan, on Administrative Directive 227: Alleged Neglect and Abuse. c. The Clinical Director gave written direction to the Residence and Program Managers to: meet with all staff on duty and ensure that they understand that clients' supervision levels must be implemented per the client IPP; reevaluate staffing deployment immediately; and meet that day to review staffing levels with the Program Directors and Nursing Coordinators to ensure effective staff deployment.	1/5/13 2/12/13 10/25/13 10/25/13	
	 Circumstances related to Client 97's expiration were documented in the investigative file indicating on 1/5/13 Client 97 was found unresponsive in bed at approximately 4:30 PM by a Psychiatric Technician (PT. B). CPR was initiated by responding PT (PT. A), the facility's emergency notification system was activated and ancillary facility personnel responded to the code blue call.			09/23/13	

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W 127	Continued From page 28 Review of the "Telephone/Dispatch Activity Log" documented a code blue was requested at 4:35 PM. Paramedics arrived at 4:52 PM and took over lifesaving measures while in contact with the ER physician at [Community Hospital's name]. The code blue was canceled at 5:15 PM. The facility reported the death with additional background information on its General Event Report (GER) dated 1/5/13 entered at 7:33 PM [REDACTED]	W 127	W127 #1 cont. d. Program Managers reported to the Clinical Director that modification to deployment was not warranted at the time. Program Managers are responsible to assure that an adequate number of staff are on duty and that adjustments are made based on acuity level on a continuum. e. The CD reviews staffing minimums/ deployment with the PDs quarterly and as needed. Interim staffing changes are requested by the Program Director and approved by the Clinical Director. Temporary staffing changes can be approved by the Program Manager based on level of care staff input when acuity levels warrant an immediate change. f. The CD and Program 2 Director met to discuss and develop a Client Supervision Accountability System for level of care staff which includes: a Residence-specific reference tool which provides each client's name and their supervision level; a signed acknowledgement of the review and understanding of the client supervision levels. g. The Client Supervision Accountability System was implemented on Residence 31, including a review of the residence-specific reference tool and a signed acknowledgement of the review for all staff on duty.	09/23/13 10/25/13 09/23/13 09/23/13	
	[REDACTED] Client 97 is enhanced supervision thus this writer went to check on him with his group leader. We found Client 97 in his bed, laying on his side. [REDACTED] When he was found with no pulse, his group leader began compressions. I called for help and the med person immediately arrived with the crash cart. CPR was initiated immediately. Another staff also came to assist us. I called a code and 911. The MOD and code blue team arrived shortly and began to treat Client 97. This writer received the code blue team and the ambulance." A Crime Incident Report (CIR) dated 7/18/13, was also completed with the following narrative,				

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W 127 Continued From page 29

[REDACTED]

According to the police report on 1/4/13 (PT) noticed that he had two discolorations on his left hip and upper thigh. The time and means of the injury were not witnessed."

Another GER dated 1/7/13 at 4:40 PM was [REDACTED]

W 127 W127 #1 cont.
h. A review of each residence-specific reference tool was conducted to ensure each client's supervision levels are clearly defined and consistent with the individual's IPP. The Residence Manager is responsible for the review of the reference tool. Any findings in need of improvement are referred to the ID Team for revision, for which the IPC is responsible for coordinating.
i. When an individual experiences a situation that requires short-term increased supervision, the level of supervision and the duration of the increase will be specified and documented as appropriate in the Clinical Record (Temporary Intervention Plan/ TIP, Short Term Nursing Observation/STNO, or

09/23/13
10/25/13

The Office of Protective Services (OPS) investigative report completed 7/18/13 constructed a timeline beginning 1/3/13 through 1/7/13 from the time Client 97 was seen at the on campus dental clinic through the time bruises were discovered on 1/4/13 and the allegation of abuse that was made by another client from Residence 33 on 1/7/13. All three incidents were referenced in one investigation.

Temporary Condition/TC, etc) and on the 24-hour Report. The information is communicated by Residence Manager/Shift Supervisors to level of care staff at intershift huddles. Huddle attendance is acknowledged on the 24-hour Report. All staff on the incoming shift will initial the 24-hour Report to verify receipt of the information. The Shift Supervisor will assure completion. The increase in supervision will be carried over to each 24-Hour Report log until concluded.

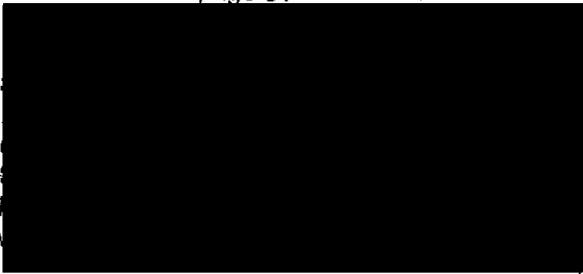
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W 127	Continued From page 30   	W 127	W127 #1 cont. j. The Client Supervision Accountability System was implemented for all ICF residences. Residence Managers are responsible for accuracy and to ensure that all on-duty level of care staff have been trained on the supervision levels, and have signed an acknowledgement of the review and understanding of supervision levels. The Program Assistant will ensure this occurs for all the DTAC/worksite staff and Rehabilitation Therapists. k. The acknowledgement for the client supervision accountability system and the Residence specific reference tool has been incorporated into new staff orientation and cross-training for staff transfers due to consolidation. l. The "Orientation for Relief Staff Providing Client Services" was revised to ensure the review of client supervision is included. The Clinical Director coordinated the revision of the form, which is now titled, "New Staff and Float Orientation". m. Use of the "New Staff and Float Orientation" has been implemented immediately following training to Residence Managers by the Clinical Director. Shift Supervisors are responsible for ensuring the review of supervision levels is completed for any/all relief/float staff and documented on the form.	09/27/13 09/25/13 09/25/13 09/25/13	
	Factual findings of the OPS were written including documentation an autopsy was completed by the [County Coroner's office] on 1/16/13 reported the immediate cause of death was listed as Idiopathic Cardiomyopathy and the manner of death was natural. However, the investigator's narrative attached to the autopsy report also had the following statements, "According to the medical record, the decedent had a fall to the ground during the dental visit. Due to the fall and possible bruising to his left hip and upper thigh, I changed the mode from natural to accident versus natural." 				

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W 127	Continued From page 31  It was also documented and concluded: Client 97's IPP required enhanced supervision on and off the residence (in the presence of staff during waking hours); it was out of character for Client 97 to take a nap at 4:30 PM; the responsible PT, PTA did not confirm Client 97 was asleep prior to leaving Client 97 unsupervised. The responsible PT for Client 97 admitted that leaving a client alone who was on one-to one supervision was neglect. Client 97 was left unsupervised for at least ten minutes. During this period he became non-responsive and was subsequently pronounced dead. Client 97 would have been undiscovered in this condition if another PT (PT B) had not intervened. Per interview with the Medical Director on 9/20/13 commencing at 9:00 AM, it was revealed the Mortality Review (MR) minutes for Client 97 had not yet been summarized. On 9/23/13, typed minutes and handwritten notes were presented for review. Though the minutes documented an assertion that medical management was appropriate and the cause of death was due to underlying idiopathic cardiomyopathy, the MR was absent of any discussion regarding the coroner's narrative and the issue identified regarding the nature of the lower limb bruising presumed to have	W 127	W127 #1 cont. n. Training on Administrative 226: Client Supervision and Personal Care was initiated on 9/23/13 with all level of care staff by Residence Managers. DTAC/worksite staff will be trained by the Program Assistant, initiated on 9/25/13. o. An informational flyer describing definitions of level supervision was created at the direction of the Clinical Director and posted on each residence in the Nursing Station by Program Managers. p. Program Assistants will ensure that the flyer is posted in DTAC/classroom/worksites. q. The flyer will be posted on the facility Intranet and emailed to all staff. r. Shift/Site Supervisors will review the information on the flyer at daily huddles on residences and DTAC/worksite effective immediately through 9/27/13 s. The Clinical Director and ICF Program Directors met with Residence Managers, IPCs, and Quality Assurance staff to review client supervision expectations, and regarding IPP implementation to ensure protection from harm for clients. AD 226 was also reviewed with emphasis on Section 4.5	09/27/13 09/24/13 09/25/13 09/25/13 09/27/13 09/24/13	

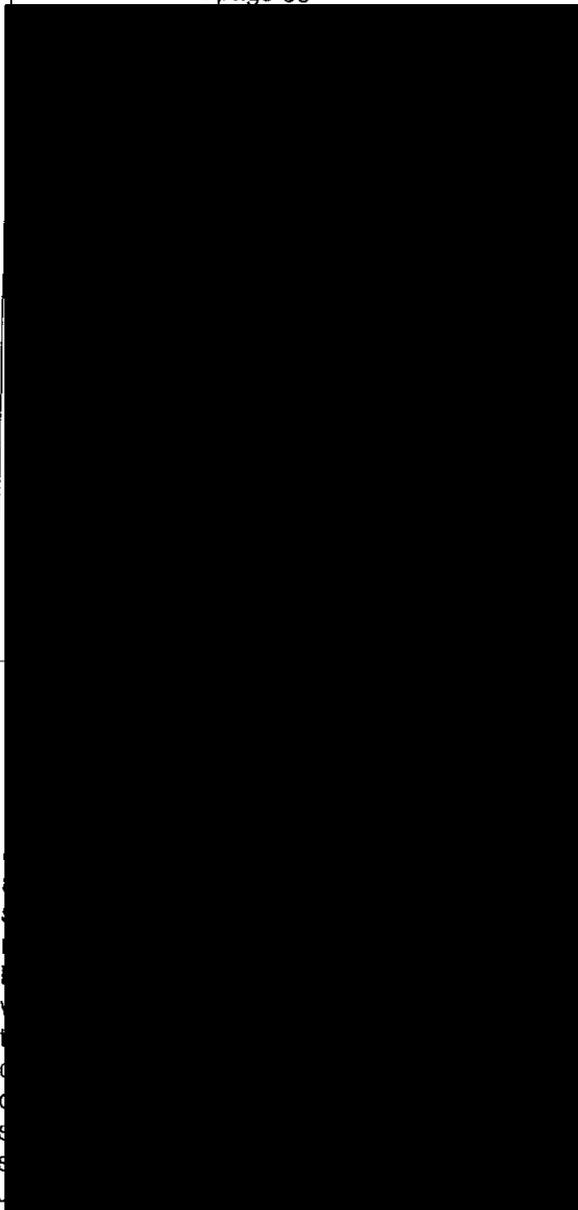
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W 127	Continued From page 32 occurred during recovery at the dental clinic. There was a nexus identified between the use of restraints and placement proximity to Client 97's upper hip bruises, but there was no discussion in the MR regarding the efficacy of the use of restraints, the appropriateness of application used during the event as described and any other recommendations regarding client behavior and safety during a recovery period. The MR also reflected the autopsy findings of 1/16/13 which stated, "Cardiomegaly 480 gms. - left ventricular and intra-ventricular hypertrophy with slight increased bulk in sub-aortic distribution - heavy lungs with pink edema fluid, no evidence of fatal traumatic injuries." The investigation was also referred to the California Highway Patrol (CHP). 	W 127	W127 #1 cont. t. The Executive Director instructed Program and Residence Managers to conduct rounds on all ICF residences to assess staff knowledge and ability to implement supervision levels, and provide prompting and intervention where needed. Specific findings were relayed to the Residence Manager of the involved residence(s) for follow-up. u. A debrief of the 9/24/13 rounds was held to review overall findings of the staff knowledge and ability to implement supervision levels. Program and Residence Managers conduct rounds with random competency checks for staff knowledge of client supervision levels and implement. Outcomes were forwarded to the Executive and/or Clinical Director and on review, there were some instances in which staff was provided immediate feedback and coaching. v. The Clinical Director initiated the policy review/revision process for Administrative 226: Client Supervision and Personal Care to incorporate the Client Supervision Accountability System as well as any other revisions identified via the facility rounds. Additionally, definitions of commonly used descriptors pertaining to supervision levels will be added to the policy.	09/24/13 09/25/13 09/25/13	

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W 127	Continued From page 33 	W 127	<p>W127 #1 cont.</p> <p>w. On completion and approval of the revised Administrative 226: Client Supervision and Personal Care all level of care staff will be trained on the changes. Further orientation to the policy changes will be provided in employee meetings (such as Program meetings, and General Employee Meetings).</p> <p>x. The Individual Program Coordinator (IPC) will be responsible for updating the client supervision reference tool when any individual's supervision level is changed following any IPP meeting. The update will be completed by close of business the day the supervision level is changed. Supervision change will be documented on the 24 Hour Report and incoming staff will initial for acknowledgement.</p> <p>y. The Program Assistant will review the changes/updates with DTAC/worksite staff and Rehabilitation Therapists which will be acknowledged by signing a Training Record.</p> <p>z. The Residence Manager/Program Assistants will ensure that the updated client supervision reference tool is promptly disseminated.</p>	<p>10/25/13</p> <p>09/25/13</p> <p>09/25/13</p>	

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W 127	<p>Continued From page 35</p> <p>minutes. On 9/18/13 commencing at 3:00 PM, Client 56 was left unattended again in the Group 2 dayroom for 2 minutes while a staff member left the room to take two clients to the restroom.</p> <p>In an interview on 9/23/13 at 9:30 AM with the Residence Manager (RM) the RM stated Client 56 was on enhanced supervision and staff should always be within visual sight.</p> <p>Concurrent record review for Client 56 on 9/23/13 at 9:30 AM verified Client 56 required enhanced supervision, defined as within visual sight on the residence, off and on grounds and in the restroom.</p> <p>On 9/23/13 the facility generated a GER for Client #56 describing "two staff members did not follow the appropriate supervision on the AM shift on 9/17/13 and the PM shift on 9/18/13 as identified in [Client 56's] IPP."</p>	W 127	<p>W127 #1 cont.</p> <p>cc. If a supervisor finds that supervision is not being implemented per plan, immediate corrective action will be taken by the site supervisor with notification to the Residence or Program Manager for appropriate follow up.</p> <p>dd. A workgroup will be convened to develop a standardized Client Supervision Guide to identify the most effective residence-specific reference tool to use facility-wide. This workgroup will also be tasked with developing a standardized staff assignment sheet that will at a minimum identify staff "group" assignments and break times. The workgroup will consist of level of care staff, Shift Supervisor/s, IPC/s, and clinical managers. Membership will be determined at a DERMT meeting during the week of 9/30/13.</p> <p>ee. The Shift Supervisor is responsible to assign relief staff as well as redeploy staff based on client need. Residence Manager will monitor for compliance and provide guidance and direction to ensure effective deployment.</p>	10/25/13 09/30/13	
	<p>Interviews conducted during the survey revealed enhanced supervision and 1:1 assignments were rarely documented to ensure accountability and the process for communicating and ensuring such varied from residence to residence.</p> <p>Per interview with a PT from Residence 33 on 9/17/13 at 11:09 AM the PT revealed the RM would tell him if he would be assigned 1:1. The PT also said the distance for 1:1 is usually at arm's length, but if it was different the RM would tell him.</p> <p>Per interview with a SPT on Residence 30 on 9/19/13 at 10:30 AM, the SPT revealed the assignments for staff are recorded in a staffing book with their scheduled lunches. The SPT will</p>			10/25/13	

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W 127	Continued From page 36 relieve the assigned staff for 1:1 who will go on their break or lunch after verbal endorsement as 1:1 relief. Per interview with a SPT on Residence 33 on 9/19/13 at 10:30 AM it was revealed 1:1 supervision is to be determined for each client on the residence. The staff assigned 1:1 is recorded in the communication book, but it's different on different units. If staff needs a break it's only verbally communicated with the person who takes over. When asked to see a sample 1:1 assignment sheet for April 2013, the SPT said it has already been shredded. Per interview with the Unit Supervisor (US) for Residence 33 on 9/19/13 at 10:50 AM it was revealed "SPTs train floats" on levels of supervision verbally without any written documentation.	W 127	W127 #1 cont. ff. The standardized tool will be implemented facility-wide, including training to all IPCs, level of care staff, DTAC, shift supervisors and clinical managers. Training will be initiated within 30 days of the development of the form and will be ongoing for new and returning staff. gg. Random competency checks of level of care staff on all ICF residences will be conducted during scheduled: Residence Manager rounds, Program Management rounds, IPC rounds and Executive rounds. Results of the competency checks will be submitted to Quality Assurance. hh. Any/all findings of insufficient competency will be relayed to the Residence Manager of the involved staff for immediate attention.	10/25/13 09/24/13 10/25/13	
	Per interview with the Residence Manager (RM) for Residence 29 on 9/24/13 at 9:00 AM, the RM stated the communication was reviewed for 1:1 assignment during a huddle. Break times and assignments were documented in the communication book. During relief of 1:1 observation, staff will conduct verbal endorsement to another staff assuming the 1:1 observation. No documentation will be written in interdisciplinary notes for the endorsement or behaviors and interventions for the client. Per interview with a PT from Residence 29 on 9/24/13 at 9:50 AM, the PT stated staff will do verbal endorsement during 1:1 relief coverage. No documentation will be made in the IDN notes. In a discussion with the Deputy Director of DDS,		ii. The Quality Assurance Department will review the results and report out at the Clinical Quality Management. Findings and recommendations are forwarded to Governing Body members via the Quality Management Council meeting. jj. The Director of Quality Assurance will monitor to assure completion of competency checks and review of the results for the first 90 days. kk. Recommendations for continued monitoring will be submitted to the Executive Committee for consideration.	09/24/13 09/24/13 10/25/13	

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W 127	Continued From page 37 the Executive Director (ED) and Director of Quality Assurance on 9/24/13 commencing at 10:05 AM, an inquiry was made about the system in place to ensure all clients at Lanterman receive enhanced supervision in accord with their plans. The ED articulated some of the protection from harm strategies - i.e. governing body rounds and training initiatives that started in November 2012. When asked if there was any corrective action taken in response to lessons learned or gleaned from the death of Client 97, or the allegation of potential neglect for Clients 66 and 92, no additional action was identified. Administrative action is however pending with the responsible employee. For the neglect substantiated for Client 97 and the facility's failure to implement a center-wide accountability system to ensure clients receive enhanced supervision in accord with individual plans immediate jeopardy was declared on 9/24/13 at 10:30 AM.	W 127	W127 #1 cont. I. All level of care (residence, DTAC, Rehab Therapists) staff will be provided a whistle to use when assistance is needed and other staff are not in the immediate vicinity. These will be distributed to on-duty staff on a continuum by Shift Supervisors. Residence Manager/Program Assistant will monitor for compliance. This system is in place on Residence 15 mm. An analysis of the number of clients who need enhanced or greater supervision in the various environments (dining room, living room, bathroom, worksite, etc.) on the staffing ratios in effect on each residence. Staffing adjustments needs will be formally made as needed (such as higher ratio of individuals under enhanced supervision).	09/27/13 09/27/13	
	The survey team met with Executive Director, Deputy Director of DDS and Director of Quality Assurance and informed them of the Immediate Jeopardy on 9/24/13 at 10:30 AM for facility's failure to ensure that supervision was provided to the clients with identified needs and behavior problems and for lack of evidence that facility has taken corrective actions to ensure that supervision to the clients were implemented. The facility presented to the team the facility's immediate corrective actions on 9/24/13. An updated immediate corrective action plan was submitted to the team upon conclusion of the survey on 9/26/13 at 6:00 PM. The Immediate Jeopardy remained in effect upon		nn. When one staff relieves another, endorsement with the receiving staff will occur providing any unusual/out of the ordinary behaviors or activities of the individuals to be supervised. If the time of the "relief" for staff to go on a break is different than was originally scheduled, the Staff Assignment Sheet will be updated by the Shift Supervisor.	10/25/13	

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W 127	Continued From page 38 conclusion of the survey on 9/26/13. On 10/2/13, the team conducted an onsite evaluation of the facility's implementation of the corrective actions for the Immediate Jeopardy situation. The facility implemented immediate corrective actions which included the following: 1. Clinical Director (CD) gave written direction to the Residence and Program Managers (PM) to meet with all staff on duty and ensure that they understand that clients' supervision levels must be implemented per the clients' Individual program Plan; to reevaluate staffing deployment immediately; to review staffing levels with Program Directors (PD) and Nursing Coordinators (NC) to ensure effective staff deployment. 2. Program Managers are responsible to assure that an adequate number of staff are on duty and that adjustments are based on acuity level on a continuum. 3. CD reviewed staffing minimums/deployment with the PDs. 4. A Client Supervision Accountability System for level of care staff was developed which included: 1) a Residence -specific reference tool which provides each client's name and their supervision level; 2) a signed acknowledgement of the review and understanding of the supervision levels. 5. The "Orientation for Relief Staff Providing Client Services" was revised to ensure the review of client supervision is included, CD coordinated the revision of the form, which is now titled " New Staff and Float Orientation". 6. " New Staff and Float Orientation" was implemented immediately following training to RM by the CD.	W 127	W127 #1 cont. oo. At weekly staffing meetings and as needed, Residence Managers will report to Program Managers (Nursing Coordinator, Program Assistant, or Program Director) if any increased staffing is needed due to client activities, medical condition, or behaviors. pp. The Clinical Director reviewed the current client supervision reference tools and selected one to be the format implemented ICF-wide until the workgroup develops an alternate. qq. The interim client supervision reference tool will be enacted by each Residence Manager. rr. The revision of AD 226 will include definitions of commonly used terms. Interim definitions will be "waking hours"- an individual's usual hours of being awake (a conscious or alert state- http://www.merriam-webster.com/dictionary/waking) in the rhythm of their day. "Napping" (to sleep briefly especially during the day- http://www.merriam-webster.com/dictionary/napping)	10/25/13 09/26/13 09/27/13 09/26/13	

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W 127	<p>Continued From page 39</p> <p>7. Training on Administrative 226: Client Supervision and Personal Care was provided to level of care staff by Residence Managers. Training to worksite staff was provided by Program Assistants.</p> <p>8. The Executive Director instructed Program and Residence Managers to conduct rounds on all Intermediate Care Facilities (ICF IID) residences to assess staff knowledge and ability to implement supervision levels, and provide prompting and intervention when needed.</p> <p>9. Program and Residence Managers conducted random competency checks for staff knowledge of client supervision levels.</p> <p>10. All level of staff were provided a whistle to use when assistance is needed and when other staff are not in the immediate vicinity.</p> <p>11. An analysis of the number of clients who need enhanced supervision or greater supervision in the various environments on the staffing ratios in effect on each residences was completed on 9/27/13. Shift Supervisor is responsible for updating the Staff Assignment Sheet.</p> <p>12. A work group convened to develop a standardized Client Supervision Guide to identify the most effective residence-specific reference tool to use facility-wide. The standardized tool will be implemented facility-wide, including training to all Individual Program Coordinators.</p> <p>On 10/2/13 at 1:25 PM, the team met with the Executive Director, Director of Quality Assurance, Clinical Director and Standards Compliance Coordinator and informed them that the facility had corrected the immediacy and the Immediate Jeopardy had been abated. On the same date and time, the team also informed Deputy Director of DDS through a conference call with the facility's Distractive staff that the Immediate</p>	W 127		

