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

PRINTED: 01/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	05G014		R-C 10/25/2013

NAME OF PROVIDER OR SUPPLIER
PORTERVILLE DEVELOPMENT CENTER - DP ICF/IID

STREET ADDRESS, CITY, STATE, ZIP CODE
26501 AVENUE 140
PORTERVILLE, CA 93257

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a re-visit full recertification survey of the ICF/IID. Representing the Department were the following HFENs: Health Facilities Evaluator Nurses: 22327, 16553, 05008, 14907, 13033, 27090, 21752, 10933, 26917, and Federal Surveyor, 16442 Census: 185 APOC 2/5/14 Sampled clients: 19 Unsampled clients: 25 During the survey, four Immediate Jeopardies (IJ) were called: An IJ was called on 10/14/13 and abated on 10/23/13. Deficiencies were written at W 104, W 406 and W454. An IJ was called on 10/15/13 and abated on 10/17/13. Deficiencies were written at W 192, W 318, W 331 and W 368. An IJ was called on 10/18/13 and abated on 10/18/13. Deficiencies were written at W 104 and W 120. During the survey, the following entity reported incidents were investigated: CA373930 - An Immediate Jeopardy (IJ) was called on 10/16/13 and abated on 10/23/13. Deficiencies were written at W 149, W 104, and	{W 000}	W 000 Entity Reported Incidents (ERI): ERI 374555 1. Client 59 and the other client involved in the incident were assessed by the RN/HSS. 2. Both clients involved in the incident were separated, and a Client Immediate Protection Plans were initiated. 3. No other Program 5 clients were affected. 4. All Unit 21 LOC staff will review Client 59's Approaches & Strategies and behavior plans. 5. Unit Supervisor and/or Senior PT will monitor staff compliance via rounds and client observation at least monthly, and document the findings. 6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 7. Program Director is responsible.	10-21-13 10-21-13 10-21-13 11-25-13 11-25-13 11-25-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marion Butler
TITLE: Executive Director
(X6) DATE: 1/24/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	Continued From page 1 W 331.	{W 000}		
W 100	CA374555 - One deficiency was issued. 440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "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 document 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 ensure that 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	W 100	W100 The Governing Body of Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Conditions of Participation for Active Treatment are met. The Governing Body will ensure that clients receive continuous active treatment programs that emphasize comprehensive assessment information, development of an individual-centered plan, and consistent implementation/ monitoring/revision of training plans. See also W195.	10-25-13

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W 100	Continued From page 2 consistent implementation of training programs to teach skills and increase independence. See W 195	W 100	W102 The Governing Body of Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Conditions of Participation are met. The Governing Body will ensure that clients receive continuous active treatment programs that emphasize comprehensive assessment information, development of an individual-centered plan, and consistent implementation/ monitoring/revision of training plans. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags.	10-25-13
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, document review and interviews, the facility failed to ensure the Condition of Participation, Governing Body and Management, was met when six of seven Conditions of Participation were not met (Client Protections (See W 122), Facility Staffing (See 158), Active Treatment (See 195), Health Care Services (See 318) and Physical Environment (See 406,) and the governing body failed to take responsibility and action to identify and resolve systemic problems of a serious and recurrent nature. The facility failed to exercise, monitor and implement policies to ensure the health and safety of all clients residing at the facility. Findings: 1. The condition of Participation, Governing Body was not met as evidenced by: A. The facility failed to ensure that the governing body took action that identified systemic problems when insulin was given to hypoglycemic clients (clients with blood sugars of less than 70 mg/dl	{W 102}	W102 #1.A (See also W104) - The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. - Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed. - Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus". - Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	10-16-13 10-16-13 10-16-13 10-17-13 11-15-13 11-25-13

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{W 102}	Continued From page 3 [deciliter]). (See W 104) B. The facility failed to have an effective pest control program in place in the main kitchen or residence kitchens in the ICF. (See W 104) C. Facility policy and good nursing practice were not implemented after a client fell and sustained a head injury. (See W 104) D. Monitoring of food temperatures at the Blue Heron was not done during the cooling process of potentially hazardous foods, with the potential infection of clients and staff with a food borne illness. (See W 104, W 120) 2. The Condition of Participation, Client Protections, was not met as evidence by: A. The facility failed to ensure that Client 49 who tripped and fell on the floor, hitting his head and sustaining a head injury, was assessed by an RN until almost 12 hours after the fall. Due to this lack of care to the client, an Immediate Jeopardy was called on 10/15/13 and was abated on 10/23/13. B. The facility did not implement the plan of correction from the recertification survey of July, 2013 when there was no evidence that all the clients in Program 5 were assessed for appropriate placement, according to their age, developmental and social levels. C. The facility also did not ensure that clients' freedoms were not denied or restricted when clients on Residence 36 were not provided with appropriate money management skills; when clients were not provided with appropriate	{W 102}	W102 #1.A (See also W104) (cont.) - Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. - Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. - Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W102 #1.B (See also W104) - All food in the kitchens on units 5, 6, 21, 23, 25, 26, and 36 that originated from the Main Kitchen were discarded. Emergency food plan was immediately activated. - The use of the Main Kitchen was suspended, and a satellite kitchen was set up to be used for food preparation until the grout issues were resolved. - Facility Vector Control immediately sprayed kitchen areas on units 5, 6, 21, 23, 25, 26, 36, Main Kitchen, and the satellite kitchens. - All floor surfaces, utensils, dishes, kitchen surfaces in kitchens on units 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen were cleaned.	11-25-13 11-25-13 11-25-13 10-14-13 10-14-13 10-14-13 10-15-13

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{W 102}	Continued From page 4 supervision to ensure privacy while getting dressed; when clients were observed with ill-fitting or soiled clothing; when no community activities were provided to clients on Residences 5, 23 and 36; when clients were provided with activities that were not appropriate for their age; when clients were denied access to their locked wardrobes; when Client 26 had items listed on his personal property card that could not be located. See W 126, W 127, W 130, 136, W 137, and W 149 3. The Condition of Participation, Facility Staffing, was not met as evidenced by: A. There were insufficient numbers of trained and knowledgeable staff available to ensure that clients' individual programs were carried out. B. The facility did not provide active treatment to the clients according to their assessed needs when insufficient staff were available to supervise clients on Residence 23 and no active treatment was ongoing. Clients A and 55 were allowed to walk in untied or unlaced tennis shoes without staff intervention. C. Dietary staff were unable to take the temperature of food being served to clients and were unable to prepare the food without burning it. D. The Interdisciplinary Team did not re-assess Client 39's stigmatizing mechanical restraints and research treatment alternatives. E. There was no intervention by staff to redirect a client from inappropriate behaviors during work. A client with a training objective to reduce	{W 102}	W102 #1.B (See also W104) (cont.) - Facility Vector Control laid traps in the kitchen areas on units 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen. - Outside consultant from Department of Public Health, Environmental Science division (DPH-EVS) was contacted. - Outside consultant from DPH-EVS advised the facility and provided a written summary of the actions discussed. - Emergency contracts with outside Vector Control company was established for treatment services. - Acting Director of Dietetics developed new Dietetics Procedure L-19 "Production - Cleaning Procedure" on the sanitation process to be used prior to and after food preparation. Dietetics Procedures E-10 "Presentation - Cleaning Procedure" and D-10 "Production - Food Storage/Receiving Procedure" were revised. - Dietetics staff were trained by the Acting Director of Dietetics or designee on the new and revised procedures. - Supervising Housekeeping Supervisor III developed procedure for "Housekeeping Vector Control". - Janitorial staff were trained by the Supervising Housekeeping Supervisor III or designee on the new procedure "Housekeeping Vector Control". - Facility Bulletin 144 "Pest and Animal Control" was revised. - Dietetics staff, janitorial staff, and Program 5 staff were trained by their supervisors or designees on the revised Facility Bulletin 144 "Pest and Animal Control". - Dietetics Supervisors, Housekeeping Supervisors, Unit Supervisors Program Management, and Quality Assurance will monitor unit environment and staff compliance via rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body	10-15-13 10-15-13 10-17-13 10-22-13 10-23-13 10-23-13 10-23-13 10-23-13 10-23-13 11-25-13 11-25-13 11-25-13

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{W 102}	Continued From page 5 banging his head was allowed to continue that behavior without staff intervention. F. Multiple clients did not have their treatment programs monitored and coordinated by the IPC's. G. Client 27 was not assessed in his home or work environment by the expert in autism and autistic services . See W 159, W 164, W 186, W 189, W 191, W 192, W 193, and W 194 4. The Condition of Active Treatment was not met as evidenced by: A. Clients were not involved in activities that addressed their individualized priority needs nor had opportunities to practice new or existing skills and to make choices in their daily routines. B. The Interdisciplinary teams did not assess the appropriateness of the access restriction to the fenced backyard for multiple clients. C. A client expressed an interest in a food service job and he was not assessed as to what his needs would be for that job. A client was not re-assessed for the appropriateness of his placement in a day program. D. Multiple clients were not given the opportunity to perform dining and meal preparation activities that they were capable of doing. E. Activities were presented to multiple clients that were clearly inappropriate for them; the activities were clearly meant for young children.	{W 102}	W 102 #1.B (See also W104) (cont.) will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W102 #1.C (See also W104) - Program 5 NOC shift staff audited the last 24-hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. - RN/HSS and/or ACNS contacted each Program 5 units, via call or visit, every hour to verity no client had fallen and/or struck head. - Program 5 LOC staff were trained by their Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". - Facility Bulletin 105 "Client Protections" was revised. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Baulletin 105 "Client Protections", Clinical Recording Guideline 2 "Temporary Conditions", and Clinical Recording Guideline 5 "Client Immediate Protection Plan". - Program Management will review Daily Reports at the morning meeting for any report of client(s) falling or striking head on previous shift(s) and actions taken. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W102 #1.D (See also W104 and W120) - Acting Director of Dietetics provided on-site training to the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling and set up/service of cold food items.	10-17-13 10-17-13 10-17-13 10-21-13 10-23-13 10-23-13 11-25-13 10-18-13

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{W 102}	Continued From page 6 F. Clients' activities of daily living plans were not implemented. G. A client's money management objectives were met and no new objectives were developed. See W 196, W 214, W 225, W 247, W 249, W 255 and W 256. 5. The Condition of Participation for Health Care services was not met as evidenced by: A. Clients did not receive adequate health care and monitoring when [redacted] diabetic clients receiving insulin were administered insulin while they were hypoglycemic. An Immediate Jeopardy was called on 10/15/13 and abated on 10/17/13. These failures had the potential to result in severe illness, coma, brain injury or death. The fact that these hypoglycemic reactions occurred in clients who may not have had the intellectual capacity to alert anyone to any symptoms increased the potential for severe adverse reactions. B. Client 49 tripped, fell, hit his head and was not monitored nor assessed until approximately 12 hours after the fall. An Immediate Jeopardy was called on 10/16/13 under Client Protections and was abated on 10/23/13. This Immediate Jeopardy also contained aspects of lack of monitoring and assessment. The lack of follow-up for a client with a head injury had the potential to miss significant warning signs of a worsening condition. There was also a systems failure in that there was a conflict between policy and procedure in regards to reporting a head injury to the RN/MD.	{W 102}	W102 #1.D (See also W104 and W120) (cont.) - Acting Director of Dietetics reviewed the system for tracking food temperatures and food temperature log, and provided training to the Blue Heron staff. Acting Director of Dietetics also conducted an environmental check of the Blue Heron, and identified areas that needed to be corrected - Director of Central Program Services who oversee the Blue Heron set expectation for the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling, set up/service of cold food items, and food temperature log. - Program 5 LOC staff were trained by their Unit Supervisors or designees on Infection Control Guideline 3.14 "Food-borne Illnesses". - Food Services Supervisors will monitor Blue Heron food preparation and service of cold foods no less than twice per week. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W102 #2.A (See also W126, W127, W130, W136, W137, and W149) - Program 5 NOC shift staff audited the last 24-hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. - RN/HSS and/or ACNS contacted each Program 5 units, via call or visit, every hour to verity no client had fallen and/or struck head. - Program 5 LOC staff were trained by their Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". - Facility Bulletin 105 "Client Protections" was revised. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 105 "Client Protections", Clinical	10-18-13 10-18-13 10-20-13 10-20-13 11-25-13 10-17-13 10-17-13 10-17-13 10-21-13 10-23-13

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{W 102}	Continued From page 7 C. A client's recommended ophthalmology follow-up was not done. D. Diabetic health care plans were not implemented when there was no documentation of monitoring for hypoglycemic symptoms in diabetic clients. E. There were no drug regimen reviews that identified and addressed the hypoglycemic reactions for clients who were administered insulin. F. There were no current drug references in the pharmacy. G. There was inadequate temperature monitoring of the refrigerator in the pharmacy that contained temperature sensitive vaccines. See W 322, W 331, W 363, W 368, and W 378 6. The Condition of Participation for Physical Environment was not met as evidenced by: A. The Central Kitchen and the residence kitchens were not maintained in a sanitary manner and there was an ineffective pest control program in place. An Immediate Jeopardy was called on 10/14/13 and abated on 10/23/13. These failures resulted in a potential infection control problem due to the contamination of food served to clients and infestation throughout the whole facility if the pests were not adequately controlled. B. The facility did not provide oversight for the kitchen in the Blue Heron. There were no	{W 102}	W102 #2.A (See also W126, W127, W130, W136, W137, and W149) (cont.) Recording Guideline 2 "Temporary Conditions", and Clinical Recording Guideline 5 "Client Immediate Protection Plan". - Program Management will review Daily Reports at the morning meeting for any report of client(s) falling or striking head on previous shift(s) and actions taken. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W102 #2.B (See also W126, W127, W130, W136, W137, and W149) - A review of assessment information for clients residing in Program 5 was conducted to ensure appropriate placement based on developmental and functioning levels, and social/medical needs. - An IPP review and/or Emerging Risk Notification/Evaluation meeting was held to address each Program 5 client's placement. Any clients identified as requiring further assessment for possible alternate placement was referred to the Interdisciplinary Team. - Program Director will monitor and review the assessment process and Interdisciplinary Team recommendations for appropriateness of placement. - Program Management will conduct monthly review of the unit population/client grouping via the Overview System Comprehensive Assessment of Risk (OSCAR) meetings. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-23-13 11-25-13 11-24-13 11-24-13 11-24-13 11-24-13 11-25-13

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			W102 #2.C (See also W126, W127, W130, W136, W137, and W149)	
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" with emphasis on assisting clients with meeting their dressing and grooming needs.	11-25-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients", and Facility Bulletini 79 "Client Rights".	11-25-13
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment to ensure they address concerns for dignity during the assessment process, client preferences, personal possessions, individualized rooms, and make recommendations as needed.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training objectives, monitoring client possessions, and client restricted access.	11-25-13
			- IPC's will monitor clients' training via monthly audit of the progress notes in the clients' records and via rounds at least monthly.	11-25-13
			- Program Management will review the quarterly audit of all client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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			W102 #3.A (See also W159, W164, W186, W189, W191, W192, W193, and W194) - The Governing Body of Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Conditions of Participation are met. The Governing Body will ensure sufficient numbers of trained and knowledgeable staff are available to monitor the implementation of the clients' individual programs.	10-25-13
			W102 #3.B (See also W159, W164, W186, W189, W191, W192, W193, and W194) - Unit 23 unit routine were revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered.	11-18-13
			- Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine.	11-24-13
			- Unit Supervisor and/or Senior PT will monitor active treatment during rounds at least monthly.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #3.C (See also W159, W164, W186, W189, W191, W192, W193, and W194) - Acting Director of Dietetics set the expectations at the October Monthly Mandatory Meeting with Dietetics staff of calibrating thermometers at least once a month and how to take accurate reading of the thermometer.	10-25-13
			- Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the unit kitchens.	10-25-13

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			W102 #3.C (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.) - Any issues requiring further actions will be reviewed monthly at the Administrative Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-25-13
			W102 #3.D (See also W159, W164, W186, W189, W191, W192, W193, and W194) - A Special IPP was held for the client to review past restrictive devices used for SIB.	11-15-13
			- Director of Quality Assurance conducted research of restrictive devices available or in use elsewhere. It was determined that the current device is the least stigmatizing and most effective for the client.	11-15-13
			- Psychologist was in the process of reviewing the client's Functional Analysis of Behavior (FAB), and will be updating the FAB by 12/12/13 to reflect his use of the plastic hand device.	11-15-13
			- Unit Supervisor and/or Senior PT will monitor staff compliance with client behavior plans during rounds at least monthly.	11-15-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-15-13
			W102 #3.E (See also W159, W164, W186, W189, W191, W192, W193, and W194) - The client was redirected from the behavior by by staff.	10-15-13
			- Unit routine and day program training was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered.	11-20-13

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			W102 #3.E (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.)	
			- Unit LOC staff were trained by the Unit Supervisor or designee on the client's behavior plan and Functional Analysis of Behavior.	11-24-13
			- Unit Supervisor and/or Senior PT will monitor active treatment and staff compliance with client behavior plans during rounds at least monthly.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-24-13
			W102 #3.F (See also W159, W164, W186, W189, W191, W192, W193, and W194)	
			- Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client programs.	11-25-13
			- IPC, Unit Supervisor and/or Senior PT will monitor client programs during rounds at least monthly to observe client participation.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #3.G (See also W159, W164, W186, W189, W191, W192, W193, and W194)	
			- Client 27 was referred to the facility autism specialist.	10-31-13
			- Program Management identified autistic clients in the program. An IPP review was held for each of the identified autistic client to discuss any identified issues that may be a result of their autism and any need for further assessment.	11-01-13

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			W102 #3.G (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.) - IPC's will monitor progress notes recording for clients via monthly audit of the client clinical records.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-24-13
			W102 #4.A (See also W196, W214, W225, W247, W249, W255, and W256) - Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices.	11-25-13
			- IPC's will monitor client assessments and objectives during rounds at least monthly to observe client participation.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation during rounds at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #4.B (See also W196, W214, W225, W247, W249, W255, and W256) - A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client.	11-24-13
			- IPP reviews were held for Program 5 clients to assess restrictive access along with the	11-24-13

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			W102 #4.B (See also W196, W214, W225, W247, W249, W255, and W256) (cont.) clients' IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement.	
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and address client access during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring clients' restricted access and client rights.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client access during rounds at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #4.C (See also W196, W214, W225, W247, W249, W255, and W256)	
			- A vocational assessment was completed for the client that addressed the client's desire to work in a restaurant.	11-24-13
			- Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessment.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #4.D (See also W196, W214, W225, W247, W249, W255, and W256)	
			- Classes for clients to learn about meal preparation, consumer budget for meals, and infection control to be held three times per week was in	11-25-13

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			W102 #4.D (See also W196, W214, W225, W247, W249, W255, and W256) (cont.) the process of being developed and was anticipated on being finalized on 12/11/13 and added to the unit activity calendar and schedule. Shopping trips for meals/cooking classes were also added to the unit activity calendar.	
			- Unit routines were in the process of being reviewed and will be completed on 12/11/13 to include meal preparation and clean-up groups prior to meals.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation during meal classes.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #4.E (See also W196, W214, W225, W247, W249, W255, and W256)	
			- Program 5 units were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the unit. New training supplies were ordered and obtained from Curriculum Services.	10-22-13
			- Unit routine and training site schedule were revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered.	11-18-13
			- Unit LOC staff were trained by the Unit Supervisor or designee on the revised unit routine.	11-24-13
			- Unit Supervisor and/or Senior PT will monitor active treatment during rounds at least monthly.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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			W102 #4.F (See also W196, W214, W225, W247, W249, W255, and W256)	
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices.	11-25-13
			- IPC's will monitor client assessments and objectives via rounds at least monthly to observe client participation.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation via rounds at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #4.G (See also W196, W214, W225, W247, W249, W255, and W256)	
			- An IPP review was held for the client, and a new training objective for money management was developed.	10-24-13
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the clients' current objectives during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
			- Unit Supervisor or designee were in the process of training the unit LOC staff on the client's new training objective for money management. The training is anticipated to be completed by 12/13/13.	11-25-13

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			W102 #4.G (See also W196, W214, W225, W247, W249, W255, and W256) (cont.)	
			- IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #5.A (See also W322, W331, W363, W368, and W378)	
			- The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			- Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed.	10-16-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	10-17-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes.	11-15-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	11-25-13
			- Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the	11-25-13

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			W102 #5.A (See also W322, W331, W363, W368, and W378) (cont.) Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. - Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia.	11-25-13
			- Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #5.B (See also W322, W331, W363, W368, and W378) - Program 5 NOC shift staff audited the last 24-hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head.	10-17-13
			- RN/HSS and/or ACNS contacted each Program 5 units, via call or visit, every hour to verity no client had fallen and/or struck head.	10-17-13
			- Program 5 LOC staff were trained by their Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of".	10-17-13
			- Facility Bulletin 105 "Client Protections" was revised.	10-21-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Baulletin 105 "Client Protections", Clinical Recording Guideline 2 "Temporary Conditions", and Clinical Recording Guideline 5 "Client Immediate Protection Plan".	10-23-13
			- Program Management will review Daily Reports at the morning meeting for any report of client(s)	10-23-13

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			W102 #5.B (See also W322, W331, W363, W368, and W378) (cont.) falling or striking head on previous shift(s) and actions taken. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #5.C (See also W322, W331, W363, W368, and W378) - The client was seen by the ophthalmologist at the Eye Clinic. The result of the dilated eye exam showed no evidence of toxicity to the medication.	06-26-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's special clinic consults.	11-25-13
			- Program 5 Management and Unit Supervisor will monitor client special clinic consults via the Behavior Intervention Review Team meetings.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #5.D (See also W322, W331, W363, W368, and W378) - The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			- Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed.	10-16-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic	10-16-13

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			W102 #5.D (See also W322, W331, W363, W368, and W378) (cont.) Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	10-17-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes.	11-15-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	11-25-13
			- Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			- Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia.	11-25-13
			- Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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			W102 #5.E (See also W322, W331, W363, W368, and W378)	
			- The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			- Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed.	10-16-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	10-17-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes.	11-15-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	11-25-13
			- Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			- Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia.	11-25-13
			- Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting	11-25-13

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			W102 #5.E (See also W322, W331, W363, W368, and W378) (cont.) and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	
			W102 #5.F (See also W322, W331, W363, W368, and W378) - A request for purchase of the "Clinical Pharmacology" was submitted.	11-18-13
			- Pharmacy Services Manager will ensure the drug references manual is current via yearly review of the drug references manuals.	11-18-13
			- Any elevated issues will be reviewed monthly at Administrative Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W102 #5.G (See also W322, W331, W363, W368, and W378) - Pharmacy temperature log was modified with instructions on what to do if the temperature is out of range. Pharmacy personnel were trained by the Pharmacy Services Manager on the modified log.	11-20-13
			- A purchase order was submitted for a new pharmaceutical grade refrigerators and freezer with product temperature sampling, continuous temperature monitoring, web-based access to temperature data, tamper-proof data integrity, and high/low temperature alarm system.	11-25-13
			- Pharmacists will monitor the temperature via rounds at least monthly.	11-25-13

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{W 104}	Continued From page 26 communications between dietetics staff and the pest control and housekeeping staff, and training attendance logs showed that the facility was aware of the problem with the roaches and mice. Review of the facility Infection Control Guideline titled "Housekeeping/Janitorial" dated June 2010 stated the "Environmental services department is responsible for maintaining a safe, clean and orderly interior of all residential units, program offices, class rooms, public buildings and special designated areas." The Infection Control Guideline, titled Plant Operations/ Vector control/Animal Control, dated April 2009, under the heading Plant Operations, places responsibility for inspecting all buildings and grounds for evidence of infestation of such vectors as ants, cockroaches, mice, rats, flies, bats and other vector problems on the Plant Operations. The guideline further states that Plant Operations will contract with an outside vendor to provide pest/vector services when necessary. With documented evidence of the roach problem going on for over two years and the in-house attempts at controlling not being effective, the facility failed to follow its own guidelines. There was no evidence that Plant Operations, Housekeeping, or Dietetics identified the problems of the roach infestation and the presence of mice or shared information with the infection control committee. Review of the Infection Control minutes from May 2013 through September 2013 did not show that any pest control issues had been brought forward for discussion and/or resolution.	{W 104}	W 104 (cont.) 9.1. A work order was submitted to repair the dripping of water from a pipe attached to the side of the building from the roof to the ground. 9.2. The repair was completed. 9.3. The work order form was revised to include a section for staff completing the work to note any additional findings when they are in the area. 9.4. Janitorial staff and FEAT team will monitor the physical environment via rounds at least monthly. Any issues identified will be reported via the work order system. 9.5. Any issues requiring further actions will be reviewed monthly at the Administrative Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 9.6. Chief of Plant Operations is responsible.	10-24-13 10-24-13 11-13-13 11-13-13 11-13-13

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{W 104}	Continued From page 27 The facility failed to develop an effective pest control program. The PCT failed to follow manufacturer's instructions on the use of the chemical pesticide, failed to provide guidance on the effective management of the cockroaches by failing to ensure that the cracks in the floors and walls were sealed to prevent the harboring of the cockroaches. The different departments failed to bring attention to the problem by failing to inform the infection control committee. In addition the facility failed to follow its guidelines by failing to contract with an outside vendor when the pest services were necessary. (See W 454) 5. Immediate jeopardy was declared on 10/18/13 at 11:20 AM. A corrective action plan was provided by the facility administrator on 10/18/13 at 1:15 PM. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate jeopardy on 10/18/13 at 1:15 PM. At approximately 11:10 AM on 10/17/13, a tour of the Blue Heron, a contracted canteen, on the [Facility name] campus was conducted. One of the sampled clients (Client 5) was observed eating a chicken sandwich out in the dining area.	{W 104}	W 104 (cont.) 10.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 10.2. Recreational Therapist/unit staff scheduled trips for Client 19 and Client 35 to go on a community outing three times in a quarter. 10.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 10.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review. 10.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 10.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 10.7. Program Director is responsible.	11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13
	A tour of the kitchen was conducted. There was a sandwich bar in the kitchen that opened to a service window in the dining area. There were items used to make sandwiches such as onions, tomatoes, mayonnaise, chicken salad, tuna salad, etc. A request was made to test the temperature of the potentially hazardous foods on the sandwich bar. Potentially hazardous foods are foods that require time and temperature control			