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W 127	<p>Continued From page 40 Jeopardy had been abated during the onsite visit.</p> <p>2. During a full survey of the facility, entity reported incident 332312, which was initiated in November 2012 and remained an open investigation was included as part of the review of the facility's system to prevent abuse, neglect and mistreatment.</p> <p>On 11/7/12 at 2:20 PM, an unannounced visit was made to the facility to investigate an entity reported incident of a focus sampled client 98, who was noted to have a genital injury of an unknown origin on 11/6/12.</p> <p>During an interview with the Director of Quality Assurance (DQA) on the same day and time, she stated that the client resided in Residence 21</p>	W 127	<p>W127 #2</p> <p>a. Client 98 was examined by the residence physician who determined that a possible sexual assault may have occurred. OPS/Investigators were notified. Client 98 was escorted to [REDACTED] sexual assault response unit for further examination. Residence Psychologist and staff who care for Client 98 provided ongoing assessment to monitor for any adverse outcomes based on the injury.</p>	11/6/12	
			<p>b. Program 2 Management increased NOC rounds for Res 21. A summary of the completed rounds was sent to the PD/CD for review.</p> <p>c. Program Management, Administrative staff and Quality Assurance staff initiated Protection from Harm rounds on all residences.</p> <p>d. The OPS Commander contacted the local DOJ - Elder Abuse Hotline office to report incident, via voicemail.</p> <p>e. The Office of Protective Services (OPS) Commander informed Executive staff that the CHP Investigative Unit would take the lead in the Criminal Investigation and OPS would conduct an Administrative Investigation concurrently.</p> <p>f. The Program's Health Services Specialist initiated a review (11/7/12) of all recently opened medical</p>	11/6/12 11/6/12 11/6/12	
	<p>She also stated that four staff members (Psychiatric Technician 1 (PT 1), Psychiatric Technician 2 (PT 2), Psychiatric Technician Assistant 1 (PTA 1), and Psychiatric Technician Assistant 2 (PTA 2) from the night shift were removed from client's contact. She further stated that the case was transferred to California Highway Patrol (CHP) by the Office of Protective Service (OPS) for a criminal case investigation.</p> <p>During an observation on 11/7/12 at 3:20 PM in Residence 21, focus sampled client 98 was observed in her bed, located in room [REDACTED]. Room [REDACTED] was shared by focus sampled client 98 and two other clients divided by a partial wall. Focus sampled client 98's bed was located near the door entrance of the room, while the two other</p>			11/7/12 11/7/12 11/7/12	

98

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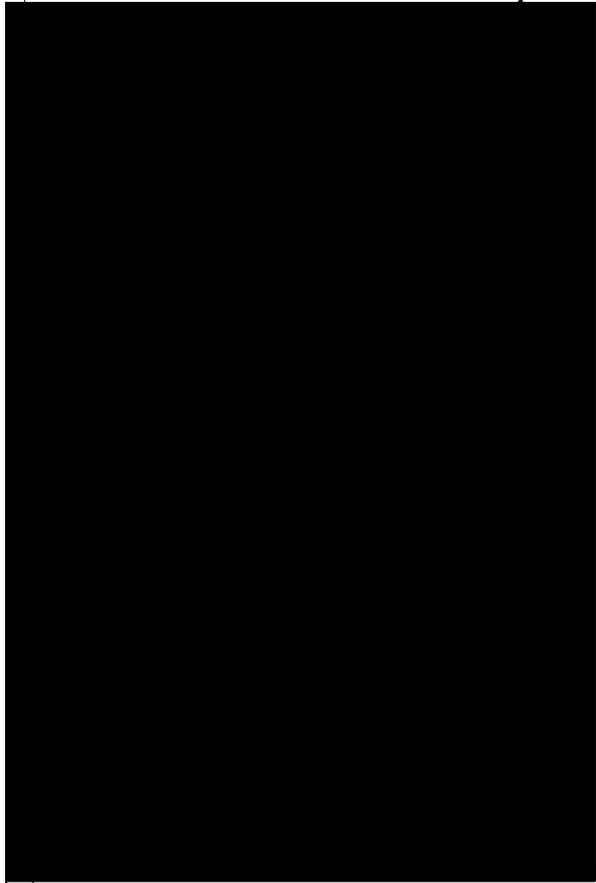
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W 127	<p>Continued From page 41</p> <p>beds for clients were located behind a partial wall separating the space.</p> <p>During an interview with focus sampled client 98 on the same day and time, she was unable to respond verbally when asked how she was feeling.</p> <p>During an interview with the Residence Manager (RM) of Residence 21 11/7/12 at 3:40 PM, he stated that Psychiatric Technician 3 (PT 3) discovered the laceration in the vaginal area of focus sampled client 98 while conducting perineal care on the morning of 11/6/12. PT 3 immediately reported to the Health Service Specialist. Focus sampled client 98 was examined by the residence physician and determined a possible sexual assault.</p> <p>An 888 (facility's abuse hotline) number was dialed by staff to make an initial report of the possible sexual abuse. Focus sampled client 98 was transferred to the community hospital on 11/6/12 for a sexual assault examination. The RM stated that four night shift staff (three males and one female) were removed from client's contact. Four other female clients in the residence were examined by the residence physician for possible sexual assault and the 13 male clients will be examined as well, according to the RM.</p> <p>During an interview with the CHP Investigator assigned to the case on 11/15/12 at 2:28 PM, he stated that their department took over the case of focus sampled client 98 on 11/7/12. According to the CHP Investigator, they had collected evidence including the SART (Sexual Assault response Team) kit, which will be processed in [County</p>	W 127	<p>W127 #2 cont.</p> <p>conditions related to the perineal area, such as rashes, impaired skin integrity, and urinary tract infections to determine any areas of concern. A summary indicating no abnormal findings were observed was provided to the PD/CD.</p> <p>g. QA Risk Manager completed an Incident Report review for all injuries occurring on Residence 21 and all ICF clients for the previous 6 months.</p> <p>h. The Program 2 Program Assistant reviewed the Program Injury/Fall Log, identifying types of injuries that had been documented on this residence (11/7/12), which was distributed to members of the Daily Executive Risk Management Team (DERMT) on 11/16/12. Findings of no issues related to special medical conditions were discussed at the DERMT meeting on 11/20/12 and during the Program's Risk Management Meeting.</p> <p>i. Special Risk Management Meetings were held beginning 11/7/13 in all Programs to review AD 124: Incidents and Unusual Occurrence, AD 227: Alleged Abuse, Neglect or Exploitation, AD 225: Client Supervision and Personal Care, and Quality Assessment and Performance Improvement Plan for Special Medical Conditions.</p> <p>j. Acting Clinical Director conducted rounds on Res. 21, and met with CDPH SFU licensing surveyor.</p>	<p>11/21/12</p> <p>11/7/12</p> <p>11/7/12</p> <p>11/16/12</p> <p>11/20/12</p> <p>11/30/12</p> <p>11/7/12</p>

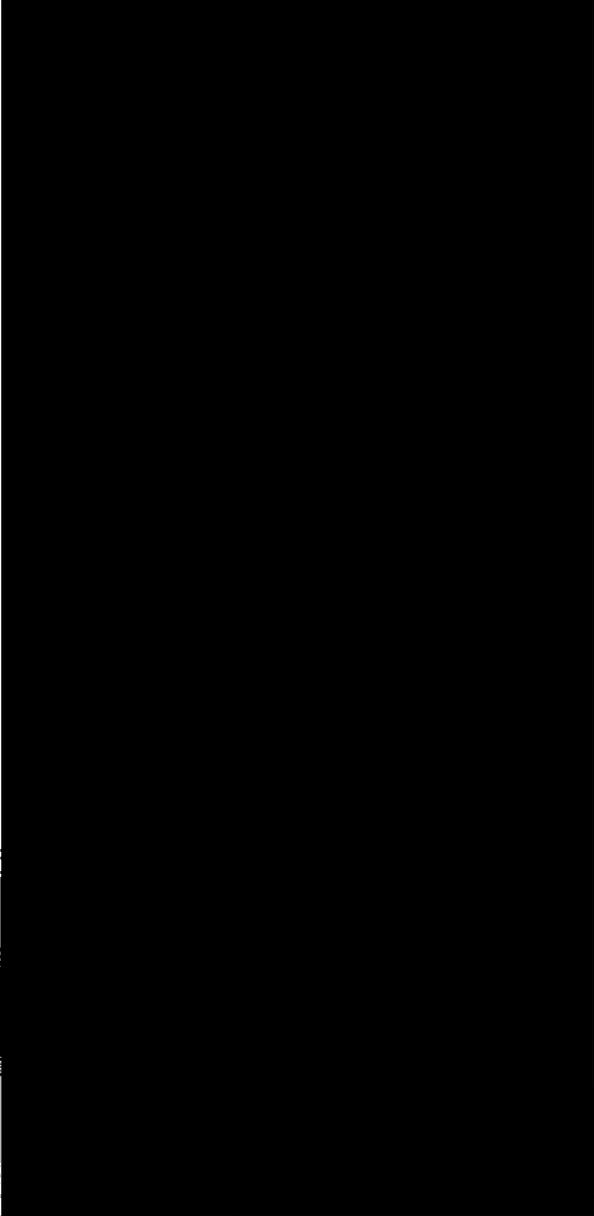
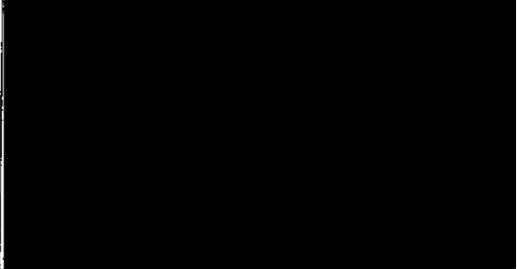
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W 127	Continued From page 42 Crime Laboratory's name]. He also stated that they had not conducted any interviews yet and advised the surveyor to hold off on interviewing anyone that might had any involvement in the case. 	W 127	W127 #2 cont. k. Executive Director made rounds on residence 21. l. Residence HSS and Physician completed physical examinations to rule out any further potential victims on all clients living on Residence 21. The Physicals were completed on the female clients first (11/8/12), followed by the male clients (11/15/12). m. Memorandum from Acting Clinical Director to all Program Managers, Residence Managers and Shift Supervisors re: heightened awareness by all staff regarding Protection from Harm (PFH) measures (Steps b, c, k, n, and p) for all clients. n. The OPS Commander instructed the OPS Sergeant to have Police Officers initiate daily rounds on residences at random times of the day. These are logged on the OPS Police Daily Activity Log as well as the residence 24-Hour Report. o. The Director of Quality Assurance contacted the Sexual Assault Response Team (SART) Nurse  to inquire if there were any recommendations regarding protection from harm. p. Program Management and Quality Assurance staff conducted rounds for the holiday weekend on each residence and each shift. q. The Individual Program Coordinator and Program 2 Management reviewed Interdisciplinary Notes and Nursing	11/8/12 11/8/12 11/8/12 11/15/12 11/8/12 11/8/12 11/8/12 11/9/12 11/9/12	

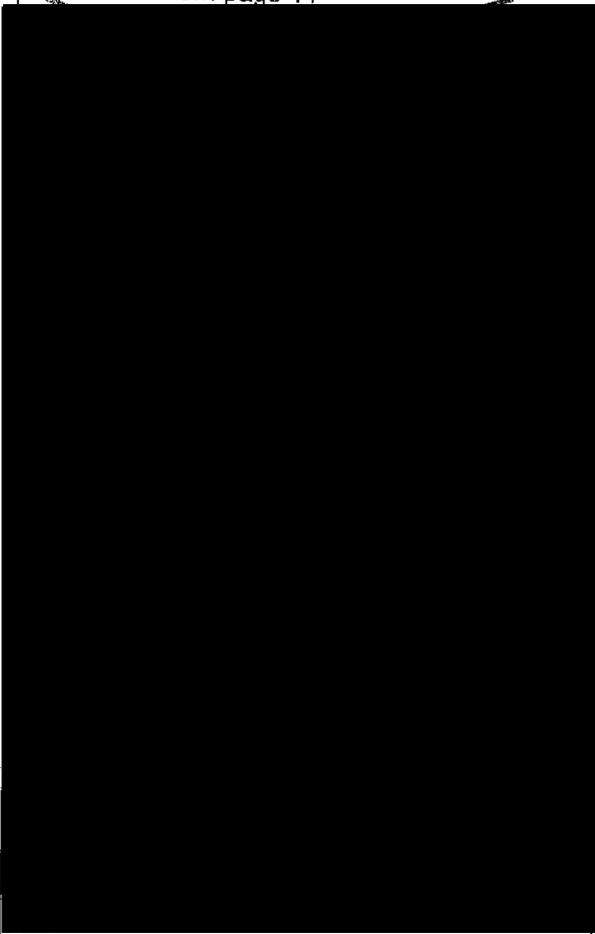
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W 127	Continued From page 43 	W 127	W127 #2 cont. Assessments for all clients living on Residence 21 for the previous 6 months, with no unusual findings reported to the Program Director and Clinical Director. (Female clients' record review completed on 11/9/12. Male clients record review completed on 11/16/12.) r. Enhanced Rounds by all Program Managers and Supervisors and Quality Assurance staff to all residences and all shifts are on an ongoing, weekly random schedule. Identified issues are reported and elevated to Executive Committee members if resolution is needed. Rounds data will be collected and presented to the Clinical Director for review at the Clinical Quality Management Committee Meetings and the Quality Management Council Meetings.  t. Senior Supervising Psychologist reviewed strategies to assist individuals in dealing with sexual assault with the DERMT members and Executive Committee.	11/16/12 11/13/12 11/13/12 11/14/12 11/16/12 and 11/19/12	

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W 127	Continued From page 44 	W 127	W127 #2 cont. u. A Special Team meeting was held to review Client 98's program plans and data collection, and modifications were implemented. v. Center-wide training on Protection From Harm scheduled for all staff in 3 separate training sessions. Curriculum was developed and two training sessions were held on 1/22/13 and two additional sessions were held on 2/21/13. (See also continuation pages 6a-d.)	11/28/12 1/22/13 and 2/21/13	
	During an interview with the CHP Investigator on 12/20/12 at 10:02 AM, he stated that there were no DNA (Deoxyribonucleic Acid, a molecule that encodes a genetic makeup of living organism) test results available as of yet from the SART kit. He was not able to give a time frame as to when the test will be completed. He also stated that they had interviewed staff including PT 2, PTA 1, PTA 2, and another PT (PT 4), who was assigned				

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W 127	<p>Continued From page 45 to focus sampled client 98 before PT 1 took over her care.</p> <p>According to the CHP Investigator, PT 2, PTA 1, and PTA 2 came into their office voluntarily for interviews, with the exception of PT 1. PT 1 refused to be interviewed and gave every excuse in the book according to the investigator. The Investigator did not want to provide details of their investigation until he interviewed PT 1.</p> <p>Although the case was still pending, he stated that he had gathered good information from the staff that were interviewed. He further stated that the investigator at the facility was told by the SART Nurse that it was sexual assault and they were notified by the facility investigator a day later after the incident. The Investigator requested the surveyor to continue holding off on the investigation until they were done.</p> <p>During an interview with the CHP Investigator on 1/25/13 at 1:03 PM, he stated that there were no DNA test results available. According to the Investigator, PT 1 refused to be interviewed until the DNA results came back.</p> <p>During an interview with the Compliance Officer of the community hospital on 1/28/13 at 1:10 PM, she stated that the SART Nurse who conducted the exam on focus sampled client 98 was contracted by the hospital. The records (Sexual Examination Report) were kept by the SART Nurse and had to be requested.</p> <p>The Sexual Examination Report dated 11/6/12 conducted by the SART Nurse was received and reviewed on 2/7/13 at 5 PM [REDACTED]</p>	W 127			

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W 127	<p>Continued From page 46</p>  <p>During an interview with the CHP Investigator on 2/28/13 at 11:58 AM, he stated that he had not received any results from the crime laboratory for the DNA test results. He also stated that the investigation was on-going while waiting for results. He further stated that the turn-around time for DNA test results was around eight months.</p> <p>During an interview with PTA 2 on 3/14/13 at 10:16 AM, she stated that she was removed from client's care on 11/7/12 and she had been working in the training office since 11/9/12. She also stated that she volunteered to work in Residence 21 on 11/5/12 during-NOC shift (night shift) as a PTA. She was assigned on a 1:1 observation with another client by the shift lead (PT 1). According to her, she didn't have any contact with any client that night (11/5/12 thru 11/6/12) except for the one she was assigned to.</p> <p>There were four staff in the residence during NOC shift including her and three of them were floaters, except for PT 1. She had worked in the residence twice for overtime. She denied knowing focus sampled client 98 nor the room where she was located at. She also stated that it was quiet on the night of 11/5/12, there was no screaming and she did not notice anything unusual on staff or clients. PTA 2 voluntarily went to CHP office for an interview.</p>	W 127			

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W 127	<p>Continued From page 47</p> <p>During an interview with PT 1 on 3/14/13 at 11:47 AM, he stated that he currently worked in the main kitchen of the facility. PT 1 was accompanied by a union representative. He stated that he retained a lawyer and refused to be interviewed.</p> <p>During an interview with the Standard Compliance Coordinator (SCC) on 8/6/13 at 10:15 AM, she stated that PT 1 passed away about two months ago due to his medical condition. An attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>During an interview with the CHP Investigator on 8/6/13 at 11:05 AM, he stated that they finally concluded their investigation. The DNA test results came back negative and could not be linked to any staff investigated. He also stated that even though the DNA test came back negative, it did not mean that focus sampled client 98 was not sexually assaulted. He further stated that their "suspect" (PT 1) died of a medical condition.</p> <p>During an interview with the SART Nurse on 9/9/13 at 2 PM, she confirmed the findings on the Sexual Examination Report dated 11/6/12. She stated that the injury of focus sampled client 98 was consistent with sexual assault. She also stated that the injury was not consistent with "cleaning her area" because there was a certain degree of force applied to the area. She further stated, "It was some type of blunt force trauma, but I cannot tell what."</p> <p>During an interview with the SCC on 9/9/13 at 10:30 AM, she stated that the sign-in sheet for</p>	W 127		

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W 127	<p>Continued From page 48</p> <p>11/5/12 indicated that PT 1 was in-charge on NOC shift and was also the medication person. PT 2 was assigned on the left side of the residence hallway, PTA 1 was assigned on the right side of the residence hallway, and PTA 2 was assigned to a 1:1 observation. Another attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>The Daily Time Record for the morning shift and night shift dated 11/5/12 was reviewed on 9/9/13 at 10:45 AM. The review confirmed what the SCC stated regarding assignments of staff on 11/5/12 during NOC shift. The review also indicated that PT 1 reported to work in Residence 21 at 2:30 PM on 11/5/12 and continued to work until 7 AM on 11/6/12 for overtime. The review further indicated that PT 4 reported to work on 11/5/12 at 2:30 PM in the residence.</p> <p>During an interview with PT 3 on 9/9/13 at 11:30 AM, she stated that she worked on the morning shift of 11/5/12 and 11/6/12 assigned to group 4 where focus sampled client 98 was part of the group.</p> <div style="background-color: black; width: 100%; height: 100px; margin-top: 10px;"></div>	W 127		

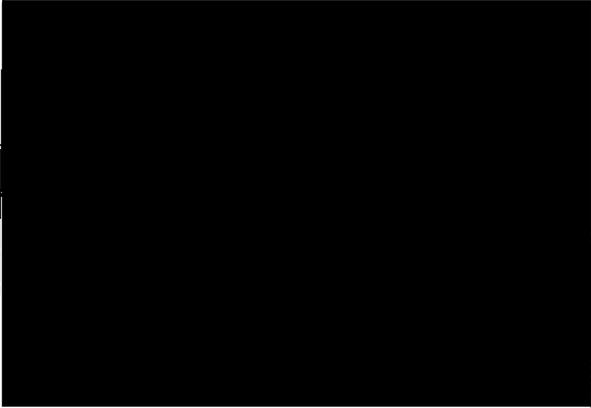
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W 127	<p>Continued From page 49</p>  <p>The HSS arrived in the residence when PT 3 was transferring focus sampled client 98 from shower chair to bed. Drops of blood were observed on the floor by PT 3. The HSS conducted an assessment and noted a laceration on the perineal area, between the rectum and vagina of focus sampled client 98. The residence physician was notified and arrived in the unit shortly to assess the client. PT 3 stated that the residence physician stated that focus sampled client 98 was sexually assaulted. She stated that the residence physician seemed to be sure of it when he said it. PT 3 was upset after hearing the residence physician.</p> <p>PT 3 stated that PT 1, PT 2, PTA 1, and PTA 2 were working on the NOC shift of 11/5/12. PT 1 was in-charge of the NOC shift and clients were assigned on the left and right side of the hall. PT 3 stated that PT 1 was in-charge of the front hall and focus sampled client 98. PTA 1 was on the right side and PT 2 was assigned on the left side of the hallway. PTA 2 was assigned to a 1:1 observation, located on the left side of the hallway.</p> <p>PT 3 stated that there was no sexual abuse in the past that she knew of involving staff or clients in Residence 21. </p>	W 127		

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W 127	Continued From page 50  PT 3 explained that management did not have a live interaction with PT 1 and did not pick up on his issues. Focus sampled client 98 was very comfortable and very familiar with PT 1. According to PT 3, focus sampled client 98 likes attention from men. She was very playful especially with men. During a re-interview with the RM of Residence 21 on 9/9/13 at 12:30 PM, he stated that focus sampled client 98 was on general supervision on 11/5/12 during NOC shift. PT 1 was assigned to focus sampled client 98 on the night of 11/5/12 and had full access to the client. The RM was notified by PT 3 on the morning of 11/6/12 that focus sampled client 98 was bleeding from the vaginal area. He confirmed the findings of PT 3 and the residence physician was notified, who re-assessed focus sampled client 98. The residence physician felt that there was some sort of violations, sexual in nature according to the RM. The RM stated that the floaters (PT 2, PTA 1, and	W 127			

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W 127	<p>Continued From page 51</p> <p>PTA 2) had never been involved with any type of abuse in the residence. He was not aware of any inappropriate contact by PT 1 to any staff or clients and was not aware of him being stressed out. The RM was unable to characterize PT 1's interaction with clients, because according to him, he (PT 1) always works nights.</p> <p>According to the RM, he did not believe the residence physician's finding and did not formulate any suspicion at the time. He was in disbelief that something had happened. He also stated that [focus sampled client 98's name] did not have SIB. He did not believe that focus sampled client 98 would hurt herself that way.</p> <p>The RM mentioned that PT 1 told him that he was in focus sampled client 98's room on the night of 11/5/12. [REDACTED] PT 1 told him, "She was fine when I left." PT 1 also talked to him about being stressed out and CHP investigators wanting to talk to him. PT 1 told the RM that he hired a lawyer because he did not trust the system. The RM also stated, "I felt that one of the staff accidentally harm the client, and instead of admitting it, they left it."</p> <p>During an interview with PTA 1 on 9/9/13 at 1:25 PM, he stated that he had worked many times in Residence for overtime. On the night of 11/5/12, he was covering the right side of the hallway. He stated that PT 1 was assigned to focus sampled client 98 during NOC shift of 11/5/12.</p> <p>PTA 1 mentioned that he did not have any contact with focus sampled client 98 and did not notice anything unusual during NOC shift on 11/5/12. He did not see anyone go in and out of the client's room when he made his rounds. Focus</p>	W 127			