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{W 104}	Continued From page 28 for food safety. These were the chicken and tuna salads. The chicken salad was 46.7 degrees Fahrenheit (F) and the tuna salad was 40.8 degrees F. The recommended holding temperature for cold food is 41 degrees F and below. The Food Instructor (FI) who was responsible for managing the kitchen asked another employee to take some of the chicken salad out and returned the scooped out portion into another refrigerator. The original container was never removed from the sandwich bar. A few minutes later, the chicken salad was rechecked and the temperature was 43.3 degrees F. As the tour continued, another container was found in the reach-in refrigerator containing a larger amount of the chicken salad. The temperature of the chicken salad in the refrigerator was 48.7 degrees F. The FI was interviewed on the process and meal preparation method for the chicken Salad. She indicated that the chicken salad was prepared from chicken breasts cooked in a crock pot from 10 AM to 4 PM the day before, 10/16/13. She stated that the chicken breasts were then placed in a metal container pulled apart and placed on ice until it reached 70 degrees F, which is approximately about 1-1/2 hours later. The metal container with the chicken was then placed in the refrigerator for further cooling. The FI stated the Blue Heron closed at 5:30 PM but there was another staff present till 7 PM. When interviewed on the responsibilities of this employee, she acknowledged, they had no temperature cooling/monitoring responsibilities. FI stated in an interview on 10/17/13 at	{W 104}	W 104 (cont.) 11.1. A work order was submitted to repair the exit doors in the auditorium. 11.2. The work order for the door repair was completed. 11.3. The work order form was revised to include a section for staff completing the work to note any additional findings when they are in the area. 11.4. Janitorial staff and FEAT team will monitor the physical environment via rounds at least monthly. Any issues identified will be reported via the work order system. 11.5. Any issues requiring further actions will be reviewed monthly at the Administrative Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 11.6. Chief of Plant Operations is responsible.	10-24-13 11-20-13 11-13-13 11-13-13 11-13-13

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{W 104}	Continued From page 29 approximately 11:30 AM that they had cooling logs. A review of the temperature log that was presented indicated that the temperature of the chicken had not been recorded and the form presented was not an actual cooling log. There were only two items regularly monitored for temperature from July 2013 to October 2013. These two items were chili and cheese. Section 3-401.14 (E) of the 2009 Food Code states that "Raw animal foods that are cooked using a non-continuous cooking process shall be cooled according to the time and temperatures parameters specified for cooked potentially hazardous food (Time/Temperature Control for Safety Food). The (Time/Temperature Control for Safety Food) is cooling within 2 hours from 135 degrees F to 70 degrees F and within a total of 6 hours from 135 degrees F to 41 degrees F. In addition, Section 3-401.14 (F) (2) of the 2009 Food Code requires that the raw foods be prepared and stored according to written procedures that are maintained in the food establishment are available to the regulatory authority on request. The FI pointed to a column that showed how all the items that had been cooled were 70 degrees. When the FI was asked the significance of 70 degrees Fahrenheit, she stated that when food was cooled they monitor to make sure it reaches 70 degrees. When asked if any further steps were monitored she stated "No". The FI and the food manager stated they had food safety certifications and neither was able to state that the correct process of cooling to include the further cooling to 41 degrees Fahrenheit. The FI and canteen manager were not able to show previous cooling logs and knowledge on the	{W 104}	W 104 (cont.) 12.1. The identified chairs were immediately removed from the area, and replaced with sturdy chairs. An environmental check was conducted. No other potential hazards were noted. 12.2. Housekeeping Supervisor III provided training to Housekeeping Supervisors and FEAT team members to specifically check for condition of furniture when conducting rounds at least monthly. 12.3. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" and on checking for conditions of furniture when conducting rounds. 12.4. Janitorial staff and FEAT team will monitor the condition of the furniture on the residence via rounds at least monthly, and elevate any concerns to the Unit Supervisor or designee. 12.5. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor the condition of furniture via rounds at least monthly, and document the findings. 12.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 12.7. Program Director is responsible.	10-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 30 proper cooling process. The Blue Heron had stopped monitoring the cooling of the chicken after 5:30 PM. They were not able to state if the food had cooled down to the proper temperature. Temperatures were not taken before additional items such as the mayonnaise, apple and nuts were added on 10/16/13. The appropriate time to check that the chicken had cooled down to 41 degrees Fahrenheit or below was prior to the addition of those other ingredients. Therefore, the possibility exists that the food may have been in the danger zone for over 16 hours. Review of the facility document titled Canteen Lease, dated June 4, 2013 between the facility and the food vendor, Blue Heron was conducted. Included in the terms of the lease was the requirement that the Administrative Services Director of the facility had the right to regulate the operations of Blue Heron as they affect the "...safety and conduct of the facility." In addition, the lease had the Blue Heron "comply with all rules and regulations" adopted by the facility. At approximately 11:46 AM on 10/17/13, the Acting Director of Dietetics (ADD) was interviewed on the dietetics department's responsibility for oversight for food safety at the Blue Heron. She stated that there was no affiliation with the Blue Heron as it was managed by a separate entity. In an interview at approximately 1:12 PM on 10/17/13, the facility staff in charge of the contract was interviewed. She stated that she does not provide any oversight to the Blue Heron but includes them in training provided to staff. She	{W 104}	W 104 (cont.) 13.1. The identified water fountain was immediately cleaned by Janitorial staff. 13.2. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" and on checking for conditions of furniture when conducting rounds. 13.3. Janitorial staff and FEAT team will monitor environmental issues via rounds at least monthly, and elevate any concerns to the Unit Supervisor or designee. 13.4. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor environmental issues via rounds at least monthly, and document the findings. 13.5. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 13.6. Program Director is responsible.	10-14-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 31 stated that the food manager was certified in food safety. Improper cooling is a major factor in causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease-causing microorganisms that may survive the cooking process. All persons including those with compromised immune systems are at increased risk of foodborne illness such as Salmonella, Norovirus, Clostridium Perfringens, E. Coli, when food is not held at the appropriate temperature. Some of the symptoms include fever, diarrhea and vomiting and in some cases death. The facility failed to provide oversight to the contracted service. There was lack of supervision and monitoring of the food service activities by the staff at [facility name]. The food vendor failed to put a system in place to ensure that food was cooled in a manner consistent with recognized food standards. 6. According to the breakfast menu on 10/16/13, the following items were offered: Juice, pancakes with syrup, egg patty, cold cereal, toast with jelly and milk. At approximately 8:12 AM on 10/16/13, Client 5 was overheard stating "This [expletive] is cold". The resident told the Residence staff present that his food was cold. The food service worker (FW) serving the food felt the eggs and pancakes and agreed it was cold. She took the temperature and stated it was 80 degrees Fahrenheit (F). FW then proceeded to return the items to the oven to reheat. A few minutes later, FW pulled	{W 104}	W 104 (cont.) 14.1. The three identified staff were trained by Unit Supervisor or designee on Client Abuse Prevention Training. 14.2. Program Director reviewed training records for all Program 5 LOC staff to ensure staff are current in their Client Abuse Prevention Training. 14.3. Program 5 LOC staff not current in Client Abuse Prevention Training were trained by their Unit Supervisors or designees. 14.4. Unit Supervisor will monitor staff staff compliance via review of the staff training records. Action will be taken to correct any deficiencies noted. 14.5. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 14.6. Program Director is responsible.	11-25-13 11-18-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 32 out the food but was not observed to recheck the food temperatures prior to serving the clients. Section 3-403.11 of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds." The facility failed to ensure that the food was either cooled or reheated to the appropriate temperature to prevent the growth of microorganisms or toxin formation. The facility failed to put systems in place to ensure that staff consistently practiced safe food production procedures. (see W 120) 7. A review of the Plan of Correction that was received in the CDPH office on 9/6/13 indicated that Step 12 of the correction plan for W 102, W 122, W 127, W 149 and W 407, stated that " All client in Program 5 were assessed by the ID Teams for appropriate housing based on ages, developmental levels and social needs. Teams reviewed client assessments to ensure the assessments are current, valid and accurate. " A spread sheet was presented as evidence that all the clients had been assessed. The spread sheet listed each client ' s name, date of assessment, unit, age, the different assessments used to verify the assessment of correct placement, whether clients had a history of sexual behaviors or of being victimized and columns for the unit supervisor and program director to fill in dates when all the assessments were complete and had been reviewed. All of the dates for unit supervisors and program director	{W 104}	W 104 (cont.) 15.1. The identified sofa and chair on residence 5 were immediately removed and replaced. An environmental check was conducted. No other potential hazards were noted. 15.2. The 1:1 assignment sheets for the two identified clients with Pica behavior were revised to specify environmental sweep activity as well as providing a place to note findings, actions taken, or other comments. 15.3. Unit 25 LOC staff were trained by the Unit Supervisor or designee on the revised 1:1 assignment sheets. 15.4. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Protocol 12 "Care of Client with Pica". 15.5. Housekeeping Supervisor III provided training to Housekeeping Supervisors and FEAT team members to specifically check for condition of furniture when conducting rounds at least monthly. 15.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" and on checking for conditions of furniture when conducting rounds. 15.7. Janitorial staff and FEAT team will monitor the condition of the furniture on the residence via rounds at least monthly, and elevate any concerns to the Unit Supervisor or designee. 15.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor the condition of furniture via rounds at least monthly, and document the findings. 15.9. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 15.10. Program Director is responsible.	10-14-13 11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 33 were blank except for the spread sheet for Residence 21, which had unit supervisor review dates of 6/23/13. There were several dates of different assessments used for evaluating clients that were more than two years old on each spread sheet except for that of Residence 26. In an interview with Program Management Staff on 10/23/13 at 11:00 AM, she stated that the spread sheet was the only evidence the facility had for verification that all assessments had been completed by the correction plan date of 6/28/13. Program Staff stated that all the unit supervisors had reviewed the spreadsheets and that all the assessments were current, accurate and valid. She stated that the spreadsheet was used to determine who would be moved to which residence. When questioned why the dates of some assessments were more than two years old, Program Staff could not explain why that was except to say she thought those dates had just not been updated. Staff stated that she was sure that more current assessments had been used to evaluate clients for appropriate placement. She could not explain why there was no documentation of review dates by the unit supervisor or herself noted on the spread sheets. When asked what evidence Program Staff could provide to verify that all clients, not just those who had been moved to different residences, had been assessed, she stated that the spreadsheet was the evidence. When she was asked how the spread sheet provided evidence of assessment, she could not explain that idea. In an interview with Facility Management Staff on 10/23/13 at 12:00 PM, she stated that the facility had evidence that the 20 clients who had moved to different residences had all been assessed.	{W 104}	W 104 (cont.) 16.1. A work order was submitted to replace the metal glides on the chairs. 16.2. The repair was completed. 16.3. The identified settees and chairs were removed and replaced. An environmental check was conducted. No other potential hazards were noted. 16.4. The 1:1 assignment sheet for Client 58 was revised to specify environmental sweep activity as well as providing a place to note findings, actions taken, or other comments. 16.5. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised 1:1 assignment sheet. 16.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Protocol 12 "Care of Client with Pica". 16.7. Housekeeping Supervisor III provided training to Housekeeping Supervisors and FEAT team members to specifically check for condition of furniture when conducting rounds. 16.8. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" and on checking for conditions of furniture when conducting rounds. 16.9. Janitorial staff and FEAT team will monitor the condition of the furniture on the residence via rounds at least monthly, and elevate any concerns to the Unit Supervisor or designee. 16.10. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor the condition of furniture via rounds at least monthly, and document the findings. 16.11. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 16.12. Program Director is responsible.	10/22/13 10/22/13 10/22/13 11/20/13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 34 She stated that the unit supervisors and different members of the Interdisciplinary Teams had not kept any evidence of assessments being done on clients who were not moved off of the residences. On 10/24/13 at approximately 8:00 AM, facility management provided e-mails from Interdisciplinary team members sharing information concerning client assessments for seven named clients. There were also several e-mails that showed general information of assessments were being done on the residences but did not list specific clients being assessed. Reports also were provided that showed general client groupings according to residence but still did not document individual client assessments. See W 122, W 127, and W 407 8. On 10/24/13 at 10:00 AM, the auditorium was toured with administrative staff. Three sets of exist doors in the auditorium were observed to be very difficult to open from inside. These doors included those on the side of the building to the immediate left of the main entrance, those on the opposite side of the building to the immediate right of the main entrance, and those on the right closest to the stage. Administrative staff stated the doors should have been easier to open, especially in an emergency. 9. On 10/24/13 at 10:00 AM, an area of standing water approximately 10 to 12 feet long by 2 feet wide was observed outside of the exit doors immediately to the right of the stage of the auditorium.	{W 104}	W 104 (cont.) 16.1. The identified settees and chairs were removed and replaced. An environmental check was conducted. No other potential hazards were noted. 16.2. The 1:1 assignment sheet for Client 58 was revised to specify environmental sweep activity as well as providing a place to note findings, actions taken, or other comments. 16.3. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised 1:1 assignment sheet. 16.4. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Protocol 12 "Care of Client with Pica". 16.5. Housekeeping Supervisor III provided training to Housekeeping Supervisors and FEAT team members to specifically check for condition of furniture when conducting rounds. 16.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" and on checking for conditions of furniture when conducting rounds. 16.7. Janitorial staff and FEAT team will monitor the condition of the furniture on the residence via rounds at least monthly, and elevate any concerns to the Unit Supervisor or designee. 16.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor the condition of furniture via rounds at least monthly, and document the findings. 16.9. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 16.10. Program Director is responsible.	10/22/13 11/20/13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 104}	Continued From page 35 Green algae was observed to be growing on the concrete where the water was pooling. A continuous drip of water was observed from a pipe attached to the side of the building from the roof to the ground. During an interview at the time, administrative staff stated the water and area needed to be cleaned up and the dripping water stopped. 10. The Recreational Activities Log for Residence 36 was reviewed on 10/21/13. a. The log documented that core sample Client 19 had not been afforded the opportunity to participate in off-campus, community activities during the months of August and September 2013. [redacted] During an interview on 10/24/13 at 8:50 AM, the Leisure Coordinator for Residence 36 confirmed that Client 19 had not been included in community activities during August and September. b. The log further documented that core sample Client 35 had not been afforded the opportunity to participate in off-campus community activities during August and September 2013. [redacted]	{W 104}		

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{W 104}	Continued From page 36 During an interview on 10/24/13 at 8:50 AM, the Leisure Coordinator for Residence 36 confirmed that Client 35 had not been included in community activities during August and September. She stated the residence had only one van to transport clients into the community. She further stated the van could only accommodate two wheelchairs at a time and the majority of clients on the residence required wheelchairs when going a long distance, like going into the community. She also stated that the van was also used for medical transportation and was borrowed by other residences. The Leisure Coordinator further stated that staffing was often an issue in order to maintain supervision levels when clients were off campus. 11. On 10/24/13 at 9:30 AM, observations in the Protestant Chapel at the Religious Center revealed that the flooring/tile between pews 6 and 7 was chipped and in disrepair. Staff present stated that she would put in a work order to have it fixed. 12. Observations on 10/17/13 at 7 AM and 7:10 AM revealed three unstable /unsteady chairs in both client group areas on Residence 5, posing a potential accident hazard. Staff present stated that the chairs did not have screws but were held together by wooden pegs and "glue must have come undone."	{W 104}		

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{W 104}	Continued From page 37 13. On 10/14/13 at 3:45 PM, the water fountain, utilized by clients in Residence 5's outside patio was soiled. 14. The Facility Bulletin #103 for "Alleged Client Abuse, Mistreatment, or Neglect," dated 5/2013, included the following: All [facility name] employees will be required to attend Abuse Prevention and Response training during the new employee orientation and at least annually thereafter. The facility failed to provide evidence of current abuse training for 3 of 18 employee files reviewed. (See 149). 15. Observations on 10/14/13 at 4:45 PM on Residence 25 revealed two pieces of furniture in the livingroom area; one sofa and one chair with torn fabric exposing their contents. During a concurrent interview, the staff stated that there were two individuals who resided on this residence with an identified behavior ~~of~~ [redacted] 16. Observations were conducted on Unit 23 beginning at 2:15 PM on 10/22/13. There were seven chairs and three settees located in the " west end television area. " All three of the vinyl covered settees had tears in the fabric. Six of the vinyl covered chairs had tears in the fabric, including the chair in which Client 58 was seated next to his one-on-one staff. When asked why Client 58 received one-on-one supervision, the direct support staff serving as the one-on-one explained Client 58 exhibited [redacted] " favored "	{W 104}		

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{W 104}	Continued From page 38 items appeared to be metal objects. Upon examination of the chair in which Client 58 was seated, two of the metal glides on the bottom of the chair legs were missing. When asked if she knew what had happened to the chair glides, neither the direct support staff serving as Client 58 ' s one-on-one staff nor the direct support staff supervising the other eight men in the room, knew the metal glides were missing. 17. The direct support staff providing supervision to the other eight men in the room confirmed that the settees and the chairs had torn vinyl. The direct support staff providing supervision for the other eight men in the room confirmed several men wore disposable briefs which sometimes leaked. When asked how the chairs and settees with the torn vinyl could be cleaned once urine or feces were on the compromised surfaces of the chairs and/or settees, the direct support staff said he was not sure how they would be thoroughly cleaned due to the torn vinyl.	{W 104}	W 120 1. Chicken salad was discarded from the Blue Heron. 2. Effective 6:30 pm, Blue Heron sold only pre-packaged, ready-to-eat food items and food items prepared on the grill. 3. All prepared food at the Blue Heron were discarded. 4. A Client Immediate Protection Plan was initiated for Client 5. Client 5 was assessed by RN/HSS, and was monitored for signs and symptoms of food poisoning, i.e. abdominal pain, diarrhea, fever, and vomiting. 5. No other clients were affected. 6. Acting Director of Dietetics provided on-site training to the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling and set up/service of cold food items. 7. Acting Director of Dietetics reviewed the system for tracking food temperatures and food temperature log, and provided training to the Blue Heron staff. 8. Acting Director of Dietetics conducted an environmental check of the Blue Heron, and identified areas that needed to be corrected.	10-17-13 10-17-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the governing body of the facility failed to ensure a contracted food vendor prepared food in a safe manner. The Blue Heron did not have systems in place to ensure the cooked potentially hazardous foods were cooled in a manner consistent with	W 120	9. The Blue Heron Manager/Vocational Instructor was verified to be currently certified as Food Safety Manager. 10. Acting Director of Dietetics and Food Services Supervisor II conducted follow-up check to ensure identified areas had been corrected. 11. Director of Central Program Services set expectations for Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling, set up/service of cold food items, and food temperature log. 12. The Blue Heron Manager/Vocational Instructor reviewed and updated the Food Storage Manual at the Blue Heron. 13. Blue Heron staff completely sanitized all surfaces, utensils, and dishes prior to re-opening.	10-18-13 10-18-13 10-18-13 10-18-13 10-18-13

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W 120	Continued From page 39 recognized food safety practices. Cooked potentially hazardous foods that are subject to time and temperature control for safety are best cooled rapidly within 2 hours from 135 to 70 degrees Fahrenheit (F) and within 4 hours to approximately 41 degrees F. The total cooling time from 135 degrees to 41 degrees F should not exceed 6 hours. The facility failed to provide any oversight on the operation of sanitary and safe food service operation. Findings: At approximately 11:10 AM on 10/17/13, a tour of the Blue Heron, a contracted canteen, on the [Facility name] campus was conducted. A request was made to test the temperature of the potentially hazardous foods on the sandwich bar. Potentially hazardous foods are foods that require time and temperature control for safety to limit growth of bacteria and toxin formation. On the sandwich bar were chicken salad and tuna salad. The temperature of the chicken salad was 46.7 degrees Fahrenheit (F) and the tuna salad was 40.8 degrees F. The recommended holding temperature for cold food is 41 degrees F and below. As the tour continued, a larger container of the chicken salad was found in the reach-in refrigerator. The temperature of this chicken salad was 48.7 degrees F. The Food Instructor (FI) responsible for the day-to-day management of the canteen was interviewed on the process of preparing the chicken salad. She indicated that the chicken salad was prepared from chicken breasts cooked in a crock pot from 10 AM to 4 PM the day before, 10/16/13. She stated that the	W 120	W 120 (cont.) 14. Monitoring of the Blue Heron food preparation and service of cold foods was completed. 15. Program 5 LOC staff were trained by the Unit Supervisor or designee on Infection Control Guideline 3.14 "Food-borne Illnesses". 16. Food Services Supervisor will monitor Blue Heron food preparation and service of cold foods no less than twice per week, and document the visit in the Visitor Log at the Blue Heron. Any issues identified will be elevated to the Director of Central Program Services. 17. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 18. Acting Director of Dietetics and Director of Central Program Services are responsible.	10-18-13 10-20-13 10-20-13 10-20-13

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W 120	Continued From page 40 chicken breasts were then placed in a metal container, pulled apart, and placed on ice until the temperature reached 70 degrees F, which was approximately about 1-1/2 hours later. The metal container with the chicken was then placed in the refrigerator for further cooling. The FI stated the Blue Heron closed at 5:30 PM but there was another staff present until 7 PM. When interviewed on the responsibilities of this employee, the FI acknowledged, the employee had no temperature cooling/monitoring responsibilities. Therefore, the possibility existed that the food may have been in the danger zone for over 16 hours. Cooked potentially hazardous foods that are subject to time and temperature control for safety are best cooled rapidly within 2 hours from 135 to 70 degrees Fahrenheit(F) and within 4 hours to approximately 41 degrees F. The total cooling time from 135 degrees to 41 degrees F should not exceed 6 hours. The facility failed to provide any oversight on the operation of sanitary and safe food service operation. The FI stated in an interview on 10/17/13 at approximately 11:30 AM that they had cooling logs. A review of the temperature log that was presented indicated that the temperature of the chicken had not been recorded and the form presented was not an actual cooling log. The FI and the food manager, stated that they had food safety certifications and neither was able to state the correct process of cooling to include the further cooling to 40 degrees Fahrenheit. The FI and canteen manager were not able to show previous cooling logs and knowledge on the proper cooling process.	W 120		

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W 120	Continued From page 41 Review of the facility document titled Canteen Lease, dated June 4, 2013, between the facility and the food vendor, Blue Heron, was conducted. Included in the terms of the lease was the requirement that the Administrative Services Director of the facility had the right to regulate the operations of Blue Heron as they affect the "...safety and conduct of the facility. In addition, the lease had the Blue Heron "comply with all rules and regulations" adopted by the facility. At approximately 11:46 AM on 10/17/13, the Acting Director of Dietetics (ADD) was interviewed on the dietetics department's responsibility for oversight for food safety at the Blue Heron. She stated that there was no affiliation with the Blue Heron as it was managed by a separate entity. In an interview at approximately 1:12 PM on 10/17/13, the facility staff in charge of the contract was interviewed. She stated that she does not provide any oversight to the Blue Heron but includes them in training provided to staff. She stated that the food manager was certified in food safety. On 10/18/13 at 12:10 PM a Blue Heron dietary staff stated, "We don't have a cool down log." Improper cooling is a major factor in causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that may survive the cooking process. All persons including those with compromised immune systems are at increased risk of food borne illness such as Salmonella, Norovirus,	W 120		

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W 120	Continued From page 42 Clostridium Perfringens, E. Coli, when food is not held at the appropriate temperature. Some of symptoms include fever, diarrhea and vomiting and in some cases death. The facility failed to provide oversight to the contracted service. There was lack of supervision and monitoring of the food service activities by the staff of the [facility name]. The food vendor failed to put a system in place to ensure that food was cooled in a manner consistent with recognized food standards.	W 120	W122 (See also W126, W127, W130, W136, W137, and W149) Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Condition of Participation for Client Protection is met. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags.	
{W 122}	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, document review and interviews, the Condition of Participation for Client Protections was not met. Findings: The Client 49 tripped and fell on the floor, hitting his head and sustaining a head injury, with subsequent abrasions and bruising noted the next day. The client was allowed to go to bed and was not monitored through the night for changes in vital signs and/or neurological symptoms that could have alerted staff to a worsening of his condition. He also was not assessed by an RN until almost 12 hours after the fall. Due to this lack of care to the client, an Immediate Jeopardy was called on 10/15/13 and was abated on 10/23/13.	{W 122}	W122 #1 (See also W126, W127, W130, W136, W137, and W149) - Program 5 NOC shift staff audited the last 24-hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. - RN/HSS and/or ACNS contacted each Program 5 units, via call or visit, every hour to verity no client had fallen and/or struck head. - Program 5 LOC staff were trained by their Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". - Facility Bulletin 105 "Client Protections" was revised. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 105 "Client Protections", Clinical Recording Guideline 2 "Temporary Conditions", and Clinical Recording Guideline 5 "Client Immediate Protection Plan". - Program Management will review Daily Reports at the morning meeting for any report of client(s) falling or striking head on previous shift(s) and actions taken. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-17-13 10-17-13 10-17-13 10-21-13 10-23-13 10-23-13 11-25-13

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			W122 #2 (See also W126, W127, W130, W136, W137, and W149)	
			- A review of assessment information for clients residing in Program 5 was conducted to ensure appropriate placement based on developmental and functioning levels, and social/medical needs.	11-24-13
			- An IPP review and/or Emerging Risk Notification/Evaluation meeting was held to address each Program 5 client's placement. Any clients identified as requiring further assessment for possible alternate placement was referred to the Interdisciplinary Team.	11-24-13
			- Program Director will monitor and review the assessment process and Interdisciplinary Team recommendations for appropriateness of placement.	11-24-13
			- Program Management will conduct monthly review of the unit population/client grouping via the Overview System Comprehensive Assessment of Risk (OSCAR) meetings.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W122 #3 (See also W126, W127, W130, W136, W137, and W149)	
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" with emphasis on assisting clients with meeting their dressing and grooming needs.	11-25-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients", and Facility Bulletini 79 "Client Rights".	11-25-13
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment to ensure they address	11-25-13