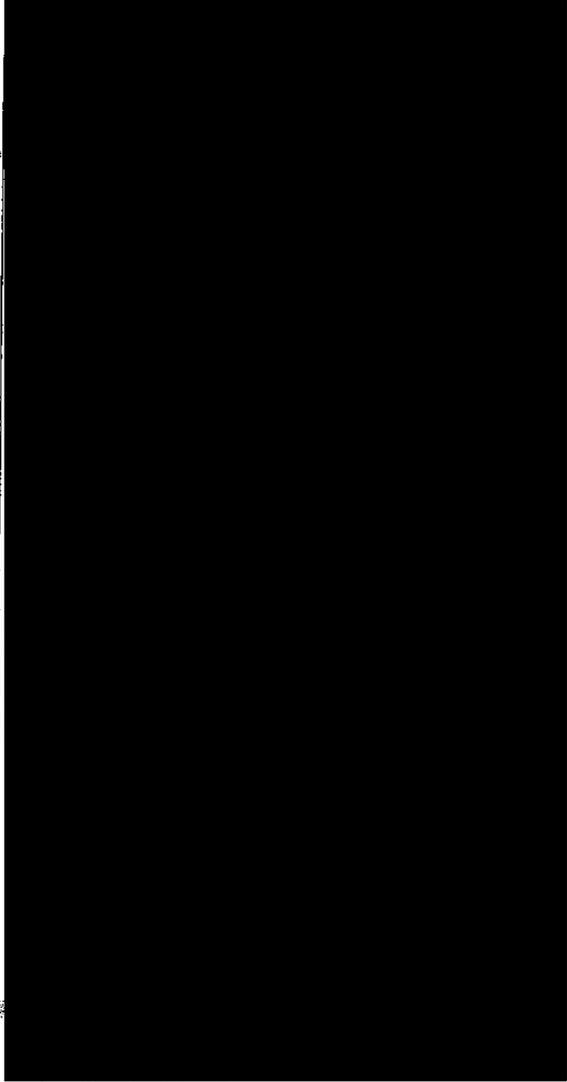
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W 127	<p>Continued From page 52</p> <p>sampled client 98 was in room [REDACTED] with two other clients and she was observed sleeping at 11 p.m. on 11/5/12, before 1 a.m., 3 a.m., and 5 a.m. on 11/6/12. However, he observed PT 1 inside focus sampled client 98's room a little bit after 5 a.m. on 11/6/12.</p> <p>PTA 1 denied assaulting focus sampled client 98. He voluntarily went to CHP office for an interview. He stated, "I have a family member who had disability also and I would not abuse anyone who has a disability." PTA 1 was removed from client's contact after receiving a phone call from the Program Director on 11/6/12.</p> <p>During an interview with PT 2 on 9/9/13 at 2:15 PM, he stated that during NOC shift on 11/5/12 he was covering the left side of the hallway where focus sampled client 98's bedroom was located. According to PT 2, he had only worked twice in the residence for overtime.</p> <p>PT 2 denied knowing focus sampled client 98 and her room and stated that she was not one of the clients assigned to him on 11/5/12. He stated that he conducted 30 minutes check on clients, randomly throughout the night. PT 2 did not observe anyone entering or leaving focus sampled client 98's room. He did not hear any commotion in the room either, according to him.</p> <p>PT 2 did not know most of the clients in the residence. He stated that he did not change or take care of focus sampled client 98 the night of 11/5/12, because he had no reason to. He voluntarily went to CHP office for an interview and expressed to CHP Investigators that he had nothing to do with it. He stated, "If you want DNA, I'm willing to give it at anytime." PT 2 stated, "I</p>	W 127		

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W 127	Continued From page 53 wished that I never did overtime in Residence 21 on 11/5/12." 	W 127			

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W 127	Continued From page 54 an immediate cause of death, according to the Certificate of Death. The facility policy and procedure titled "Client Services - 227: Alleged Abuse, Neglect or Exploitation" dated 10/26/11, reviewed on 9/25/13 at 4:20 p.m. indicated, "1. POLICY - ...Any neglect, abuse, or exploitation by any person, whether staff, visitor, volunteer, student, family, or other clients, is prohibited....Training:...All staff shall receive training to assist in the prevention of abuse, neglect, mistreatment and misappropriation of property as well as client abuse reporting procedures..." The review also indicated, "2. DEFINITIONS - 2.3 Sexual Abuse - Sexual contact that results from threats, or fear, and involving range of activities, including, but not limited to, assault, rape, molestation sexual harassment."	W 127		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of clients to be free from unnecessary drugs and provided active treatment to reduce dependency on drugs for one of 10 core sampled and two focus clients. (Clients 36, 47, and 69)	W 128		

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W 128	<p>Continued From page 55</p> <p>The facility also failed to ensure 11 clients living on Residence 15 were free use from an unnecessary drug for which there was no substantiated use or active monitoring to support its use.</p> <p>Findings:</p> <div style="background-color: black; width: 100%; height: 100px; margin: 5px 0;"></div> <p>Staff explained two clients on Residence 15 attended the same vocational setting on campus where a community based client was "thought" to have scabies but did not return to work and it was never confirmed.</p> <p>The Residence Manager further indicated a dermatologist did skin scraping on the two Residence 15 clients and they were negative for scabies mites. However the facility management determined all 11 clients had to receive "prophylaxis" scabies treatment.</p> <p>Guidelines from LA County Public Health and Center for Disease Control indicate a confirmed diagnosis of scabies should be made in at least one symptomatic case (itchy rash) before scabicide prophylaxis in a health care setting is used. The facility failed to ensure the rights of 11 clients on Residence 15 when they received "prophylaxis" scabies treatment and unnecessary drug Permethrin 5%.</p>	W 128	<p>W128 #1</p> <p>The Nurse Consultant II investigated the sequence of events involved in this event and noted the following:</p> <p>a. The Public Health Nurse designee was in consultation with L.A. County Public Health concerning the information brought to Community Industries staff about possible scabies exposure to LDC clients, and during the duration of this event. (Please see continuation page 56a-b.)</p>	08/20/13

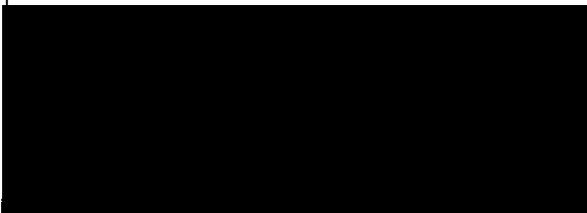
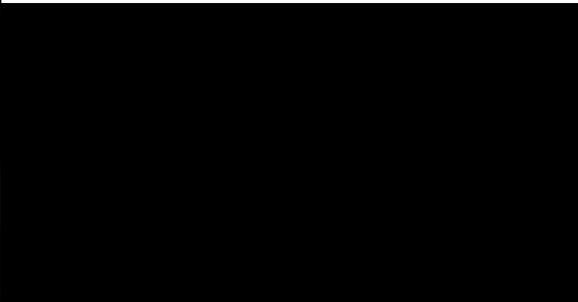
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	W128 #1 (cont. from p. 56)				
	b. After receiving this information, Community Industries staff notified the Program Director and Residence 15's Residence Manager (Res. 15 has clients that worked in the same area). It was determined that the Physician would decide the course of action to be taken regarding the clients under their care. According to Public Health guidelines, "... exposed individual is potentially immediately infectious to others, even in the absence of symptoms. Cases are communicable from the time of infestation until mites and eggs are destroyed by treatment. (LDC Infection Control Manual Section 10 Protocol: Scabies) Definitive diagnosis requires microscopic identification of the mite and/or its eggs or fecal pellets or specimens collected by skin scraping, biopsy or other means. Properly performed skin scraping will almost always be positive in persons with crusted scabies but are generally negative in cases of typical scabies, even when performed by experienced operators. A negative skin scraping from a person with typical scabies does not conclusively rule out scabies infestation, mites are easily recovered, however, in skin scrapings from person with crusted scabies. " The Physician treated eleven clients on Residence 15 with prophylactic scabicide as a proactive measure. L.A. County Public Health guidelines will be strictly followed in the future so that clients do not receive unnecessary drugs.			8/22/13	
	c. The Medical Director directed physicians to: follow L.A. County Department of Public Health (or similar authority) guidelines for prophylactic treatments for scabies or other highly contagious/ communicable diseases or conditions. To ensure the health of all clients in the event of a possible scabies outbreak, a meeting with key staff will be held to coordinate control measures, comprised of the Executive Team and representatives from these departments: Public Health, Employee Health, Environmental Services, Infection Control, Pharmacy, Medical Staff, and ACNS. One person, generally the Infection Control Practitioner/Public Health Officer, will coordinate control measures and should be given adequate resources to accomplish this objective in a timely and efficient manner.			10/29/13	
	d. The Public Health Nurse will ensure compliance with this policy through daily surveillance of clinical laboratory findings and review of the Daily Morbidity Report.			9/26/13	
	e. Any issues, concerns, or new information gathered from the above reports will be shared with the Infection Control Committee. Any recommendations following this will be forwarded to the Medical Executive Committee for follow-up.			9/26/13	
	f. Infection Control education on scabies was provided to staff on Res. 15 on 8/22/13 and in Community Industries on 8/23/13.			8/22/13 8/23/13	
	g. This event was reviewed at the Infection Control Committee meeting on 10/2/13.			10/2/13	

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W 128	Continued From page 56  <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 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>In an interview with the Health Services Specialist, Individual Program Coordinator and Residence Manager on 9/25/13 at 2 PM, revealed</p>	W 128	W128 #2, #3, #4 (Please see continuation pages 57 a-b)		

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	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. Atarax was decreased from 200MG/day to 100MG/day on 9/27/13.				
	e. A Special meeting was held to discuss [REDACTED]				10/25/13
	[REDACTED] After review, the Physician discontinued the order for Hydroxyzine (Atarax). [REDACTED]				
	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 [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 eviws 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:				

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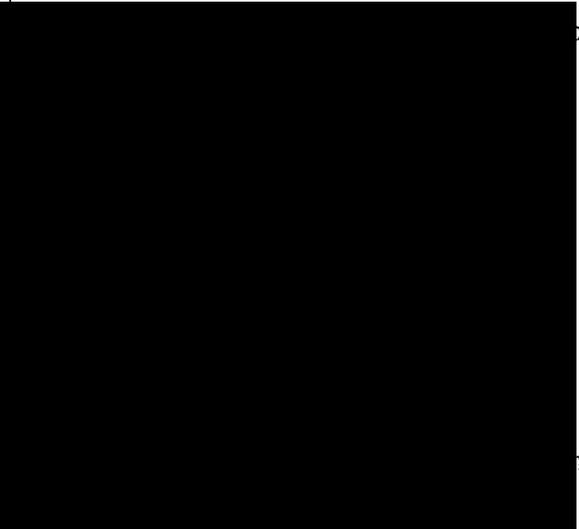
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	(cont. W104-3,4,5,6,7,8; W128-1,3; W159-3; W290-1; W312-1; W314-1,2,3; W331-14)				
	<p>1. The clients' drug therapy must fit the diagnosis. 2. The potential for adverse reaction to a medication must be minimal. 3. Medication used to treat any physical 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

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W 128	<p>Continued From page 57</p> <p>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.</p> <p>The facility failed to assure the right of Client 69 to be free from an unnecessary drug, failed to assess, develop and implement effective non-drug interventions that addressed Client 69's long term usage of Restoril.</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</p>	W 128		

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W 128	Continued From page 58 motor activity, confusion, constipation, drying and thickening of oral and respiratory secretions. (Reference: National Institutes of Health www.NIH.gov)	W 128			
W 130	4. Review of Client 47's Physician orders revealed the long term usage of Hydroxyzine 50 mg (Atarax) four times day, for a problem defined as an unspecific allergy, itching or irritation of left eye which was closed and resolved in September 2012. There was no indication for the usage of the Hydroxyzine. 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. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the right of privacy was provided during personal care for one focused client (Client 82) when incontinence care was being provided in the presence of four other individuals. Findings: On 9/17/13 at 12:25 PM, the surveyor entered	W 130 W 130	W130 a) Privacy curtains were obtained immediately for use for client 82. b) Additional privacy curtains were obtained for use in all client bedrooms on Residence 120. c) The Residence Manager provided training to the staff on duty on Administrative Directive 201, Clients Rights with particular attention to the right to privacy. d) All Shift Supervisors will monitor for client privacy 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.	09/17/13 09/17/13 10/25/13 10/25/13	

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W 130	Continued From page 59 room 13 on Unit 20 [REDACTED] [REDACTED] Upon entering the room, Client 82 was observed uncovered laying in his bed being provided incontinence care by his 1:1 staff. There was no provision of privacy despite having four other individuals in the room. Also present in the room was Client 79 and his caregiver and Client 94 and his caregiver. Client 94 did not reside in this room.	W 130	W130 cont. e) All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure client privacy 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 and submit to the Program Director weekly. (please see continuation page 60a)	10/25/13	
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that clients participated in various types of community activities on a regular basis for four of 10 core sampled and nine focus clients (Clients 5, 19, 21, 37, 47, 54, 61, 67, 69, 75, 84, 79, 94,). Findings: 1. Review of Client 94's record indicated that the Recreation/community outings report indicated that there were no community outings documented for 4/2013, 5/2013, or 7/2013. Reports were not available in the record for 6/2013 or 8/2013. These findings were acknowledged by the Recreation Therapist present. Additional information, identified as the	W 136	W136 #1-2 a) Program Assistant and Rehab Therapist will audit Clinical Records of Clients on Res 120, that include Client 79 and Client 94, to ensure accurate Leisure Activities Attendance Record (LAAR) documentation is in place. b) Program Assistant provided in-service training to Rehab Therapists on Administrative Directive (AD) 240 Community Integration and Off-Campus Trips. c) Rehab Therapist completed in-service training for staff on duty on Res 120 on protocol for completing LAAR form # e1126. d) Rehab Therapist provided in-service training to staff on duty on Res 120 on guidelines of completing On/Off Grounds Activity Trip Sheet form #SR2054. (Please see also cont. pages 61a & 69a)	10/25/13 10/25/13 10/25/13 10/25/13	

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W130 (cont. from p.60)	<p>f)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. Should concerns related to client privacy be observed during routine rounds, corrective action will be taken to rectify the immediate situation and follow-up with staff with additional training, or progressive supervision as warranted.</p> <p>g)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>

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	W136 #1-2 (cont.)				
	g. The Program Assistants will submit a report on both the location of the community outings and attendance for all clients to the Clinical Director quarterly.				10/25/13
	h. The Program Assistants, Residence Manager(s), Senior Psychiatric Technicians will monitor all clients for opportunities for monthly community skills trips.				10/20/13
	i. Program Management will provide random monitoring for compliance and document on the 24-Hour Report. Re-training and instruction will be provided as needed with corrective action taken as indicated.				10/26/13
	j. A comprehensive report on the types and frequency of Community Outings completed by the Rehabilitation Therapists will be scheduled for review at the Clinical Quality Management Committee.				10/25/13
	W136 #3 (cont.)				
	b. The Program Assistant will monitor the "On/Off Grounds Activity Trip Sheets daily to ensure that all 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 Review.				10/24/13
	e. The Program Assistant will monitor each annual assessment for compliance.				10/24/13
	f. The IPC will monitor each client's progress in the area of money management on a monthly basis and forward any lack of progress or participation to the Program Director for resolution.				10/25/13
	g. All ICF clients' IPPs are reviewed monthly by the IPC and addressed with the ID Team where appropriate.				10/25/13
	h. Any program changes will be elevated to the Program Management by the Residence Manager.				10/25/13

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W 136	Continued From page 61 interview, we don't have enough staff to do that. 4. During an observation on 9/25/13 at 11 AM in Residence 23 with the Residence Manager (RM), five client's bedrooms areas were observed not containing visual items (personal items of a client placed in his living space) to indicate the occupants of each bed. During the tour the RM stated that the clients had recently been transferred to Residence 23. The staff had not put up the personal items of the clients in their living area. She further stated that the latest client that got transferred to the residence was about two months ago.	W 136	W136 #4 a. The Residence Manager and identified Shift Supervisor will work with staff who know each client the best, to ensure that each client's room is personalized with items that they would most enjoy. b. All Residence Managers and Rehabilitation Therapists will complete the necessary paperwork to shop for personalized items. c. Plant Operations will safely secure the items to the wall as appropriate. d. All Shift Supervisors will monitor the environment in each bedroom and living room and document observational findings on the Shift Supervisor rounds sheet.	10/25/13	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to protect and ensure the rights of clients to retain and use appropriate personal possessions and clothing. The facility further failed to implement their policy titled Clients' Personal Property that instructs personal property shall be itemized and posted to the Client's Personal Property Card, Form DS 5269. This affected seven of 10 sampled and four focused clients. (Clients 1, 29, 17, 37, 43, 47, 64, 69, 77, 79, 94) Findings:	W 137	e. All Residence Managers will monitor the daily Shift Supervisor Rounds Sheets and resolve any identified issues. f. Shift Supervisor and Residence Manager Rounds sheets will be submitted to the Program Office weekly for monitoring of identified issues and resolution. g. Any identified action items on the Shift Supervisor Rounds Sheet or Residence Manager Rounds Sheet will be addressed during monthly Risk Management Meetings. h. Please see cont. page 69a	10/25/13	

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W 137	Continued From page 62 1. The facility failed to implement Clients' Personal Property policy and procedure which indicated clothing and personal property shall be itemized and posted to the Client's Personal Property Card, Form DS 5269. The policy directs that the Residence Manager shall ensure procedures are followed and a current personal property card shall be maintained for each client. Items shall be marked and the personal property card identifying the brand name, model, size and serial number. The policy did not indicate that changes of residence must be noted and the property inventoried per the legend on the Personal Property Card. Auditing procedures were not implemented to maintain the integrity of personal property and their records. Staff interviews conducted 9/18/13 at 11:30 AM and 9/19/13 at 9 AM were inconsistent regarding the documentation of client belongings. They were unaware of how long the property cards should be kept, if gifts, purchases and donated items belonging to the clients should be inventoried. For example: a. Client 47's property card indicated he had on 11/20 = TOYS, 11/20 = RADIO, 6/12 = TABLETOP GAMES, 6/12 = WALKMAN, 6/12 = PHOTOBOOK. There was no year shown on the property card entries and staff were unable to show where these personal items were. There was no notation on the property card if items were lost or condemned, and the descriptions were not accurate, i.e. TOYS, RADIO.	W 137	W137 #1 a-e a. The Property Cards for the identified clients have been updated and corrected to reflect accurate information by the Residence Manager(s). b. The Property Cards for all clients identified have been updated and corrected to reflect accurate information by the Residence Manager(s). c. The Client Property Card for all clients will be filed in the Clinical Record under section 3. d. Residence Manager(s) provided training to staff on duty on Administrative Directive 276, Client's Personal Property. e. The Residence Manager/designee will conduct a random audit of Property Cards for 50% of clients on the residence quarterly to check for compliance with the AD, document the audit, provide corrective action where necessary, and identify issues on the Residence Manager Rounds Sheet (if any). f. Program Management will monitor the Residence Manager rounds sheet for the audit and conduct a random audit of Client Property Cards on each ICF residence at least quarterly and document on the 24-hour report.	10/26/13 10/26/13 10/25/13 10/26/13 10/26/13 10/26/13

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W 137	Continued From page 63 b. Client 37 trust account revealed withdrawal amounts of \$49.00 on 1/3/13 for DVD's not listed on the property card, \$100.00 on 3/1/13 at the Music Store with no documentation on the property card and \$75.00 on 3/14/13 at Mo's Music with no inventory listing. There was a note of "Christmas Gifts" in July without other description. c. Client 69's room was devoid of any personal items. Review of Client 69's record revealed his Clothing and Property Card was blank. d. Client 17 had a 1:1 staff helping him pack his room to move to the community and numerous personal belongings including a TV, VCR and approximately 50 DVD's which were not listed on his property card. e. During an interview with the Residence Manager (RM) on 9/24/13 at 8:50 a.m., he stated that property cards were kept in the residence located inside room 16's file cabinet. According to the RM, he was responsible for reviewing and approving the Property Orders and Receipt. Once he signed, it will be sent to the program office for another approval. The Property Orders and Receipt will be sent to the trust office for another review and approval. Once approved, purchase will be made for the requested items and the receipt of the purchase will be sent to the trust office. The items or properties purchased will be sent to the clothing center to be marked and inventoried. During observation on the same day at 9 a.m. in room 16, multiple folders containing property cards were noted. Core sampled client 43 and	W 137	W 137 #1 a-e cont. g. The PD 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		

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W 137	<p>Continued From page 64 64's property card was observed.</p> <p>The Property Order and Receipt, Client 's Personal Clothing Record, and Client's Personal Property Card of core sampled client 43 were reviewed on the same day at 9:15 a.m. The Property Order and Receipt indicated that a request for \$250.00 was made on 10/13/08 and approved by the trust office on 10/23/08 to purchase several items (four pants, 2 shirts, 2 sweatshirts). The Client's Personal Clothing Record indicated that the last entry made was in 11/26/08. The Client 's Personal Property Card indicated that the last entry made was in 12/7/07. There were no other current documented requests found in the folder to purchase any items.</p> <p>The Property Order and Receipt, Client's Personal Clothing Record, and Client's Personal Property Card of core sampled client 64 were reviewed on the same day at 9:25 a.m. The Property Order and Receipt indicated that a request for \$150.00 was made on 2/11/13 and approved by the trust office on 2/13/13 to purchase several items (electric razor, backpack, insulated lunch bag, two hats, and storage container). The Client 's Personal Clothing Record indicated that the last entry made was in 11/26/08. There were no other current documented requests found in the folder to purchase any properties.</p> <p>During an interview with Psychiatric Technician 1 (PT 1) on 9/24/13 at 8:50 a.m., she stated that she was not sure where the properties of core sampled client 43 and core sampled client 64 were.</p>	W 137			

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W 137	<p>Continued From page 65</p> <p>During an observation on the same day and time with PT 1 in core sampled client 64's bedroom, the following items were noted inside his closet: folded underwear inside a drawer, five shirts hanging, and multiple folded white shirts. An observation was also conducted inside the client's bathroom, and the items purchased on 2/13/13 were not located.</p> <p>During an interview with Psychiatric Technician 2 (PT 2) on the same day at 9:17 AM, he stated that he was not able to locate the items purchased for core sampled client 64, except for his electric razor which was found in the property room.</p> <p>During an interview with the Patient Benefit Insurance Officer on 9/25/13 at 1:39 PM, she stated that she was in-charge of the client's trust account. According to her, she was the one who signs-off on request and purchases for clients. She also stated that any purchases made for the client should be documented in the property card. When she was shown core sampled client 64 Client's Personal Property Card where purchase was made on 2/13/13, she stated, "Based on the record, it couldn't be identified whether it was received or not." She was asked if there were any other recent purchases made for core sampled client 43 and 64, she stated that she will check the record and will return with receipts.</p> <p>The Property Order and Receipt for core sampled client 43 provided by the Patient Benefit Insurance Officer as reviewed on 9/25/13 at 3:30 p.m. The review indicated that there were purchased made for core sampled client 43 on 11/7/12, 4/29/13, 5/31/13, and 8/28/13. Multiple items purchased on those dates were not</p>	W 137		

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W 137	<p>Continued From page 66</p> <p>documented or listed in core sampled client 43 Client's Personal Property Card nor observed in his bedroom or property room.</p> <p>The Property Order and Receipt for core sampled client 64 provided by the Patient Benefit Insurance Officer as reviewed on 9/25/13 at 3:40 p.m. The review indicated that there were purchased made for core sampled client 43 on 10/15/12, 11/28/12, 2/19/13, 4/3/13, and 9/5/13. Multiple items purchased on those dates were not documented or listed in core sampled client 64 Client's Personal Property Card nor observed in his bedroom or property room.</p> <p>The facility policy and procedure titled "Client services - 276: Client's Personal Property dated 10/25/07 reviewed on 9/26/13 at 10:45 a.m., indicated, "2. GENERAL PURCHASING, 2.1 Residence Manager...2.1.5 Maintain a current personal property card for each client. Items such as TVs (Televisions), VCRs (Video Cassette Recorders), and razors must have a notation on the personal property card identifying brand name, model, size, and serial number."</p> <p>f. During a review of Client 77's personal property card, it was noted that it didn't properly reflect his personal property inventory and it listed his last purchase had been made back in 2012.</p> <p>During an interview with a recreational staff member on the morning of 9/25/13, she stated that just recently at the L.A. County fair the client had purchased a hat. She said that she believed after a purchase was made, all copies of the "RESIDENTS' PROPERTY ORDER AND RECEIPT" went the trust office, followed by the pink copy being sent back to the residence. She</p>	W 137	<p>W137 1-f</p> <p>a. The Property Card for Client 77 has been updated to account for all recent purchases.</p> <p>b. The Property Cards for all clients identified have been updated and corrected to reflect accurate information by the Residence Manager(s).</p> <p>c. The Client Property Card for all clients will be filed in the Clinical Record under section 3.</p> <p>d. Residence Manager(s) provided training to staff on duty on Administrative Directive 276, Clients Personal Property.</p> <p>e. The Residence Manager/designee will conduct a random audit of Property Cards for 50% of clients on each residence quarterly to check for compliance with the AD, document the audit, provide corrective action where necessary, and identify issues on the Residence Manager Rounds Sheet (if any).</p> <p>f. Program Management will monitor the Residence Manager rounds sheet for the audit and conduct a random audit of Client Property Cards on each ICF residence at least quarterly and document on the 24-hour report.</p> <p>g. See continuation page 68a.</p> <p>W137 #1-g</p> <p>a). The Property Card for Clients 79 and 94 have been updated to account</p>	<p>09/26/13</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>09/26/13</p>

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W 137	Continued From page 68 the client's property card. The facility policy and procedure titled, "Client's Personal Property" dated 10/25/07, was reviewed on 9/25/13. The policy indicated, "2.1.5 Maintain a current personal property card for each client..." 2. On 9/18/13 and 9/19/13 focus sampled Client 53 was observed to be wearing pants that were so long that the pant legs were underneath the heels of his shoes as he walked. On 9/23/13 at 8:35 AM, Client 77 emerged from his room with pants that were approximately five to six inches above his ankles. A residence staff member asked him to go change his pants because they were too short. He complied but changed into a pair that the pant legs were so long that he stepped on them as he walked. On 9/23/13 at 8:40 AM, residence staff acknowledged the lack of proper fitting pants in Client 77 's possession. The following morning of 9/24/13 at 9:35 AM a residence staff member was observed at the Fashion Center ordering pants for Client 77. She said Client 77 hadn 't come to the Fashion Center with her to choose pants for himself because he had gone to work that morning.	W 137	W137 #2 a) Appropriate fitting clothing was offered to both Client 53 and 77 when it was determined that the length of the pants were ill-fitting. b) For all clients that have either gained or lost weight in the past year, request made with clothing center staff to re-measure to ensure a proper fit. c) When going to clothing center, staff will ensure that Client 53 and 77 are encouraged to pick out their own clothes, and staff will assist as needed to ensure proper fit. Shopping trips with the Rehabilitation Therapist to purchase clothing of their choice will continue. d) All Shift Supervisors will monitor that all clients are dressed with dignity 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. (Please see continuation page 69a.)	09/16/13 10/25/13 10/25/13 10/25/13	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148			

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	W137 #2 (cont.)				
	e) All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that clients' clothing is well fitted and appropriate for the weather and activity, 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 and submit to the Program Director weekly.				10/25/13
	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.				10/25/13

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W 148	Continued From page 69 This STANDARD is not met as evidenced by: Based on review of a GER (General Event Report) the facility failed to ensure that a client's parent was notified of a significant incident for emergency chemical restraint usage in a timely manner for one of 10 sampled clients (Client 94). Findings: On 9/24/13, during review of a GER for Client 94, the "Event Information" indicated the following: 7/1/13: Late Entry for 6/21/13. Client became "uncontrolled," SIB (self injurious behavior) and difficult to redirect. The client was agitated and attempted to hit himself in the face, kicking at staff ... Two point soft ties (restraints) were applied to both arms. The physician ordered ... Zyprexa Zydis (antipsychotic) for severe agitation and SIB. The General Event Reports (GER) dated 4/19/13 to 9/15/13 was reviewed on 9/20/13 at 10:30 a.m. The reviews indicated: a. Incident dated 5/19/13(GER - LDCA-B7N3EWV77D); the conservator was not informed promptly of the client 's skin discoloration to the upper left inner thigh posteriorly measuring 8x3 centimeters. The conservator was notified on 5/20/13. b. Incident dated 7/20/13 (ERI# 363484); the legal guardian was not informed promptly that the client fell off the shower chair. The conservator was notified on 7/22/13. c. Incident dated 8/15/13 (ERI# 366362); indicated that the legal guardians was not notified promptly that during the shower, the client attempted to stand off the shower chair and fell	W 148	W148 a-c a) Residence Manager provided training to staff on duty on General Event Report (GER) to be generated for each use of stat medication for behavioral episodes. b) Program Director reviewed the family notification requirements with the Program Social Workers. c) The conservator for client 94 and 91 was notified of the use of stat medications on 7/9/13. This was a late notification as noted on the General Event Report. The conservator was informed that this was a late report at the time of the notification. d) A family notification checklist has been updated and made available to staff on the residence indicating the families who wish notification; how they prefer to be notified and under what circumstances and the method of notification. The Residence Manager reviewed the content and location of this information with staff on duty. e) The Program Director/designee will review all GER to ensure all notifications have been made. f) Program Directors will bring any systems issues/ unresolved concerns to the attention of the Governing Body via the Clinical Quality Management Committee.	10/26/13 10/25/13 10/26/13 10/25/13 10/25/13 10/25/13	

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W 148	Continued From page 70 landing on his buttocks.	W 148			
W 149	Documentation indicated that the family / guardian was notified on 7/9/13 at 1:15 PM, eighteen days (18) days after the incident. 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to implement its procedures requiring notification to outside entities of incidents in accord with facility policy. This occurred for one injury of unknown origin investigated as part of a death review and one allegation of neglect that was reported during the time parameter of 4/17/13 through 9/27/13. This affected one decedent, Client 97 and two focus sampled clients, Clients 66 and 92. The facility failed to implement procedures to ensure two focused clients were supervised according to the identified RISKS outlined in the Client 13's Approaches and Strategies dated 8/20/13, as a result Client 13 was not supervised and assaulted a focus sampled client, Client 89, with a wooden stick causing distress and multiple injuries. The facility failed to provide the supervision necessary to avoid physical and psychological harm to Client 89. The facility failed to identify a pattern of unknown injuries and two unwitnessed assaults to regression and lack of active treatment occurring for one focus sampled client. (Client 89).	W 149			

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W 149	Continued From page 71. Findings: 1. During review of the investigative file associated with the death of Client 97 on 9/18/13 commencing at 2:45 PM it was revealed the facility internally reported an injury of unknown origin on 1/4/13 that documented Client #97 was observed with a 15.5 cm x 7 cm purple discoloration and a 15.5 cm reddish to light purple bruise to Client 97's left thigh also described as warm to touch. Review of the General Event Report (GER) evinced the California Department of Public Health (CDPH) was not notified until 1/7/13. In an interview with the Licensing Coordinator on 9/25/13 at 8:35 AM, she explained the facility had developed a one page document related to injuries, events and notification requirements as a method for staff to use as a quick reference guide when the need to report such incidents occurs. Review of the reference sheet identified bruising, contusions, and/or hematomas 5 cm or greater, or any bruising to the head, neck, breasts, genitals or rectal/anal area as requiring completion of a "high" General Event Report (GER). Administrative Directive 124 entitled Incident/Unusual Occurrence Reports dated 4/15/11, was reviewed on 9/25/13 at 8:37 AM. Under " Office of Quality Assurance - Licensing Coordinator " it stated, " As directed by the Director of Quality Assurance, report the following occurrences by e-mail to the California Department of Public Health - Licensing and Certification - State Facilities Unit (CDPH) and by facsimile to the Regional Center Directors within	W 149	W149 #1 a. Administrative Directive 124: Incident/Unusual Occurrence Reporting was revised and changes approved by the Executive Committee on behalf of the Governing Body. The policy now includes the requirement for notification to CDPH within 24 hours of the incident for: injuries of unknown origin that meet CDPH reporting criteria and all allegations of abuse and/or neglect. b. Program Directors will notify the Director of Quality Assurance (DQA) or designee by phone of the incident. c. The DQA/designee will provide preliminary notification to CDPH via email- providing information about the incident. d. The Standards Compliance Coordinator will ensure that CDPH is notified on the next working day by sending an Event Summary Notification or equivalent. This procedure has been in effect for allegations of abuse and neglect since February, 2011. The preliminary notification (date, time, who made the notification) will be logged into the Therap system by Quality Assurance staff.	9/25/13 10/25/13 10/25/13 10/25/13	

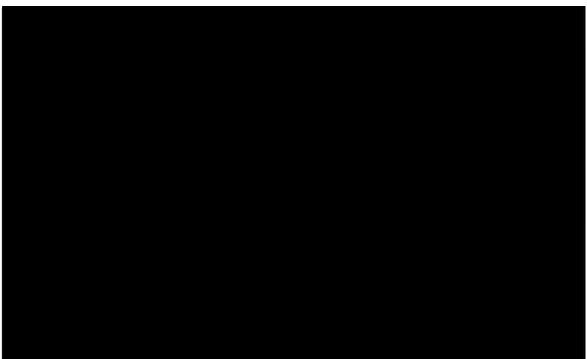
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W 149	Continued From page 72 24 hours, or the following workday if an incident occurs on a weekend or a holiday." One of the categories listed as requiring notification was serious injuries of known and unknown source. Per follow-up interview with the Director of Quality Assurance (DQA) on 9/25/13 at 11:35 AM, the DQA explained since the incident occurred on a Friday, the incident would not have needed to be reported until 1/7/13. Per, California Code of Regulations Title 22, Division 5, Chapter 8, Article 4, Section 76551 - Unusual Occurrences it listed " (a) Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or catastrophes and unusual occurrences which threaten the welfare, safety, or health of clients, personnel or visitors shall be reported by the facility within 24 hours either by telephone, with written confirmation or by telegraph to the local health officer and the Department." 2. On 9/23/13 commencing at 10:30 AM incident DS13-04-L-107-A was reviewed. The General Event Report (GER) and Office of Protective Services (OPS) investigative report were examined and it was revealed an allegation of failure to provide supervision was reported on 4/24/13 at 4:20 PM, wherein it was alleged Clients 66 and 92 were left unattended in their group living room. As a result, Client 92 was sent to the hospital for a precautionary x-ray to r/o possible ingestion of a foreign object [REDACTED]. During the course of the investigation it was determined the reporter did not notify the OPS until eighteen hours later. In an interview with the Licensing Coordinator	W 149	W149 #1 cont. e. The DQA will ensure this system occurs with a monthly audit of timely notifications completed by the QA Risk Manager and reviewed at the Daily Executive Risk Management Team (DERMT) meeting by the 10th of the following month. W149 #2 a. On the day the incident was reported, the IPC Supervisor ensured the reporting party called the Abuse Hotline to report the incident to OPS. b. Staff who had allegedly not supervised Clients 66 and 92 were reassigned to non-client care duties pending the outcome of the investigation. c. To ensure staff's understanding of Center policy related to incident reporting and reporting of alleged abuse/neglect, the IPC Supervisor provided training to the staff who made the late report of alleged neglect in AD 227: Alleged Abuse, Neglect or Exploitation, AD 226: Client Supervision and Personal Care, and AD 124 Incident/Unusual Occurrence Reports. d. The Standards Compliance Coordinator will monitor for staff compliance in timely reporting and report any concerns or issues to the individual supervisor and bring any systems issues to the attention of the Governing Body via the Clinical Quality Management Committee.	10/25/13 4/25/13 4/25/13 6/28/13 9/23/13

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W 149	<p>Continued From page 73</p> <p>(LC) on 9/25/13 at 8:35 AM, the LC explained though there was no specific time parameter for reporting incidents to OPS, Administrative Directive #227 required immediate notification to OPS.</p> <p>Review of Administrative Directive #227 dated 10/26/11, entitled Alleged Abuse, Neglect or Exploitation, on 9/25/13 at 8:37 AM revealed a section entitled "Reporting Requirements," which stated "After ensuring the safety of the client, staff must immediately make a telephone or verbal report of possible neglect or abuse to the Office of Protective Services (OPS) by dialing extension 888; this number will ring directly at the OPS station and if not answered by the officer, will roll over to communications staff, who will immediately notify the officer on duty."</p> <p>3. Observation on 9/24/13 at 9:30 AM revealed Client 89 laying in bed fully clothed with the lights out tearing pieces of paper and putting them into her purse. The bedroom door was closed, curtains drawn and there was no stimulus in the room such as TV or music playing .</p> 	W 149	<p>W149 #3</p> <p>a. 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.</p> <p>b. Residence Manager and Shift Supervisors provided training to all staff on duty on Administrative Directive 226: Client supervision levels.</p> <p>c. Residence Manager and Shift Supervisor provided training to all staff on duty on Administrative Directive 235: Individual Program Plan Implementation.</p>	09/24/13 09/24/13 10/25/13	

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W 149	Continued From page 74  The IPP indicated Client 89 was on Enhanced Supervision and should be on Line of Sight when "active" on the residence. The term "active" was not defined. Although, the IPP instructed staff to increase awareness of Client 89's whereabouts to protect her from harm, she was not receiving Enhanced supervision during the observation period. At 1:30 PM, the same day Client 89 was going through a closed door onto the residence patio in a wheelchair alone. A review of 10 General Event Reports were completed for the past eight months for Client 89, showing a pattern of unknown injuries and two unwitnessed assaults by other clients, once with a wooden stick by Client 13 who has a history of pre-mediated assaults on clients and staff. On six occasions Client 89 was discovered to have injuries of unknown origin with bruises up to 10 x 10 cm. On 5/27/13 at 7:43 AM, while in the dining room, Client 89 became unresponsive and stopped breathing. Staff initiated abdominal thrusts and she began breathing and was transferred by 911 to emergency room. Client 89 has a history of choking and no history of seizures. Further review of an assault on Client 89 by Client	W 149	W149 #3 cont. d. Residence Manager to monitor residence daily to ensure client safety and that staff are knowledgeable and compliance with client supervision levels. e. Shift Supervisor will complete daily rounds utilizing the Shift Supervisor Rounds Sheet and submit weekly to Residence Manager. f. Any identified action items on the Shift Supervisor or Residence Manager Rounds Sheets will be addressed at monthly Risk Management Meetings then elevated to EC committee for any unresolved issues.	10/25/13 10/25/13 10/25/13	

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W 149	<p>Continued From page 75</p> <p>13 with a wooden like stick on 8/21/13 between the hours of 9:30 AM and 11:30 AM revealed both clients were left unsupervised with no active treatment programming resulting. .</p> <p>Client 13's Approaches and Strategies dated 8/20/13 identified [REDACTED]</p> <p>[REDACTED] Staff</p> <p>are to ensure well-being and safety of peers, ensure she is in visual range and sufficient proximity to provide immediate intervention.</p> <p>[REDACTED]</p> <p>At 11:30 AM, Client 89 was in her bedroom when her peers and staff returned from lunch and was</p>	W 149			

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W 149	Continued From page 76 discovered to be distressed and have six multiple linear scratches up to 10 cm long on her face and trunk. Client 13 admitted to the assault and was found with an object described as a "wooden like stick." The facility investigation was substantiated for assault based on the circumstances, Client 13 caused Client 89's injuries and therefore violated the facility policy for Client Abuse. However, the facility investigation determined no violations of neglect related to staffing. The facility failed to ensure two clients were supervised according to the identified RISKS outlined in Client 13's Approaches and Strategies dated 8/20/13 and as a result Client 13 was not supervised and assaulted Client 89 with a wooden stick causing distress and multiple injuries. The facility failed to provide the supervision necessary to avoid physical and psychological harm to Client 89.	W 149			
W 150	483.420(d)(1)(i) STAFF TREATMENT OF CLIENTS Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one focus sampled client was not subjected to sexual abuse by a staff member. (Client 98) Findings: 1. During a full survey of the facility, entity	W 150			

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W 150	<p>Continued From page 77</p> <p>reported incident 332312, which was initiated in November 2012 and remained an open investigation was included as part of the review of the facility's system to prevent abuse, neglect and mistreatment.</p> <p>On 11/7/12 at 2:20 PM, an unannounced visit was made to the facility to investigate an entity reported incident of a focus sampled client 98, who was noted to have a genital injury of an unknown origin on 11/6/12.</p> <p>During an interview with the Director of Quality Assurance (DQA) on the same day and time, she stated that the client resided in Residence 21.</p> <p>[REDACTED]</p> <p>She also stated that four staff members (Psychiatric Technician 1 (PT 1), Psychiatric Technician 2 (PT 2), Psychiatric Technician Assistant 1 (PTA 1), and Psychiatric Technician Assistant 2 (PTA 2) from the night shift were removed from client's contact. She further stated that the case was transferred to California Highway Patrol (CHP) by the Office of Protective Service (OPS) for a criminal case investigation.</p> <p>During an observation on 11/7/12 at 3:20 PM in Residence 21, focus sampled client 98 was observed in her bed, located in room [REDACTED] Room [REDACTED] was shared by focus sampled client 98 and two other clients divided by a partial wall. Focus sampled client 98's bed was located near the door entrance of the room, while the two other beds for clients were located behind a partial wall separating the space.</p>	W 150	<p>a. Client 98 was examined by the residence physician who determined that a possible sexual assault may have occurred. Office of Protective Services/Investigators were notified. Client 98 was escorted [REDACTED] [REDACTED] sexual assault response unit for further examination. Residence Psychologist and staff who care for Client 98 provided ongoing assessment to monitor for any adverse outcomes based on the injury.</p> <p>b. Program 2 Management increased NOC rounds for Res 21. A summary of the completed rounds was sent to the PD/CD for review.</p> <p>c. Program Management, Administrative staff and Quality Assurance staff increased Protection from Harm rounds on all residences.</p> <p>d. The OPS Commander contacted the local DOJ - Elder Abuse Hotline office to report incident, via voicemail.</p> <p>e. The Office of Protective Services (OPS) Commander informed Executive staff that the CHP Investigative Unit would take the lead in the Criminal Investigation and OPS would conduct an Administrative Investigation concurrently.</p> <p>f. The Program's Health Services Specialist initiated a review (11/7/12) of all recently opened medical conditions related to the perineal area, such as rashes, impaired skin integrity, and urinary tract infections to</p>	<p>11/6/12</p> <p>11/6/12</p> <p>11/6/12</p> <p>11/7/12</p> <p>11/7/12</p> <p>11/21/12</p>

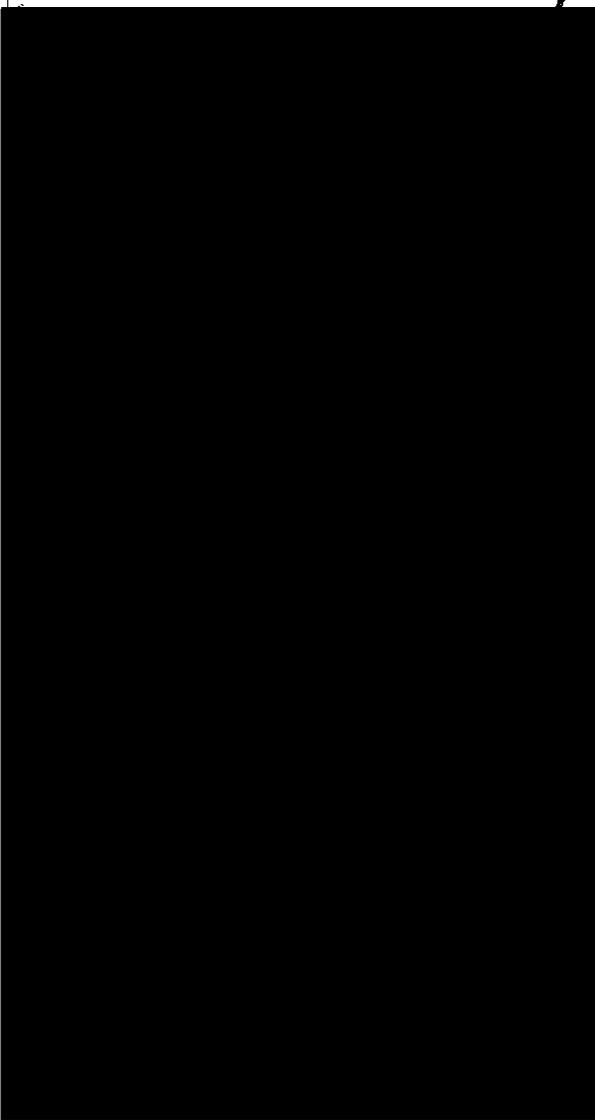
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W 150	<p>Continued From page 78</p> <p>During an interview with focus sampled client 98 on the same day and time, she was unable to respond verbally when asked how she was feeling.</p> <p>During an interview with the Residence Manager (RM) of Residence 21 11/7/12 at 3:40 PM, he stated that Psychiatric Technician 3 (PT 3) discovered the laceration in the vaginal area of focus sampled client 98 while conducting perineal care on the morning of 11/6/12. PT 3 immediately reported to the Health Service Specialist. Focus sampled client 98 was examined by the residence physician and determined a possible sexual assault.</p> <p>An 888 (facility's abuse hotline) number was dialed by staff to make an initial report of the possible sexual abuse. Focus sampled client 98 was transferred to the community hospital on 11/6/12 for a sexual assault examination. The RM stated that four night shift staffs (three-males and one female) were removed from client's contact. Four other female clients in the residence were examined by the residence physician for possible sexual assault and the 13 male clients will be examined as well, according to the RM.</p> <p>During an interview with the CHP Investigator assigned to the case on 11/15/12 at 2:28 PM, he stated that their department took over the case of focus sampled client 98 on 11/7/12. According to the CHP Investigator, they had collected evidence including the SART (Sexual Assault response Team) kit, which will be processed in [County Crime Laboratory's name]. He also stated that they had not conducted any interviews yet and advised the surveyor to hold off on interviewing</p>	W 150	<p>W150 cont.</p> <p>determine any areas of concern. A summary indicating no abnormal findings were observed was provided to the PD/CD.</p> <p>g. QA Risk Manager completed an Incident Report review for all injuries occurring on Residence 21 for the previous 6 months and then reviewed facility wide injuries for all clients.</p> <p>h. The Program 2 Program Assistant reviewed the Program Injury/Fall Log, identifying types of injuries that had been documented on this residence (11/7/12), which was distributed to members of the Daily Executive Risk Management Team (DERMT). Findings of no issues related to special medical conditions were discussed at the DERMT meeting and during the Program's Risk Management Meeting.</p> <p>i. Special Risk Management Meetings were held beginning 11/7/12 in all Programs to review AD 124: Incidents and Unusual Occurrence, AD 227: Alleged Abuse, Neglect or Exploitation, AD 225: Client Supervision and Personal Care, and Quality Assessment and Performance Improvement Plan for Special Medical Conditions.</p> <p>j. Acting Clinical Director conducted rounds on Res. 21, and met with CDPH SFU licensing surveyor.</p> <p>k. Executive Director made rounds on residence 21.</p> <p>l. Residence HSS and Physician completed physical examinations</p>	11/7/12 11/7/12 11/16/12 11/20/12 11/30/12 11/7/12 11/8/12 11/8/12 11/15/12	