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			W122 #3 (See also W126, W127, W130, W136, W137, and W149) (cont.) concerns for dignity during the assessment process, client preferences, personal possessions, individualized rooms, and make recommendations as needed.	
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training objectives, monitoring client possessions, and client restricted access.	11-25-13
			- IPC's will monitor clients' training via monthly audit of the progress notes in the clients' records and via rounds at least monthly.	11-25-13
			- Unit Supervisor or Senior PT, Program Management, and Quality Assurance will monitor during rounds at least monthly.	11-25-13
			- Program Management will review the quarterly audit of all client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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{W 122}	Continued From page 43	{W 122}		
	The facility did not implement the plan of correction from the recertification survey of July, 2013 when there was no evidence that all the clients in Program 5 were assessed for appropriate placement, according to their age, developmental and social levels.		W 126 1. The identified training material were removed from the day program classroom.	10-17-13
			2. Program 5 Assistant obtained new training supplies for the day program classroom.	11-15-13
	The facility also did not ensure that clients' freedoms weren't denied or restricted when clients on Residence 36 were not provided with appropriate money management skills; when clients were not provided with appropriate supervision to ensure privacy while getting dressed; when clients were observed with ill-fitting or soiled clothing; when no community activities were provided to clients on Residences 5, 23 and 36; when clients were provided with activities that were not appropriate for their age; when clients were denied access to their locked wardrobes; when Client 26 had items listed on his personal property card that could not be located.		3. The training objectives for Program 5 clients, including Client 62 were reviewed by the Interdisciplinary Teams. Clients identified as needing revisions to their training objectives were referred back to the Interdisciplinary Team for recommendations.	11-20-13
			4. The lesson plan for the day program class was revised to include trips to the Blue Heron for money management training using real money.	11-20-13
			5. Requests were submitted to purchase additional training supplies for Program 5 training sites.	11-20-13
			6. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training objectives.	11-25-13
	These multiple failures caused the Conditions of Participation for Client Protections to be not met.		7. IPC will monitor client money management training via monthly audit of the progress notes in the client's clinical record, and document in the IPC monthly notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes.	11-25-13
	See W 126, W 127, W 130, W136, W 137, and W 149			
{W 126}	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS	{W 126}	8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
	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.		9. Program Director is responsible.	
	This STANDARD is not met as evidenced by:			

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{W 126}	Continued From page 44 Based on observation, interview, and record review, the facility failed to teach 1 of 26 unsampled clients (Client 62) to manage her financial affairs to the extent of her capabilities. Findings: On 10/17/13 at 1:45 PM, day program staff were observed to place a round white laminated photocopy of a coin approximately 4 inches in diameter on the table in front of Client 62. In addition, staff also placed a laminated photocopy of what was identified as a dollar, an approximately 6- to 7-inch long rectangle, on the table in front of Client 62. [redacted] During record review, Desired Outcome, I-9.1 specified that staff were to "Place a picture of coins in front of [Client 62]" and "Ask [her] to point to the quarter." [redacted] In addition, the objective did not identify how identifying oversized pictures would be used to teach the client to identify real money. On 10/24/13 at 9:00 AM, residence administrative staff and the Individual Plan Coordinator responsible for the program plan for Client 62	{W 126}		

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{W 126}	Continued From page 45 were concurrently interviewed. They acknowledged that the use of real money for client education had not been considered. Residence administrative staff stated he could see how learning would not translate to real life situations if the learning tools did not resemble real life objects.	{W 126}		
{W 127}	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 psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to provide documented evidence that all clients in Program 5 were assessed for appropriate placement. Findings: A review of the Plan of Correction that was received in the CDPH office on 9/6/13 indicated that Step 12 of the correction plan for W 102, W 122, W 127, W 149 and W 407, stated that "All clients in Program 5 were assessed by the ID Teams for appropriate housing based on ages, developmental levels and social needs. Teams reviewed client assessments to ensure the assessments are current, valid and accurate." A spread sheet was presented as evidence that all the clients had been assessed. The spread sheet listed each client's name, date of assessment, unit, age, the different assessments	{W 127}	W 127 1. A review of assessment information for clients residing in Program 5 was conducted to ensure appropriate placement based on developmental and functioning levles, and social and medical needs. 2. An IPP review and/or Emerging Risk Notification/Evaluation meeting was held to address each Program 5 client's placement. 3. Any client identified as requiring further assessment for possible alternate placement was referred to the Interdisciplinary Team. If alternate placement was identified, an IPP review was held upon receipt of the assessment to discuss finding and address any recommendations. 4. Program Director will monitor and review the assessment process and Interdisciplinary Team recommendations for appropriateness of placement. 5. Program Management will conduct monthly review of the unit population/client grouping via the Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 7. Clinical Director is responsible.	11-24-13 11-24-13 11-24-13 11-24-13 11-24-13 11-24-13

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{W 127}	Continued From page 46 used to verify the assessment of correct placement, whether clients had a history of sexual behaviors or of being victimized and columns for the unit supervisor and program director to fill in dates when all the assessments were complete and had been reviewed. All of the dates for unit supervisors and program director were blank except for the spread sheet for Residence 21, which had unit supervisor review dates of 6/23/13. There were several dates of different assessments used for evaluating clients that were more than two years old on each spread sheet except for that of Residence 26. In an interview with Program Management Staff on 10/23/13 at 11:00 AM, she stated that the spread sheet was the only evidence the facility had for verification that all assessments had been completed by the correction plan date of 6/28/13. She stated that all the unit supervisors had reviewed the spreadsheets and that all the assessments were current, accurate and valid. She stated that the spreadsheet was used to determine who would be moved to which residence. When questioned why the dates of some assessments were more than two years old, management staff could not explain why that was except to say she thought those dates had just not been updated; she was sure that more current assessments had been used to evaluate clients for appropriate placement. Management staff could not explain why there was no documentation of review dates by the unit supervisor or herself noted on the spread sheets. When asked what evidence she could provide to verify that all clients, not just those who had been moved to different residences, had been assessed, she stated that the spreadsheet was the evidence. When Management Staff was	{W 127}		

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{W 127}	Continued From page 47 asked how the spread sheet provided evidence of assessment, she could not explain that idea. In an interview with Facility Management on 10/23/13 at 12:00 PM, she stated that the facility had evidence that the 20 clients who had moved to different residences had all been assessed. She stated that unit supervisors and different members of the Interdisciplinary Teams had not kept any evidence of assessments being done on clients who were not moved off of the residences. On 10/24/13 at approximately 8:00 AM, Facility Management provided e-mails from Interdisciplinary team members sharing information concerning client assessments for seven named clients. There were also several e-mails that showed general information of assessments were being done on the residences but did not list specific clients being assessed. Reports also were provided that showed general client groupings according to residence but still did not document individual client assessments.	{W 127}	W 130 1. Client 47 was redirected back to the bedroom to get dressed. No other clients were involved nor were affected. 2. A Special Interdisciplinary Team was held to discuss area of concern. [redacted] 5. Client 47 went to the Fashion Center to select clothing of his choice. A Purchase Order was placed to shop for clothes in the community. 6. Unit 25 LOC staff were trained by the Unit Supervisor or designee on Client 47's revised Approaches & Strategies and on Facility Bulletin 48 "Standards of Care" with emphasis on assisting clients with meeting their dressing and grooming needs. 7. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment to ensure they address concerns for dignity during the assessment process, and make recommendations as needed. 8. IPC will monitor implementation of program during rounds at least monthly, and document in the monthly IPC notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes. 9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 10. Program Director is responsible.	10-17-13 10-24-13 11-20-13 11-20-13 11-20-13 11-25-13 11-25-13 11-25-13 11-25-13
{W 130}	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 and interview, the facility failed to ensure that 1 of 25 unsampled client (Client 47) was not left unassisted in the hallway fully naked performing his ADL(activities of daily living). This failure resulted in client 47's privacy and dignity being violated.	{W 130}		

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{W 130}	Continued From page 48 Findings: During an observation in Residence 25 on 10/16/13 at 6:45 AM, unsampled Client 47 was seen walking in the hallway across from the nursing station. The client was fully naked. He took a shirt from a cart without any staff assistance and he headed back to his room. An interview was conducted with the facility staff on 10/16/13 at 7:10 AM, she stated that she gave Client 47 a shirt to use, but he probably did not like it. The facility staff confirmed that Client 47 was fully naked visible to the public. She also confirmed that the client should not have been naked in the hallway. A staff should have caught him and assisted him with his clothing preference. During an interview with the Residence Manager on 10/16/13 at 9:10 AM, she stated that it was a bad morning. The client should have not been naked in the hallway. A staff should have caught him and assisted him with his clothing preference to use for that day.	{W 130}	W 136 1.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 1.2. Recreational Therapist/unit staff scheduled trips for Client 19 to go on a community outing three times in a quarter. 1.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 1.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review. 1.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 1.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 1.7. Program Director is responsible.	11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-24-13
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 observation, document review and interviews, the facility failed to ensure that 5 of 61	W 136	2.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 2.2. Recreational Therapist/unit staff scheduled trips for Client 35 to go on a community outing three times in a quarter. 2.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 2.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review.	11-20-13 11-25-13 11-25-13 11-25-13

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W 136	Continued From page 49 sampled and unsampled clients (Clients 19, 27, 31, 35, and 60) were allowed the opportunity to participate in off-campus activities. 1. The Recreational Activities Log for Residence 36 was reviewed on 10/21/13. This documented that core sample Client 19 had not been afforded the opportunity to participate in off-campus, community activities during the months of August and September 2013. The Individual Program Plan (IPP) for Client 19, dated 11/15/12, documented that, although he did not like noisy and crowded areas, he did like food-related activities. The IPP further documented that the leisure plan for Client 19 was to encourage his participation in community activities. During an interview on 10/24/13 at 8:50 AM, the Leisure Coordinator for Residence 36 confirmed that Client 19 had not been included in community activities during August and September. 2. The Recreational Activities Log for Residence 36 was reviewed on 10/21/13. This documented that core sample Client 35 had not been afforded the opportunity to participate in off-campus community activities during August and September 2013. [redacted]	W 136	W 136 (cont.) 2.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 2.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 2.7. Program Director is responsible. 3.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 3.2. Recreational Therapist/unit staff scheduled trips for Client 60 and Client 27 to go on a community outing three times in a quarter. 3.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 3.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review. 3.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 3.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 3.7. Program Director is responsible.	11-25-13 11-24-13 11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-24-13

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W 136	Continued From page 50 During an interview on 10/24/13 at 8:50 AM, the Leisure Coordinator for Residence 36 confirmed that Client 35 had not been included in community activities during August and September. 3. On 10/16/13 review of the Leisure Activity Records for Clients 27 and 60 indicated that there were no community outings provided on a regular basis for the months of 8/2013 or 9/2013. This was acknowledged by recreational therapy (RT) staff during an interview on 10/23/13 at 1:48 PM. [redacted] [redacted] In the past 12 months Client 27 attended 2 community outings when he resided on another residence. [redacted] 4. Client 60's IPP draft, dated 9/12/13, indicated that the "Analysis of Reinforcers" included shopping and community outings. [redacted]	W 136	W 136 (cont.) 4.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 4.2. Recreational Therapist/unit staff scheduled trips for Client 60 to go on a community outing three times in a quarter. 4.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 4.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review. 4.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 4.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 4.7. Program Director is responsible. 5.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. 5.2. Recreational Therapist/unit staff scheduled trips for Client 31 to go on a community outing three times in a quarter. 5.3. Program 5 LOC staff was trained by their Unit Supervisors or designees on Program Procedure I-36 "Community Leisure Activities for Clients". 5.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review.	11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-24-13 11-20-13 11-25-13 11-25-13 11-25-13

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W 136	Continued From page 51 On 10/23/13 at 1:48 PM, the RT further stated that ratios in the community (staff to client ratios) must be met and sometimes the RTs will team up so it will be less impact on the staff. [redacted] The Residence 21 activity log reviewed on the same day indicated that there were no community sponsored activities provided for Client 31 during the month of August and September 2013.	W 136	W 136 (cont.) 5.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 5.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 5.7. Program Director is responsible.	11-25-13 11-24-13
{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 observations, interviews, and record review the facility failed to ensure the clients' right to retain and use their personal possessions and clothing when: two of 19 sampled clients (Client 26 and 29) did not have keys to their locked wardrobe closets, two of 19 sampled clients (Clients 26 and 30) did not have evidence of personal possessions in their rooms, Client 26 had missing personal items, clients on Residence	{W 137}	W 137 1.1. Unit Supervisors identified clients who have a locked wardrobe and/or locked bedroom, including Client 26. 1.2. An IPP review was held to review how clients with locked wardrobe and/or locked bedroom were able to access their possessions, and develop a training plan if needed. 1.3. Program 5 Group Leaders were trained by the Unit Supervisor or designee on the Independent Living Assessment to ensure they address concerns for dignity during the assessment process, and make recommendations as needed. 1.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client access. 1.5. Program 5 LOC staff were trained by their Unit Supervisors or designees on Facility Bulletin 79 "Client Rights". 1.6. Client 26's training objectives were revised to include keeping the key on a lanyard for the client to wear or put in his pocket. 1.7. Unit 26 LOC staff were trained by the Unit Supervisor or designee on Client 26's revised training objectives. 1.8. IPC will monitor implementation of program during rounds at least monthly, and document in the monthly IPC notes. Any concerns will be	11-20-13 11-24-13 11-25-13 11-25-13 11-25-13 12-11-13 12-13-13 11-25-13

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{W 137}	Continued From page 52 26 did not have free access to a locked shower, when two of 25 unsampled clients (Clients 53 and 54) were not wearing appropriate clothing, and when clients on Residence 23 were not provided age appropriate activities. Findings: 1. On 10/22/13 at 8:30 AM Client 26 asked a staff to unlock his wardrobe closet. When asked why he could not do it, the client stated that he didn't have a key. During a concurrent interview, the Unit Supervisor stated that the client frequently misplaced his key and that one would be ordered. The staff added that often a client keeps a single key in his pocket and it may drop out. [redacted] There was no evidence in the record/key plan, that identified a method to assist the client in retaining the key on his person to increase the opportunity for success. 2. Observations of Client 29 between 10/15/13 and 10/17/13 indicated that the client did not carry a wardrobe key. On 10/22/13 at 11 AM, it was noted that the lock to the client's wardrobe was unlocked. An Interdisciplinary Note (IDN), dated 10/22/13 at 12:30 PM, indicated that Client 29 told staff that he had a lanyard (a cord or strap to hold something and usually worn around the neck) but no key.	{W 137}	W 137 (cont.) 1.8. (cont.) elevated to the Unit Supervisor, and documented in the IPC monthly notes. 1.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.10. Program Director is responsible. 2.1. Data was entered for Client 29's new training objective. 2.2. A review was conducted for Program 5 clients to ensure data collection for training objectives is current. 2.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on Desired Outcome documentation. 2.4. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment", and reviewed expectations of IPC monitoring of client vocational assessments. 2.5. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 2.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 2.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.8. Program Director is responsible.	11-25-13 10-24-13 11-25-13 11-25-13 11-25-13 11-25-13 12-13-13 12-13-13

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{W 137}	Continued From page 53 [redacted] [redacted] On 10/24/13 at 1 PM, no data collection was found for this new objective. During a concurrent interview, staff stated that the information had not yet arrived from the Individual Program Coordinator after the client's recent Annual Individual Program Plan (IPP) meeting on 10/9/13. [redacted] 3. On 10/22/13 at 6:45 AM, Client 30 was about to enter the shower (Room 125). The Licensed Staff who accompanied the client opened the door with a key. A direct care staff stated that this shower room was always locked and had been since women lived on this residence, over three months ago. 4. On 10/22/13, observations of the rooms of Clients 26 and 30 revealed a lack of any furnishings or expression of the client's likes, interests or individuality. During an interview on 10/22/13 at 1 PM, regarding the lack of individuality of Client 30's room, the Unit Supervisor stated that the client [redacted] as to the reason that there was nothing displayed. Observations however, revealed that the client's roommate had photos of friends/family/activities, in two large picture frames which hung on his wall near his bed. During an interview on 10/22/13 at 8:45 AM, Client 26 described some of the things that he	{W 137}	W 137 (cont.) 3.1. The shower room was unlocked by staff for Client 30. The shower rooms remained unlocked. Other shower rooms on Program 5 units were checked to ensure they were unlocked. 3.2. Unit 26 LOC staff were trained by the Unit Supervisor or designee on the Unit 26 unit description. 3.3. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client restricted access. 3.4. Unit Supervisor or Senior PT, Program Management, and Quality Assurance will monitor restricted access on the residence during rounds at least monthly, and document any findings. 3.5. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 3.6. Program Director is responsible. 4.1. Program 5 Management identified clients whose bedrooms were not individualized and/or have personal possessions. 4.2. IPP reviews were held for any client identified as not having individualized rooms or personal possession to determine their preferences, and develop a plan to individualize their room space. 4.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on Independent Living Assessments to ensure they address client preferences, personal possessions, individualized rooms, and make recommendations as needed. 4.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client possessions.	10-22-13 11-24-13 11-25-13 11-25-13 11-25-13 11-24-13 11-24-13 11-25-13 11-25-13

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{W 137}	Continued From page 54 liked such as fishing, camping, sports. There was nothing in his room that reflected those interests. Client 26 was observed to change his bedding and had no place to put the clean linen except on the floor. Review of the client property card of Client 26 also indicated that he owned a two piece wall shelf set with lights, wall art, wall decals, and a four drawer dresser. Staff was unable to locate these items. Staff stated that she thought the dresser may have been damaged and thrown out. There was no documentation as to when these items went missing. Review of facility policy FB No. 61 titled: Clients Property and Trust Funds, dated August 2013, indicated under Section II D Unit Supervisor's Responsibility: "...If any durable item is to be condemned, it will be noted on the property card by appropriate staff." 5. On 10/16/13 at 8:50 AM, and on 10/17/13 at 9:45 AM, Client 53 and 54 were observed wearing pants that were too long. During the interview with the group leader (staff) on 10/17/13 at 2:40 PM, he agreed that the pants needed adjustment. He further stated that staff orders the clothes from Fashion Center. The Fashion Center staff would notify the residence that had ordered clothes were for pick-up. During the visit to the Fashion Center on 10/17/13 at 11:45 AM, the staff stated that a record of each client's preference and measurement were kept on record. She further stated that clothes are labeled and adjusted to the clients specification.	{W 137}	W 137 (cont.) 4.5. Decorations needed for Client 26 and 30's were assessed. Purchase orders will be submitted on 12/12/2013 to obtain new decorations for their rooms. 4.6. Unit Supervisor or Senior PT, Program Management, and Quality Assurance will monitor physical environment on the residence during rounds at least monthly, and document any findings. 4.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.8. Program Director is responsible. 5.1. The identified pants for Client 53 and Client 54 were altered for correct fit. 5.2. An inventory of clothing for Client 53 and Client 54 were completed to ensure all items were properly sized. 5.3. Program 5 clients were measured and the information was sent to the Fashion Center. 5.4. Fashion Center staff were trained by the Fashion Center Manager on the procedure to check clothing prior to release to ensure any needed alterations were completed. 5.5. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client appearance during rounds at least monthly and document any findings. 5.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 5.7. Program Director is responsible.	11-25-13 11-25-13 11-25-13 10-25-13 11-01-13 11-24-13 11-24-13 11-24-13 11-24-13

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{W 137}	Continued From page 55 Review of Client 53 and 54's record indicated that there were no in seam length. 6. During day programing observations, Client 32 was observed wearing [redacted] t-shirt for two consecutive days, 10/21/13 and 10/22/13. During an interview with the program staff on 10/22/13 at 10:45 AM, she stated that Client 32 owned several t-shirts of the same color and style. On the same day, at 2:30 PM, together with the Residence Manager, Client 32's closet was inspected. Inside the closet were found six [redacted] long sleeved shirt of different colors. Review of Client 32's property card indicated seven longsleeve t-shirts. 7. Observations were conducted on Unit 23 beginning at 2:15 PM on 10/22/13. At the beginning of the observation eight men were seated in the settees and the chairs in the " west end television room. " Client #58 was seated next to his one-on-one staff in a chair located behind the settee. The direct support staff providing general supervision said the men were watching a movie. When asked what movie was playing, the direct support staff explained that the DVD Player was broken so the men were watching a moving on television titled, " Scream. " None of the men appeared to be watching the movie and the direct support staff was constantly giving verbal instruction to the men such as " hands down, pull your shirt down, keep your hands to yourself, etc. " When asked if there were recreational or leisure time supplies	{W 137}	W 137 (cont.) 6.1. The seventh long-sleeve T-shirt was retrieved from the laundry. 6.2. Program 5 Group Leaders were trained by their Unit Supervisors or designees on Independent Living Assessments to ensure they address client's property during the assessment process, and make recommendations as needed. 6.3. Program 5 IPC's were trained by the Program Assistant on monitoring client possessions. 6.4. IPC's will monitor to ensure clients have sufficient property and personalized room decor unless otherwise specified in the IPP. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes. 6.5. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 6.6. Program Director is responsible. 7.1. The age-inappropriate recreational or leisure time supplies were removed from Unit 23. 7.2. All Program 5 units were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the units. 7.3. New training supplies were ordered and obtained from Curriculum Services. 7.4. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 7.5. Unit routines for other Program 5 units were reviewed and remained appropriate. 7.6. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine, and active treatment definition/loop training. 7.7. Unit Supervisor and/or Senior PT, Program	10-22-13 11-24-13 11-24-13 11-24-13 11-24-13 10-22-13 10-22-13 11-18-13 11-18-13 11-18-13 11-24-13 11-24-13

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{W 137}	Continued From page 56 available to the men if they didn ' t want to watch the movie, the direct support staff began getting out games and toys, all designed for use by young children. The games and toys included an Etch-A-Sketch, brightly colored ' lego ' blocks, a plastic clock, and an alphabet puzzle with large plastic letters. The direct support staff assigned as the one-on-one with Client #58 consistently handed him a toy which played songs typically enjoyed by very young children. Client #58 pushed the toy away at least three times and dropped the toy to the floor twice. Residence 23 8. On 10/15/13, review of an untitled, undated facility document described Residence 23 as part of the program, "Life Management Development through Behavior and Social Skills." The document showed that the residence was designed to serve adult male clients with profound and severe intellectual disabilities with a major focus on reduction of challenging behaviors. Training opportunities were to be provided to enhance and develop new skills, with a major focus on developing independence in leisure, vocational, and social skills. On 10/22/13 from 2:12 PM to approximately 2:45 PM, eight clients were observed in a group activity room. The animated version of "The Hunchback of Notre Dame," geared to appeal to young children was running. Most of the clients were seated on couches or chairs facing each other, [redacted] A few clients milled about and wandered away from the group and one sampled client (Client 34) engaged in self-injurious	{W 137}	W 137 (cont.) 7.7 (cont.) Management, and Quality Assurance will monitor active treatment and physical environment during rounds at least monthly, and document any findings. 7.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 7.9. Program Director is responsible. 8.1. The age-inappropriate recreational or leisure time supplies were removed from the residence. 8.2. All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence. 8.3. New training supplies were ordered and obtained from Curriculum Services. 8.4. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 8.5. Unit routines for other Program 5 units were reviewed and remained appropriate. 8.6. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine, the active treatment definition/loop training, Client 39's behavior plans, Functional Analysis of Behavior, Independent Living Assessments, and Approaches & Strategies. 8.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment during rounds at least monthly, and document any findings. 8.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body	11-24-13 10-22-13 10-22-13 11-18-13 11-18-13 11-18-13 11-25-13 11-25-13 11-25-13

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{W 137}	Continued From page 57 behavior. A PTA encouraged clients to sit quietly and watch the movie as if in "a movie theater" despite the lack of interest displayed by the clients. During the observation period of over thirty minutes, most of the clients were watching each other rather than the movie that was not age appropriate. On 10/24/13 at 8:56 AM, observation of clients in a group area showed multiple table games and puzzles out on a table, none of which were age appropriate. The puzzles were block puzzles with themes/pictures geared to a toddler or young child and included an etch-a-sketch type toy. With the exclusion of activities of daily living being performed with some individual clients and a marching-in-place activity which one client participated in, none of the clients were offered any age appropriate activity from 8 AM to 9 AM. This included Client 39. During a concurrent interview at 8:56 AM, a psychiatric technician (PT) stated that Client 39 did not like the puzzles and games on the table. The PT stated, "He is one of our smarter clients." The PT also stated that he thought that Client 39 was bored which increased the client's undesirable behaviors.	{W 137}	W137 (cont.) 8.8. (cont.) will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 8.9. Program Director is responsible.	
{W 149}	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 observation, interview, and record review, the facility failed to ensure the health and	{W 149}	W 149 [redacted] 1.2. A General Event Report was initiated for Client 49. 1.3. Program 5 NOC shift staff audited the last 24 hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. The audit findings were documented on the daily report. 1.4. RN/HSS and/or ACNS contacted each Program 5 residence, via call or visit, every hour to verity no client had fallen and/or struck head, and documented via NOD report through 1700 hours. 1.5. Program 5 LOC staff discussed at huddles the need to train and implement Nursing Procedure 80 "Head Injuries, Care Of", and document on the daily report through PM shift. 1.6. Program 5 LOC staff were trained by the Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". 1.7. Facility Bulletin 105 "Client Protections" was revised to include the following: a. Each change of shift will include a report on any clients who have fallen or struck their head on previous shift(s), and actions taken. b. Documentation of change of shift report on fall or hitting head will be on Daily Report. c. SRPT/NPIC on duty will include communication of information about clients who have fallen or have hit their head and action taken, as well as responsibility to elevate concern or seek clarification as needed, to US/AOD immediately, to ensure actions taken meet expectations.	10-15-13 10-17-13 10-17-13 10/17/13 10/17/13 10/18/13 10/21/13