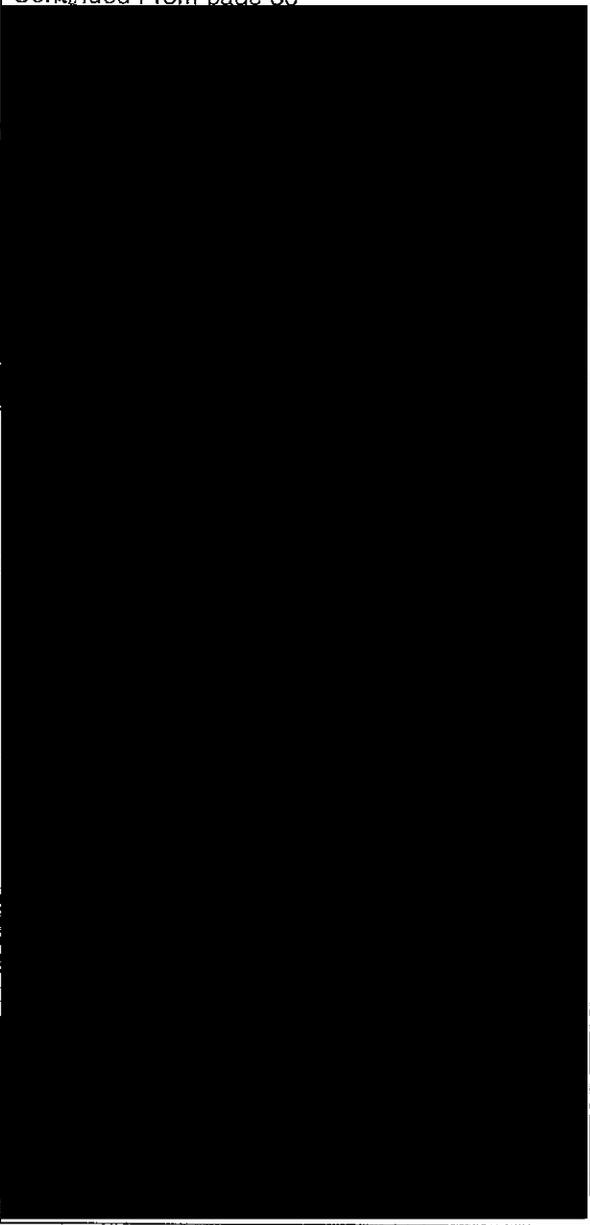
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W 150	Continued From page 79 anyone that might had any involvement in the case. 	W 150	<p>W150 cont.</p> <p>to rule out any further potential victims on all clients living on Residence 21. The Physicals were completed on the female clients first (11/8/12), followed by the male clients (11/15/12).</p> <p>m.Memorandum from Acting Clinical Director to all Program Managers, Residence Managers and Shift Supervisors re: heightened awareness by all staff regarding Protection from Harm (PFH) measures for all clients.</p> <p>n.The OPS Commander instructed the OPS Sergeant to have Police Officers initiate daily rounds on residences at random times of the day. These are logged on the OPS Police Daily Activity Log as well as the residence 24-Hour Report.</p> <p>o.The Director of Quality Assurance contacted the SART Nurse (SART) from PVCH to inquire if there were any recommendations regarding protection from harm.</p> <p>p.Program Management and Quality Assurance staff conducted rounds for the holiday weekend on each residence and each shift.</p> <p>q.The Individual Program Coordinator and Program 2 Management reviewed Interdisciplinary Notes and Nursing Assessments for all clients living on Residence 21 for the previous 6 months, with no unusual findings reported to the Program Director and Clinical Director. (Female clients' record review completed on 11/9/12.</p>	<p>11/8/12</p> <p>11/8/12</p> <p>11/9/12</p> <p>11/9/12</p> <p>11/16/12</p>	

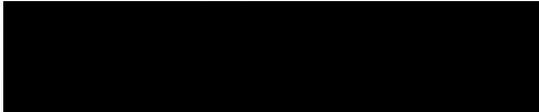
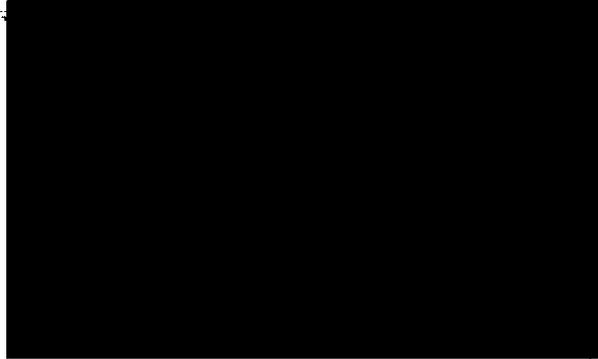
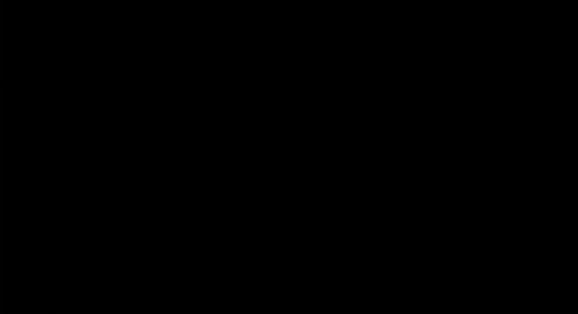
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W 150	Continued From page 80 	W 150	<p>W150 cont. Male clients record review completed on 11/16/12.) r.Enhanced Rounds by all Program Managers and Supervisors and Quality Assurance staff to all residences and all shifts on an ongoing, weekly random schedule. Identified issues are reported and elevated to Executive Committee members if resolution is needed. Rounds data has been collected and presented to the Clinical Director for review at the Clinical Quality Management Committee Meetings and the Quality Management Council Meetings.</p>  <p>t.Senior Supervising Psychologist reviewed strategies to assist individuals in dealing with sexual assault with the DERMT members and Executive Committee. u.A Special Team meeting was held to review Client 98's program plans and data collection, and modifications were implemented. v.Center-wide training on Protection From Harm scheduled for all staff in 3 separate training sessions. Curriculum was developed and two training sessions were held on 1/22/13 and two</p>	<p>11/13/12 11/13/12 11/14/12 11/16/12 11/19/12 11/28/12 1/22/13 2/21/13</p>	

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W 150	Continued From page 81    During an interview with the CHP Investigator on 12/20/12 at 10:02 AM, he stated that there were no DNA (Deoxyribonucleic Acid, a molecule that encodes a genetic makeup of living organism) test results available as of yet from the SART kit. He was not able to give a time frame as to when the test will be completed. He also stated that they had interviewed staff including PT 2, PTA 1, PTA 2, and another PT (PT 4), who was assigned to focus sampled client 98 before PT 1 took over her care.	W 150	W150 cont. additional sessions were held on 2/21/13. w. To improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective) and how those coincide with investigations by OPS by Disability Rights, California (DRC) Director, Investigations Unit and Senior Investigator. x. To further improve clinical staff's investigation skills: Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations (from the clinical perspective). y. The DQA and QA Program Assistant have sent out a Template to Residence Managers and acting Residence Managers to assist in the completion of the Level 1 Review/investigation process. z. Standards Compliance Coordinator (SCC) provided training on 10/25/13 to the facility's Managers and Supervisors re: expectations to investigate and/or analyze each incident, review findings, document the	2/14/13 5/1-2/13 12/26/12 10/25/13	

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W 150	<p>Continued From page 82</p> <p>According to the CHP Investigator, PT 2, PTA 1, and PTA 2 came into their office voluntarily for interviews, with the exception of PT 1. PT 1 refused to be interviewed and gave every excuse in the book according to the investigator. The Investigator did not want to provide details of their investigation until he interviewed PT 1.</p> <p>Although the case was still pending, he stated that he had gathered good information from the staff that were interviewed. He further stated that the investigator at the facility was told by the SART Nurse that it was sexual assault and they were notified by the facility investigator a day later after the incident. The Investigator requested the surveyor to continue holding off on the investigation until they were done.</p> <p>During an interview with the CHP Investigator on 1/25/13 at 1:03 PM, he stated that there were no DNA test results available. According to the Investigator, PT-1 refused to be interviewed until the DNA results came back.</p> <p>During an interview with the Compliance Officer of the community hospital on 1/28/13 at 1:10 PM, she stated that the SART Nurse who conducted the exam on focus sampled client 98 was contracted by the hospital. The records (Sexual Examination Report) were kept by the SART Nurse and had to be requested.</p> <p>The Sexual Examination Report dated 11/6/12 conducted by the SART Nurse was received and reviewed on 2/7/13 at 5 PM. [REDACTED]</p>	W 150	<p>W150 cont. action taken, and make recommendations to the next level of management to ensure that active treatment programs and supervision are provided and/or needed revisions to plans are identified.</p> <p>aa) The Office of Quality Assurance will monitor all generated General Event Reports (GER) for complete and thorough investigations daily. Any issues will be brought up to Program Management and Exective Management at the Daily Executive Risk Management Team meeting (DERMT) for corrective action as warranted.</p> <p>bb) The four staff who had worked on the night shift prior to the discovery of the injury were reassigned to non-client care duties pending the outcome of the investigation.</p> <p>cc) The Office of Protective Services administrative investigation was initiated in August 2013 upon receipt of the completed California Highway Patrol case. The OPS investigation included a review of historic information related to the alleged perpetrator's prior work assignments compared with incident data and was completed on October 17, 2013.</p> <p>dd) Supervising Investigator provided training to OPS Investigators re: expectations for requests of historical reviews of subjects identified in administrative investigations and</p>	10/6/12 10/17/13 10/30/13	

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W 150	<p>Continued From page 83</p>  <p>During an interview with the CHP Investigator on 2/28/13 at 11:58 AM, he stated that he had not received any results from the crime laboratory for the DNA test results. He also stated that the investigation was on-going while waiting for results. He further stated that the turn-around time for DNA test results was around eight months.</p> <p>During an interview with PTA 2 on 3/14/13 at 10:16 AM, she stated that she was removed from client's care on 11/7/12 and she had been working in the training office since 11/9/12. She also stated that she volunteered to work in Residence 21 on 11/5/12 during NOC shift (night shift) as a PTA. She was assigned on a 1:1 observation with another client by the shift lead (PT 1). According to her, she didn't have any contact with any client that night (11/5/12 thru 11/6/12) except for the one she was assigned to.</p> <p>There were four staff in the residence during NOC shift including her and three of them were floaters, except for PT 1. She had worked in the residence twice for overtime. She denied knowing focus sampled client 98 nor the room where she was located at. She also stated that it was quiet on the night of 11/5/12, there was no screaming and she did not notice anything unusual on staff or clients. PTA 2 voluntarily went to CHP office for an interview.</p> <p>During an interview with PT 1 on 3/14/13 at 11:47 AM, he stated that he currently worked in the main kitchen of the facility. PT 1 was</p>	W 150	<p>W150 cont. weekly written updates from investigators on administrative tasks completed on investigations while criminal investigations are conducted. ee) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an investigation so that it is included as part of the investigative process.</p>	10/25/13
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W 150	<p>Continued From page 84</p> <p>accompanied by a union representative. He stated that he retained a lawyer and refused to be interviewed.</p> <p>During an interview with the Standard Compliance Coordinator (SCC) on 8/6/13 at 10:15 AM, she stated that PT 1 passed away about two months ago due to his medical condition. An attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>During an interview with the CHP Investigator on 8/6/13 at 11:05 AM, he stated that they finally concluded their investigation. The DNA test results came back negative and could not be linked to any staff investigated. He also stated that even though the DNA test came back negative, it did not mean that focus sampled client 98 was not sexually assaulted. He further stated that their "suspect" (PT 1) died of a medical condition.</p> <p>During an interview with the SART Nurse on 9/9/13 at 2 PM, she confirmed the findings on the Sexual Examination Report dated 11/6/12. She stated that the injury of focus sampled client 98 was consistent with sexual assault. She also stated that the injury was not consistent with "cleaning her area" because there was a certain degree of force applied to the area. She further stated, "It was some type of blunt force trauma, but I cannot tell what."</p> <p>During an interview with the SCC on 9/9/13 at 10:30 AM, she stated that the sign-in sheet for 11/5/12 indicated that PT 1 was in-charge on NOC shift and was also the medication person. PT 2 was assigned on the left side of the</p>	W 150		
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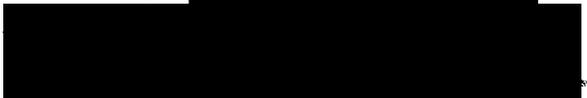
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W 150	<p>Continued From page 85</p> <p>residence hallway, PTA 1 was assigned on the right side of the residence hallway, and PTA 2 was assigned to a 1:1 observation. Another attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>The Daily Time Record for the morning shift and night shift dated 11/5/12 was reviewed on 9/9/13 at 10:45 AM. The review confirmed what the SCC stated regarding assignments of staff on 11/5/12 during NOC shift. The review also indicated that PT 1 reported to work in Residence 21 at 2:30 PM on 11/5/12 and continued to work until 7 AM on 11/6/12 for overtime. The review further indicated that PT 4 reported to work on 11/5/12 at 2:30 PM in the residence.</p> <p>During an interview with PT 3 on 9/9/13 at 11:30 AM, she stated that she worked on the morning shift of 11/5/12 and 11/6/12 assigned to group 4 where focus sampled client 98 was part of the group.</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	W 150			

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W 150	Continued From page 86  The HSS arrived in the residence when PT 3 was transferring focus sampled client 98 from shower chair to bed. Drops of blood were observed on the floor by PT 3. The HSS conducted an assessment and noted a laceration on the perineal area, between the rectum and vagina of focus sampled client 98. The residence physician was notified and arrived in the unit shortly to assess the client. PT 3 stated that the residence physician stated that focus sampled client 98 was sexually assaulted. She stated that the residence physician seemed to be sure of it when he said it. PT 3 was upset after hearing the residence physician. PT 3 stated that PT 1, PT 2, PTA 1, and PTA 2 were working on the NOC shift of 11/5/12. PT 1 was in-charge of the NOC shift and clients were assigned on the left and right side of the hall. PT 3 stated that PT 1 was in-charge of the front hall and focus sampled client 98. PTA 1 was on the right side and PT 2 was assigned on the left side of the hallway. PTA 2 was assigned to a 1:1 observation, located on the left side of the hallway. PT 3 stated that there was no sexual abuse in the past that she knew of involving staff or clients in Residence 21. 	W 150			

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W 150	<p>Continued From page 87</p>  <p>PT 3 explained that management did not have a live interaction with PT 1 and did not pick up on his issues. Focus sampled client 98 was very comfortable and very familiar with PT 1. According to PT 3, focus sampled client 98 likes attention from men. She was very playful especially with men.</p> <p>During a re-interview with the RM of Residence 21 on 9/9/13 at 12:30 PM, he stated that focus sampled client 98 was on general supervision on 11/5/12 during NOC shift. PT 1 was assigned to focus sampled client 98 on the night of 11/5/12 and had full access to the client.</p> <p>The RM was notified by PT 3 on the morning of 11/6/12 that focus sampled client 98 was bleeding from the vaginal area. He confirmed the findings of PT 3 and the residence physician was notified, who re-assessed focus sampled client 98. The residence physician felt that there was some sort of violations, sexual in nature according to the RM.</p> <p>The RM stated that the floaters (PT 2, PTA 1, and PTA 2) had never been involved with any type of abuse in the residence. He was not aware of any inappropriate contact by PT 1 to any staff or</p>	W 150			

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W 150	<p>Continued From page 88</p> <p>clients and was not aware of him being stressed out. The RM was unable to characterize PT 1's interaction with clients, because according to him, he (PT 1) always works nights.</p> <p>According to the RM, he did not believe the residence physician's finding and did not formulate any suspicion at the time. He was in disbelief that something had happened. He also stated that [focus sampled client 98's name] did not have SIB. He did not believe that focus sampled client 98 would hurt herself that way.</p> <p>The RM mentioned that PT 1 told him that he was in focus sampled client 98's room on the night of 11/5/12 [REDACTED] PT 1 told him, "She was fine when I left." PT 1 also talked to him about being stressed out and CHP Investigators wanting to talk to him. PT 1 told the RM that he hired a lawyer because he did not trust the system. The RM also stated, "I felt that one of the staff accidentally harm the client, and instead of admitting it, they left it."</p> <p>During an interview with PTA 1 on 9/9/13 at 1:25 PM, he stated that he had worked many times in Residence for overtime. On the night of 11/5/12, he was covering the right side of the hallway. He stated that PT 1 was assigned to focus sampled client 98 during NOC shift of 11/5/12.</p> <p>PTA 1 mentioned that he did not have any contact with focus sampled client 98 and did not notice anything unusual during NOC shift on 11/5/12. He did not see anyone go in and out of the client's room when he made his rounds. Focus sampled client 98 was in room [REDACTED] with two other clients and she was observed sleeping at 11 p.m. on 11/5/12, before 1 a.m., 3 a.m., and 5 a.m. on</p>	W 150			

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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		
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W 150	<p>Continued From page 89 11/6/12. However, he observed PT 1 inside focus sampled client 98's room a little bit after 5 a.m. on 11/6/12.</p> <p>PTA-1 denied assaulting focus sampled client 98. He voluntarily went to CHP office for an interview. He stated, "I have a family member who had disability also and I would not abuse anyone who has a disability." PTA 1 was removed from client's contact after receiving a phone call from the Program Director on 11/6/12.</p> <p>During an interview with PT 2 on 9/9/13 at 2:15 PM, he stated that during NOC shift on 11/5/12 he was covering the left side of the hallway where focus sampled client 98's bedroom was located. According to PT 2, he had only worked twice in the residence for overtime.</p> <p>PT 2 denied knowing focus sampled client 98 and her room and stated that she was not one of the clients assigned to him on 11/5/12. He stated that he conducted 30 minutes check on clients, randomly throughout the night. PT 2 did not observe anyone entering or leaving focus sampled client 98's room. He did not hear any commotion in the room either, according to him.</p> <p>PT 2 did not know most of the clients in the residence. He stated that he did not change or take care of focus sampled client 98 the night of 11/5/12, because he had no reason to. He voluntarily went to CHP office for an interview and expressed to CHP Investigators that he had nothing to do with it. He stated, "If you want DNA, I'm willing to give it at anytime." PT 2 stated, "I wished that I never did overtime in Residence 21 on 11/5/12."</p>	W 150			

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W 150	Continued From page 90  PT 1 expired on 6/25/13 due to septic shock as an immediate cause of death, according to the Certificate of Death.	W 150		
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W 150	Continued From page 91 The facility policy and procedure titled "Client Services - 227: Alleged Abuse, Neglect or Exploitation" dated 10/26/11, reviewed on 9/25/13 at 4:20 p.m. indicated, "1. POLICY - Any neglect, abuse, or exploitation by any person, whether staff, visitor, volunteer, student, family, or other clients, is prohibited....Training:....All staff shall receive training to assist in the prevention of abuse, neglect, mistreatment and misappropriation of property as well as client abuse reporting procedures..." The review also indicated, "2. DEFINITIONS - 2.3 Sexual Abuse - Sexual contact that results from threats, or fear, and involving range of activities, including, but not limited to, assault, rape, molestation sexual harassment."	W 150			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure incidents were reported to outside entities in accordance with State law for one death and one of six allegations of abuse, neglect, mistreatment or exploitation that occurred during the time parameter of 4/17/13 through 9/27/13. This affected one decedent, Client 97 and two focus sampled clients, Clients 66 and 92. The facility also failed to ensure that the	W 153			

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W 153	Continued From page 92 Administrator was notified timely of chemical restraint usage for self injurious behaviors for one of 10 core sampled clients (Client 94) and failed to ensure that the Department of Public Health was notified of bruises or injuries of unknown origin timely for one of 10 core sampled clients (Client 94) and four focus sampled clients (Clients 95, 32, 13, and 59). Findings: 1. During review of the investigative file associated with the death of Client 97 on 9/18/13 commencing at 2:45 PM it was revealed the facility internally reported an injury of unknown origin on 1/4/13 that documented Client 97 was observed with a 15.5 cm x 7 cm purple discoloration and a 15.5 cm reddish to light purple bruise to Client 97 ' s left thigh also described as warm to touch. Review of the General Event Report (GER) evinced the California Department of Public Health (CDPH) was not notified until 1/7/13. In an interview with the Licensing Coordinator (LC) on 9/25/13 at 8:35 AM to discuss reporting procedures for outside entities the LC explained the facility had developed a reference sheet to assist staff in the reporting of incidents. Administrative Directive 124 entitled Incident/Unusual Occurrence Reports dated 4/15/11, was reviewed on 9/25/13 at 8:37 AM. Under " Office of Quality Assurance - Licensing Coordinator " it stated, " As directed by the Director of Quality Assurance, report the following occurrences by e-mail to the California Department of Public Health - Licensing and Certification - State Facilities Unit (CDPH) and by facsimile to the Regional Center Directors within 24 hours, or the following workday if an incident	W 153	W153 #1-2 a. Administrative Directive 124: Incident/Unusual Occurrence Reporting was revised and changes approved by the Executive Committee on behalf of the Governing Body. The policy now includes the requirement for notification to CDPH within 24 hours of the incident for: injuries of unknown origin that meet CDPH reporting criteria and all allegations of abuse and/or neglect. b. Program Directors will notify the Director of Quality Assurance (DQA) or designee by phone of the incident. c. The DQA/designee will provide preliminary notification to CDPH via email- providing information about the incident. d. The Standards Compliance Coordinator will ensure that CDPH is notified on the next working day by sending an Event Summary Notification or equivalent. This procedure has been in effect for allegations of abuse and neglect since February, 2011. The preliminary notification (date, time, who made the notification) will be logged into the Therap system by Quality Assurance staff. e. The DQA will ensure this system occurs with a monthly audit of timely notifications completed by the QA Risk Manager and reviewed at the Daily Executive Risk Management Team (DERMT) meeting by the 10th of the following month.	09/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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W 153	<p>Continued From page 93</p> <p>occurs on a weekend or a holiday. One of the categories listed as requiring notification was serious injuries, of known and unknown source. Per follow-up interview with the Director of Quality Assurance (DQA) on 9/25/13 at 11:35 AM, the DQA explained since the incident occurred on a Friday, the incident would not have needed to be reported until 1/7/13.</p> <p>Per Barclays' California Code of Regulations under subsection 76551 - Unusual Occurrences it listed " (a) Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or catastrophes and unusual occurrences which threaten the welfare, safety, or health of clients, personnel or visitors shall be reported by the facility within 24 hours either by telephone, with written confirmation or by telegraph to the local health officer and the Department.</p> <p>2. On 9/23/13 commencing at 10:30 AM incident DS13-04-L-107-A was reviewed. The General Event Report (GER) and Office of Protective Services (OPS) investigative report were examined and it was revealed an allegation for failure to provide supervision was reported on 4/24/13 at 4:20 PM wherein it was alleged Clients #66 and #92 were left unattended in their group living room. As a result, Client #92 was sent to the hospital for a precautionary x-ray to r/o possible ingestion of a foreign object [REDACTED].</p> <p>[REDACTED] During the course of the investigation it was determined the reporter did not notify the Office of Protective Services (OPS) until eighteen hours later. In an interview with the Licensing Coordinator (LC) on 9/25/13 at 8:35 AM the LC explained though there was no specific time parameter for reporting incidents to OPS, Administrative Directive #227 required immediate notification to</p>	W 153			

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W 153	Continued From page 94 OPS. Review of Administrative Directive #227 dated 10/26/11, entitled Alleged Abuse, Neglect or Exploitation on 9/25/13 at 8:37 AM revealed a section entitled " Reporting Requirements, " which stated " After ensuring the safety of the client, staff must immediately make a telephone or verbal report of possible neglect or abuse to the Office of Protective Services (OPS) by dialing extension 888; this number will ring directly at the OPS station and if not answered by the officer, will roll over to communications staff, who will immediately notify the officer on duty. " 3. On 9/24/13, during review of a GER for Client 94, the "Event Information" indicated the following: 7/1/13: Late Entry for 6/21/13. Client became "uncontrolled," SIB (self injurious behavior) and difficult to redirect. The client was agitated and attempted to hit himself in the face, kicking at staff ... Two point soft ties (restraints) were applied to both arms. The physician ordered Zyprexa Zydys (antipsychotic) for severe agitation and SIB. The Program Director's Level 2 review indicated that Client 94 received both 2 point soft tie restraints as well as Zyprexa Zydys as a behavioral emergency on 6/21/13, however proper documentation and follow-up was not completed at that time. Therefore, late notification was completed on 7/1/13. Documentation indicated that the Administrator was notified on 7/1/13 at 6:23 PM, ten (10) days after the incident occurred. 4. Review of a GER, dated 7/17/13 at 6:45 AM,	W 153	W153 #3 a) The Residence Manager for client 94 provided training to staff on duty the requirement that a General Event Report (GER) be generated for each use of stat medication for behavioral episodes. b) all Residence Managers provided training to all staff on duty the requirement that a General Event Report (GER) be generated for each use of stat medication for behavioral episodes. c) The Program Director reviewed the injuries, Events and notification requirements for a General Event Report with the Residence Manager. d) The Program Director/designee will review all GER's to ensure all notifications.	10/26/13	10/25/13	10/25/13

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W 153	Continued From page 95 indicated that Client 94 had a bruise of undetermined cause to his mid forehead. The bruise measured 2.5 cm by 1.5 cm. Documentation indicated that the Department of Public Health was notified on 7/18/13 at 2:33 PM. 5. Review of a GER, dated 8/3/13 at 1:30 PM, indicated that Client 95 had a bruise of undetermined cause to her left inner arm. One discoloration measured 16x4 cm and a second discoloration measure 6x3 cm. Documentation indicated that the Department of Public Health was notified on 8/5/13 at 9:20 AM. 6. Review of entity reported incident, (ERI# 363818), indicated that on 7/27/13 at 6:25 AM, Client 32 had an injury of unknown origin, a 6.5 cm scratch on her left breast. Documentation revealed that the Department of Public Health was notified on 7/29/13 at 8:45 AM. 7. Review of GER, (re: DDSLDCA-BAR4STGZL82XQ) dated 8/23/13 entered at 7:07 PM, indicated that Client 13 had multiple discolorations in the right inner arm measuring 28x8 cm., circular discolorations to the chest area times three measuring 4x5 cm, and circular purplish/brown discolorations to bilateral posterior hands. Documentation indicated that the Department of Public Health was notified on 8/26/13 at 11:30 AM. 8. Review of GER, (re: DDSLDCA-B9543SAMNV) dated 7/03/13 entered at 3:58 PM, indicated that Client 59 had multiple discolorations to her bilateral legs. Areas measured as follows: right lateral aspect of leg having a bluish discoloration measuring 5x4 cm, inner aspect of right thigh having a 7x4 cm bluish	W 153	W153 #4-8 a. Administrative Directive 124: Incident/Unusual Occurrence Reporting was revised and changes approved by the Executive Committee on behalf of the Governing Body. The policy now includes the requirement for notification to CDPH within 24 hours of the incident for: injuries of unknown origin that meet CDPH reporting criteria and all allegations of abuse and/or neglect. b. Program Directors will notify the Director of Quality Assurance (DQA) or designee by phone of the incident. c. The DQA/designee will provide preliminary notification to CDPH via email- providing information about the incident. d. The Standards Compliance Coordinator will ensure that CDPH is notified on the next working day by sending an Event Summary Notification or equivalent. This procedure has been in effect for allegations of abuse and neglect since February, 2011. The preliminary notification (date, time, who made the notification) will be logged into the Therap system by Quality Assurance staff. e. The DQA will ensure this system occurs with a monthly audit of timely notifications completed by the QA Risk Manager and reviewed at the Daily Executive Risk Management Team (DERMT) meeting by the 10th of the following month.	09/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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W 153	Continued From page 96 discoloration, left inner posterior thigh having a 5x3 cm bluish purple discoloration, and the lateral aspect of left thigh having a brownish 6x7 cm discoloration. Documentation indicated that the Department of Public Health was notified on 7/5/13 at 10 AM.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and multiple injuries of unknown origin were thoroughly investigated when incident reports and level reviews reviewed, indicated that components needed to complete an internal investigation for thoroughness were missing for three focus sampled clients (Client 98, Client 44 and Client 89) and one client outside core sample (Client 93). This failure affected one focus sampled client (Client 98), who had an open sexual assault allegation, one focus sampled client (Client 44), who had an injury of unknown origin that was reported by a guardian during the time parameter of 4/17/13 through 9/26/13, injuries of unknown origin to one focus client (Client 89) and Client 93, who had an injury of unknown origin Findings: 1. During a full survey of the facility, entity reported incident 332312, which was initiated in November 2012 and remained an open	W 154	W154 #1 a) It is the expectation that all staff to be vigilant and constantly alert to ensure that each person's physical and emotional well-being is not endangered in any way and that protection from harm measures are incorporated into every area of our service delivery activities. (Administrative Directive 227: Alleged Abuse, Neglect or Exploitation)	10/25/13

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W 154	<p>Continued From page 97</p> <p>investigation was included as part of the review of the facility's system to prevent abuse, neglect and mistreatment.</p> <p>On 11/7/12 at 2:20 PM, an unannounced visit was made to the facility to investigate an entity reported incident of a focus sampled client 98, who was noted to have a genital injury of an unknown origin on 11/6/12.</p> <p>During an interview with the Director of Quality Assurance (DQA) on the same day and time, she stated that the client resided in Residence 21.</p> <p>[REDACTED]</p> <p>She also stated that four staff members (Psychiatric Technician 1 (PT 1), Psychiatric Technician 2 (PT 2), Psychiatric Technician Assistant 1 (PTA 1), and Psychiatric Technician Assistant 2 (PTA 2) from the night shift were removed from client's contact. She further stated that the case was transferred to California Highway Patrol (CHP) by the Office of Protective Service (OPS) for a criminal case investigation.</p> <p>During an observation on 11/7/12 at 3:20 PM in Residence 21, focus sampled client 98 was observed in her bed, located in room [REDACTED]. Room [REDACTED] was shared by focus sampled client 98 and two other clients divided by a partial wall. Focus sampled client 98's bed was located near the door entrance of the room, while the two other beds for clients were located behind a partial wall separating the space.</p> <p>During an interview with focus sampled client 98 on the same day and time, she was unable to</p>	W 154	<p>W154 #1 cont.</p> <p>b) Every year, each employee reviews and acknowledges training in AD227: Alleged Abuse, Neglect or Exploitation at least annually, which includes expectations regarding the investigative process.</p> <p>c) The Office of Protective Services administrative investigation was initiated in August 2013 upon receipt of the completed California Highway Patrol case and was completed on October 17, 2013.</p> <p>d) The Commander of the Office of Protective Services (OPS Commander) will ensure that all allegations and/or suspected sexual assault are reported to outside law enforcement.</p> <p>e) The OPS Commander will ensure that Investigators assigned to administrative investigations handled criminally by outside law enforcement agencies will complete as much of the administrative investigation as possible while the criminal investigation is being conducted so that the investigative results are available for facility disposition and corrective action.</p> <p>f) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an administrative investigation so that it is included as part of the investigative process.</p>	<p>10/25/13</p> <p>10/17/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>

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W 154	<p>Continued From page 98</p> <p>respond verbally when asked how she was feeling.</p> <p>During an interview with the Residence Manager (RM) of Residence 21 11/7/12 at 3:40 PM, he stated that Psychiatric Technician 3 (PT 3) discovered the laceration in the vaginal area of focus sampled client 98 while conducting perineal care on the morning of 11/6/12. PT 3 immediately reported to the Health Service Specialist. Focus sampled client 98 was examined by the residence physician and determined a possible sexual assault.</p> <p>An 888 (facility's abuse hotline) number was dialed by staff to make an initial report of the possible sexual abuse. Focus sampled client 98 was transferred to the community hospital on 11/6/12 for a sexual assault examination. The RM stated that four night shift staffs (three males and one female) were removed from client's contact. Four other female clients in the residence were examined by the residence physician for possible sexual assault and the 13 male clients will be examined as well, according to the RM.</p> <p>During an interview with the CHP Investigator assigned to the case on 11/15/12 at 2:28 PM, he stated that their department took over the case of focus sampled client 98 on 11/7/12. According to the CHP Investigator, they had collected evidence including the SART (Sexual Assault response Team) kit, which will be processed in [County Crime Laboratory's name]. He also stated that they had not conducted any interviews yet and advised the surveyor to hold off on interviewing anyone that might had any involvement in the case.</p>	W 154	<p>W154 #1 cont.</p> <p>g) Supervising Investigator provided training to OPS Investigators re: expectations for requests of historical reviews of subjects identified in administrative investigations and weekly written updates from Investigators on administrative tasks completed on investigations while criminal investigations are conducted.</p> <p>h) Standards Compliance Coordinator provided training on 10/25/13 to Managers and Supervisor re: expectations to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations to the next level of management to ensure that active treatment programs and supervision are provided and/or needed revisions to plans are identified.</p> <p>See also W127 #1 and #2 and cont. pages 6a-d.</p>	10/30/13	10/25/13

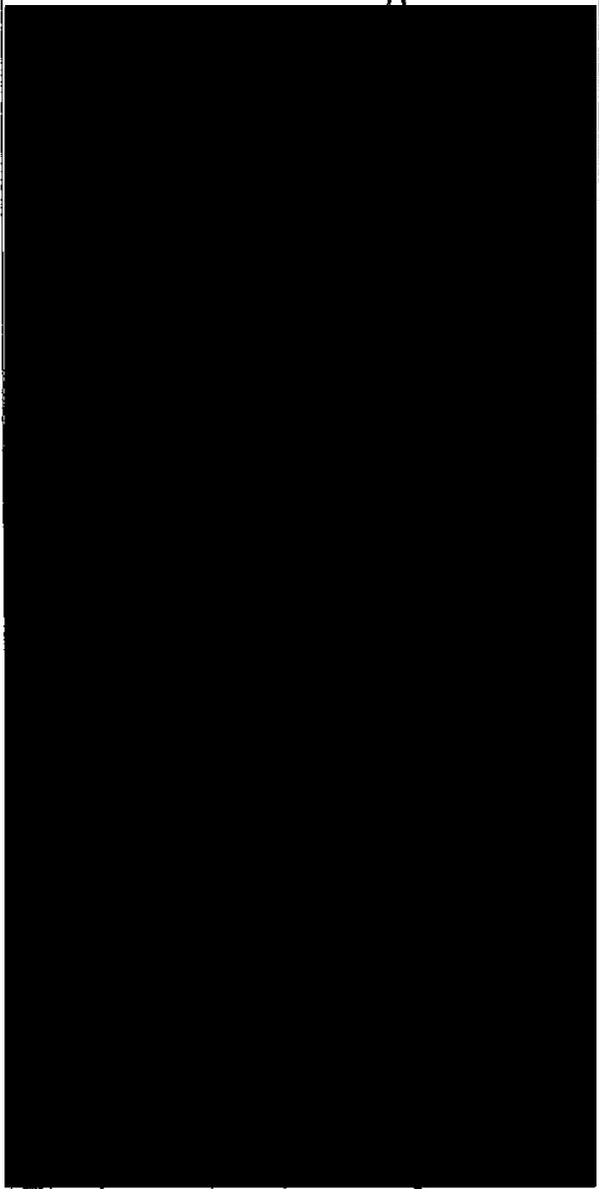
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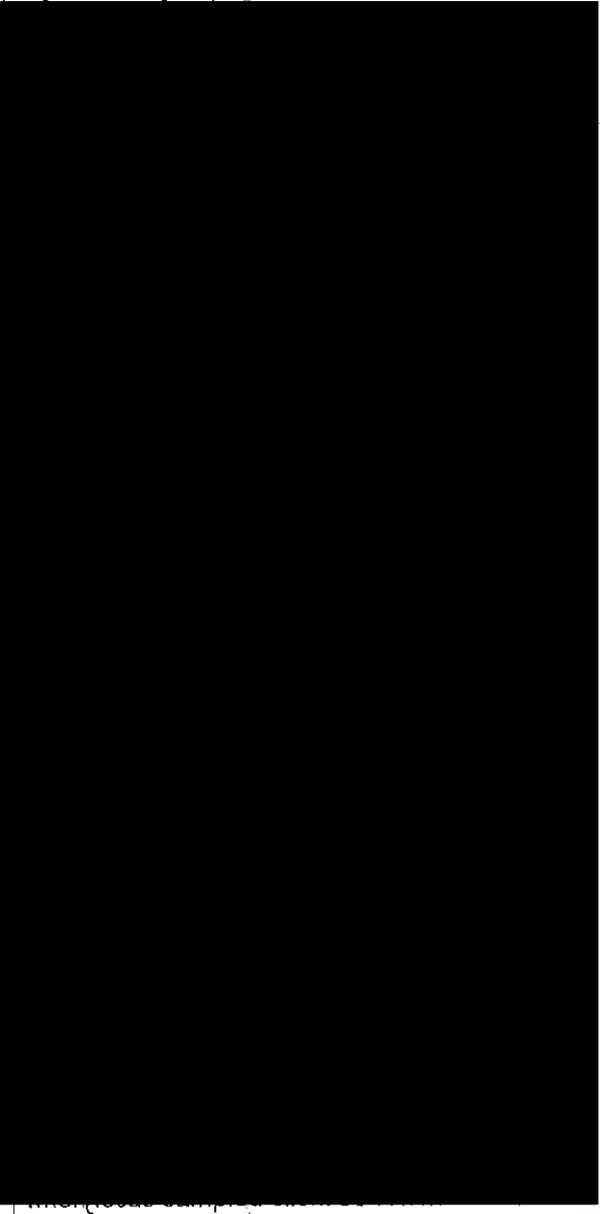
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W 154	Continued From page 99 	W 154		
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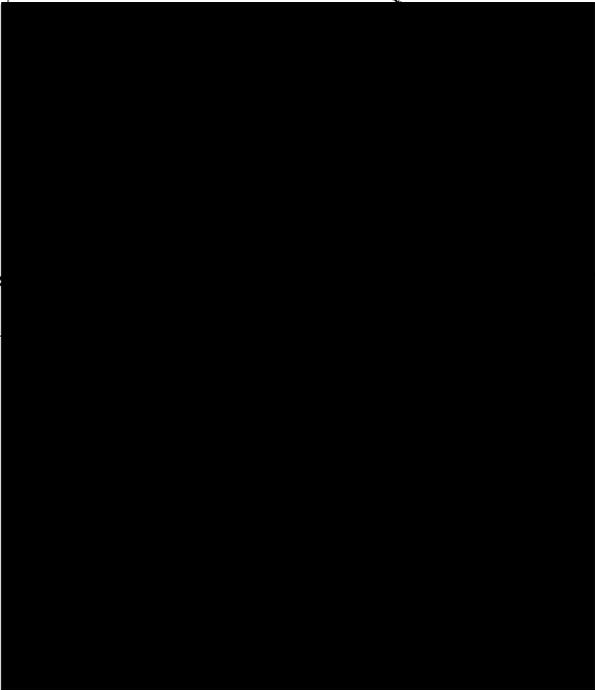
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
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W 154	<p>Continued From page 101 facility from the community hospital.</p>  <p>During an interview with the CHP investigator on 12/20/12 at 10:02 AM, he stated that there were no DNA (Deoxyribonucleic Acid, a molecule that encodes a genetic makeup of living organism) test results available as of yet from the SART kit. He was not able to give a time frame as to when the test will be completed. He also stated that they had interviewed staff including PT 2, PTA 1, PTA 2, and another PT (PT 4), who was assigned to focus sampled client 98 before PT 1 took over her care.</p> <p>According to the CHP Investigator, PT 2, PTA 1, and PTA 2 came into their office voluntarily for</p>	W 154		

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W 154	<p>Continued From page 102</p> <p>interviews, with the exception of PT 1. PT 1 refused to be interviewed and gave every excuse in the book according to the investigator. The Investigator did not want to provide details of their investigation until he interviewed PT 1.</p> <p>Although the case was still pending, he stated that he had gathered good information from the staff that were interviewed. He further stated that the investigator at the facility was told by the SART Nurse that it was sexual assault and they were notified by the facility investigator a day later after the incident. The Investigator requested the surveyor to continue holding off on the investigation until they were done.</p> <p>During an interview with the CHP Investigator on 1/25/13 at 1:03 PM, he stated that there were no DNA test results available. According to the Investigator, PT 1 refused to be interviewed until the DNA results came back.</p> <p>During an interview with the Compliance Officer of the community hospital on 1/28/13 at 1:10 PM, she stated that the SART Nurse who conducted the exam on focus sampled client 98 was contracted by the hospital. The records (Sexual Examination Report) were kept by the SART Nurse and had to be requested.</p> <p>The Sexual Examination Report dated 11/6/12 conducted by the SART Nurse was received and reviewed on 2/7/13 at 5 PM. [REDACTED]</p>	W 154			

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W 154	<p>Continued From page 103</p> <p>[REDACTED]</p> <p>During an interview with the CHP Investigator on 2/28/13 at 11:58 AM, he stated that he had not received any results from the crime laboratory for the DNA test results. He also stated that the investigation was on-going while waiting for results. He further stated that the turn-around time for DNA test results was around eight months.</p> <p>During an interview with PTA 2 on 3/14/13 at 10:16 AM, she stated that she was removed from client's care on 11/7/12 and she had been working in the training office since 11/9/12. She also stated that she volunteered to work in Residence 21 on 11/5/12 during NOC shift (night shift) as a PTA. She was assigned on a 1:1 observation with another client by the shift lead (PT 1). According to her, she didn't have any contact with any client that night (11/5/12 thru 11/6/12) except for the one she was assigned to.</p> <p>There were four staff in the residence during NOC shift including her and three of them were floaters, except for PT 1. She had worked in the residence twice for overtime. She denied knowing focus sampled client 98 nor the room where she was located at. She also stated that it was quiet on the night of 11/5/12, there was no screaming and she did not notice anything unusual on staff or clients. PTA 2 voluntarily went to CHP office for an interview.</p> <p>During an interview with PT 1 on 3/14/13 at 11:47 AM, he stated that he currently worked in the main kitchen of the facility. PT 1 was accompanied by a union representative. He stated that he retained a lawyer and refused to be</p>	W 154			

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W 154	<p>Continued From page 104 interviewed.</p> <p>During an interview with the Standard Compliance Coordinator (SCC) on 8/6/13 at 10:15 AM, she stated that PT 1 passed away about two months ago due to his medical condition. An attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>During an interview with the CHP Investigator on 8/6/13 at 11:05 AM, he stated that they finally concluded their investigation. The DNA test results came back negative and could not be linked to any staff investigated. He also stated that even though the DNA test came back negative, it did not mean that focus sampled client 98 was not sexually assaulted. He further stated that their "suspect" (PT 1) died of a medical condition.</p> <p>During an interview with the SART Nurse on 9/9/13 at 2 PM, she confirmed the findings on the Sexual Examination Report dated 11/6/12. She stated that the injury of focus sampled client 98 was consistent with sexual assault. She also stated that the injury was not consistent with "cleaning her area" because there was a certain degree of force applied to the area. She further stated, "It was some type of blunt force trauma, but I cannot tell what."</p> <p>During an interview with the SCC on 9/9/13 at 10:30 AM, she stated that the sign-in sheet for 11/5/12 indicated that PT 1 was in-charge on NOC shift and was also the medication person. PT 2 was assigned on the left side of the residence hallway, PTA 1 was assigned on the right side of the residence hallway, and PTA 2</p>	W 154		

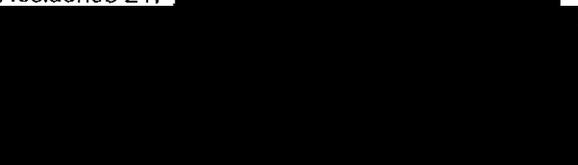
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W 154	<p>Continued From page 105</p> <p>was assigned to a 1:1 observation. Another attempt to interview the residence physician was made, but the SCC was unable to locate him.</p> <p>The Daily Time Record for the morning shift and night shift dated 11/5/12 was reviewed on 9/9/13 at 10:45 AM. The review confirmed what the SCC stated regarding assignments of staff on 11/5/12 during NOC shift. The review also indicated that PT 1 reported to work in Residence 21 at 2:30 PM on 11/5/12 and continued to work until 7 AM on 11/6/12 for overtime. The review further indicated that PT 4 reported to work on 11/5/12 at 2:30 PM in the residence.</p> <p>During an interview with PT 3 on 9/9/13 at 11:30 AM, she stated that she worked on the morning shift of 11/5/12 and 11/6/12 assigned to group 4 where focus sampled client 98 was part of the group.</p> <div style="background-color: black; width: 100%; height: 100px; margin-top: 10px;"></div>	W 154			