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{W 149}	Continued From page 58 well-being of one un-sampled individual (Client 49), when the client fell, struck his head and was not assessed by a registered nurse (RN) or physician nor closely monitored overnight for almost 12 hours. In addition, this was the second fall with head trauma that Client 49 had sustained within the recent past. This failure to assess and implement policies and procedures (P&P) after a fall and head injury had the potential to cause serious impairment and harm to this individual and any other individual in the facility who might fall and/or sustain head trauma. On 10/16/13 at 6:50 PM, the survey team met with the Executive Director, Clinical Director and the Director of Agency Evaluation and declared IMMEDIATE JEOPARDY (IJ). A corrective action plan was received from the facility and reviewed on 10/16/13 at 8:20 PM. On 10/23/13 at 3:35 PM, upon review of the evidence of implementation of the corrective action plan, the survey team met with the Executive Director, Clinical Director and Director of Agency Evaluation and abated the immediate jeopardy. The facility also failed to ensure implementation of its Facility Bulletin for "Alleged Client Abuse, Mistreatment, and Neglect" when three of 18 staff training records lacked evidence of attending the required annual abuse training. Findings: 1. On 10/16/13 at 11:00 AM, during observations at a day program, un-sampled Client 49 had	{W 149}	W 149 (cont.) 1.8. Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 105 "Client Protections". 1.9. Program 5 LOC staff were trained by their Unit Supervisors or designees on the Clinical Recording Guideline #2 "Temporary Conditions", and Clinical Recording Guideline #5 "Client Immediate Protection Plan". 1.10. Daily Report will be reviewed at the morning Program Management meeting daily, Monday through Friday. 1.11. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.12. Program Director is responsible.	10-23-13 10-23-13 10-23-13 10-23-13

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{W 149}	Continued From page 59 noticeable bruising around the left eye orbit and on the left cheekbone. During a concurrent interview, Client 49 stated that he had fallen two nights previously at home (Residence 26). [redacted] [redacted] During a concurrent interview, the shift lead stated that staff should have initiated the head injury protocol and notified the Health Services Specialist (HSS) at the time of the fall, and communicated the incident to the next shift. During an interview on 10/16/13 at 7:30 PM a licensed staff stated that she checked the client immediately after the fall, but didn't think the client was hurt. Staff stated that she did not know at the time, that the client had struck his head and did not notify the HSS or physician. There was no documentation until the following morning on 10/15/13 at 6:45 AM, [redacted]	{W 149}	W 149 (cont.) 2.1. Program Director reviewed training records for all Program 5 LOC staff to ensure staff are current in their Client Abuse Prevention Training. 2.2. The three identified staff were trained by the Unit Supervisor or designee on Client Abuse Prevention Training. 2.3. Program 5 LOC staff not current in Client Abuse Prevention Training were trained by the Unit Supervisor or designee. 2.4. Unit Supervisor will monitor staff staff compliance via review of the staff training records. Action will be taken to correct any deficiencies noted. 2.5. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 2.6. Program Director is responsible.	11-18-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 149}	Continued From page 60	{W 149}	W 149 (cont.)	
	[redacted]		3.1. The identified Psychiatric Technician attended Client Abuse and Prevention Training.	11-18-13
			3.2. Program Director reviewed training records for all Program 5 LOC staff to ensure staff are current in their Client Abuse Prevention Training.	11-18-13
	Review of physician progress notes (ppn's) on 10/17/13 indicated the last entry by a physician was dated 9/27/13.		3.3. The identified Food Services Technician was enrolled in the 12/16/2013 class on Client Abuse and Prevention Training.	11-25-13
			3.4. Program 5 LOC staff not current in Client Abuse Prevention Training were trained by the Unit Supervisor or designee.	11-25-13
	[redacted]		3.5. Acting Director of Dietetics reviewed training records for Dietetics staff to ensure staff are current in their Client Abuse Prevention Training.	11-25-13
	During an interview on 10/17/13 at 11:30 AM, the licensed staff who worked overnight and discovered the client's injury on 10/15/13 at 6:45 AM, stated that there had been no communication from the evening shift on 10/14/13 that Client 49 had fallen that evening.		3.6. Unit Supervisor and Acting Director of Dietetics will monitor staff compliance via review of the staff training records. Action will be taken to correct any deficiencies noted.	11-25-13
	Review of Nursing Procedure No. 80 titled: "Head Injuries - Care of," indicated under Section B Definition: #1. Trauma to the head (including the face) resulting from a blow, impact with an object, fall, etc. Section III Special Considerations: Immediate Management for Severe Injury or Injury with loss of consciousness. Subsection G: "Notify Residence Physician/HSS/Assistant Coordinator of Nursing Services."		3.7. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
	The policy for Falls N 16 titled: "First Aid for Falls and or Suspected Fractures" was the only policy received regarding falls. When asked if a General Event Report (GER) was initiated on 10/15/13, Quality Assurance Staff stated that it was not,		3.8. Program Director and Acting Director of Dietetics are responsible.	

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{W 149}	Continued From page 61 because "it did not meet the criteria for a GER." When asked if the facility tracked client falls, Quality Assurance Staff stated that only through the GER process. On 10/16/13 at 6:50 PM, based on the facility's failure to ensure that the client was not subjected to further injury and impairment, IMMEDIATE JEOPARDY was declared. On 10/16/13, at 8:20 PM, the survey team accepted the facility's immediate corrective action plan. On 10/23/13 at 11:50 AM, after review of the evidence that the facility's corrective action plan had been implemented, the survey team abated the IMMEDIATE JEOPARDY. 2. On 10/16/13 and 10/24/13, 3 of 18 staff training records failed to contain evidence of annual abuse prevention and reporting training. 3. During an interview with Quality Assurance (QA) staff, on 10/22/13 at 3 PM, QA staff stated that both the Psychiatric Technician and Food Service Technician were scheduled for abuse training in April but the facility had no record of the training. QA staff further stated that the PT staff's last abuse training was in 8/2011 and there was no evidence of any abuse training for the Food Service Technician. The Facility Bulletin #103 for "Alleged Client Abuse, Mistreatment, or Neglect," dated 5/2013, included the following: All [facility name] employees will be required to attend Abuse Prevention and Response training during the new employee orientation and at least	{W 149}		

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{W 149}	Continued From page 62	{W 149}	W158 (See also W159, W164, W186, W189, W191, W192, W193, and W194)	
	annually thereafter.		Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Condition of Participation for Facility Staffing is met. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags.	
W 158	483.430 FACILITY STAFFING	W 158		
	The facility must ensure that specific facility staffing requirements are met.			
	This CONDITION is not met as evidenced by: Based on observation, document review and interviews, the Condition of Participation for Facility Staffing was not met.		W158 #1 (See also W159, W164, W186, W189, W191, W192, W193, and W194)	
			- Program staffing ratios on the units were reviewed by Program Management, and they remain adequate.	11-25-13
	Findings:		- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process.	11-25-13
	There were insufficient numbers of trained and knowledgeable staff available to ensure that clients' individual programs were carried out. The facility did not provide active treatment to the clients according to their assessed needs when insufficient staff were available to supervise clients on Residence 23 and no active treatment was ongoing. Clients A and 55 were allowed to walk in untied or unlaced tennis shoes without staff intervention. Dietary staff were unable to take the temperature of food being served to clients and were unable to prepare the food without burning it. The Interdisciplinary Team did not re-assess Client 39's stigmatizing mechanical restraints and research treatment alternatives. There was no intervention by staff to redirect a client from inappropriate behaviors during work. A client with a training objective to reduce banging his head was allowed to continue that behavior without staff intervention. Multiple clients did not have their treatment programs monitored and coordinated by the IPC's. Client 27 was not assessed in his home or work environment by the expert in [redacted] The fact		- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices.	11-25-13
			- IPC's will monitor client assessments and objectives via rounds at least monthly to observe client participation.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation during rounds at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W158 #2 (See also W159, W164, W186, W189, W191, W192, W193, and W194)	
			- Acting Director of Dietetics set the expectations at the October Monthly Mandatory Meeting with Dietetics staff of calibrating thermometers at least once a month and how to take accurate	10-25-13

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PORTERVILLE DEVELOPMENT CENTER - DP ICF/IID	26501 AVENUE 140 PORTERVILLE, CA 93257

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			W158 #2 (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.) reading of the thermometer. - Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the unit kitchens. - Any issues requiring further actions will be reviewed monthly at the Administrative Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-25-13 10-25-13
			W158 #3 (See also W159, W164, W186, W189, W191, W192, W193, and W194) - A Special IPP was held for the client to review past restrictive devices used for SIB. - Director of Quality Assurance conducted research of restrictive devices available or in use elsewhere. It was determined that the current device is the least stigmatizing and most effective for the client. [redacted] - Unit Supervisor and/or Senior PT will monitor staff compliance with client behavior plans during rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-15-13 11-15-13 11-15-13 11-15-13 11-15-13
			W158 #4 (See also W159, W164, W186, W189, W191, W192, W193, and W194) - The client was redirected from the behavior by by staff. - Unit routine and day program training was revised to include encouraging alternate	10-15-13 11-20-13

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			W158 #4 (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.) activities for clients exhibiting disinterest in current activity offered. - Unit LOC staff were trained by the Unit Supervisor or designee on the client's behavior plan and Functional Analysis of Behavior. - Unit Supervisor and/or Senior PT will monitor active treatment and staff compliance with client behavior plans during rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-24-13 11-24-13 11-24-13
			W158 #5 (See also W159, W164, W186, W189, W191, W192, W193, and W194) (cont.) - Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client programs. - IPC's will monitor client programs via rounds to observe client participation. - Unit Supervisor and/or Senior PT will monitor client participation during rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13 11-25-13 11-25-13 11-25-13
			W158 #5 (See also W159, W164, W186, W189, W191, W192, W193, and W194) - Client 27 was referred to the facility autism specialist. - Program Management identified [redacted] clients in the program. An IPP review was held for each of the identified [redacted] client to discuss any	10-31-13 11-01-13

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			W158 #5 (See also W159, W164, W186, W189, W191, W192, W193, and W194) identified issues that may be a result of their [redacted] and any need for further assessment. - IPC's will monitor progress notes recording for clients via monthly audit of the client clinical records. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-24-13 11-24-13

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W 158	Continued From page 63 that there was insufficient staffing to adequately monitor clients and to provide the active treatment that they required created a potential for increased frequency of accidents, behaviors and a lack of progression toward independence in life skills. These multiple failures and the fact that the Condition of Participation for Active Treatment was not met resulted in the Condition of Participation for Facility Staffing to be not met. See W 159, W 164, W 186, W 189, W 191, W 192, W 193, and W 194	W 158	W 159 1.1. All Program 5 training sites were checked to ensure all age-inappropriate training supplies were removed. 1.2. New training supplies were obtained for the day program on 36-Annex. 1.3. 36-Annex day program site lesson plan was revised to include engaging clients with activities that matched the functioning levels of the clients. 1.4. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 1.5. A new training assessment was initiated for Client 36 to ensure proper placement in the day program. The new assessment will be completed by 12/13/2013.	10-22-13 11-15-13 11-15-13 11-15-13 11-25-13
{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. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Individual Plan Coordinator coordinated and monitored the active treatment programs of Clients 36, 45, 46, and 31.) 1. On 10/16/13 beginning at 1:00 PM, observations were made in the day program in the 36-Annex. Two staff, one of which was a float from another residence, and seven clients were present. Six clients, including core sample Client 36, were positioned around a table. Staff stated the activity was gardening.	{W 159}	1.6. Unit 36 LOC staff who work with the clients at the day program on 36-Annex will be trained by the Unit Supervisor or designee by 12/13/2013 on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop training, and the new training assessment for Client 36. 1.7. Unit Supervisor and/or Senior PT will monitor during rounds to ensure clients can physically and/or cognitively participate in the activities provided. Immediate actions will be taken to correct any deficiency observed. 1.8. Program 5 IPC's will monitor progress notes recording for clients via monthly audit of the client clinical record, and document in the IPC monthly notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes. 1.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.10. Program Director is responsible.	11-25-13 11-25-13 11-25-13 11-25-13

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{W 159}	Continued From page 64 One staff member began to read the back of a packet of seeds, including information about planting depth and time to germination. [redacted] Staff then began to ask questions such as, "What grows here in the valley?, "Where do you go to buy plants?", and "Raise your hand if you like shade." The staff answered each other's questions. [redacted] Client 36 was observed repeatedly bouncing a ball, attached to his wheelchair by a cord, onto his wheelchair tray until he fell asleep. [redacted] The Individual Program Plan, dated 10/26/12, listed objective I-6.4 under the section, Vocational Evaluation. The objective was to place simulated mail in a simulated mail box. This activity was not observed. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator agreed that the activity during the day program did not meet the clients' developmental needs. She further stated, "Perhaps more training" for day program staff.	{W 159}	W 159 (cont.) 2.1. A special IPP was held to review the Approaches & Strategies for Client 45. 2.2. Unit 36 LOC staff were trained by the Unit Unit Supervisor or designee on Client 45's Approaches & Strategies with emphasis on the use of protective helmet. 2.3. Program 5 Management identified clients in the program who uses a restrictive device and/or protection device. An IPP review was held for each of the identified clients to discuss appropriateness of the device, plan to use the device, and if alternatives to the device should be explored. 2.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client use of restrictive device and/or protection device. 2.5. Unit Supervisor and/or Senior PT will monitor staff compliance during rounds at least monthly, and document any findings. 2.6. IPC's will monitor via rounds to ensure that the clients' restrictive/protection devices are being used as per IPP and are in good repair. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 2.7. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 2.8. Program Director is responsible.	11-15-13 11-19-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 159}	Continued From page 65 2. On 10/16/13 at 7:00 AM, Client 45 was observed sitting in a chair in one of the activity areas on Residence 36. He was not wearing a helmet. A few minutes later, licensed staff placed a helmet on his head and transferred the client to a wheelchair with a seat belt. The client remained in the wheelchair with the helmet on. At 8:20 AM, Client 45 was wheeled into the dining room for breakfast, wearing his helmet. It was removed when the client was transferred to a dining chair. At 1:05 PM, Client 45 was again observed in the dining room. After finishing lunch, staff assisted the client from the dining chair to his wheelchair without placing the helmet. The client left the dining room independently. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator stated that Client 45 should wear his helmet when he is ambulating and not when he is sitting in a chair or when he is in his wheelchair. She further stated that the client does not ambulate very often. The client's record was reviewed on 10/17/13 at 1:30 PM. [redacted]	{W 159}	W 159 (cont.) 3.1. An assessment of Client 46's placement at the day program was completed. 3.2. Residence 36 day program site schedule was revised to include engaging clients with activities that matched the functioning levels of the clients. 3.3. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 3.4. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 3.5. The Interdisciplinary Team is in the process to hold an IPP review for Client 46 to address the updated assessment information. The meeting is anticipated to be held on 12/4/13. 3.6. Unit Supervisor or designee is in the process of providing training to Unit 36 LOC staff who work with the clients at the day program on 36-Annex on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop training, and the new training assessment for Client 36. The anticipated date of completion is 12/13/2013. 3.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 3.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 3.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-12-13 11-15-13 11-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 159}	Continued From page 66 [redacted] On 10/24/13 at 8:10 AM, Client 45 was observed sitting in a dining chair in the dining room eating breakfast independently. He was wearing his helmet. During an interview at the time, licensed staff sitting at the client's table was asked if the client was supposed to be wearing his helmet while eating. Staff stated, "No" and removed the helmet. 3. On 10/15/13, observations were made in one of the day rooms on Residence 36. There were two staff and 10 clients in the room. One of the staff stated he had been floated from another residence. Staff stated the activity was "watching TV." From 8:30 AM until 9:00 AM, Client 46 was observed sitting in a chair holding a ball and not watching TV. No other activity was offered to Client 46. On 10/16/13 at 1:30 PM, observations were made in Client 46's day program. There were seven clients and two staff. Six clients were positioned around a table on one side of the room and Client 46 was seated in a chair on the other side of the room. Client 46 was observed to sit holding a ball for 30 minutes with no other activity. A staff would occasionally verbally prompt him from the other side of the room to join the group. Client 46 never joined the group or engaged in any other activity except holding the ball.	{W 159}	W159 (cont.) 3.10. Program Director is responsible. [redacted]	10-24-13
			4.2. Program 5 Management identified clients whose objectives were not current and/or accurate. An IPP review was held for the identified clients to update their objectives.	11-24-13
			4.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the client's current objectives during the assessment process, and make recommendations as needed.	11-24-13
			4.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
			4.5. Unit 21 Supervisor or designee was in the process of providing training to the unit LOC staff on Client 31's training plan. The anticipated completion date was 12/13/2013.	11-25-13
			4.6. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			4.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings.	11-25-13
			4.8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			4.9. Program Director is responsible.	

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{W 159}	Continued From page 67 At 1:45 PM, Client 46 stood up and attempted to sit in another chair. When staff asked him to join the group, the client immediately turned around and sat back down in his original chair. Staff responded by stating, "Good job [client's first name]." During an interview on 10/16/13 at 2:00 PM, licensed day program staff stated that Client 46 had been in that day program "for a long time." [redacted] Client 46 was again observed sitting, holding a ball with no other activity on the residence on 10/21/13 from 7:30 PM until 8:00 PM. [redacted]	{W 159}	W 159 (cont.) [redacted]	10-24-13
			5.2. Program 5 Management identified clients whose objectives were not current and/or accurate. An IPP review was held for the identified clients to update their objectives.	11-24-13
			5.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the client's current objectives during the assessment process, and make recommendations as needed.	11-24-13
			5.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
			5.5. Unit 21 Supervisor or designee was in the process of providing training to the unit LOC staff on Client 31's training plan. The anticipated completion date was 12/13/2013.	11-25-13
			5.6. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			5.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings.	11-25-13
			5.8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			5.9. Program Director is responsible. .	

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{W 159}	Continued From page 68 [redacted] There was no documented evidence that the Individual Plan Coordinator (IPC) had evaluated the client's day program for proper placement. During an interview on 10/17/13 at 10:30 AM, the IPC stated that no vocational assessment was done for Client 46 because he does not get paid for his time in the day program. The IPC stated that the staff who work with clients in the day program were staff who are assigned to work on the residence that day, including staff who have floated from other residences. She was not aware of what training staff received before becoming day program instructors. The IPC further stated that no documented review of the appropriateness of the Client 46's placement in the day program was available. [redacted] During an interview with the Individual Program Coordinator on 10/24/13 at 9:15 AM., she stated that the team had not decided as to the new plan. [redacted]	{W 159}		

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{W 159}	Continued From page 69 [redacted] During an interview with the Individual Program Coordinator (IPC) on 10/24/13 at 9:15 AM, she stated that the team had not decided on a new plan. The IPC was reminded that the previous money management objective was met last 7/31/12, and the annual program planning conference was conducted approximately five months ago.	{W 159}		
W 164	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that clients received professional services in accordance with their needs for one of 19 sampled clients (Client 27). Although a behavioral specialist was identified by the facility as having expertise in [redacted] there was no evidence that the team utilized those services for an [redacted] client with [redacted] behaviors (requiring highly restrictive interventions / mechanical restraints), and with a long history of minimal attendance at the day program. Findings:	W 164	W 164 [redacted] 1.3. Program Management identified [redacted] clients in the program. An IPP review was held for each of the identified [redacted] client to discuss any identified issues that may be a result of their [redacted] and any need for further assessment. 1.4. Clients identified as requiring further assessment by the facility [redacted] specialist were referred. 1.5. IPC's will monitor progress notes recording for clients via monthly audit of the client clinical records, and document in the IPC monthly notes. Any increase in behavior or other concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes. 1.6. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting . with further corrective actions taken as necessary. 1.7. Program Director is responsible.	10-31-13 11-01-13 11-15-13 11-24-13 11-24-13 11-24-13

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W 164	Continued From page 70 [redacted] During staff interview on 10/23/13 at 10:10 AM, staff stated that Client 27's behaviors began at 3:35 AM and he was placed in 5 point restraints	W 164	W 164 (cont.) [redacted]	10-31-13 11-01-13
			2.3. Program Management identified [redacted] clients in the program. An IPP review was held for each of the identified [redacted] client to discuss any identified issues that may be a result of their [redacted] and any need for further assessment.	11-15-13
			2.4. Clients identified as requiring further assessment by the facility [redacted] specialist were referred.	11-24-13
			2.5. IPC's will monitor progress notes recording for clients via monthly audit of the client clinical records, and document in the IPC monthly notes. Any increase in behavior or other concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes.	11-24-13
			2.6. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-2413
			2.7. Program Director is responsible.	

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W 164	Continued From page 71 at that time. The physician's restraint order was renewed at 7:35 AM as the client was still agitated and was assessed for a chemical restraint. He received Ziprasidone (antipsychotic medication) 20 mg IM (intramuscularly). Staff stated that Client 27 was released from restraints at 10:20 AM, approximately seven (7) hours later. Client 27 sustained dark purple discoloration to his right outer corner of his upper eyelid, measuring 2.5 x 3 cm, multiple pin point petechiae all over his face, (tiny red / purple spots on skin caused by abnormal bleeding from small blood vessels that have broken close to the skin) and a skin abrasion to his finger. 2. IPP documentation indicated that Client 27 was currently enrolled in the Day Training Activity Center (DTAC) [redacted] The class focus was to enhance basic living skills in socialization, communication, vocational training, fine and gross motor abilities, and clients were given the opportunity to express themselves through their choice of activities. [redacted]	W 164		

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W 164	Continued From page 72 [redacted] A recommendation was made to open a "Desired Outcome" to increase the number of sessions Client 27 attends at the DTAC site. During an interview with DTAC staff on 10/15/13 at 10:25 AM, staff stated that Client 27 often refused to attend DTAC and when he did attend, he tore paper from magazines and needed a lot of reinforcement. On multiple occasions throughout the survey, Client 27 was observed in bed with the covers over his head. On 10/15/13, Client 27 left DTAC, returned to the unit, and went back into bed. On 10/16/13 at 10 AM, Client 27 was observed on the unit after returning from a dental appointment. Staff asked him if he wanted to do activities and walk to work, Client 27 stated "No Work" and went in his room and closed the door. On 10/22/13 he attended DTAC for a short period of time and became fixated on a hat and was taken back to the residence. He returned later and was observed attempting to hit staff and used his fingernails to dig into his arm.	W 164		

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W 164	Continued From page 73 From the locked patio area on 10/23/13 Client 27 was observed inside of the residence repeatedly pounding on the door window with his hands. During an interview with supervisory staff on 10/24/13 at 1:30 PM, staff identified a doctor at the facility as being a behavioral [redacted] specialist. When asked if the doctor spent time with the client and observed Client 27 on the unit or in the day program environment, staff said, "no." Staff further stated that Client 27 was so new, was still getting acclimated and was in the assessment phase.	W 164	W 186 1.1. The age-inappropriate recreational or leisure time supplies were removed from the residence.	10-22-13
			1.2. All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence.	10-22-13
			1.3. New training supplies were ordered and obtained from Curriculum Services.	11-18-13
			1.4. The staffing ratio on Program 5 units were reviewed and was adequate.	11-18-13
			1.5. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered.	11-18-13
			1.6. Unit routines for other Program 5 units were reviewed and remained appropriate.	11-18-13
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: Based on observation, record review, and staff interview, the facility: 1. failed to provide sufficient staff to manage and supervise clients. This failure resulted in one of 19 sampled clients (Client 34) displaying self-injurious behaviors with no attempt by staff to redirect the client. Additionally, the lack of staffing left other clients who were not engaged in the group activity with provision of no alternate activities; 2. failed to provide sufficient staffing so that one of 25 unsampled clients (Client 39) could be provided meaningful activities with the required supervision. This failure resulted in staff reliance	W 186	1.7. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine.	11-24-13
			1.8. Interdisciplinary Team for Client 34 is in the process of updating the Approaches & Strategies to include staff intervention when client exhibits SIB and assist client with handwashing when hands are covered with bodily fluid.	11-25-13
			1.9. Unit 23 Supervisor or designee is in the process of training unit LOC staff on Client 34's behavior plan, revised Approaches & Strategies, definition of active treatment, and the unit infection control training curriculum. The anticipated date of completion is 12/13/2013.	11-25-13
			1.10. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment via rounds at least monthly, and document any findings.	11-25-13
			1.11. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13

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W 186	Continued From page 74 on the use of restrictive hand devices to prevent self-injurious behaviors; 3. failed to ensure that one sampled client (Clients 19) and one unsampled client (Client 35) were afforded opportunities to participate in off-campus activities and; 4. ten clients were crowded around a table for six at a worksite, with insufficient staffing available for that number of clients. Findings: Residence 23 1. On 10/22/13 from 2:12 PM to approximately 2:45 PM, eight clients were observed being attended to primarily by one direct care staff, a psychiatric technician assistant (PTA) in a group activity room. The animated version of "The Hunchback of Notre Dame" was running. Most of the clients were seated on couches or chairs facing each other, displaying self-stimulating behaviors such as clapping hands, making loud enunciations, and rocking. A few clients milled about and wandered away from the group. Client 34 engaged in self-injurious behavior without intervention. The PTA encouraged clients to sit quietly and watch the movie. During most of the observation period of over thirty minutes, the PTA was alone with the eight clients and her time was occupied mainly with preventing altercations or discouraging disruptive behaviors. On 10/15/13, review of an untitled, undated facility document described Residence 23 as part of a program, "Life Management Development through Behavior and Social Skills," designed to serve adult male clients with [redacted] with a major focus on reduction of challenging behaviors. Average	W 186	W186 (cont.) 1.12. Program Director is responsible. 2.1. The age-inappropriate recreational or leisure time supplies were removed from the residence. 2.2. All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence. 2.3. The staffing ratio on Program 5 units were reviewed and was adequate. 2.4. New training supplies were ordered and obtained from Curriculum Services. 2.5. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 2.6. Unit routines for other Program 5 units were reviewed and remained appropriate. 2.7. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine. 2.8. Client 39's behavior plans were reviewed by the Unit Supervisor and were appropriate. 2.9. Unit 23 LOC staff were trained by the Unit Supervisor or designee on Client 39's behavior plan. 2.10. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment during rounds at least monthly, and document any findings. 2.11. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.12. Program Director is responsible.	10-22-13 10-22-13 11-18-13 11-18-13 11-18-13 11-18-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 186	Continued From page 75 behavior level was described as moderate to severe including self-injurious behavior, socially undesirable behavior, property destruction, physical aggression and elopement. Training opportunities were to be provided to enhance and develop new skills, with a major focus on developing independence in leisure, vocational, and social skills. On 10/22/13 at 2:12 PM, Client 34 was observed stretched out on a couch with his back and head against the arm of the couch, facing the television. Client 34 rarely looked at the movie on the TV directly in front of him. The position of the couch, relative to where the PTA sat, obstructed the PTA's view of much of the client's upper body. On 10/22/13 at 2:15 PM, one client stood up and paced. Another client, seated alone on a couch to the right of the PTA restlessly attracted the attention of the PTA with disruptive behavior such [redacted] The PTA prompted the client to sit up and when the client became vocal said, "Shhhh. We're practicing to sit and be quiet because that's what we would do in the theaters." The PTA then said to another client, "We don't stand up at the movies." Clients were instructed, by the PTA, to sit quietly. For the first ten minutes of observation, the client on a couch beside the PTA commanded most of that PTA's attention. Although the clients were unengaged in the movie watching activity, there was insufficient staff to provide training opportunities or help the clients develop skills and/or independence in activities. The PTA was predominantly alone with the clients.	W 186	W 186 (cont.) 3.1. An audit of Program 5 client community outings was conducted by the Recreational Therapists. No other deficiencies were noted. [redacted] 3.3. Program 5 LOC staff was trained by the Unit Supervisor or designee on Program Procedure I-36 "Community Leisure Activities for Clients". Staff not on duty will be trained by the Unit Supervisor or designee upon their return. 3.4. Recreational Therapists in Program 5 will submit a quarterly audit of all client outings to the Program Assistant for review. 3.5. Program Management will review the quarterly audit of client outings at the monthly Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 3.6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 3.7. Program Director is responsible.	11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 186	Continued From page 76 On 10/22/13 at 2:18 PM, Client 34 remained on his back, hands clasped, watching others in the group, then closed his eyes. Concurrently, the PTA said, "Shhh," putting finger to lips. "You're doing a great job." Another client sat with eyes closed; one was told to turn around. One client was [redacted] while another, not watching the movie, had his head on a chair arm. The clients were not watching the movie. A second staff, a psychiatric technician (PT), came and went intermittently for approximately ten minutes. At 2:20 PM, that PT told one client to put his hands down and then left the PTA with the group. Shortly thereafter, another client stood up, milled around, would not be redirected, and because there was not another staff to intervene, the client left the group and walked down the hall to the nurses' station unaccompanied. The PTA remained alone with the remaining clients who were not watching the movie. [redacted]. A PT joined the group and, with her back to Client 34, swept the area for approximately two minutes. Subsequently, the PTA left the group briefly. When the PTA returned, the PT left. On 10/22/13 at 2:33 PM, six clients remained unattended while the PTA walked to a room with one client and another went to use a bathroom by himself then returned, and despite urging by the	W 186	W 186 (cont.) 4.1 The day program area on residence 22 was returned to its normal capacity of 3 to 4 clients seating at a table. 4.2. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor the physical environment during rounds at least monthly, and document the findings. 4.3. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.4. Program Director is responsible.	10-23-13 10-23-13 10-23-13

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W 186	Continued From page 77 PTA to join the group, left the seating area to do a puzzle at a table. Client 34 turned onto his left side and closed his eyes a few minutes later. Another client sat and ~~rocked continuously~~, looking down and then at others who remained seated. The lack of staff contributed to a lack of activities being offered to the clients who were not engaged in the movie activity. From 2:26 PM to approximately 2:39 PM, the PTA spent time attempting to keep two clients away from each other. During interview on 10/22/13 from 2:39 PM through 2:45 PM, the PTA stated she did not see the self-injurious behavior of Client 34. The PTA said that normally there were two staff per group and each positioned themselves so that all clients could be observed. The PTA stated the group was one staff short because one of the staff needed training. During the interview, when asked about the reason for the movie activity, the reason given was to increase the attention span of the clients. When asked about all the clients' attention spans the PTA said it was short. As the PTA had eight clients with short attention spans in the room for half and hour, mostly by herself, providing individualized attention to promote growth opportunities was not possible. 2. On 10/24/13 at 8 AM, Client 39 sat on a couch in a group activity room. [redacted]	W 186	W 186 (cont.) 5.1. The age-inappropriate recreational or leisure time supplies were removed from the residence. 5.2. All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence. 5.3. The staffing ratio on Program 5 units were reviewed and was adequate. 5.4. New training supplies were ordered and obtained from Curriculum Services. 5.5. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 5.6. Unit routines for other Program 5 units were reviewed and remained appropriate. 5.7. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine. [redacted] 5.9. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment during rounds at least monthly, and document any findings. 5.10. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 5.11. Program Director is responsible.	10-22-13 10-22-13 11-18-13 11-18-13 11-18-13 11-18-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 186	Continued From page 78 [redacted] further limiting movement. Other than being escorted to the restroom at 8:20 AM, the client sat and watched others as his movements were highly restricted by [redacted] On 10/24/13 from 8 AM to 9 AM, an average of eight clients were observed with one to two direct care staff. The staff were busy toileting some of the clients, helping some complete getting dressed, performing related activities and engaging one client in a march-in-place activity, leaving an insufficient number of staff to provide the supervision and intervention for Client 34 to engage in an activity without [redacted] On 10/24/13 at 8:45 PM, a psychiatric technician (PT) stated that the [redacted] were to prevent [redacted] behaviors [redacted] The PT stated that the client had not had such behaviors for about ten years. The PT stated that Client 39 was out of the [redacted] from approximately 9:30 AM to 11 AM every day and again from 1:30 PM to 3 PM when he was at day program. The PT stated that he did not engage in this behavior when he was at the day program because he folded towels there, a task that he enjoyed and which kept him focused. When asked if the extensive reliance on the [redacted] would be necessary with increased supervision and engagement in activities at the residence, the PT stated, "You hit the nail on the head." On 10/24/13 at approximately 8:55 AM, the PT stated that Client 39 utilized a [redacted] at the	W 186		

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W 186	Continued From page 79 day program and stated the [redacted] devices continued to be used on the residence because Client 39 continued to show antecedent behaviors however, stated that Client 39 was bored which increased the undesirable behaviors. The PT commented, "He is one of our smarter clients." [redacted] [redacted] On 10/24/13 from 9 AM to 10 AM, Client 39 was not observed in any	W 186		

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W 186	Continued From page 80 of the listed precursors and remained in the [redacted] restraints as there was an insufficient number of staff to remain with Client 39 so that the client could engage in an activity. In the IPP, in the section, "Proactive Plans" the following interventions were listed and with sufficient staff, some could have been utilized, "6. Provide (Client 39) with training in folding linens, and towels as replacement behavior for the use of his hands in self-injury. Provide dense reinforcement of both primary and social when (Client 39) is on task with adaptive use of his hands. 7. During leisure time, encourage (Client 39) to look at magazines, manipulate other items, such as a sport ball, or interact socially with peers and staff ..." From 9 AM to 10 AM on 10//24/13, none of the proactive interventions occurred due to the lack of sufficient staff. [redacted] Despite multiple risks listed in a "Functional Analysis of Behavior," in the 1/8/13 IPP, observation from 9 AM to 10 AM showed	W 186		

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W 186	Continued From page 81 insufficient staff did not make it possible to safely remove the [redacted] On 10/24/13 at 12:15 PM, the Unit Supervisor (US) stated that if Client 39 was pulled up close to a table and engaged in an activity of interest that the [redacted] restraints could be removed however, this would require close supervision. The US stated that the client was a high risk for self-injury and possibly death due to his quickness and dangerous SIB behaviors. The US stated that close supervision was necessary to remove the [redacted] and prevent serious Sibs. 3. The Recreational Activities Log for Residence 36 was reviewed on 10/21/13. [redacted] The IPP further documented that the leisure plan for Client 19 was to encourage his participation in community activities.	W 186		

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W 186	Continued From page 82	W 186		
	[redacted]			
	During an interview on 10/24/13 at 8:50 AM, the Leisure Coordinator for Residence 36 confirmed that Clients 19 and 35 had not been included in community activities during August and September. She further stated that there had to be enough staff available to maintain supervision levels before clients could be taken into the community and that staffing was often an issue. 4. A program observation was conducted in room 109 of residence 22 for clients from residence 23 on 10/16/13 at 2:05 PM. In the room there were 4 clients seated by U-shaped table with the staff sitting inside the U area of the table, another four client seated in the large table, one client with a staff by the paper shredder machine, one client on a chair with the 1:1 staff. The room was crowded with clients going in and out of the room and staff following them. The group leader (staff) in the room was asked why another vacant room on the residence could not be used as overcrowding was evident. The room was previously used as a two client bedroom. The group leader (staff) responded that it required another two staff to open another programming area or room.			

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W 186	Continued From page 83 5. Observations were conducted on Unit 23 beginning at 2:15 PM on 10/22/13. At the beginning of the observation eight men were seated in the settees and the chairs in the " west end television room. " Client #58 was seated next to his one-on-one staff in a chair located behind the settee. The direct support staff providing general supervision said the men were watching a movie. None of the men appeared to be watching the movie and the direct support staff was constantly giving verbal instruction to the men such as " hands down, pull your shirt down, keep your hands to yourself, etc. " When asked if the men enjoyed being outside, the direct support staff said, " Yes, some of them really do. " When asked why some of the men couldn ' t go outside since it was such a beautiful day, the direct support staff said [redacted] there was not enough direct support staff to supervise them if they went outside.	W 186	W 189 1.1. Acting Director of Dietetics set the following expectations at the Dietetics Services October Monthly Mandatory Meeting with the Dietetics staff on duty: a. Thermometers need to be calibrated regularly - at least once a month and at any conflict. b. Dimple needs to be submerged in the center of food to allow for accurate temperature reading c. Need to put thermometer in at an angle to allow for accurate reading of thermometer d. If for any reason you think that your thermometer may not be reading accurately/ is broken, a supervisor should be contacted for a replacement. e. In an emergency situation where ready-to-eat food may have been delivered frozen, cooking times may deviate from the standard length of time f. Food to be reheated to 165 degrees F and held at 140 degrees F or above	10-25-13
			1.2. No negative impact was observed to the clients on Unit 6.	10-25-13
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, staff interviews and review of food temperature and training logs, the facility failed to ensure a food worker (FW) was able to take food temperatures using a properly calibrated thermometer. FW was also unable to accurately use the food thermometer. FW also failed to ensure that the temperature of reheated	W 189	1.3. Unit Supervisor or designee was in the process of arranging a Unit Government meeting to discuss food substitutions and preferences with the clients. The anticipated date of the meeting was 12/9/13.	11-25-13
			1.4. Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the residence kitchens. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by Food Services Supervisor on the applicable procedures.	11-25-13
			1.5. Any elevated issues will be reviewed at the Administrative Quality Management Council meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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W 189	Continued From page 84 eggs met food safety standards. Time and temperature control play a critical role in food safety. These failures provide the facility a false sense of security that food is being safely held and/or stored. In addition, improper use of food thermometers could result in the provision of food that is unpalatable due to improper holding temperatures (see W473). The facility also failed to ensure that staff provided safe and competent care to clients, when 1 of 25 un-sampled clients (Client 55) was allowed to walk around in shoes without laces, causing the client to have an awkward and unsafe gait. Findings: 1. During the tour of the kitchen on Residence 6 on 10/17/13 at approximately 8:40 AM, the food temperature log for the meal was reviewed. There was a significant drop in temperatures from beginning of the meal to thirty minutes later. FW stated she had taken the temperatures and that the steam table where the food was held was working properly. FW was asked to take temperature of the remaining items in the pan. She stated the egg patty was 110 degrees Fahrenheit (F). The surveyor determined using ice-water method that the facility thermometer was out of calibration. A properly calibrated thermometer would read 32 (+/- 2) degrees F in an ice water slush. The facility thermometer was 26 degrees F in ice water slush. FW recalibrated the thermometer and stated the temperature of the egg patty was still 110 degrees F. At approximately 8:45 AM, using the surveyor's calibrated thermometer, the egg patty was 131.6	W 189	W189 (cont.) 1.6. Acting Director of Dietetics is responsible. 2.1. Acting Director of Dietetics set the following expectations at the Dietetics Services October Monthly Mandatory Meeting with the Dietetics staff on duty: a. Thermometers need to be calibrated regularly - at least once a month and at any conflict. b. Dimple needs to be submerged in the center of food to allow for accurate temperature reading c. Need to put thermometer in at an angle to allow for accurate reading of thermometer d. If for any reason you think that your thermometer may not be reading accurately/ is broken, a supervisor should be contacted for a replacement. e. In an emergency situation where ready-to-eat food may have been delivered frozen, cooking times may deviate from the standard length of time f. Food to be reheated to 165 degrees F and held at 140 degrees F or above 2.2. No negative impact was observed to the clients on Unit 6. 2.3. Unit Supervisor or designee was in the process of arranging a Unit Government meeting to discuss food substitutions and preferences with the clients. The anticipated date of the meeting was 12/9/13. 2.4. Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the residence kitchens. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by Food Services Supervisor on the applicable procedures. 2.5. Any elevated issues will be reviewed at the Administrative Quality Management Council meeting, along with any corrective plan.	10-25-13 10-25-13 11-25-13 11-25-13 11-25-13

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W 189	Continued From page 85 degrees F. FW was asked to retake the temperature of the egg patty. Observation revealed that the food item being tested did not go past the sensor on the thermometer. The sensor is a dimple on the stem of a bimetal thermometer. The thermometer needed to be inserted in food about 2-3 inches from the tip (location of the sensor) to the stem. If used to measure thin foods, the thermometer needs to be inserted sideways. At approximately 9:00 AM, with the thermometer repositioned, the egg patty was 122 degrees F. 2. At approximately 8:12 AM on 10/16/13, Client 5 was overheard stating "This [expletive] is cold". The resident told the Residence staff present that his food was cold. The food service worker (FW) serving the food felt the eggs and pancakes and agreed it was cold. She took the temperature and stated it was 80 degrees Fahrenheit (F). She then proceeded to return the items to the oven to reheat. A few minutes later, FW pulled out the food but was not observed to recheck the food temperatures prior to serving the clients. Section 3-403.11of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds." A review of the menu for 10/16/13, which included documentation of food temperatures for breakfast items, showed the initial food temperature (taken at the beginning of service) of the pancakes was	W 189	W189 (cont.) Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 2.6. Acting Director of Dietetics is responsible. 3.1. Staff replaced Client 55's shoes with a pair that had shoelaces on them. 3.2. Staff checked the shoes for other clients in Program 5, and no deficiencies were noted. 3.3. IPC updated Client 55's Approaches & Strategies to include staff monitoring and assisting the client in keeping her shoes tied. 3.4. Unit 21 LOC staff were trained by the Unit Supervisor or designee on Client 55's Approaches & Strategies with emphasis on encouraging/assisting Client 55 with tying her shoelaces. 3.5. Program 5 LOC staff received training by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" with emphasis on assisting clients with meeting their dressing and grooming needs. 3.6. Program 5 Group Leaders were trained by the Unit Supervisor on ILA's to ensure they address client's preferences for clothing during the assessment process, and make recommendations as needed. 3.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client appearance and staff compliance with client plans during rounds at least monthly, and document any findings. 3.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 3.9. Program Director is responsible.	10-21-13 10-21-13 11-21-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 189	Continued From page 86 166 degrees and the egg patty was 160 degrees F. The second temperatures were 140 and 142 degrees F respectively. Review of the training attendance logs provided by the facility from June 2012 through September 2013 did not include any training provided to food service staff on how to take food temperatures or reheating foods. 3. During Day Programing observation on 10/21/13 at 2:05 PM, Client 55 entered the room with a male staff holding [redacted] hand. Client 55 was obse[redacted]d walking with a kicking motion of the feet, [redacted] tennis shoes did not have any shoelaces on and the tongue of the tennis shoes were flipped outward. The male staff guided Client 55 to sit on a chair and left the room. There was no intervention by staff to put shoelaces on the shoe untill intervention by surveyor 4. During dinner on 10/21/13 at 5:45 PM, Client A was observed with both shoelaces untied. He walked with untied shoe laces from his table to the kitchen sink to placed his used utensils then he exited the dining area. The client was walking with both shoe laces untied without any staff intervention. An interview was conducted with the facility staff on 10/21/13 at 5:48 PM, the facility staff acknowledged that the client's shoe laces were untied. She stated that a staff should have assisted the client while walking to make sure he does not fall since the client refused to have his shoe laces tied. The facility staff further stated that she did not assisted the client while exiting	W 189	W 189 (cont.) 4.1. Client A selected new shoes with velcro closures from the Fashion Center. 4.2. Staff checked the shoes for other clients in Program 5, and no deficiencies were noted. 4.3. Client A's Group Leader updated his Independent Living Assessment (ILA) to reflect the client's preference for velcro closures on his shoes. 4.4. A Special IPP was held to review and update Client A's Approaches & Strategies to reflect the client's preference for velcro closures on his shoes. 4.5. Unit 25 LOC staff were trained by the Unit Supervisor or designee on Client A's updated Approaches & Strategies. 4.6. Program 5 LOC staff received training by their Unit Supervisors or designees on Facility Bulletin 48 "Standards of Care" with emphasis on assisting clients with meeting their dressing and grooming needs. 4.7. Program 5 Group Leaders were trained by the Unit Supervisor on ILA's to ensure they address client's preferences for clothing during the assessment process, and make recommendations as needed. 4.8. Program 5 IPC's were trained by the Program Assistant on monitoring client preferences. 4.9. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client appearance during rounds at least monthly, and document any findings. 4.10. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.11. Program Director is responsible.	10-22-13 10-21-13 10-30-13 11-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 189	Continued From page 87 the dining area with his shoe laces untied because there were other clients in the dining room who were still eating. During an interview with the Resident Manager on 10/22/13 at 10:50 AM regarding the observation. She stated that the client was given a Velcro shoe to use and confirmed that the staff should have intervened with Client A having to walk with both shoelaces untied to prevent the client from falling.	W 189	W 191 [redacted]	11-15-13
			2. Director of Quality Assurance conducted research of restrictive devices available or in use elsewhere. [redacted] The results were provided to the Program Director.	11-21-13
			[redacted]	11-22-13
W 191	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, staff failed to demonstrate cross-cutting skills when no attempt was made to obtain products that were less restrictive and less stigmatizing for one of 25 unsampled clients (Client 39) therefore, continued to use highly restrictive plastic hand devices (hand restraints) on the client, designed years ago by the facility, to prevent self-injurious behaviors. Findings: Residence 23 On 10/24/13 at 8 AM, Client 39 sat on a couch in a group activity room. [redacted]	W 191	4. Program 5 Management identified clients in the program who uses a restrictive device and/or protection device. An IPP review was held for each of the identified client to discuss appropriateness of the device, plan to use the device, and if alternatives to the device should be explored.	11-24-13
			5. The psychologist was in the process of updating Client 39's Functional Analysis of Behavior [redacted] The anticipated date of completion was 12/12/13.	11-25-13
			6. Client 39's Interdisciplinary Team was in the process of planning a meeting to discuss the result of the research conducted by the Director of Quality Assurance. The anticipated date of the meeting was 12/13/13.	11-25-13
			7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance with client behavior plans during rounds at least monthly, and document any findings.	11-25-13
			8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
			9. Program Director is responsible.	

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W 191	Continued From page 88 [redacted] Other than being escorted to the restroom at 8:20 AM, the client sat and watched others as his movements were highly restricted [redacted]. On 10/24/13 at 8:45 PM, a psychiatric technician (PT) stated that the [redacted] were to prevent [redacted] The PT stated that the client had not had such behaviors for about ten years. The PT stated that Client 39 was out of the [redacted] when at the day program however, wore the [redacted] most of the remainder of the time. Although the [redacted] restraints were removed for five minutes to promote circulation, from 9 AM to 10 AM the client remained in the highly restrictive [redacted] restraints. On 10/24/13 at approximately 8:55 AM, the PT stated that Client 39 utilized a [redacted] at the day program and stated the [redacted] devices continued to be used on the residence because Client 39 continued to show antecedent behaviors. [redacted]	W 191		

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W 191	Continued From page 89 [redacted]	W 191		

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W 191	Continued From page 90 [redacted]	W 191	W 192 1.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
			1.2. A medication error report was initiated for Clients 26.	10-15-13
			1.3. Physician reviewed the medication error reports for Client 26, and determined that the client was not adversely affected.	10-15-13
			1.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
			1.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
	During an interview with the Unit Supervisor (US) on 10/24/13 at 12:15 PM, the US stated that the [redacted] had been manufactured by the facility, used for years on the client, and the facility had not looked at different products available on the market that were less restrictive and less stigmatizing. The US stated he had not researched to see what products were available. The US agreed that without change the facility would probably continue to use the [redacted] for the remainder of Client 39's life.		1.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			1.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
			1.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			1.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.	W 192	1.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			1.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
	This STANDARD is not met as evidenced by: Based on interviews and document reviews the facility's staff (pharmacists, nurses, and psych techs) failed to demonstrate competency in medication safety for the use of insulin when psychiatric technicians administered insulin to clients (review of 3 of 6 clinical records) that were		1.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
			1.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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W 192	Continued From page 91 hypoglycemic (low blood sugar). Insulin is a medication used to lower blood sugar levels to treat diabetes. When too much insulin is administered and blood sugar levels drop below 70 mg/dl a patient becomes hypoglycemic. Hypoglycemia may result in convulsions, unconsciousness, temporary or permanent brain damage, or even death. Findings: [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. A review of Lexicomp Online indicated that Humulin R had a duration of 4 to 12 hours and a onset of 30 minutes. Humulin R can have an effect on lowering blood sugars for 4 to 12 hours and can begin lowering blood sugar within 30 minutes. [redacted]	W 192	W 192 (cont.) 1.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 1.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 1.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 1.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 1.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 1.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 192	Continued From page 92 [redacted]	W 192	W 192 (cont.) 1.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 1.20. Program Director is responsible.	11-25-13

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PORTERVILLE, CA 93257

(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 192	Continued From page 93 [redacted] The psychiatric technicians (psych techs) continued to administer Lantus and Humulin R when Client 26 was hypoglycemic. Humulin R is short acting insulin and may promptly lower blood sugars. Humulin R was administered 6 times when Client 26 was hypoglycemic (43 mg/dl, 45 mg/dl, 47 mg/dl, 60 mg/dl, 62 mg/dl, 66 mg/dl). During an interview on 10/15/13 at 11:30 AM, the Psych Tech stated she had administered Client 26's insulin. She also stated she thought the physician orders were to give the insulin when blood sugars were less than 70 mg/dl and then call the clinician. A review of the diabetes care plan for Client 26 indicated that daily monitoring for hypoglycemia would be done. [redacted]	W 192	W 192 (cont.) 2.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 2.2. A medication error report was initiated for Clients 42. 2.3. Physician reviewed the medication error reports for Client 42, and determined that the client was not adversely affected. 2.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 2.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 2.6. Physicians were notified of blood sugar level prior to administration of insulin. 2.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 2.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 2.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 2.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 2.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 2.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 2.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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	05G014		R-C 10/25/2013

NAME OF PROVIDER OR SUPPLIER: PORTERVILLE DEVELOPMENT CENTER - DP ICF/IID

STREET ADDRESS, CITY, STATE, ZIP CODE: 26501 AVENUE 140, PORTERVILLE, CA 93257

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W 192	Continued From page 94 observing for symptoms of hypoglycemia which include sweating, tremors, pallor, rapid heartbeat, confusion, and nervousness. There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 pm, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 26. 2. A review of the clinical record on 10/15/13 at 10:00 AM indicated Client 42 had a history of diabetes. Client 42's most current physician Insulin orders included Lantus 55 units daily. [redacted]	W 192	W 192 (cont.) 2.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 2.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 2.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 2.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 2.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 2.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 192	Continued From page 95 [redacted] The psych techs continued to administer Lantus daily when Client 42 was hypoglycemic. Client 42 had 21 hypoglycemic events from 08/21/13 to 10/14/13 without a Lantus dosage change. During an interview on 10/15/13 at 10:59 AM, the Psych Tech stated she had administered Client	W 192	W 192 (cont.) 2.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 2.20. Program Director is responsible.	11-25-13

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W 192	Continued From page 96 42's Insulin. She also stated that you always give the Lantus insulin. She said that the Lantus should always be administered even with low blood sugars. A review of the diabetes care plan for Client 42 indicated that daily and as needed monitoring for hypoglycemia would be done [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:15 pm, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 42. 3. A review of the clinical record on 10/15/13 at 1:00 PM indicated Client 43 had a history of diabetes. [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. According to Lexicomp Online Lispro has a duration of about 5 hours. Lispro can have an effect on lower blood	W 192	W 192 (cont.) 3.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 3.2. A medication error report was initiated for Clients 43. 3.3. Physician reviewed the medication error reports for Client 43, and determined that the client was not adversely affected. 3.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 3.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 3.6. Physicians were notified of blood sugar level prior to administration of insulin. 3.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 3.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 3.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 3.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 3.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 3.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 3.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 192	Continued From page 97 sugar for about 5 hours. [redacted]	W 192	W 192 (cont.) 3.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
			3.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			3.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			3.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			3.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			3.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 192	Continued From page 98 [redacted]	W 192	W 192 (cont.) 3.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 3.20. Program Director is responsible.	11-25-13

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W 192	Continued From page 99 [redacted] The psych techs continued to administer the Lantus and Lispro when Client 43 was hypoglycemic. Client 43 had 36 hypoglycemic events from 08/19/13 to 10/15/13 with blood sugars as low as 20 mg/dl and several blood sugars in the 30s (30 mg/dl, 32 mg/dl, 32 mg/dl, 33 mg/dl, 34 mg/dl, 37 mg/dl) . On average Client 43 was hypoglycemic once every 1.6 days (57 days divided by 36 hypoglycemic events). A review of the diabetes care plan for Client 43 indicated monitoring for hypoglycemia would be done every shift. [redacted] There was no documented evidence in the clinical record of every shift monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 pm, the Health	W 192		