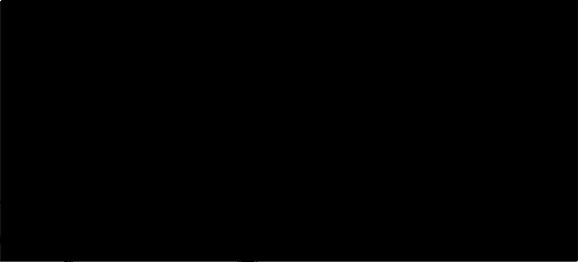
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W 154	<p>Continued From page 106.</p>  <p>The HSS arrived in the residence when PT 3 was transferring focus sampled client 98 from shower chair to bed. Drops of blood were observed on the floor by PT 3. The HSS conducted an assessment and noted a laceration on the perineal area, between the rectum and vagina of focus sampled client 98. The residence physician was notified and arrived in the unit shortly to assess the client. PT 3 stated that the residence physician stated that focus sampled client 98 was sexually assaulted. She stated that the residence physician seemed to be sure of it when he said it. PT 3 was upset after hearing the residence physician.</p> <p>PT 3 stated that PT 1, PT 2, PTA 1, and PTA 2 were working on the NOC shift of 11/5/12. PT 1 was in-charge of the NOC shift and clients were assigned on the left and right side of the hall. PT 3 stated that PT 1 was in-charge of the front hall and focus sampled client 98. PTA 1 was on the right side and PT 2 was assigned on the left side of the hallway. PTA 2 was assigned to a 1:1 observation, located on the left side of the hallway.</p> <p>PT 3 stated that there was no sexual abuse in the past that she knew of involving staff or clients in Residence 21.</p> 	W 154			

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W 154	<p>Continued From page 107</p>  <p>PT 3 explained that management did not have a live interaction with PT 1 and did not pick up on his issues. Focus sampled client 98 was very comfortable and very familiar with PT 1. According to PT 3, focus sampled client 98 likes attention from men. She was very playful especially with men.</p> <p>During a re-interview with the RM of Residence 21 on 9/9/13 at 12:30 PM, he stated that focus sampled client 98 was on general supervision on 11/5/12 during NOC shift. PT 1 was assigned to focus sampled client 98 on the night of 11/5/12 and had full access to the client.</p> <p>The RM was notified by PT 3 on the morning of 11/6/12 that focus sampled client 98 was bleeding from the vaginal area. He confirmed the findings of PT 3 and the residence physician was notified, who re-assessed focus sampled client 98. The residence physician felt that there was some sort of violations, sexual in nature according to the RM.</p> <p>The RM stated that the floaters (PT 2, PTA 1, and PTA 2) had never been involved with any type of abuse in the residence. He was not aware of any inappropriate contact by PT 1 to any staff or clients and was not aware of him being stressed out. The RM was unable to characterize PT 1's</p>	W 154			

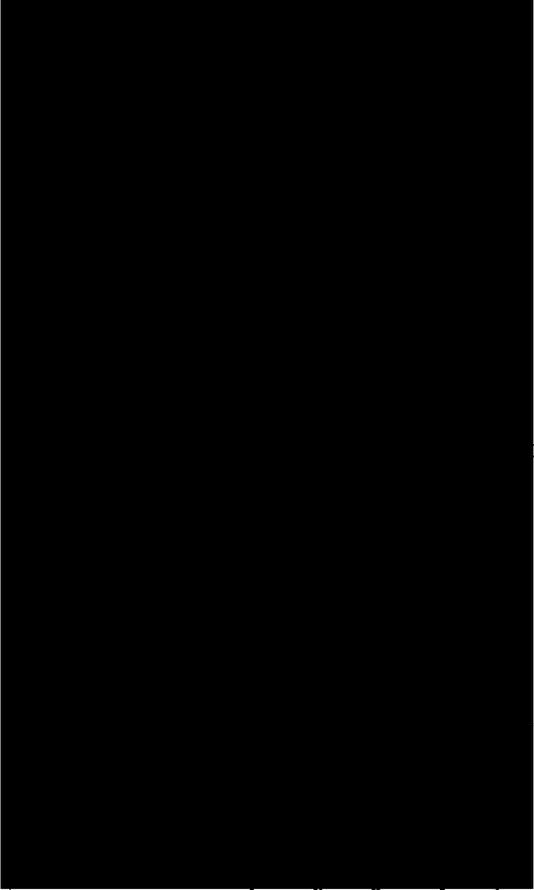
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W 154	<p>Continued From page 108</p> <p>interaction with clients, because according to him, he (PT 1) always works nights.</p> <p>According to the RM, he did not believe the residence physician's finding and did not formulate any suspicion at the time. He was in disbelief that something had happened. He also stated that [focus sampled client 98's name] did not have SIB. He did not believe that focus sampled client 98 would hurt herself that way.</p> <p>The RM mentioned that PT 1 told him that he was in focus sampled client 98's room on the night of 11/5/12- [REDACTED] PT 1 told him, "She was fine when I left." PT 1 also talked to him about being stressed out and CHP Investigators wanting to talk to him. PT 1 told the RM that he hired a lawyer because he did not trust the system. The RM also stated, "I felt that one of the staff accidentally harm the client, and instead of admitting it, they left it."</p> <p>During an interview with PTA 1 on 9/9/13 at 1:25 PM, he stated that he had worked many times in Residence for overtime. On the night of 11/5/12, he was covering the right side of the hallway. He stated that PT 1 was assigned to focus sampled client 98 during NOC shift of 11/5/12.</p> <p>PTA 1 mentioned that he did not have any contact with focus sampled client 98 and did not notice anything unusual during NOC shift on 11/5/12. He did not see anyone go in and out of the client's room when he made his rounds. Focus sampled client 98 was in room [REDACTED] with two other clients and she was observed sleeping at 11 p.m. on 11/5/12, before 1 a.m., 3 a.m., and 5 a.m. on 11/6/12. However, he observed PT 1 inside focus sampled client 98's room a little bit after 5 a.m. on</p>	W 154			

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W 154	Continued From page 110 	W 154	W154 #2 cont. c) Every year, each employee reviews and acknowledges training in AD227: Alleged Abuse, Neglect or Exploitation at least annually, which includes expectations regarding the investigative process. d) Special Risk Management Meetings were held beginning 11/7/12 in all Programs to review AD 124: Incidents and Unusual Occurrence, AD 225: Client Supervision and Personal Care, and Quality Assessment and Performance Improvement Plan for Special Medical Conditions. e) The Governing Body of Lanterman Developmental Center utilizes the General Event Reporting (GER) process as the primary Internal Investigation. The Level 1 and 2 Reviews contain investigative findings and recommendations/corrective actions. The individual completing the Level 3 Review reviews the event description, investigation, and recommendations/corrective actions identified to prevent recurrence or reduce risk factors, and makes a determination if further review or investigative actions are necessary. f) The Governing Body utilizes the investigations conducted by the Office of Protective Services and Outside Law Enforcement (OLE) and takes corrective action based on the administrative and criminal investigative findings. These findings	10/25/13	11/30/12
	PT 1 expired on 6/25/13 due to septic shock as an immediate cause of death, according to the Certificate of Death. During an interview with the OPS Commander on 9/25/13 at 2:35 PM, he indicated that their			9/26/13	9/26/13

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W 154	Continued From page 111 investigation report on the case of focus sampled client 98 was not yet completed. The OPS Commander stated that the case was substantiated by CHP against PT 1, based on suspicion and opportunity. The OPS Commander couldn't see how to substantiate the case, because he wanted a clear concise statement from the SART Nurse and the consistency of sexual abuse, stating, "I'm stuck on SART Nurse not consistent with her report." When he was asked if a hypothesis was considered, he stated, "At first, but the SART Nurse was tolling at sexual assault." According to the OPS Commander, the reporting was made based on the assumption of sexual assault. However, there were no witnesses identified and that he could not take any action because the alleged perpetrator was deceased. CHP, according to the OPS Commander narrowed it to one guy and nothing on anyone else. There were no DNA hits or semen found when items were tested. The OPS Commander also mentioned that there was a possibility that the injury was self-inflicted [REDACTED] However, based on interviews and review of focus sampled client 98's medical record, there were no documented evidence that she would engage in SIB [REDACTED] The OPS Commander also offered a possibility that the injury could be from a loose arm chair. He was asked if the officer responded to the scene conducted a search. He stated that the officer took photographs of the scene and did not	W 154	W154 #2 cont. are reviewed by GB members in the Disposition Process. Corrective actions are initiated if indicated and documented in Disposition Meetings Minutes. The implementation of the actions is monitored by Governing Body members. Quality Assurance staff monitors completion of follow up actions and documents the completion on the Incident Review Form. g) The OPS Commander will ensure that OPS receives a historical review of all incidents involving a subject identified in an administrative investigation so that it is included as part of the investigative process. h) Training on completing an Internal Investigation has been provided to staff in the following: *Clinical Critical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and IPCs about how to conduct incident investigations and how those coincide with investigations by OPS. Trainers- the Disability Rights, California (DRC) Director-Investigations Unit and Senior Investigator. *Clinical Incident Investigation- Training provided to Residence Managers, Program Managers, Executive Committee Members, available Medical/Nursing staff and	9/26/13 2/14/13 5/1-2/13

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W 154	<p>Continued From page 112</p> <p>know at the time that it was a sexual assault. Review of the GER dated 11/6/12 indicated that an 888 was dialed by staff and OPS/Investigator was notified of the sexual assault incident.</p> <p>The OPS Commander was also asked if there was any documentation, analysis, or investigation made to trace where the alleged perpetrator (PT 1) worked in the last six months, record reviews where he might had come in contact with female clients, whether he was alone with female clients, review of female clients injury, sexual assault, or inappropriate contact. The OPS Commander was unable to provide a clear and concise answer, stating that it might have been documented in the report.</p> <p>During another interview with the OPS Commander on the same day at 4 PM, he presented with a CHP "ARREST - INVESTIGATION REPORT" dated 8/8/13. A report received by the surveyor from the CHP Investigator and reviewed on 9/13/13. He indicated that the report was received sometime in August. The investigation was not completed because he needed to see clarity from the SART Nurse. He also stated that he was waiting on the interview of the investigator (OPS Investigator) with the SART Nurse.</p> <p>The OPS Commander stated that it was not routine to get cases done quickly, prior to his arrival. He further stated, "If the SART Nurse said it was sexual assault, will go to a different route and investigate further." He iterated the importance of interviewing the SART Nurse first to be able to close the case. At this time, the surveyor told the OPS Commander that he (surveyor) was able to interview the SART Nurse</p>	W 154	<p>W154 #2 cont.</p> <p>IPCs about how to conduct incident investigations. Trainer- Office of Protective Services Investigator, DDS Headquarters</p> <p>See also W154 #3 b-k</p>		

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W 154	<p>Continued From page 113 on 9/9/13 and confirmed the finding of sexual assault.</p> <p>The facility policy and procedure titled "Client Services - 227: Alleged Abuse, Neglect or Exploitation" dated 10/26/11, reviewed on 9/25/13 at 4:20 p.m. indicated, "1. POLICY - ...Any neglect, abuse, or exploitation by any person, whether staff, visitor, volunteer, student, family, or other clients, is prohibited....Training: ...All staff shall receive training to assist in the prevention of abuse, neglect, mistreatment and misappropriation of property as well as client abuse reporting procedures..." The review also indicated, "2. DEFINITIONS - 2.3 Sexual Abuse - Sexual contact that results from threats, or fear, and involving range of activities, including, but not limited to, assault, rape, molestation sexual harassment."</p> <p>The facility policy and procedure titled "General - 124: Incident/Unusual Occurrence Reports" dated 4/15/11, reviewed on 9/25/13 at 4:25 p.m. indicated, "1. POLICY - People who live at [Facility's name] have the right to be protected from harm...The system provide for documentation of these events and the review, investigation, analysis, corrective action and monitoring for each event in order to reduce occurrences..." The review also indicated, "3. GUIDELINES FOR REVIEWING INCIDENT/UNUSUAL OCCURRENCES REPORTS - Each level of management that reviews Incident/Unusual Occurrence Reports is expected to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations..."</p> <p>2. On 9/23/13 commencing at 11:30 AM Incident</p>	W 154			

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W 154	Continued From page 114 DS13-06-L-150-A was reviewed. It was documented on 6/27/13 the guardian of Client #44 complained about the lack of a Sexual Assault Rape Test (SART) being conducted when her daughter was noted with spotting on 12/19/12. The Office of Protective Services (OPS) investigation focused on the possibility of neglect with emphasis on determining whether or not a protocol was properly administered. The conclusion determined there was insufficient evidence to substantiate any finding of abuse or neglect. From the General Event Report (GER) generated for this incident on 6/27/13, there was additional narrative indicating the guardian had a report documenting her daughter was noted with bruising to her inner thighs about two weeks after the spotting was reported on 12/19/12. The guardian was also told after a gynecological visit at [REDACTED] outpatient clinic her daughter had "vaginal scarring that could not be explained." Record review verified an HSS note was written on 1/11/13 documenting lower extremity discoloration discovered during AM care with "Noted ecchymosis bluish skin discolorations to lower left calf" with measurement of 4.8 cm x 4.8 cm and inner aspect of leg and knee, 1.5 cm x 1.5 cm. Additional review of the OPS file revealed no mention of any inquiry into the cause of the bruise. Per interview with the Licensing Coordinator (LC) on 9/26/13 at 8:00 AM, the LC explained that since the bruises identified did not meet the dimensional requirements for notification to OPS, the matter was reviewed internally and both Level 1 and Level 2 reviews were conducted. Review of the General Event Report associated	W 154	W154 #3 a. Client #93 was transferred to the community on 10/16/2013. The final x-ray taken on 9/23/2013 report noted "previously noted rib fracture healed". b. 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. c. The Medical Director met with physicians to review survey findings and provided direction on follow-up actions to ensure compliance. d. 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. e. The Medical Director instructed all Physicians to raise any issues/concerns for discussions at the weekly physicians' rounds for recommendations and resolution. f. Any systemic issues/concerns will be elevated to Medical Quality Assurance and Improvement (MQA&I) with recommendation, review & follow up. g. All Shift Supervisors will monitor for unreported client related injuries/medical concerns daily and take corrective action as needed. Rounds and any corrective actions will be documented on the Shift Supervisors Rounds Sheet (SSRS)	11/27/13 10/29/13 10/29/13 10/29/13
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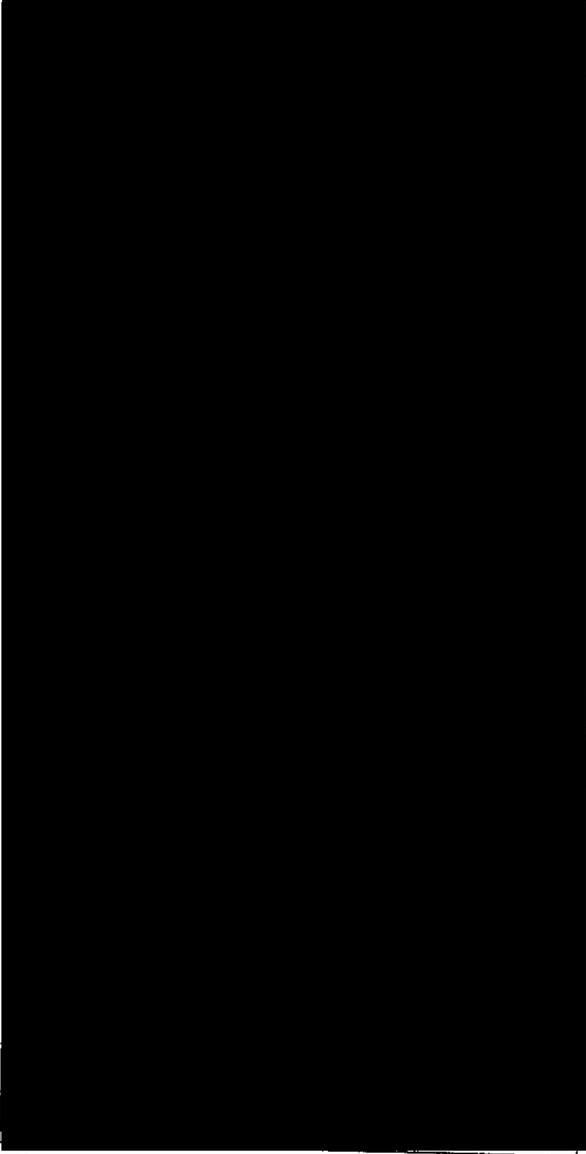
93

W 154	Continued From page 115 with this investigation revealed there was no discussion about bruising documented in the Level 1 review, but in the Level 2 review it stated, " There was no mention in our Program injury log of any bruising to the inner thighs during the time frame that the guardian mentioned at the meeting yesterday, just a bruise to her left knee on January 14, 2013. There were other bruises noted later (usually after behavioral episodes) after that time period. " There was no reference to the progress note written on 1/11/13 and no identification as to possible cause. In an interview with the Residence Manager (RM) on 9/27/13 at 10:05 AM the RM reviewed the record and determined the progress notes from January 2013 had been purged. When the RM was asked if the unit based inquiry into the cause yielded any cause for the bruise documented as occurring on 1/11/13, the RM reviewed the physician notes and determined no notification was made to a physician. No other documentation was available conclusively addressing the guardian inquiry about bruising to her daughter ' s inner thighs. 3. An entity reported incident dated 7/23/13 (GER-LDCA-B9R3S7SNM5) for Client 93 was reviewed on 9/25/13 at 9:30 AM. The General Event Report and clinical record indicated that staff noted a skin discoloration on the left shoulder extending to the chest area of Client 93 on 7/23/13. The skin discoloration measured 15x11 centimeters. An X-ray taken 7/23/13 for the left upper rib indicated a fracture of the 9th rib at the posterior axillary line. The Investigation Disposition Report dated 8/7/13 was reviewed on 9/25/13. The report indicated that an X-ray taken to rule out fracture was negative for fracture, contrary to the X-ray	W 154	W154 #3 contd. and submitted to the Residence Manager weekly. h. All Residence Managers will monitor through review of the SSRS and during weekly rounds to ensure that (insert compliance outcome here) 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 and submit to the Program Director weekly. i. 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. j. 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. k. Please see also continuation page 10a-h.	10/25/13 10/25/13 10/25/13 10/25/13
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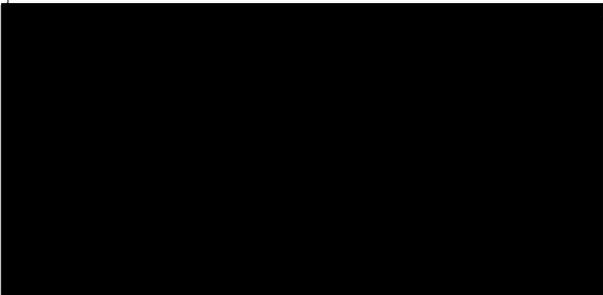
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W 154	Continued From page 117 	W 154			

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W 154	Continued From page 118  The facility failed to implement their policy titled "Guidelines for Reviewing Incident/Unusual Occurrence Reports" and plan of correction resulting from the the survey completed 4/16/13 to ensure the thoroughness of investigations of injuries of unknown origin, allegations of abuse, mistreatment and neglect. The facility's policy and procedure titled "Administrative Directive - 124: Incident/Unusual Occurrence Report" indicated each level of management that reviews Incident/Unusual Occurrence Reports is expected to investigate and/or analyze each incident, review findings, document the action taken, and make recommendations to the next level of management. Reports provided by the facility addressing the above concerns failed to make an impact and decrease the pattern of injuries.	W 154			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159			

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W 159	<p>Continued From page 119</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the active treatment programs for five of 10 core sampled and three focus clients were coordinated and monitored by the <u>Qualified Mental Retardation Professional (QMRP)/Individual Program Coordinator (IPC)</u>.</p> <p>(Client 12, 37, 47, 61, 69, 77, 89, 94,)</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> <p>[REDACTED]</p> <p>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</p>	W 159	<p>W159 #1</p> <p>a) a special IDTeam meeting was scheduled 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.</p> <p>b) At the special IDTeam meeting, the IDTeam referred Client 89 to the Senior Program for structured weekday activities and residence staff will develop a training objective in Household Management while Client 89 is on the residence.</p> <p>c) Level of care staff on the residence will ensure that Client 89's active treatment plan is implemented on the residence as developed by her IDTeam.</p> <p>d) 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 training objectives.</p> <p>e) The SrPTs will ensure active treatment plans as developed by each client's IDTeam are implemented on the residence. SrPT will ensure re-training/instruction is given and corrective action taken, as needed.</p> <p>f) Residence Manager will ensure compliance during daily routine rounds, ensuring re-training/instruction is given and corrective action taken, if needed.</p>	<p>10/24/13</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>

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W 159	<p>Continued From page 120</p> <p>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 revisions in her active treatment goals were observed or being implemented.</p> <p>Record review confirmed no evidence of new assessment, revision and/or plan implementation to promote Client 89's physical wellness and fitness, socialization or tasks that maintain coordination skills and reduce the rate of loss of skills that can accompany the physical aspects of the aging process.</p> <p>2. The IPC failed to ensure objectives of the individual program plan were stated separately, in terms of a single behavioral outcomes affecting two of 10 core sampled and two focus clients and failed to ensure objectives were revised when no progress was made. (Client 37, 47, 61, 69)</p> <div style="background-color: black; width: 100%; height: 50px; margin: 10px 0;"></div> <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,</p>	W 159	<p>W159 #1 cont.</p> <p>g) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC Monthly Report to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client.</p> <p>h) IPC will monitor Client 89's progress and document findings on the IPC Monthly Report.</p> <p>i) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved.</p> <p>j) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports. Any unresolved issues/ concerns will be brought forward to the CQM committee for resolution.</p> <p>W159 #2</p> <p>a) 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. (please see continuation page 121a)</p> <p>W159 #3 (please see continuation page 121a)</p>	<p>10/24/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p> <p>10/25/13</p>	

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	W159 #2 cont. a) cont. IPCs document monitoring and follow-up activities on the IPC Monthly Report to ensure that training objectives continue to meet the needs of each client.			10/25/13	
	b) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved.			10/25/13	
	c) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports. Any unresolved issues/ concerns will be brought forward to the CQM committee for resolution.			10/25/13	
	W159 #3 cont.			10/24/13	
	a) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including drug regimen review at monthly Behavior Review Group meetings. IPCs document monitoring and follow-up activities on the IPC Monthly Report to ensure that program plans continue to meet the needs of each client.			10/25/13	
	b) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved.			10/25/13	
	c) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports.			10/25/13	