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W 192	Continued From page 100 Services Nurse stated there was no documentation of monitoring every shift for hypoglycemia for Client 43. During an interview on 10/18/13 at 9:00 AM the Executive Director stated that their staff competency training did not identify problems with hypoglycemic clients being administered insulin. She acknowledged that the competency training program had to improve.	W 192	W 193 1.1. The identified towels were removed from the folded pile and placed in dirty laundry. 1.2. Program 5 Management identified clients in the program who may have unaddressed issues or behaviors that impact infection control or cross contamination. A special IPP or Emerging Risk Notification/Evaluation meeting was held for any identified client to ensure the issues/behaviors have been addressed. 1.3. Unit 23 LOC staff were trained by the Unit Supervisor or designee on Client 39's hand-washing plan and his Approaches & Strategies.	10-15-13 11-25-13 11-25-13
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that staff intervened when 1 of 25 un-sampled clients (Client 39) wiped his face with clean towels that he was folding for the laundry service. Findings: 1. A day program observation on 10/15/13 at 9:25 AM, in room 161 of residence 22, was conducted. Client 39 was folding towels on the table. The day program staff was standing beside Client 39 and was providing the towels to be folded by Client 39. While folding the towels, Client 39 was observed to wipe each folded towel [redacted] then placed them on the folded pile. There was no intervention from the two staff in the room from 9:25 AM to 10:15 AM. The folded towels were place inside the plastic bin. The staff stated to the group that the towels will	W 193	1.4. Program 5 Group Leaders were trained by the Unit Supervisor or designee on the Independent Living Assessments to ensure they address client's hygiene abilities during the assessment process, and make recommendations as needed. 1.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client activities that may compromise their health or the health of others due to inflection control concerns. 1.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing", and Nursing Protocol 5 "Blood and Body Fluid Precautions". 1.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor for possible infection control issues during rounds at least monthly, and document any findings. 1.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 1.9 Program Director is responsible.	11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 193	Continued From page 101 be distributed to the residence for use. At 10:30 AM, while the clients were having snacks, the staff was informed of the observation and how no intervention was implemented. The staff stated that the bin of folded towels will be sent back to laundry. 2. On 10/21/13 from 4:30 PM to 5:10 PM, in the group area of residence 21, Client 52 was sitting on the chair. He was observed to wipe the floor ~~with his hand and with the same hand wipe his mouth and tongue~~. This was observed several times without intervention by staff.	W 193	W 193 (cont.) 2.1. Staff assisted Client 52 with washing his hands. 2.2. Program 5 Management identified clients in the program who may have unaddressed issues or behaviors that impact infection control or cross contamination. A special IPP or Emerging Risk Notification/Evaluation meeting was held for any identified client to ensure the issues/behaviors have been addressed. 2.3. Unit 21 LOC staff were trained by the Unit Supervisor or designee on Client 52's Approaches & Strategies. 2.4. Program 5 Group Leaders were trained by the Unit Supervisor or designee on the Independent Living Assessments to ensure they address client's hygiene abilities during the assessment process, and make recommendations as needed.	10-21-13 11-24-13 11-24-13 11-24-13
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, document review and interviews, the facility failed to ensure that staff implemented 3 clients' (Clients 36, 41,and 45) IPP's (Individual Program Plans). Findings: 1. On 10/16/13 at 7:00 AM, Client 45 was observed sitting in a chair in one of the activity areas on Residence 36. He was not wearing a helmet. A few minutes later, licensed staff placed a helmet on his head and transferred the client to a wheelchair with a seat belt. The client remained	W 194	2.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client activities that may compromise their health or the health of others due to inflection control concerns. 2.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing", and Nursing Protocol 5 "Blood and Body Fluid Precautions". 2.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor for possible infection control issues during rounds at least monthly, and document any findings. 2.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.9 Program Director is responsible.	11-24-13 11-24-13 11-24-13

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W 194	Continued From page 102 in the wheelchair with the helmet on. At 8:20 AM, Client 45 was wheeled into the dining room for breakfast, wearing his helmet. It was removed when the client was transferred to a dining chair. At 1:05 PM, Client 45 was again observed in the dining room. After finishing lunch, staff assisted the client from the dining chair to his wheelchair without placing the helmet. The client left the dining room independently. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator stated that Client 45 should wear his helmet when he is ambulating and not when he is sitting in a chair or when he is in his wheelchair. She further stated that the client does not ambulate very often. [redacted] On 10/24/13 at 8:10 AM, Client 45 was observed sitting in a dining chair in the dining room eating breakfast independently. He was wearing his helmet. During an at the time, licensed staff sitting at the	W 194	W 194 1.1. A special IPP was held to review the Approaches & Strategies for Client 45. 1.2. Unit 36 LOC staff were trained by the Unit Unit Supervisor or designee on Client 45's Approaches & Strategies with emphasis on the use of protective helmet. 1.3. Program 5 Management identified clients in the program who uses a restrictive device and/or protection device. An IPP review was held for each of the identified clients to discuss appropriateness of the device, plan to use the device, and if alternatives to the device should be explored. 1.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client use of restrictive device and/or protection device. 1.5. Unit Supervisor and/or Senior PT will monitor staff compliance during rounds at least monthly, and document any findings. 1.6. IPC's will monitor via rounds at least monthly to ensure that the clients' restrictive/protection devices are being used as per IPP and are in good repair. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 1.7. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.8. Program Director is responsible.	11-15-13 11-19-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 194	Continued From page 103 client's table was asked if the client was supposed to be wearing his helmet while eating. Staff stated, "No" and removed the helmet. 2. On 10/16/13 beginning at 1:00 PM, observations were made in the day program in the 36-Annex. Two staff, one of which was a float from another residence, and seven clients were present. Six clients, including core sample Client 36, were positioned around a table. Staff stated the activity was gardening. One staff member began to read the back of a packet of seeds, including information about planting depth and time to germination. [redacted] Staff then began to ask questions such as, "What grows here in the valley?, "Where do you go to buy plants?", and "Raise your hand if you like shade." The staff answered each other's questions. [redacted] Client 36 was observed repeatedly bouncing a ball, attached to his wheelchair by a cord, onto his wheelchair tray until he fell asleep. [redacted]	W 194	W 194 (cont.) 2.1. All Program 5 training sites were checked to ensure all age-inappropriate training supplies were removed. 2.2. New training supplies were obtained for the day program on 36-Annex. 2.3. 36-Annex day program site lesson plan was revised to include engaging clients with activities that matched the functioning levels of the clients. 2.4. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 2.5. A new training assessment was initiated for Client 36 to ensure proper placement in the day program. The new assessment will be completed by 12/13/2013. 2.6. Unit 36 Supervisor or designee was in the process of training unit LOC staff, including staff who work with the clients at the day program on 36-Annex on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop, and the new training assessment for Client 36. The anticipated completion date was 12/13/13. 2.7. Unit Supervisor and/or Senior PT will monitor during rounds at least monthly to ensure clients can physically and/or cognitively participate in the activities provided. Immediate actions will be taken to correct any deficiency observed. 2.8. Program 5 IPC's will monitor progress notes recording for clients via monthly audit of the client clinical record, and document in the IPC monthly notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes. 2.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-22-13 11-15-13 11-15-13 11-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 194	Continued From page 104 [redacted] This activity was not observed. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator agreed that the activity during the day program did not meet the clients' developmental needs. She further stated, "Perhaps more training" for day program staff. 3. During day programming observation on 10/15/13 at 11:00 AM, Client 41 was transferred to a wheelchair. At 11:05 AM, while awaiting for transport back to the unit, [redacted] This behavior was repeated at 11:20 AM. At both times of the behavior there were no intervention from either staff in the room. Client 41, on 10/16/13 at 8:50 AM, in the group room area, was observed [redacted] There was no intervention implemented by the staff in the group room. A record review for Client 41 on 10/24/13 at 8:40 AM, was conducted. A training objective dated 8/27/13, indicated Client 41 will reduce striking [redacted] that is either hard or soft. One of the various the interventions addressed in the training objective was for staff to sign "stop". Then sign "what's wrong". This was not observed as implemented.	W 194	W 194 (cont.) 2.10. Program Director is responsible. [redacted] 3.2. The staffing ratios on Program 5 units and day program training sites were reviewed and were adequate. 3.3. Unit 23 unit routine and day program training site schedule were revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 3.4. Program 5 training site lesson plans were reviewed. Revisions were made to lesson plans as needed. 3.5. Unit 23 LOC staff, including those who work with the clients at the day program training site were trained by the Unit Supervisor or designee on Client 41's behavior plan and Functional Analysis of Behavior. 3.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment via rounds at least monthly, and document any findings. 3.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 3.8. Program Director is responsible.	10-15-13 11-18-13 11-20-13 11-25-13 11-25-13 11-25-13
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met.	W 195		

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W 195	Continued From page 105 This CONDITION is not met as evidenced by: Based on observation, document review and interviews, the Condition of Active Treatment was not met. Findings: Clients were not involved in activities that addressed their individualized priority needs nor had opportunities to practice new or existing skills and to make choices in their daily routines. The interdisciplinary teams did not assess the appropriateness of the access restriction to the fenced backyard for multiple clients. A client expressed an interest in a food service job and he was not assessed as to what his needs would be for that job. A client was not re-assessed for the appropriateness of his placement in a day program. Multiple clients were not given the opportunity to perform dining and meal preparation activities that they were capable of doing. Activities were presented to multiple clients that were clearly inappropriate for them; the activities were clearly meant for young children. Clients' activities of daily living plans were not implemented. A client ' s money management objectives were met and no new objectives were developed. These failures resulted in clients being placed in inappropriate day programs, lack of progress in their training plans and no active treatment to increase new or existing skills. There was also a lack of choices in access to parts of clients ' home environments, meals and potential jobs. The cumulative effect of theses system problems	W 195	W195 (See also W196, W214, W225, W247, W249, W255, and W264) Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Condition of Participation for Active Treatment is met. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags. W195 #1 (See also W196, W214, W225, W247, W249, W255, and W264) - Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process. - Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices. - IPC's will monitor client assessments and objectives during rounds at least monthly to observe client participation. - Unit Supervisor and/or Senior PT will monitor client participation during rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W195 #2 (See also W196, W214, W225, W247, W249, W255, and W264) - A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. - IPP reviews were held for Program 5 clients to assess restrictive access along with the clients' IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to	11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-24-13 11-24-13

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			W195 #2 (See also W196, W214, W225, W247, W249, W255, and W264) (cont.) ensure appropriateness of placement. clients' IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement. - Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and address client access during the assessment process. - Program 5 IPC's were trained by the Program Assistant or designee on monitoring clients' restricted access and client rights. - Unit Supervisor and/or Senior PT will monitor client access during rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13 11-25-13 11-25-13 11-25-13
			W195 #3 (See also W196, W214, W225, W247, W249, W255, and W264) - Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process. - Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices. - IPC's will monitor client assessments and objectives via rounds at least monthly to observe client participation. - Unit Supervisor and/or Senior PT will monitor client participation via rounds at least monthly. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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			W195 #4 (See also W196, W214, W225, W247, W249, W255, and W264)	
			- A vocational assessment was completed for the client that addressed the client's desire to work in a restaurant.	11-24-13
			- Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessment.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W195 #5 (See also W196, W214, W225, W247, W249, W255, and W264)	
			- Classes for clients to learn about meal preparation, consumer budget for meals, and infection control to be held three times per week was in the process of being developed and was anticipated on being finalized on 12/11/13 and added to the unit activity calendar and schedule. Shopping trips for meals/cooking classes were also added to the unit activity calendar.	11-25-13
			- Unit routines were in the process of being reviewed and will be completed on 12/11/13 to include meal preparation and clean-up groups prior to meals.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation during meal classes.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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			W195 #6 (See also W196, W214, W225, W247, W249, W255, and W264)	
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments for clients to ensure they discuss the clients' current objectives and preferences during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs and choices.	11-25-13
			- IPC's will monitor client assessments and objectives via rounds at least monthly to observe client participation.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client participation via rounds at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W195 #7 (See also W196, W214, W225, W247, W249, W255, and W264)	
			- Program 5 units were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the unit. New training supplies were ordered and obtained from Curriculum Services.	10-22-13
			- Unit routine and training site schedule were revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered.	11-18-13
			- Unit LOC staff were trained by the Unit Supervisor or designee on the revised unit routine.	11-24-13
			- Unit Supervisor and/or Senior PT will monitor active treatment during rounds at least monthly.	11-24-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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			W195 #8 (See also W196, W214, W225, W247, W249, W255, and W256)	
			[redacted]	10-24-13
			- Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the clients' current objectives during the assessment process.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
			- Unit Supervisor or designee were in the process of training the unit LOC staff on the client's new training objective for money management. The training is anticipated to be completed by 12/13/13.	11-25-13

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W 195	Continued From page 106 resulted in the facility's failure to ensure that active treatment objectives and programs were provided. Due to these failures, the Condition of Participation for Active Treatment was determined to be not met. See W 196, W 214, W 225, W 247, W 249, W 255 and W 264.	W 195	W 196 1.1 All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence.	10-22-13
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, staff failed to ensure active treatment for nine of 25 unsampled clients (Client 31, Client 32, Client 33, Client 36, Client 39, Client 46 , Client 52, Client 53 and Client 58): Findings: Residence 23 1. On 10/24/13 at 8 AM, Client 39 sat on a couch in a group activity room. [redacted]	W 196	1.2. New training supplies were ordered and obtained from Curriculum Services. 1.3. The staffing ratios on Program 5 units were reviewed and were adequate. 1.4. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 1.5. Other Program 5 unit routines were reviewed, and no deficiencies were noted. 1.6. Director of Quality Assurance conducted research of restrictive devices available or in use elsewhere. It was determined that the current device is the least stigmatizing and most effective for Client 39. The results were provided to the Program Director. 1.7. The psychologist was in the process of updating Client 39's Functional Analysis of Behavior to reflect the history and rationale for his current use of the [redacted] device. The anticipated date of completion was 12/12/13. 1.8. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine. Staff also reviewed Client 39's behavior plans. Staff were reminded to implement Client 39's behavior plans in conjunction with the revised unit routine. 1.9. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment via rounds at least monthly, and document any findings. 1.10. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-18-13 11-18-13 11-18-13 11-18-13 11-21-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 196	Continued From page 107 [redacted] Other than being escorted to the restroom at 8:20 AM, the client sat and watched others as his movements were highly restricted by the [redacted]. No leisure activities or active treatment were observed from 8 AM to 9 AM. On 10/24/13 at 8:45 AM, a psychiatric technician (PT) stated that the [redacted] were to prevent [redacted] behaviors [redacted] The PT stated that the client had not had such behaviors for about ten years. The PT stated that he did not engage in this behavior when he was at the day program because he folded towels there, a task that he enjoyed and which kept him focused. Although the [redacted] restraints were removed for five minutes to promote circulation during the one hour observation, staff never removed Client 39's [redacted] restraints so that the client could engage in any activity requiring the use of [redacted] On 10/24/13 at approximately 8:55 AM, the PT stated that Client 39 utilized a [redacted] at the day program and stated the [redacted] devices continued to be used on the residence because Client 39 continued to show antecedent behaviors however, stated that Client 39 was bored which increased undesirable behaviors. According to the PT, Client 39 did not like the puzzles and table games at the residence and commented, "He is one of our smarter clients."	W 196	W196 (cont.) 1.1. Program Director is responsible. 2.1. An assessment of Client 46's placement at the day program was completed. 2.2. Residence 36 Day Program site schedule was revised to include engaging clients with activities that matched the functioning levels of the clients. 2.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 2.4. Program 5 IPC's were trained by the Program Director or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 2.5. Client 46's Interdisciplinary Team was in the process of addressing the updated assessment information. The anticipated completion date was 12/4/13. 2.6. Unit 36 Supervisor or designee was in the process of training unit LOC staff, including staff who work with clients at the day program training site, on the updated lesson plan at the day program site and the assessment of Client 46's placement at the day program. The anticipated completion date was 12/13/13. 2.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 2.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 2.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as	11-12-13 11-15-13 11-15-13 11-25-13 11-25-13 11-25-13 12-13-13 12-13-13 12-13-13

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W 196	Continued From page 108 [redacted] No activity was offered. [redacted] from 9 AM to 10 AM staff did not engage Client 39 in any leisure activity or active treatment activity so the restraints could be removed and the client could be trained towards greater independence, increased choice, and potentially acquire new skills. [redacted]	W 196	W196 (cont.) 2.9. (cont.) necessary. 2.10. Program Director is responsible.	
			3.1. An assessment of Client 46's placement at the day program was completed.	11-12-13
			3.2. Residence 36 Day Program site schedule was revised to include engaging clients with activities that matched the functioning levels of the clients.	11-15-13
			3.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed.	11-15-13
			3.4. Program 5 IPC's were trained by the Program Director or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments.	11-25-13
			3.5. Client 46's Interdisciplinary Team was in the process of addressing the updated assessment information. The anticipated completion date was 12/4/13.	11-25-13
			3.6. Unit 36 Supervisor or designee was in the process of training unit LOC staff, including staff who work with clients at the day program training site, on the updated lesson plan at the day program site and the assessment of Client 46's placement at the day program. The anticipated completion date was 12/13/13.	11-25-13
			3.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	12-13-13
			3.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings.	12-13-13
			3.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting	12-13-13

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W 196	Continued From page 109 ~~items off tables or counters."~~ [redacted]	W 196	W196 (cont.) 3.9 (cont.) with further corrective actions taken as necessary. 3.10. Program Director is responsible.	
			4.1. All Program 5 training sites were checked to ensure all age-inappropriate training supplies were removed.	10-22-13
			4.1. New training supplies were obtained for the day program on 36-Annex.	11-15-13
			4.2. 36-Annex day program site lesson plan was revised to include engaging clients with activities that matched the functioning levels of the clients.	11-15-13
			4.3. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed.	11-15-13
			4.4. A new training assessment was initiated for Client 36 to ensure proper placement in the day program. The new assessment will be completed by 12/13/2013.	11-25-13
			4.5. Unit 36 Supervisor or designee was in the process of training unit LOC staff, including staff who work with the clients at the day program on 36-Annex on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop, and the new training assessment for Client 36. The anticipated completion date was 12/13/13.	11-25-13
			4.6. Unit Supervisor and/or Senior PT will monitor during rounds to ensure clients can physically and/or cognitively participate in the activities provided. Immediate actions will be taken to correct any deficiency observed.	11-25-13
			4.7. Program 5 IPC's will monitor progress notes recording for clients via monthly audit of the client clinical record, and document in the IPC monthly notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes.	11-25-13
			4.8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via	11-25-13

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W 196	Continued From page 110 [redacted] Because staff was not providing opportunities for the client to develop appropriate behavior by removing the [redacted]estraints and engaging the client in activities, the ability for the client to attain the goal was limited. [redacted]	W 196	W196 (cont.) 4.8. (cont.) monthly Quality Management Council meeting with further corrective actions taken as necessary. 4.9. Program Director is responsible.	
			5.1. The non-functioning paper shredder was removed and replaced.	10-15-13
			5.2. The training site lesson plan were updated to include alternate activities for when the main activity is unavailable.	11-20-13
			5.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed.	11-15-13
			5.4. The paper shredder was repaired and brought back to the training site as a back up.	11-24-13
			5.5. Unit 23 Supervisor or designee was in the process of training unit LOC staff, including staff who work with the clients at the training site on the revised training site schedule/lesson plan. Staff were also trained to call Central Program Services for any shredder repairs. The anticipated completion date was 12/13/13.	11-25-13
			5.6. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training assessments and objectives.	11-25-13
			5.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	12-13-13
			5.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings.	12-13-13
			5.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 5.10. Program Director is responsible.	12-13-13

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W 196	Continued From page 111 [redacted] During an interview with the Unit Supervisor (US) on 10/24/13 at 12:15 PM, the US stated that the [redacted] had been used for years on the client and agreed that without change, the facility would continue to use the [redacted] for the remainder of Client 39's life. Active treatment was not provided to Client 39, who wore highly restrictive [redacted] devices [redacted] to prevent [redacted] behaviors most of the day and night. The constant use of the restrictive devices prevented the client from opportunities to develop appropriate behavior, develop greater independence and choice, and acquire new skills. The facility failed to ensure active treatment was consistently implemented in all relevant settings as the need arose or opportunities presented themselves for Client 39; 2. The facility also failed to provide active treatment for Client 46 during multiple observations both at the residence and day program; when, not one of seven clients observed participated in any type of activity that appeared to be designed to increase independence and learn new skills. Residence 36 3. On 10/15/13, observations were made in one of the day rooms on Residence 36. There were	W 196	W 196 (cont.) 6.1. The non-functioning paper shredder was removed and replaced. 6.2. The training site lesson plan were updated to include alternate activities for when the main activity is unavailable. 6.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 6.4. The paper shredder was repaired and brought back to the training site as a back up. 6.5. Unit 23 Supervisor or designee was in the process of training unit LOC staff, including staff who work with the clients at the training site on the revised training site schedule/lesson plan. Staff were also trained to call Central Program Services for any shredder repairs. The anticipated completion date was 12/13/13. 6.6. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training assessments and objectives. 6.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 6.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 6.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 6.10. Program Director is responsible.	10-15-13 11-20-13 11-15-13 11-24-13 11-25-13 11-25-13 12-13-13 12-13-13 12-13-13

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W 196	Continued From page 112 two staff and 10 clients in the room. One of the staff stated he had been floated from another residence. Staff stated the activity was "watching TV." From 8:30 AM until 9:00 AM, Client 46 was observed sitting in a chair holding a ball and not watching TV. No other activity was offered to Client 46. On 10/16/13 at 1:30 PM, observations were made in Client 46's day program. There were seven clients and two staff. Six clients were positioned around a table on one side of the room and Client 46 was seated in a chair on the other side of the room. Client 46 was observed to sit holding a ball for 30 minutes with no other activity. A staff would occasionally verbally prompt him from the other side of the room to join the group. Client 46 never joined the group or engaged in any other activity except holding the ball. At 1:45 PM, Client 46 stood up and attempted to sit in another chair. When staff asked him to join the group, the client immediately turned around and sat back down in his original chair. Staff responded by stating, "Good job [client's first name]." During an interview on 10/16/13 at 2:00 PM, licensed day program staff stated that Client 46 had been in that day program "for a long time." When asked if the client ever engaged in any activity other than holding a ball, staff stated the client rarely participated in any of the activities in the class.	W 196	W 196 (cont.) 7.1. A new training objective was opened for Client 53 to transfer items into a container. 7.2. Client 53's IPP and Desired Outcome were reviewed and remained current. 7.3. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 7.4. The staffing ratio on Program 5 units were reviewed and was adequate. 1.5. Unit routines for other Program 5 units were reviewed and remained appropriate. 7.6. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 7.7. Program 5 Group Leaders were trained by their Unit Supervisors or designees on Desired Outcomes documentation. 7.8. Unit 23 Supervisor or designee was in the process of training unit LOC staff on the revised unit routine and on Client 53's new training objective. The anticipated date of completion was 12/20/13. 7.9. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 7.10. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings. 7.11. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 7.12. Program Director is responsible.	09-24-13 11-12-13 11-18-13 11-18-13 11-18-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 196	Continued From page 113	W 196	W 196 (cont.)	
	[redacted]		[redacted]	10-24-13
	Client 46 was again observed sitting, holding a ball with no other activity on the residence on 10/21/13 from 7:30 PM until 8:00 PM.		8.2. Program 5 Management identified clients whose objectives were not current and/or accurate. An IPP review was held for the identified clients to update their objectives.	11-25-13
	[redacted]		8.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the client's current objectives during the assessment process, and make recommendations as needed.	11-25-13
	[redacted]		8.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
	[redacted]		8.5. Unit 21 Supervisor or designee was in the process of training unit LOC staff on Client 31's training plan. The anticipated completion date was 12/13/13.	11-25-13
	During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator (IPC) stated stated that the staff who work with clients in the day program are staff who are assigned to work on the residence that day, including staff who have floated from other residences.		8.6. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
	Client 46 did not participate in any type of activity that appeared to be designed to increase his independence and learn new skills.		8.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings.	11-25-13
	4. On 10/16/13 beginning at 1:00 PM, observations were made in the day program in		8.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
			8.9. Program Director is responsible.	

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W 196	Continued From page 114 the 36-Annex. Two staff, one of which was a float from another residence, and seven clients were present. Six clients, including core sample Client 36, were positioned around a table. Staff stated the activity was gardening. One staff member began to read the back of a packet of seeds, including information about planting depth and time to germination. One client began screaming and engaging in self-injurious behavior and had to be wheeled from the table. [redacted] Staff then began to ask questions such as, "What grows here in the valley?, "Where do you go to buy plants?", and "Raise your hand if you like shade." The staff answered each other's questions. [redacted] Client 36 was observed repeatedly bouncing a ball, attached to his wheelchair by a cord, onto his wheelchair tray until he fell asleep. None of the 7 clients participated in any type of activity that appeared to be designed to increase their independence and learn new skills. [redacted]	W 196	W 196 (cont.) [redacted]	10-21-13
			9.2. The staff ratios for Program 5 units were reviewed and was adequate.	11-25-13
			9.3. Unit 21 Supervisor or designee was in the process of training unit LOC staff on Client 32's Approaches & Strategies, [redacted] The anticipated completion date was 12/2/13.	11-25-13
			9.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client behavior plans.	11-25-13
			9.5. IPC will monitor client behavior during rounds at least monthly. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			9.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client behavior via rounds at least monthly, and document any findings.	11-25-13
			9.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
			9.8. Program Director is responsible.	

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W 196	Continued From page 115 [redacted] During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator agreed that the activity during the day program did not meet the clients' developmental needs. She further stated, "Perhaps more training" for day program staff. 5. Day program observation for Client 33 on 10/15/13 starting at 9:25 AM was conducted. From the time of arrival to the room to 9:52 AM, Client 33 remained on his wheel looking at peers, no activity was provided. On same day at 10 AM Client 33 was sleeping in his wheelchair. At 10:20 AM, Client 33 was awakened by staff for a snack. In the same program room, Client 40 and a peer were sitting by the window looking outside with no meaningful activity. At 9:55 AM, a staff entered the room and encourage Client 40 and peers to work on the puzzles on the table. Staff also stated that Client 40 and a peer had a training objective to shred paper, however the shredder was broken. Staff also stated that the alternative activity is any leisure activity of choice. [redacted]. Client 41 was not participating in any meaningful activity. 6. On 10/16/13 at 6:35 AM, Clients 39, 40, and 33 were in the group room. The staff was talking	W 196	W 196 (cont.) 10.1. Staff assisted Client 52 with washing his hands. 10.2. Program 5 Management identified clients in the program who may have unaddressed issues or behaviors that impact infection control or cross contamination. A special IPP or Emerging Risk Notification/Evaluation meeting was held for any identified client to ensure the issues/behaviors have been addressed. 10.3. Unit 21 LOC staff were trained by the Unit Supervisor or designee on Client 52s Approaches & Strategies. 10.4. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they address client's hygiene abilities during the assessment process, and make recommendations as needed. 10.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client activities that may compromise their health or the health of others due to infection control concerns. 10.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing", and Nursing Protocol 5 "Blood and Body Fluid Precautions". 10.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor for possible infection control issues during rounds at least monthly, and document any findings. 10.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 10.9 Program Director is responsible.	10-21-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 196	Continued From page 116 about the weather for the day and menu for breakfast. The clients were observed not recognizing the topic discussed. At 9:30 AM, in the day program room, Client 39 was handed a box of Legos for stacking. Staff stated that there were no towels to fold today. Client 33 was sleeping in his wheelchair and continued to sleep till 10:10 AM (asleep for 40 minutes), when he was awakened by staff to touch a musical instrument and play a tune. Client 40 remained looking through the window refusing to work on table top activities. 7. On 10/16/13 at 1:30 PM in room 109, Client 53 was observed sliding paper into a simulated shredder. The staff in the room stated that his objective was to slide paper into the opening. [redacted] 8. On 10/17/13 at 1:30 PM, a day program observation at the annex building of Unit 21 was conducted. Client 31 was observed sleeping on the floor mat. Staff stated his wheelchair was picked up by the washing crew. At 2:10 PM, he was transferred to his high back padded wheelchair. He was also given a puzzle placed on his lap tray. The puzzle did not have the all the pieces to complete the puzzle. The staff stated that he needed the pieces to manipulate the puzzle spaces.	W 196	W 196 (cont.) 11.1 All Program 5 residences were checked to ensure all age-inappropriate recreational or leisure time supplies were removed from the residence. 11.2. New training supplies were ordered and obtained from Curriculum Services. 11.3. The staffing ratios on Program 5 units were reviewed and were adequate. 11.4. Unit 23 unit routine was revised to include encouraging alternate activities for clients exhibiting disinterest in current activity offered. 11.5. Other Program 5 unit routines were reviewed, and no deficiencies were noted. 11.6. Unit 23 LOC staff were trained by the Unit Supervisor or designee on the revised unit routine, the active treatment definition/loop training, and Client 58 Approaches & Strategies. 11.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor active treatment and physical environment via rounds at least monthly, and document any findings. 11.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 11.9. Program Director is responsible.	10-22-13 11-18-13 11-18-13 11-18-13 11-18-13 11-25-13 11-25-13 11-25-13

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W 196	Continued From page 117 At 2:30 PM, Client 31 was observed sleeping in his wheelchair. The staff was tracing and cutting pumpkins. Staff also cut out the eyes, nose, and mouth. The cut out was pasted to the pumpkin by the clients through hand over hand by staff. At 3:30 PM, Client 31 was taken to the residence with the puzzle board on his laptray without the pieces. [redacted] 9. On 10/21/13 at 2:05 PM, a day program observation at the annex building on residence 21 was conducted. Client 32 was walking around the room not participating in any activity, except during snack time. At 4:05 PM, in the residence group room, Client 32 was sitting on the sofa with both feet up, knees bent and face over his knees. An adult education teacher from the college came, and read the story of [redacted] The clients were not engaged with the story. [redacted]	W 196		

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W 196	Continued From page 118 [redacted]	W 196		
	10. On 10/21/13 at 4:30 PM, in the group area of residence 21, Client 52 was sitting on the chair. He was observed to touch the floor with his hand and with the same hand wipe his mouth and tongue several times. There was no staff intervention.			
	11. Observations were conducted on Unit 23 beginning at 2:15 PM on 10/22/13. At the beginning of the observation eight men were seated in the settees and the chairs in the " west end television room." Client #58 was seated next to his one-on-one staff in a chair located behind the settee. The direct support staff providing general supervision said the men were watching a movie. When asked what movie was playing, the direct support staff explained that the DVD Player was broken so the men were watching a moving on television titled, " Scream. " None of the men appeared to be watching the movie and the direct support staff was constantly giving verbal instruction to the men such as "hands down, pull your shirt down, keep your hands to yourself, etc." When asked about the purpose of the movie activity since none of the men appeared to be interested in watching the movie, the direct care staff explained that this was the day a " work group " came and cleaned wheelchairs; therefore, the men who lived at Unit 23 did not have day programming in the afternoon. When asked if there were recreational or leisure time supplies available to the men if they didn ' t want to watch the movie, the direct support staff began getting out games and toys, all designed for use by young children. The staff assigned as the one-on-one staff with Client #58			

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W 196	Continued From page 119 consistently handed him a toy which played songs typically enjoyed by very young children. Client #58 pushed the toy away at least three times and dropped the toy to the floor twice. Once after retrieving the toy, the one-on-one staff began to sign along with the song played by the toy although there was a movie playing in the same room which was identified as the " activity " in which the men were participating. From 2:15 PM to 2:40 PM, none of the nine men in the "west end television room" on Unit 23 participated in any type of activity that appeared to be designed to increase their independence and learn new skills. Neither the one-on-one staff nor the direct support staff providing general supervision was able to identify the purpose of having a movie on the television which no one seemed to be watching. Neither staff could identify what activities could be initiated which might teach skills to the nine men in the room and/or to lead to greater independence.	W 196		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to individually assess needs related to living in residences with restricted access to the locked and fenced backyard for six of 19 sampled clients (Clients 5, 22 and 23 on Residence 6, and Clients 26, 29 and 30 on Residence 26), and when the facility failed to ensure that the Comprehensive Functional Assessment identified the	W 214	W 214 1.1. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. 1.2. A Special IPP was held for each client to assess restrictive access along with the client's IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement. 1.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed. 1.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights. 1.5. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings. 1.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 1.7. Program Director is responsible.	11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 214	Continued From page 120 [redacted] needs of Client 46. Findings: 1. Observations on Residence 26 at various times between 10/14/13 and 10/17/13 indicated that no clients had free access to the backyard which was fenced and locked. Observations of the backyard revealed a very high fence with a gate that was locked and could only be opened by a key. During an interview on 10/16/13 at 10 a.m., the Licensed Staff in charge stated that the door to the backyard was always locked because some clients on the residence had a history of AWOL, leaving without supervision. When asked about the fact that the backyard had a high fence and the gate was locked the staff stated that no clients can be in the backyard without supervision. Staff stated that all the exit doors were always locked and none of the client's had keys. The first of two entrance doors to the residence were unlocked between certain hours of the day however, the second door used to enter and exit the residence was always locked preventing exit without a key. 2. Observations of Client 30 revealed that the client was always accompanied by a staff [redacted] The client was not observed enjoying the backyard on the mild weather during this time frame. Staff were not observed to offer time in the backyard as an activity.	W 214	W 214 (cont.) 2.1. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. [redacted] 2.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed. 2.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights. 2.5. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings. 2.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.7. Program Director is responsible.	11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 214	Continued From page 121 [redacted] 3. The two Individual Program Coordinators (IPC), who serve as the Qualified Intellectual Disability Professionals, assigned to Residence 6, were interviewed at 9:00 AM on 10/23/13 with client records available for reference. The IPC's confirmed the front door of the residence was unlocked between the hours of 8:00 AM to noon and from 1:00 PM to 4:30 PM, Monday through Friday. However, when asked if clients could leave the residential section of Residence 6 through the front door when it was unlocked, the IPC's confirmed that all exit doors, including the	W 214	W 214 (cont.) 3.1. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. 3.2. A Special IPP was held for each client to assess restrictive access along with the client's IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement. 3.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed. 3.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights. 3.5. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings. 3.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 3.7. Program Director is responsible.	11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 214	Continued From page 122 door from the residential section leading to the front door, were locked at all times. When asked to identify what portions of their home clients could not access, the IPC's explained clients were unable to access rooms where family members visited and the room where snacks purchased by clients were stored. [redacted] When asked if any client who lived at Residence 6 had a key to the residence, the IPC said, "No." When asked if any client living at Residence 6 independently accessed the outside fenced yard area, the IPC's said the doors leading to the outside fenced area were locked and that clients were always accompanied by staff when outside. The IPC's said that if clients wanted to go outside or to access a snack maintained in a locked area, they asked staff and, as soon as possible, staff, all of whom carried keys, would accompany them outside or would open locked areas so the client could access items such as snacks they had purchased. When asked if comprehensive functional assessment data identified skills each client would need to learn in order to independently access the restricted areas of their home, during the 9 AM interview, the IPC's explained that clients who lived at Residence 6 were court ordered to Porterville Developmental Center (PDC) [redacted]	W 214	W 214 (cont.) 4.1. Client 5's ILA and IPP were updated to address rationale for his restricted access. 4.2. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. 4.3. A Special IPP was held for each client to assess restrictive access along with the client's IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement. 4.4. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed. 4.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights. 4.6. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings. 4.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.8. Program Director is responsible.	11-14-13 11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 214	Continued From page 123 [redacted] The IPC's explained that many clients who lived at Residence 6 were placed at PDC under the California Welfare and Institution Code 6500, "danger to self and others." When asked if commitment orders required that each client live in a home with limited access, the IPC's said the commitment orders where not that specific. The IPC's explained that access restrictions and visual surveillance were part of the program design of Residence 6. When asked if all clients presented elopement risks, the IPCs said although some clients did, some clients did not have a history of elopement. [redacted] The IPC's explained that for each client who lived at Residence 6, there was a "Restricted Access And/Or Monitoring Interventions Treatment Program Approval Summary" (Access Restriction Consent) which served as a consent for the restrictive practices included in the Residence 6 program. The IPC's explained that the Access Restriction Consents were signed by each client's legally sanctioned decision maker and were reviewed and approved by the facility's Human Rights Committee. The IPC's provided, for review, an example of the types of statements included in each client's Access Restriction Consent. The example documented the following: "Staff Alert System: Personal alarms carried by staff to alert other staff when help is needed; Electronic monitoring devices (i.e., camera/monitors); Restricted Access, including, but not limited to Residence exterior door, dining room and fenced backyard with locked gates." 4. Record review for Client 5 was conducted on	W 214	W 214 (cont.) [redacted] 5.2. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client. 5.3. A Special IPP was held for each client to assess restrictive access along with the client's IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement. 5.4. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed. 5.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights. 5.6. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings. 5.7. Rounds findings and any issues will be reviewed monthly at the Clinical Quality Management meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further actions taken as necessary. 5.8. Program Director is responsible.	11-14-13 11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 214	Continued From page 124	W 214	W214 (cont.)	
	[redacted]		[redacted]	11-14-13
			6.2. A review of restricted access consent for Program 5 clients was conducted to ensure they match the Unit Description and they are appropriate for the client.	11-24-13
			6.3. A Special IPP was held for each client to assess restrictive access along with the client's IPP, Approaches & Strategies, Functional Analysis of Behavior, and behavior plans, to ensure appropriateness of placement.	11-24-13
			6.4. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessment and addressing client access during the assessment process, and make any recommendations as needed.	11-25-13
			6.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's restricted access and client rights.	11-25-13
			6.6. Unit Supervisor and/or Senior PT, Program Director, and Quality Assurance will monitor client access during rounds at least monthly, and document any findings.	11-25-13
			6.7. Rounds findings and any issues will be reviewed monthly at the Clinical Quality Management meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further actions taken as necessary.	11-25-13
			6.8. Program Director is responsible.	

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W 214	Continued From page 125 [redacted] When asked to identify what assessment data showed the relationship between addressing the targeted behaviors with living in a secured facility, the IPC explained that the access restrictions were built into Residence 6's program and because Client 5 had a history of [redacted] his placement in Residence 6 was considered the least restrictive environment. When asked why Client 5 could not go outside his home in the fenced in back yard without staff supervision, the IPC confirmed that the structure of the Residence 6 program did not allow for any client to be outside in the fenced in yard without staff supervision. [redacted]	W 214	W 214 (cont.) 7.1. An assessment of Client 46's placement at the day program was completed. 7.2. Residence 36 Day Program site schedule was revised to include engaging clients with activities that matched the functioning levels of the clients. 7.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 7.4. Program 5 IPC's were trained by the Program Director or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 7.5. Client 46's Interdisciplinary Team was in the process of addressing the updated assessment information. The anticipated completion date was 12/4/13. 7.6. Unit 36 Supervisor or designee was in the process of training unit LOC staff, including staff who work with clients at the day program training site, on the updated lesson plan at the day program site and the assessment of Client 46's placement at the day program. The anticipated completion date was 12/13/13. 7.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 7.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 7.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 7.10. Program Director is responsible.	11-12-13 11-15-13 11-15-13 11-25-13 11-25-13 11-25-13 12-13-13 12-13-13 12-13-13

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W 214	Continued From page 126 [redacted] During the interview at 9:00 AM on 10/23/13, the IPC assigned to Client 23 confirmed that the only "targeted behavior" identified in Client 23's IPP [redacted] When asked to identify what assessment data showed the relationship between addressing [redacted] and living in a secured facility, the IPC explained that the access restrictions were built into Residence 6's program and because Client 23 had a history [redacted] his placement in Unit 6 was considered the least restrictive environment. When asked why Client 23 could not go outside his home in the fenced in back yard without staff supervision, the IPC confirmed that the structure of the Residence 6 program did not allow for any client to be outside in the fenced in yard without staff supervision. [redacted]	W 214		

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W 214	Continued From page 127 [redacted] When asked to identify what assessment data showed the relationship between addressing [redacted] and living in	W 214		

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W 214	Continued From page 128 a secured facility, the IPC explained that the access restrictions were built into Residence 6's program and because Client 22 had a history of [redacted], his placement in Unit 6 was considered the least restrictive environment. When asked why Client 22 could not go outside his home in the fenced in back yard without staff supervision, the IPC confirmed that the structure of the Unit 6 program did not allow for any client to be outside in the fenced in yard without staff supervision. 7. On 10/15/13, observations were made in one of the day rooms on Residence 36. There were two staff and 10 clients in the room. One of the staff stated he had been floated from another residence. Staff stated the activity was "watching TV." From 8:30 AM until 9:00 AM, Client 46 was observed sitting in a chair holding a ball and not watching TV. No other activity was offered to Client 46. On 10/16/13 at 1:30 PM, observations were made in Client 46's day program. There were seven clients and two staff. Six clients were positioned around a table on one side of the room and Client 46 was seated in a chair on the other side of the room. Client 46 was observed to sit holding a ball for 30 minutes with no other activity. A staff would occasionally verbally prompt him from the other side of the room to join the group. Client 46 never joined the group or engaged in any other activity except holding the ball.	W 214		

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W 214	Continued From page 129 At 1:45 PM, Client 46 stood up and attempted to sit in another chair. When staff asked him to join the group, the client immediately turned around and sat back down in his original chair. Staff responded by stating, "Good job [client's first name]." During an interview on 10/16/13 at 2:00 PM, licensed day program staff stated that Client 46 had been in that day program "for a long time." When asked if the client ever engaged in any activity other than holding a ball, staff stated the client rarely participated in any of the activities in the class. [redacted] Client 46 was again observed sitting, holding a ball with no other activity on the residence on 10/21/13 from 7:30 PM until 8:00 PM. [redacted] [redacted]	W 214		

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W 214	Continued From page 130 [redacted] There was no documented evidence that the client's day program was evaluated for proper placement. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator (IPC) stated that no vocational assessment was done for Client 46 because he does not get paid for his time in the day program. The IPC stated that the staff who work with clients in the day program are staff who are assigned to work on the residence that day, including staff who have floated from other residences. The IPC further stated that no documented review of the appropriateness of the Client 46's placement in the day program was available.	W 214		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure that the annual Vocational Evaluation Update included assessments of the vocational skills and interests for two sampled clients (Clients 26 and 30), and reflected the clients' interests and progress, when Client 30 had been doing the same job for years and when Client 26 expressed specific interest in a different job.	W 225	W 225 1.1. A vocational assessment was completed Client 26 that addressed the client's desire to work in a restaurant. 1.2. A review of vocational assessments for Program 5 clients was conducted to identify any client who does not have a current vocational assessment. 1.3. A Special IPP was held for each client to address current placement at the training site, current vocational objective, and to request an updated vocational assessment. 1.4. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 1.5. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 1.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 1.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 1.8. Program Director is responsible.	11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 225	Continued From page 131 Findings: 1. Observations of Client 26 at his worksite, on 10/22/13, revealed his job entailed sorting black and white newspaper from colored paper. During a concurrent interview the client stated that he liked his job. [redacted] 2. Observations of Client 30 during his work stacking paper at paper salvage on 10/17/13 between 10 and 11 AM, revealed that the client mostly rested his head on the table. During a concurrent interview, licensed staff stated that he had been working at the same job for many years. [redacted]	W 225	W 225 (cont.) 2.1. A review of vocational assessments for Program 5 clients was conducted to identify any client who does not have a current vocational assessment. 2.2. A Special IPP was held for each client to address current placement at the training site, current vocational objective, and to request an updated vocational assessment. 2.3. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 2.4. A vocational assessment was in the process of being completed for Client 30. The anticipated completion date was 12/10/13. 2.5. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 2.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings. 2.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.8. Program Director is responsible.	11-24-13 11-24-13 11-25-13 11-25-13 12-10-13 12-10-13 12-10-13

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W 225	Continued From page 132	W 225		
	[redacted]		W 239	
	During an interview on 10/24/13 at 10 AM, the Individual Program Coordinator was asked how the team assessed that it might be time for job change. The IPC stated that probably it comes down to the client demonstrating a behavior of resistance, disinterest or refusing to attend work.		1. A special IPP was held to review the Approaches & Strategies for Client 45.	11-15-13
			2. Unit 36 LOC staff were trained by the Unit Unit Supervisor or designee on Client 45's Approaches & Strategies [redacted]	11-19-13
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN	W 239	3. Program 5 Management identified clients in the program who uses a restrictive device and/or protection device. An IPP review was held for each of the identified clients to discuss appropriateness of the device, plan to use the device, and if alternatives to the device should be explored.	11-24-13
	Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.		4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client use of restrictive device and/or protection device.	11-25-13
			5. Unit Supervisor and/or Senior PT will monitor staff compliance during rounds at least monthly, and document any findings.	11-25-13
	This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the written program for Client 45 was implemented when staff failed to follow physician's orders.		6. IPC's will monitor via rounds at least monthly to ensure that the clients' restrictive/protection devices are being used as per IPP and are in good repair. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
	Findings:		7. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
	On 10/16/13 at 7:00 AM, Client 45 was observed sitting in a chair in one of the activity areas on Residence 36. He was not wearing a helmet.		8. Program Director is responsible.	
	A few minutes later, licensed staff placed a helmet on his head and transferred the client to a wheelchair with a seat belt. The client remained in the wheelchair with the helmet on.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 133 At 8:20 AM, Client 45 was wheeled into the dining room for breakfast, wearing his helmet. It was removed when the client was transferred to a dining chair. At 1:05 PM, Client 45 was again observed in the dining room. After finishing lunch, staff assisted the client from the dining chair to his wheelchair without placing the helmet. The client left the dining room independently. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator stated that Client 45 should wear his helmet when he is ambulating and not when he is sitting in a chair or when he is in his wheelchair. She further stated that the client does not ambulate very often. [redacted] On 10/24/13 at 8:10 AM, Client 45 was observed sitting in a dining chair in the dining room eating breakfast independently. He was wearing his helmet. During an interview at the time, licensed staff sitting at the client's table was asked if the client	W 239		

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W 239	Continued From page 134 was supposed to be wearing his helmet while eating. Staff stated, "No" and removed the helmet.	W 239	W 242 [redacted]	11-19-13
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure that 1 of 3 sampled clients (Client 29) had a program plan that included training in personal skills (shaving) until demonstrated that the client was incapable of acquiring the skill. Findings: On 10/22/13 at noon, observations revealed that Client 29 had an abrasion on his left chin area. During a concurrent interview, staff stated that he had been cut during shaving that morning. When asked if the client used an electric razor, staff stated a safety razor was used and that it was staff who shaved him. When asked the reason staff shaved him, the staff stated because the client preferred that staff did it. [redacted]	W 242	[redacted] 3. The Independent Living Assessments for Program 5 clients were reviewed. No other deficiencies were noted. 4. Unit 26 LOC staff were trained by the Unit Supervisor or designee on the updated ILA and on Facility Bulletin 131 "Assessment". 5. Program 5 Group Leaders were trained by the Unit Supervisor or designee on the Independent Living Assessments to ensure they address client's hygiene abilities during the assessment process, and make recommendations as needed. 6. Program 5 IPC's were trained by the Program Director or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings. 9. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 10. Program Director is responsible.	11-19-13 11-20-13 11-22-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 242	Continued From page 135	W 242		
	[redacted]		W 247 1.1. The Independent Living Asse4ssments for Program 5 clients were reviewed. No other deficiencies were noted.	11-20-13
			1.2. The ILA's for Clients 5, 22, and 23 were reviewed by the Group Leader, and they remained current.	11-25-13
			[redacted]	11-25-13
			[redacted] The anticipated completion date was 12/11/13.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247	1.4. Program 5 Unit Supervisors or designees reminded staff to check the unit activity calendars for daily activities.	11-25-13
			1.5. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings.	11-25-13
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to include in individual program plans (IPPs), opportunities for client choice and self-management aimed at providing opportunities to increase skills associated with self-management for three of four sampled clients (Clients 5, 22 and 23) who live at Residence 6, three of three sampled clients (Clients 26, 29 and 30) on Residence 26, and three of three un-sampled clients (Clients 56, 57 and 58) on Residence 23. Findings:		1.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 1.7. Program Director is responsible.	11-25-13

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W 247	Continued From page 136 1. During observation of breakfast beginning at 8:12 AM on 10/16/13, and during all subsequent observation of meals on Residence 6 during the survey, Clients 5, 22 and 23 were observed in the dining room. As clients entered the dining area, each sat at a table with peers. When the food service worker called each client's name, he went to where the food was placed in heated/cooled serving containers typical of cafeteria style dining. The food service worker asked each client if he/she wanted the items on the menu being served that day. The food service worker dished up all food and handed the bowls or plates to each client. Throughout all mealtime observations at Residence 6 during the survey, the food service was consistently done in a modified cafeteria style. At no time during the survey, was any client observed to help with food preparation. At no time during the survey, was any client observed to help with serving food. At no time during the survey, was any client observed to help with cleanup of the serving dishes or the kitchen area. All clients were observed to take their used dishes to an area to be washed later by the food service worker. 2. During meal observations on Residence 26, commencing on 10/15/13 through 10/22/13 meal service was conducted exactly the same. Although described as cafeteria style, the clients did not have an opportunity to choose anything other than the one item in each food group on the menu. The only choice was yes or no. All food was served by the kitchen staff onto the individual's plate and the client took their tray back to the table. All three individuals, Clients 26, 29, and 30, independently removed their dishes from trays to	W 247	W 247 (cont.) 2.1. The ILA's for Clients 26, 29, and 30 were reviewed by the Group Leader, and they remained current. [redacted] The anticipated completion date was 12/11/13. 2.3. Program 5 Unit Supervisors or designees reminded staff to check the unit activity calendars for daily activities. 2.4. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 2.5. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 2.6. Program Director is responsible.	11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 247	Continued From page 137 their place at the table and at the end of the meal independently and appropriately disposed of food, dishes and utensils. There was no opportunity to be involved in any aspect of meal prep or clean up by these three clients or any of the other individuals on this residence although the majority displayed skills that would indicate they were capable of more participation. For example there were no observations of access to a toaster, coffee maker or condiments for clients to use at breakfast or access to choice of bread, sandwich meat or fruit to make one's own lunch. In the dining room area there was a large ice machine. During an interview on 10/15/13 at 9 AM dietary staff stated that the clients did not use it and had to ask staff if they wanted ice. During an interview on 10/24/13 at 10:30 AM, the IPC stated that the individuals on Residence 26 were capable of more participation in their meals. 3. The two Individual Program Coordinators (IPC), who serve as the Qualified Intellectual Disabilities Professionals (QIDP) assigned to Residence 6, were interviewed at 9:00 AM on 10/23/13 with client records available for reference. The IPCs confirmed that none of the clients who lived at Residence 6 were currently involved in planning menus, purchasing food to make meals or cooking, except for cooking classes. When asked why clients were not involved in cooking and serving their own food or serving food to others with whom they lived, the IPC said it was not part of the Residence 6 program. When asked if any client assisted with cleaning the kitchen or preparing food in any way, the IPC said, "No." When asked how clients who lived at Residence 6 had input into menu planning, the IPC said that the clients met weekly	W 247	W247 (cont.) [redacted] The anticipated completion date was 12/11/13. 3.2. Program 5 Unit Supervisors or designees reminded staff to check the unit activity calendars for daily activities. 3.3. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 3.4. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 3.5. Program Director is responsible.	11-25-13 11-25-13 11-25-13 11-25-13