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W 159	<p>Continued From page 121</p> <p>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>There was no indication the IPC reviewed or questioned the use of the Restoril and made recommendations for review on behalf of Client 69.</p> <p>4. 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 policy instructed 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.</p>	W 159	<p>W159 #4</p> <p>a) Individual Program Coordinator (IPC) Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC Monthly Report to ensure supportive and protective devices continue to meet the needs of each client.</p> <p>b) IPC will monitor Client 69's response and effectiveness of the supportive and protective devices and the condition of the equipment and document findings on the IPC Monthly Report.</p> <p>) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved.</p> <p>k) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports. Any unresolved issues/ concerns will be brought forward to the CQM committee for resolution.</p>	<p>10/24/13</p> <p>10/24/13</p> <p>10/25/13</p> <p>10/25/13</p>	

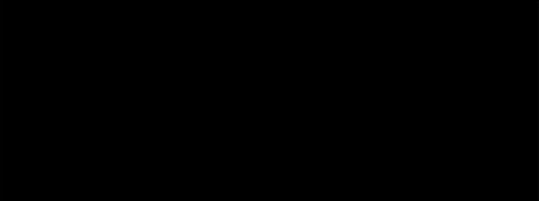
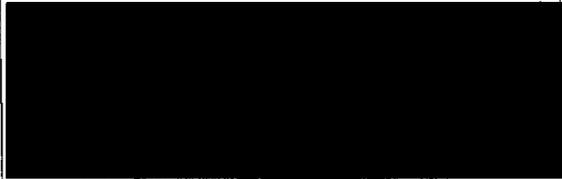
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W 159	Continued From page 122 IPC notes for Clients' 37, 47, and 69 reflected "all adaptive equipment is available, in good working condition and in use during observation." The notes failed to describe the equipment, the client response and effectiveness of treatment as well as monitoring to assure they were clean. There were no problems identified and no client/ staff training opportunities identified. In an interview with the HSS, IPC and Residence Manager on 9/25/13 at 2 PM, Client 69's helmets, 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. (SEE W436) 5. Review of a GER (General Event Report), dated 7/17/13, indicated that Client 94 was observed to have discoloration to his mid forehead, measuring 2.5 cm x 1.5 cm. Client 94 utilized bilateral arm splints to protect his face and head from soft tissue injuries due to severe self - injurious behaviors. 	W 159	W159 #5 a) Individual Program Coordinator (IPC) Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC Monthly Report to ensure supportive and protective devices continue to meet the needs of each client. b) IPC will monitor Client 94's response and effectiveness of the protective devices and the condition of the equipment and document findings on the IPC Monthly Report.	10/24/13 10/25/13

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W 159	Continued From page 123  During an interview with the RM (Resident Manager) on 9/25/13 at 3:15 PM, the RM stated that Rehabilitation had been contacted regarding the arm splints in the past by another staff member but there was no followup, no consult, and no documentation that a conversation took place. The IPC/QMRP failed to monitor Client 94's treatment plan to ensure followup to recommendations were made. 6. The IPC failed to coordinate and monitor Client 77's active treatment program when she failed to ensure his comprehensive functional assessment was actually comprehensive (refer to W214) and that his individual program plan contained objectives that were consistent with his abilities to learn to become more independent in the following areas: Managing finances (refer to W126); vocational training (refer to W240); self-administration of medication (refer to W371) and continual and meaningful active treatment (refer to W249). 	W 159	W159 #5 cont. b) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved. d) IPC Supervisor will monitor for compliance via review of the IPC Monthly ReportsAny unresolved issues/ concerns will be brought foward to the CQM committee for resolution. W159 #6 a) Residence Manager, Group Leader and IPC developed training plans, and the IPC documented on the IPP listing, Approaches & Strategies and Daily Activity Schedule. b) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC Monthly Report to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client. (please see continuation page 124a) W159 #7 a) IPC Supervisor provided training to IPCs regarding IPP monitoring, documentation and follow-up, including documentation on the IPC Monthly Report to ensure that training objectives are appropriate to clients' skill level and continue to meet the needs of each client. (please see continuation page 124a)	10/25/13 10/25/13 10/25/13 10/24/13 10/24/13	

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	W159 #6 cont. c) IPC will monitor Client 77's progress and document findings on the IPC Monthly Report. d) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved. e) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports. Any unresolved issues/ concerns will be brought foward to the CQM committee for resolution.			10/25/13 10/25/13 10/25/13	
	W159 #7 cont. b) IPC will monitor Client 12's progress and document findings on the IPC Monthly Report. c) The Program Director and Residence Manager will continue to review the IPC Monthly Report to ensure all issues are resolved. d) IPC Supervisor will monitor for compliance via review of the IPC Monthly Reports. Any unresolved issues/ concerns will be brought foward to the CQM committee for resolution.			10/25/13 10/25/13 10/25/13	

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W 159	<p>Continued From page 124</p> <p>[REDACTED]</p> <p>During observation from 1:45 PM to 3:30 PM on 9/18/13, there was no active treatment observed that was provided to Client 12.</p> <p>[REDACTED]</p> <p>[REDACTED] he had 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 which was being located three to four blocks away from the residence. He further stated that he received no responses from the team.</p> <p>During observation on the same day at 3:30 PM, a female staff came in and read current news to three clients including Client 12. There was no active participation observed from the clients on the activity provided.</p> <p>On the same day from 5:40 to 6:45 PM, a staff in the room was observed reading a book to three clients without any signs of participation. [REDACTED]</p> <p>[REDACTED]</p> <p>The medical record for Client 12 was reviewed on 9/23/13 at 10:20 AM. The narrative individual program plan indicated that Client 12 has a vocational training to work at shredding task for one minute. This has not been met for over a year as Client 12 refuses to attend and participates in DTAC (Day Treatment Activity</p>	W 159		

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W 159	Continued From page 125 Center). He also had a training objective, " to explore or touch a variety of money items. This has not been observed as being provided. The IPC (Individual Program Coordinator) notes did not address the issue of Client 12 ' s refusal to attend the DTAC program for over a year nor did it address the issue of what to take to slowly integrate him to DTAC. During an interview with the residence IPC on 9/24/13 at 2:17 PM, she stated that she had been the IPC for Client 12 approximately 2 months. She was asked if the previous IPC had given her a background or issues being worked. She replied no, and also stated that the previous IPC is on leave.	W 159			
W 185	483.430(c)(4) FACILITY STAFFING The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide sufficient support staff to perform staffing duties for the facility, diverting Residence 15 senior psychiatric technicians and or their designee from providing care and services to the clients and performing critical oversight, assignments and supervision of staff . Findings: Observations beginning on 9/16/13 at 11:30 AM on Residence 15 revealed the Senior Psychiatric Technician (SPT) designee was involved in	W 185			

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W 185	Continued From page 126 staffing duties for the facility. The SPT was diverted from providing care and services to clients and the supervision of staff (including floated staff from other residences performing overtime). The SPT was tasked with receiving and making telephone calls to other residences inquiring about census, staffing, and mandatory overtimes. The staffing activity continued every shift on Residence 15 through out the survey exited on 9/26/13. The initial staffing (telephone calls) occurred at the beginning of every shift and took 30 to 45 minutes, per shift three times per day, seven days a week. Through out each shift telephone calls were received, made and forwarded concerning staffing inquiry's. Interview with facility staff on the residence occurred on 9/16/13 at 11:45 AM, 9/18/13 at 4 PM, 9/25/13 at 2 PM confirmed the practice of Residence 15 performing staffing duties had been in place over an extended period of time and impacted the ability to manage the residence, supervise staff and provide active treatment for clients.	W 185	W185 1. All Program Management Teams meet on a weekly basis to identify the number of staff on duty and specific residential needs to assure that staff are evenly deployed throughout the program and that all services are supported. 2. All Program Nursing Coordinators will assure staffing levels are met and evenly distributed on a daily basis. The Nursing Coordinators will arrange coverage behind any identified shortage of staff or emergency need during regular business hours. 3. Each Program has established a system that ensures coordination of staff coverage on a 24 hour basis outside of regular business hours. The identified residence will arrange coverage behind any identified shortages of staff or emergency need outside of regular business hours. 4. During the NOC/AM shift overlap, the NOC shift charge will coordinate any staffing issues and forward the information to the Nursing Coordinator for resolution if warranted. 5. The Program Director will monitor staff deployment and coordination by attending weekly staffing meeting at least one time per month, to assure that staff coverage is equitable, consistent and is coordinated by the Nursing Coordinator with input from Residence Managers.	09/16/13	09/16/13
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by:	W 186		09/16/13	10/25/13

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W 186	<p>Continued From page 127</p> <p>Based on observation, interview, and record review, the facility failed to ensure that: direct care staff members were sufficient and provided, to avoid interruption of the vocational training program as part of the client's individual program plan and focus sampled Client 43 was provided his nature walk as part of his leisure and likes. The facility also failed to provide enhanced supervision to two clients outside the core sample (Clients 56 and 20).</p> <p>Findings:</p> <p>1. 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 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 stated that they're short staffed because one of the staff had to leave due to an emergency.</p> <p>During an observation in group room 3 (Room 28) of Residence 29 on 9/24/13 at 10:05 AM, it was noted that seven clients were being</p>	W 186	<p>6. Clinical Director ensures Quality improvement process for staff deployment by receiving and reviewing weekly overtime reports as well as monthly schedules from each residence. Verbal recommendations are provided to Program Management by the Clinical Director when changes are needed to ensure ongoing quality improvement for staff coordination throughout the clinical areas.</p> <p>W186 #1</p> <p>a. After review of the student attendance and DTAC Client Log it was determined that the full class was held in the afternoon.</p> <p>b. All DTAC Teachers will assemble a box/cart to include vocational activities, per the clients' desired outcomes/milestones, for use in the cases when a class needs to be held on the residence.</p> <p>c. DTAC Coordinator to monitor all box/carts during weekly rounds and will document on DTAC rounds report.</p> <p>d. Any issues/ concerns noted by the DTAC coordinator will be brought forth to their respective Program Directors for resolution.</p>	<p>09/24/13</p> <p>10/24/13</p> <p>10/25/13</p>	

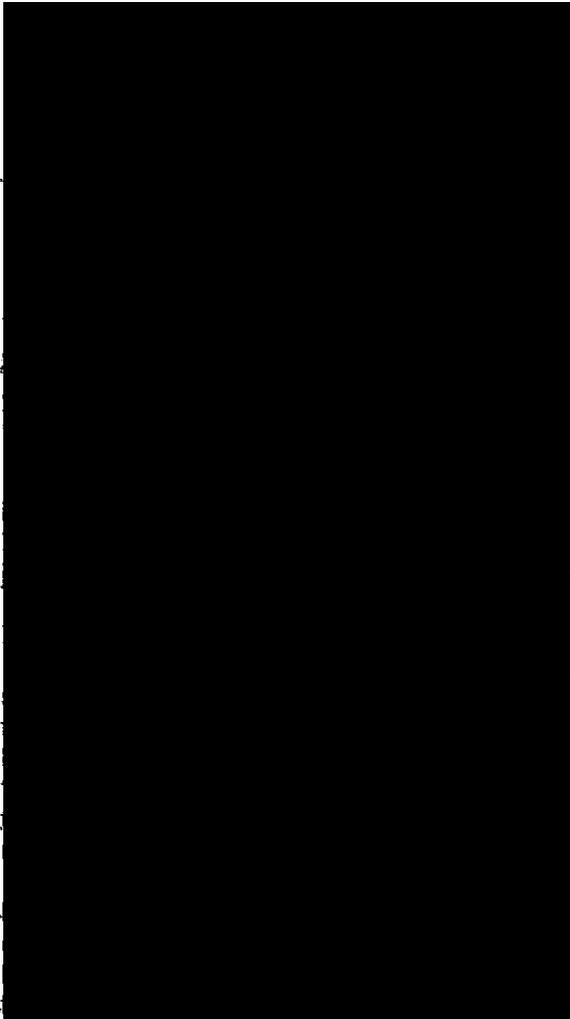
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W 186	<p>Continued From page 128</p> <p>supervised by a Pine Vocational Center Teacher at one point. One staff was observed providing 1:1 to another client, while another staff was in and out of the room escorting a client. [REDACTED]</p> <p>[REDACTED] The observed activity was totally different from the vocational training activity (shredding paper, counting, etc.) provided for clients in the classroom of Pine Vocational Center.</p> <p>During an interview with the Teacher on 9/24/13 at 10:05 AM in group room 3, she stated that the vocational training was held in the group room because they were short staffed.</p> <p>During an interview with the Individual Program Coordinator (IPC) of Residence 29 on 9/24/13 at 3:30 PM, she stated that there were no vocational training programs provided in the morning because one staff had to leave due an emergency and another vocational instructor left for cross training to Residence 15. The IPC confirmed that an activity was provided in the group room of Residence 29.</p> <p>Residence 29's Client Log dated 9/1/13 thru 9/24/13 was reviewed on 9/25/13 at 10:40 AM. The log indicated where clients went, who signed them out, when they left and came back to the residence. The log also indicated that on 9/5/13, 11 out of 13 clients were in the residence during the morning and afternoon hours, suggesting that the vocational training was not held at Pine Vocational Center.</p> <p>2. During an observation of focus sampled client 43 on 9/6/13 thru 9/23/13 at various times, it was</p>	W 186			

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W 186	Continued From page 129 noted that he was not provided his nature walk or exercise as part of his leisure and likes.  According to the TA, they walk every morning for the last three weeks. He also stated that there were shortages	W 186	W186 #2 a. The Program Assistant and DTAC Coordinator met with the teaching staff that works with Client 43 to develop a plan for consistent walks. b. The staff assigned to escort Client 43 on a walk will sign him out on the Client Log on the residence when they leave the residence. c. An informal data sheet will be initiated to track how long Client 43 walks each time he goes on a walk. d. The Program Assistant to provide training on this accountability process and have the Teaching Assistant who typically takes Client 43 on a walk in the mornings sign a training and development form. e. Individual Program Coordinator to monitor all ICF client's informal data and report on then forward to the Program Director for resolution.	10/24/13 09/24/13 10/25/13 10/25/13 10/25/13	

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W 186	<p>Continued From page 130</p> <p>in staff during morning and afternoon shift. He further stated that the client's sister and mom wanted him (focus sampled client 43) to walk. When the TA was asked if there was any documentation to prove that the client was being walked, he stated, "There's a sign in and out log (Client Log) in the residence."</p> <p>Residence 29's Client Log dated 9/1/13 thru 9/24/13 was reviewed on 9/25/13 at 10:40 AM. The log indicated where clients went, who signed them out, when they left and came back to the residence. The log also indicated from the period of 9/1/13 thru 9/23/13, focus sampled client 43 was only walked twice (once in the morning of 9/23 and once in the morning of 9/24/13), contrary to what the TA stated.</p> <p>3. On 9/17/13 at 5:45 AM, an interview was conducted with the PT (Psychiatric Technician). [REDACTED]</p> <p>During observations conducted on 9/17/13 at 7 AM, Client 56 and 20 were left unattended in the Group 2 day room. Facility staff was observed walking out of the day room, leaving both clients unattended. [REDACTED]</p> <p>At 1 PM on the same date, a PT was observed supervising six clients in the Group 2 day room. Four out of the six clients were not engaged in any activity. Client 57 was observed to get up to use the bathroom. The PT had to stop the activity and stood by the doorway to watch Client 57 go to the bathroom.</p> <p>During a concurrent interview with the PT, she stated there was supposed to be two staff in the group but the other staff had to go to lunch. She</p>	W 186	<p>W186 #3-4</p> <p>a. The Clinical Director gave written direction to the Residence and Program Managers to:</p> <ol style="list-style-type: none"> 1) meet with all staff on duty and ensure that they understand that clients' supervision levels must be implemented per the client IPP; 2) reevaluate staffing deployment immediately; and 3) meet that day to review staffing levels with the Program Directors and Nursing Coordinators to ensure effective staff deployment. <p>b. The CD and Program 2 Director met to discuss and develop a Client Supervision Accountability System for level of care staff which includes: 1) a Residence-specific reference tool which provides each client's name and their supervision level; 2) a signed acknowledgement of the review and understanding of the client supervision levels.</p> <p>c. 5 The Client Supervision Accountability System was implemented on Residence 31, including a review of the residence-specific reference tool and a signed acknowledgement of the review for all staff on duty.</p>	<p>09/25/13</p> <p>09/25/13</p> <p>09/25/13</p>	

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W 186	Continued From page 131 stated she had to do the activities one at a time because she was by herself. She stated she had to stop the activity and stand by the door to watch Client 57 go to the bathroom. [REDACTED] On 9/18/13 starting at 3 PM, a subsequent observation was conducted in Group 2 day room. A staff member was observed walking out of the day room with two clients to escort them to the bathroom. Four clients were left unattended in the day room including Client 56. On 9/23/13 at 9:30 AM, the RM was interviewed. The RM stated Client 56 ' s level of supervision was enhanced. He stated the client required visual supervision on the residence, DTAC, off grounds and in the restroom. 4. The clinical record for Client 56 was reviewed on 9/23/13. An interdisciplinary notes dated 9/18/13, indicated, " While staff was standing in the doorway of group area observing a client as she went to use the restroom, staff witnessed (Client 56) get up from her chair and strike her peer (Client 29) with the corner of a wooden puzzle board to her peer ' s rt (right) eye. " [REDACTED] On 9/24/13, at 3:15 PM, an interview with the PT who was supervising the Group 2 during the	W 186	W186 #3-4 cont. d. A review of each residence-specific reference tool was conducted to ensure each client's supervision levels are clearly defined and consistent with the individual's IPP. The Residence Manager is responsible for the review of the reference tool. Any findings in need of improvement are referred to the ID Team for revision, for which the IPC is responsible for coordinating. e. The Client Supervision Accountability System was implemented for all ICF residences. Residence Managers are responsible for accuracy and to ensure that all on-duty level of care staff have been trained on the supervision levels, and have signed an acknowledgement of the review and understanding of supervision levels. The Program Assistant will ensure this occurs for all the DTAC/worksite staff and Rehabilitation Therapists. f. Training on Administrative 226: Client Supervision and Personal Care was initiated on 9/23/13 with all level of care staff by Residence Managers. DTAC/worksite staff will be trained by the Program Assistant g. The IPC Supervisor will conduct a periodic audit to determine whether updates to the client supervision reference tools are completed on time for the first 90 days. Random audits will occur following IDTeam meetings in which the IPP documents indicate a change in level of supervision. (cont.)	09/25/13 09/27/13 09/27/13	

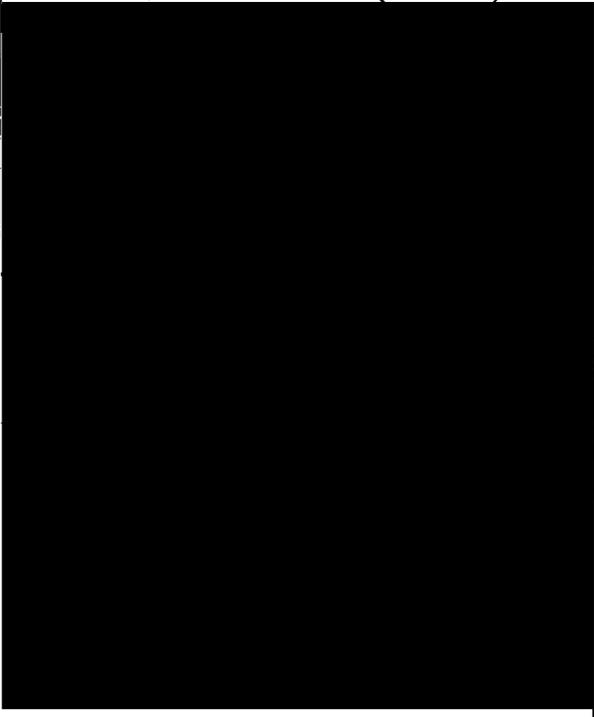
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 186	Continued From page 132 incident was interviewed. The PT stated she was the shift lead and covering the group by herself when a client needed to use the bathroom. She stated she had to stand by the doorway to be able to see the client who went to the bathroom. She stated all of a sudden, Client 56 got up and walked straight to Client 29 and hit her with a wooden puzzle. [REDACTED]	W 186	W186 #3-4 cont. g. cont.. Any findings in need of correction will be addressed with the IPC and involved residence immediately. The overall findings and recommendations will be submitted to the Executive Committee for review of compliance and of the process.	09/27/13	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and review of documents, the facility failed to provide each employee with training to perform duties competently. This affected one core sampled client (Client 64) and 10 focus sampled clients (Client 21, Client 69, Client 63, Client 26, Client 2,	W 189			

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W 189	Continued From page 133 Client 4, Client 16, Client 91, Client 43 and Client 92). Findings:  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 staff indicated 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 staff member did not wish to elaborate on what the problem concerning a client was or speak further. A request thru Standards Compliance revealed	W 189	W189 #1 a. All Day Training Activity Center (DTAC) classes in Program 2 will initiate the Orientation to DTAC Classroom form. b. All staff new to the classroom, including residence staff, Senior Companions, volunteers, and college/vocational students, will be given orientation to the classroom regarding Client 21 and the other assigned clients in the classroom. Staff 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. c. The Orientation to DTAC Classroom form will be kept in a binder in the classroom for a minimum of a month. d. The DTAC Coordinator will monitor form usage during weekly rounds and document on the DTAC Rounds Report. e. The DTAC Coordinator will maintain all Orientation to Classroom Rounds forms that are purged from the classroom binder for a year. f. All DTAC staff will sign a training sheet indicating they understand this process.	10/25/13 10/25/13 10/25/13 10/25/13 10/25/13	

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W 189	<p>Continued From page 134</p> <p>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 new to the area and just getting to know the clients. The teacher indicated he was moved after residences consolidated.</p> <p>2. In an interview with the HSS, IPC and Residence Manager on 9/25/13 at 2 PM, concerning the use of Client 69's adaptive equipment (helmets, mat, Ted Hose, and elevation of legs) 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 client adaptive equipment. At no time during the observation period at DTAC was Client 69 encouraged to elevate his legs or put on Ted Hose. (SEEW436)</p>  <p>From a distance, the surveyor noted that the client had some redness on his abdomen adjacent to his gastric tube and asked the licensed staff present if the surveyor could question him about the client. The staff stated that he was a float from another unit doing</p>	W 189	<p>W189 #2</p> <p>1. RM reviewed all adaptive equipment and its use at huddle. 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>2. The Physician, HSS, SRPT, RM and Father discussed the Risk vs Benefit of the bedside mat 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>189 #3</p> <p>a) Client # 63's medical needs were reviewed with the float staff on duty.</p> <p>b) Client # 63 had a topical treatment ordered for the Stoma site to be applied PRN. The topical treatment was applied immediately.</p> <p>c) An updated New Staff and Float orientation checklist was implemented, that includes information regarding each client including their medical, behavioral and alerts/risks. (please see continuation page 135a)</p>	09/20/13	09/16/13
				9/19/13	
				9/19/13	
				9/25/13	