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W 247	Continued From page 138 and, through those meetings, provided suggestions related to changes in the menu. When asked how clients' skills related to food handling and food preparation were assessed, the IPC said all assessment data on food preparation came from interview and past record documentation rather than functional assessment of skills. The IPC confirmed that at the present time, other than the "cooking classes" offered, there was no plan to involve the men who lived at Residence 6 to be involved in the routine shopping for food items, preparing food and/or cleaning up after meal preparation. The IPC's confirmed that the meals served to the men who lived at Residence 6, typically came prepared from the central kitchen. The IPC's (Individual Program Coordinators) confirmed that if any of the men who lived at Residence 6 were to move to a "group home" in the "community", food shopping, food preparation and kitchen safety and cleanup would be needed skills. 3. a. A meal observation was conducted on 10/15/13 at 12 noon on Unit 23. Client 56 was observed being served by dietary staff his food tray. Client 56 fed himself independently. On 10/16/13 at 7:05 AM, a meal observation was conducted for Client 56. Dietary staff was observed serving Client 56 his meal tray at his table. He ate independently. b. A meal observation was conducted on 10/15/13 at 12:00 PM on Unit 23. Client 57 picked his meal tray from dietary staff at the trayline. After the meal he dumped his plate, cups, and flatware into the kitchen bin and unfinished food	W 247	W 247 (cont.) #4.a, 4.b, 4.c [redacted] 4.2. The Independent Living Assessments for Rrogram 5 clients were reviewed. No other deficiencies were noted. 4.3. Program 5 Group Leaders were trained by by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the client's needs during the assessment process, and make recommendations as needed 4.4. Unit 23 Supervisor or designee was in the process of training unit LOC staff on the updated Approaches & Strategies for Clients 56, 57, and 58. 4.5. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor dining via rounds at least monthly, and document any findings. 4.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.7. Program Director is responsible.	11-14-13 11-20-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 247	Continued From page 139 into the trash can. On 10/16/13 at 8:00 AM, during breakfast observation, dietary staff served his meal tray at his table. After the meal he dumped his uneaten food into the trash bin, and the utensils into another bin. c. A meal observation was conducted on 10/15/13 at 12:00 PM on Unit 23. Client 58 entered the dining room, took a seat and poured himself water into the cup. A dietary staff served Client 58 his meal tray at his table. Client fed himself independently. On 10/16/13 at 7:05 a.m. Client 58 poured water into his cup. A dietary staff called out his name and he got up from the chair and picked up his food tray at the trayline. Client 58 fed himself independently. Client 56, 57, and 58 were observed to be capable of serving and feeding themselves, however the clients were not consistently provided the opportunity to choose their own food and carry their trays to their tables, thereby managing their own meals. Findings Include: 4. During observation of breakfast beginning at 8:12 AM on 10/16/13, and during all subsequent observation of meals on Unit 6 during the survey, Clients #5, #22 and #23 were observed in the dining room. As clients entered the dining area, each sat at a table with peers. When the food service worker called each client ' s name, he went to where the food was placed in heated/cooled serving containers typical of cafeteria style dining. The food service worker asked each client if he/she wanted the items on	W 247		

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W 247	Continued From page 140 the menu being served that day. The food service worker dished up all food and handed the bowls or plates to each client. Throughout all mealtime observations at Unit 6 during the survey, the food service was consistently done in a modified cafeteria style. At no time during the survey, was any client observed to help with food preparation. At no time during the survey, was any client observed to help with serving food. At no time during the survey, was any client observed to help with cleanup of the serving dishes or the kitchen area. All clients were observed to take their used dishes to an area to be washed later by the food service worker. The two Individual Program Coordinators (IPC), who serve as the Qualified Intellectual Disabilities Professionals (QIDP) assigned to Unit 6, were interviewed at 9:00 AM on 10/23/13 with client records available for reference. The IPCs confirmed that none of the clients who lived at Unit 6 were currently involved in planning menus, purchasing food to make meals or cooking, except for cooking classes. When asked why clients were not involved in cooking and serving their own food or serving food to others with whom they lived, the IPC said it was not part of the Unit 6 program. When asked if any client assisted with cleaning the kitchen or preparing food in any way, the IPC said, " No. " When asked how clients who lived at Unit 6 had input into menu planning, the IPC said that the clients met weekly and, through those meetings, provided suggestions related to changes in the menu. When asked how clients ' skills related to food handling and food preparation were assessed, the IPC said all assessment data on food preparation came from interview and past record documentation rather than functional assessment of skills.	W 247		

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W 247	Continued From page 141	W 247		
	The IPC confirmed that at the present time, other than the " cooking classes " offered, there was no plan to involve the men who lived at Unit 6 in the routine shopping for food items, preparing food and/or cleaning up after meal preparation. The IPCs confirmed that the meals served to the men who lived at Unit 6, typically came prepared from the central kitchen. The IPCs confirmed that if any of the men who lived at Unit 6 were to move to a " group home " in the " community, " food shopping, food preparation and kitchen safety and cleanup would be needed skills.			
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION	{W 249}	W 249	
	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.		[redacted]	10-21-13 10-21-13
			1.3. No other Program 5 clients were affected.	10-21-13
			1.4. All Unit 21 LOC staff will review Client 59's Approaches & Strategies and behavior plans.	11-25-13
			1.5. Unit Supervisor and/or Senior PT will monitor staff compliance via rounds and client observation at least monthly, and document the findings.	11-25-13
	This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to implement the training objectives stated in the IPP's (Individual Program Plans) for three of 19 sampled clients (Clients 7, 33, 36) and one of 25 unsampled clients (Client 59).		1.6. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
	Findings:		1.7. Program Director is responsible.	
	1. On 10/23/13, review of a facility "General Event Report," (GER) dated [redacted] showed that on			

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{W 249}	Continued From page 142 [redacted] a client was seated in a wheelchair resting when a direct care staff moved Client 59's wheelchair near enough to the client for Client 59 to grab that client. The client who was grabbed, as a result, was scratched inadvertently. The GER indicated that Client 59 was mad when staff moved Client 59's wheelchair back just before the incident. [redacted]	{W 249}	W 249 (cont.) 2.1. All Program 5 training sites were checked to ensure all age-inappropriate training supplies were removed.	10-22-13
			2.1. New training supplies were obtained for the day program on 36-Annex.	11-15-13
			2.2. 36-Annex day program site lesson plan was revised to include engaging clients with activities that matched the functioning levels of the clients.	11-15-13
			2.3. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed.	11-15-13
			2.4. A new training assessment was initiated for Client 36 to ensure proper placement in the day program. The new assessment will be completed by 12/13/2013.	11-25-13
			2.5. Unit 36 LOC staff who work with the clients at the day program on 36-Annex will be trained by the Unit Supervisor or designee by 12/13/2013 on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop training, and the new training assessment for Client 36.	11-25-13
			2.6. Unit Supervisor and/or Senior PT will monitor during rounds at least monthly to ensure clients can physically and/or cognitively participate in the activities provided. Immediate actions will be taken to correct any deficiency observed.	11-25-13
			2.7. Program 5 IPC's will monitor progress notes recording for clients via monthly audit of the client clinical record, and document in the IPC monthly notes. Any concerns will be elevated to the Unit Supervisor, and documented in the IPC monthly notes.	11-25-13
			2.8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			2.9. Program Director is responsible.	

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26501 AVENUE 140
PORTERVILLE, CA 93257

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 249}	Continued From page 143 On 10/23/13 at 10:45 AM, during interview of the psychiatric technician (PT) involved in the incident, the PT stated she was familiar with Client 59 and stated, "I do know their plans ... (Client 59) got upset." The PT stated, "We give (Client 59) his space but we try to keep him in the group." Per the PT, Client 59 started off in group, had self-propelled himself away and was being redirected back to the group. The PT stated she had "probably pushed the wheelchair back a little too close to the other client. There was so much going on that day. There was a lot going on." 2. On 10/16/13 beginning at 1:00 PM, observations were made in the day program in the 36-Annex. Two staff, one of which was a float from another residence, and seven clients were present. Six clients, including core sample Client 36, were positioned around a table. Staff stated the activity was gardening. One staff member began to read the back of a packet of seeds, including information about planting depth and time to germination. One client began screaming and engaging in self-injurious behavior and had to be wheeled from the table. None of the clients, including Client 36, was developmentally able to understand what staff was reading. Staff then began to ask questions such as, "What grows here in the valley?, "Where do you go to buy plants?", and "Raise your hand if you like shade." The staff answered each other's questions. None of the clients were physically or cognitively capable of participating.	{W 249}	W 249 (cont.) 3.1. Client 7's annual IPP review was held. [redacted]	10-15-13
			3.2. The training objectives for Program 5 clients were reviewed by the Interdisciplinary Teams. Clients identified as needing revisions to their training objectives were referred back to the Interdisciplinary Team for recommendations.	11-20-13
			3.3. Unit 5 LOC staff were trained by the Unit Supervisor or designee on Client 7's new training objective [redacted]	11-25-13
			3.4. Program 5 Group Leaders were trained by their Unit Supervisors or designees on Desired Outcome documentation and setting desired outcomes based on assessment of client's ability, and make recommendations as needed.	11-25-13
			3.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
			3.6. IPC's will monitor client training assessments and objectives via rounds at least monthly. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			3.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance during rounds at least monthly, and document any findings.	11-25-13
			3.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
			3.9. Program Director is responsible.	

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{W 249}	Continued From page 144	{W 249}	W 249 (cont.)	
	Client 36 was observed repeatedly bouncing a ball, attached to his wheelchair by a cord, onto his wheelchair tray until he fell asleep.		4.1. A Special IPP was held for Client 7 to review and update his Approaches & Strategies and Desired Outcomes & Milestones [redacted]	11-14-13
	[redacted]		4.2. The training objectives for Program 5 clients were reviewed by the Interdisciplinary Teams. Clients identified as needing revisions to their training objectives were referred back to the Interdisciplinary Team for recommendations.	11-20-13
	[redacted]		4.3. Unit 5 LOC staff were trained by the Unit Supervisor or designee on Client 7's updated Approaches & Strategies, Desired Outcomes & Milestones, Client 7's Independent Living Assessment, Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing Techniques", and Nursing Protocol 5 "Blood and Body Fluid Precautions (Standard Precautions)".	11-25-13
	None of the 7 clients participated in any type of activity that appeared to be designed to increase their independence and learn new skills.		4.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs.	11-25-13
	During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator agreed that the activity during the day program did not meet the clients' developmental needs. She further stated, "Perhaps more training" for day program staff.		4.5. IPC's will monitor client training assessments and objectives via rounds at least monthly. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
	[redacted]		4.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance during rounds at least monthly, and document any findings.	11-25-13
	On 10/17/13 at 7:18 AM, Client 7 was observed being shaved by staff utilizing a regular razor and moisturizer was not provided to the client after shaving.		4.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary.	11-25-13
			4.8. Program Director is responsible.	

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{W 249}	Continued From page 145 During an interview with unit staff on 10/24/13 at 9 AM, staff stated that Client 7 did not have an electric shaver and that staff would get him a new one. [redacted] On 10/17/13 at 7:25 AM, with staff present, Client 7 was observed preparing to brush his teeth. Client 7 squeezed a large amount of toothpaste onto his toothbrush prior to brushing his teeth and then proceeded to brush his teeth at a very fast pace lasting for only a few seconds. Staff present did not prompt Client 7 to brush all surfaces of his teeth. Client 7 then put his mouth directly under the faucet to rinse his mouth. There was no staff intervention nor was a cup provided for the client to rinse his mouth with. When staff was questioned about the observation made by the surveyor, staff stated that, "A cup would be good." Staff further stated that Client 7 had a cup before and he collected them. 5. During meal observation for Client 33 on 10/15/13 at 12:30 PM, staff applied a cloth clothing protector over his chest. The meal was dished out into a deep divided plate and served	{W 249}	W 249 (cont.) 5.1. The training objectives for Program 5 clients were reviewed by the Interdisciplinary Teams. Clients identified as needing revisions to their training objectives were referred back to the Interdisciplinary Team for recommendations. 5.2. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs. 5.3. Client 33's Interdisciplinary Team were in the process of updating his Approaches & Strategies [redacted] 5.4. Unit 23 Supervisor or designee was in the process of providing training to unit LOC staff on Client 33's updated Approaches & Strategies. The anticipated completion date was 12/20/13. 5.5. IPC's will monitor client training assessments and objectives via rounds at least monthly. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 5.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance via regular rounds at least monthly, and document any findings. 5.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 5.8. Program Director is responsible.	11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 249}	Continued From page 146 by dietary staff on the lap tray of his wheelchair. A unit staff assisted him with the set up of his food (cutting up). Client 33 had a curved black handled spoon. The staff was observed to encourage Client 33 feed himself with hand over hand assistance. Client 33 was able to drink liquids thru his sippy cup. After the meal, staff praised him for his efforts. Client 33 was taken back to group room with the staff pushing his wheel chair. On 10/16/13 at 8:25 AM. during meal observation in the dining room, staff placed a clothing protector over Client 33's chest. Dietary staff served his meal on a deep divided plate, and liquids in sippy cup. Client 33 was observed to drink his liquids by a sippy cup independently. Using the curved spoon the unit staff was observed feeding Client 33, there was no attempt to do hand over hand. At the end of the meal, the client was taken back to his group room. [redacted] 6. On 10/15/13 at 10 AM during a day program observation in room 161 of residence 22 Client 40 and a peer had puzzles and musical instruments on top of their table. Both clients were not actively engaged. During an interview, the staff stated that both clients shred paper, but today the shredder was broken. The staff could not verbalize when the machine was broken	{W 249}	W 249 (cont.) 6.1. The non-functioning paper shredder was removed and replaced. Client 40 was provided with alternate activity. 6.2. The training site lesson plan were updated to include alternate activities for when the main activity is unavailable. 6.3. Other Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 6.4. The paper shredder was repaired and brought back to the training site as a back up. 6.5. Unit 23 Supervisor or designee was in the process of training unit LOC staff, including staff who work with the clients at the training site on the revised training site schedule/lesson plan. Staff were also trained to call Central Program Services for any shredder repairs. The anticipated completion date was 12/13/13. 6.6. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training assessments and objectives. 6.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 6.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 6.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 6.10. Program Director is responsible.	10-15-13 11-20-13 11-15-13 11-24-13 11-25-13 11-25-13 12-13-13 12-13-13 12-13-13

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W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the Individual Plan Coordinator (IPC) failed to review and revise the program plan for 2 of 62 sampled and un-sampled clients (Clients 31 and 46) when they had met an identified objective in their plans. Findings: [redacted] During an interview with the Individual Program Coordinator (IPC) on 10/24/13 at 9:15 AM, she stated that thej team hae not decided on a new plan. The IPC was reminded that the previous money management objective was met last [redacted] and the annual program planning conference was conducted approximately five months ago. 2. On 10/15/13, observations were made in one	W 255	W 255 1.1. A Special IPP was held for Client 31. A new training objective was developed for Client 31: [redacted] 1.2. Program 5 Management identified clients whose objectives were not current and/or accurate. An IPP review was held for the identified clients to update their objectives. 1.3. Program 5 Group Leaders were trained by their Unit Supervisors or designees on the Independent Living Assessments to ensure they discuss the client's current objectives during the assessment process, and make recommendations as needed. 1.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs. 1.5. Unit 21 Supervisor or designee was in the process of providing training to the unit LOC staff on Client 31's training plan. The anticipated completion date was 12/13/2013. 1.6. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 1.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings. 1.8. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.9. Program Director is responsible.	10-24-13 11-24-13 11-24-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 255	Continued From page 148 of the day rooms on Residence 36. From 8:30 AM until 9:00 AM, Client 46 was observed sitting in a chair holding a ball with no other activity offered. On 10/16/13 at 1:30 PM, observations were made in Client 46's day program. There were seven clients and two staff. Six clients were positioned around a table on one side of the room and Client 46 was seated in a chair on the other side of the room. Client 46 was observed to sit holding a ball for 30 minutes with no other activity. A staff would occasionally verbally prompt him from the other side of the room to join the group. Client 46 never joined the group or engaged in any other activity except holding the ball. During an interview on 10/16/13 at 2:00 PM, licensed day program staff stated that Client 46 had been in that day program "for a long time." When asked if the client ever engaged in any activity other than holding a ball, staff stated the client rarely participated in any of the activities in the class. When asked what the client's objective for the class was, staff stated his objective was to manipulate an object for 45 seconds. Client 46 was again observed sitting, holding a ball with no other activity on the residence on 10/21/13 from 7:30 PM until 8:00 PM. [redacted]	W 255	W 255 (cont.) 2.1. An assessment of Client 46's placement at the day program was completed. 2.2. Residence 36 day program site schedule was revised to include engaging clients with activities that matched the functioning levels of the clients. 2.3. Program 5 training site lesson plans and staff ratios were reviewed. Revisions were made to lesson plans as needed. 2.4. Program 5 IPC's were trained by the Program Assistant or designee on Facility Bulletin 131 "Assessment" and reviewed expectations that IPC's will monitor client vocational assessments. 2.5. The Interdisciplinary Team is in the process to hold an IPP review for Client 46 to address the updated assessment information. The meeting is anticipated to be held on 12/4/13. 2.6. Unit Supervisor or designee is in the process of providing training to Unit 36 LOC staff who work with the clients at the day program on 36-Annex on the revised lesson plan for the day program on 36-Annex, the active treatment definition/loop training, and the new training assessment for Client 36. The anticipated date of completion is 12/13/2013. 2.7. IPC's will monitor client training assessments and objectives via rounds at least monthly to observe client participation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 2.8. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation during rounds at least monthly, and document any findings. 2.9. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-12-13 11-15-13 11-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 255	Continued From page 149 [redacted]	W 255	W255 (cont.) 2.10: Program Director is responsible.	
	There was no documented evidence that the IPC had reviewed and revised this objective when the client engaged in little activity other than holding an object. During an interview on 10/17/13 at 10:30 AM, the Individual Plan Coordinator (IPC) stated that there was no documented evidence that the client's plan had been reviewed and revised following successful completion of the objective.		W 264 1. Client 61 was assessed upon return to the facility, and no injuries were noted. No other clients were affected. 2. Facility Bulletin 104 "Behavior Management" was revised to differentiate between clinical response/highly restrictive intervention and police/OPS intervention. 3. Program 5-LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 104 "Behavior Management" with emphasis on the differentiation between clinical response and police/OPS intervention. 4. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client participation via rounds at least monthly, and document any findings. 5. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 6. Program Director is responsible.	09-01-13 11-19-13 11-25-13 11-25-13 11-25-13
{W 264}	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by:	{W 264}		

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{W 264}	Continued From page 150 Based on staff interview and review of a General Event Report, the facility failed to ensure that the specially constituted committee reviewed and monitored the use of a restrictive intervention (handcuffs) for one of one incidents reviewed for one of 25 unsampled clients (Client 61). This resulted in the use of a restrictive intervention that was not an approved behavioral management technique. Findings: Review of a General Event Report (GER) indicated on [redacted] Client 61 was transported to an outside hospital with the Office of Protective Services (OPS), Special Investigator (SI), and unit staff for an exam as a result of a previously reported event. Once staff made an attempt to begin the exam Client 61 became agitated and took a fighting stance. At 9:02 PM the SI reported to unit staff that attempts were made to return Client 61 to baseline with [redacted] All attempts were unsuccessful at which point the SI placed her in handcuffs at 8:05 PM and escorted her to the van for transport back to the facility. The handcuffs were removed at 8:15 PM. During an interview with Quality Assurance (QA) staff on 10/16/13 at 11 AM, QA staff was asked if the use of handcuffs was reviewed by the specially constituted committee (HRC). QA staff stated that the use handcuffs was not reviewed by the HRC because the restraints were used by the Office of Protective Services (OPS) and "it is not a behavioral intervention that we use." Staff further stated that the review was through the General Event Report (GER) process and the	{W 264}		

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{W 264}	Continued From page 151 police review the use of handcuffs, not QA. On 10/16/13, there was no evidence provided that the HRC evaluated the appropriateness of the response by OPS.	{W 264}		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observation, document review and interviews, the facility failed to ensure that the human right, to be treated with dignity, was protected when Client 39 was taken on outings into the community with stigmatizing hand restraints and no attempt was made to find alternate, less stigmatizing restraints for the client. Findings: Residence 23 On 10/24/13 at 8 AM, Client 39 sat on a couch in a group activity room. Both hands were covered with [redacted]	W 285	W 285 [redacted] [redacted] The anticipated date of completion was 12/12/13. 5. Client 39's Interdisciplinary Team was in the process of planning a meeting to discuss the result of the research conducted by the Director of Quality Assurance. The anticipated date of the meeting was 12/13/13. 6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance with client behavior plans during rounds at least monthly, and document any findings. 7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 8. Program Director is responsible.	11-15-13 11-21-13 11-22-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 285	Continued From page 152 [redacted] Other than being escorted to the restroom at 8:20 AM, the client sat and watched others as his movements were highly restricted [redacted] On 10/24/13 at 8:45 PM, a psychiatric technician (PT) stated that the [redacted] were to prevent [redacted] behaviors [redacted] On 10/24/13 at approximately 8:55 AM the PT stated that Client 39 was "one of our smarter clients." [redacted]	W 285		

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W 285	Continued From page 153	W 285		
	[redacted]			

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W 285	Continued From page 154	W 285	W318 (See also W322, W331, W363, W368, and W378) Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Condition of Participation for Health Care Services is met. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags.	
	[redacted] During an interview with the Unit Supervisor (US) on 10/24/13 at 12:15 PM, the US stated that Client 39 used the [redacted] devices when out in the community. The US stated the facility had not looked at different products available on the market that were less restrictive and less stigmatizing and agreed that without change the facility would continue to use the [redacted] for the remainder of Client 39's life. The US added, "I'd like to see him when he goes on outings in something less stigmatizing."		W318 #1 (See also W322, W331, W363, W368, and W378) - The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. - Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed. - Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus". - Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus". - Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	10-16-13 10-16-13 10-16-13 10-17-13 11-15-13 11-25-13 11-25-13
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, document review and interviews, the Condition of Participation for Health Care services was not met. Findings: Clients did not receive adequate health care and monitoring when 3 of 6 diabetic clients receiving insulin were administered insulin while they were hypoglycemic. An Immediate Jeopardy was called on 10/15/13 and abated on 10/17/13. These failures had the potential to result in severe illness, coma, brain injury or death. The	W 318		

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PORTERVILLE DEVELOPMENT CENTER - DP ICF/IID	26501 AVENUE 140 PORTERVILLE, CA 93257

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W 318	Continued From page 155 fact that these hypoglycemic reactions occurred in clients who may not have had the intellectual capacity to alert anyone to any symptoms increased the potential for severe adverse reactions. Client 49 tripped, fell, hit his head and was not monitored nor assessed until approximately 12 hours after the fall. An Immediate Jeopardy was called on 10/16/13 under Client Protections and was abated on 10/23/13. This Immediate Jeopardy also contained aspects of lack of monitoring and assessment. The lack of follow-up for a client with a head injury had the potential to miss significant warning signs of a worsening condition. There was also a systems failure in that there was a conflict between policy and procedure in regards to reporting a head injury to the RN/MD. A client's recommended [redacted] follow-up was not done. Diabetic health care plans were not implemented when there was no documentation of monitoring for hypoglycemic symptoms in diabetic clients. There were no drug regimen reviews that identified and addressed the hypoglycemic reactions for clients who were administered insulin. There were no current drug references in the pharmacy. There was inadequate temperature monitoring of the refrigerator in the pharmacy that contained temperature sensitive vaccines. Due to these systemic and other failures, it was determined that the Condition of Participation for Health Care Services to be not met. See W 322, W 331, W 363, W 368, and W 378	W 318	W318 #1 (See also W322, W331, W363, W368, and W378) (cont.) - Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. - Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W318 #2 (See also W322, W331, W363, W368, and W378) - Program 5 NOC shift staff audited the last 24-hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. - RN/HSS and/or ACNS contacted each Program 5 units, via call or visit, every hour to verity no client had fallen and/or struck head. - Program 5 LOC staff were trained by their Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". - Facility Bulletin 105 "Client Protections" was revised. - Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 105 "Client Protections", Clinical Recording Guideline 2 "Temporary Conditions", and Clinical Recording Guideline 5 "Client Immediate Protection Plan". - Program Management will review Daily Reports at the morning meeting for any report of client(s) falling or striking head on previous shift(s) and actions taken. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality	11-25-13 11-25-13 10-17-13 10-17-13 10-17-13 10-21-13 10-23-13 10-23-13 11-25-13

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			W318 #2 (See also W322, W331, W363, W368, and W378) (cont.) Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	
			W318 #3 (See also W322, W331, W363, W368, and W378) [redacted]	06-26-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client's special clinic consults.	11-25-13
			- Program 5 Management and Unit Supervisor will monitor client special clinic consults via the Behavior Intervention Review Team meetings.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W318 #4 (See also W322, W331, W363, W368, and W378)	
			- The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			- Health Care objectives and plans for all Program 5 clients receiving insulin were reviewed by the RN/HSS, and updated as needed.	10-16-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and PVL 593 "Diabetic Record" was revised following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13

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			W318 #4 and #5 (See also W322, W331, W363, W368, and W378) (cont.)	
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	10-17-13
			- Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was revised further to include clarity of the Interdisciplinary Notes.	11-15-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus".	11-25-13
			- Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			- Unit NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia.	11-25-13
			- Any elevated issues will be reviewed monthly at Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W318 #6 (See also W322, W331, W363, W368, and W378)	
			- Pharmacy temperature log was modified with instructions on what to do if the temperature is out of range. Pharmacy personnel were trained by the Pharmacy Services Manager on the	11-20-13

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			W318 #6 (See also W322, W331, W363, W368, and W378) (cont.)	
			modified log.	
			- A purchase order was submitted for a new pharmaceutical grade refrigerators and freezer with product temperature sampling, continuous temperature monitoring, web-based access to temperature data, tamper-proof data integrity, and high/low temperature alarm system.	11-25-13
			- Pharmacists will monitor the temperature via rounds at least monthly.	11-25-13
			- Any elevated issues will be reviewed monthly at Administrative Quality Management Council meeting and Medical/Nursing Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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W 322	Continued From page 156	W 322	W 322	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and document reviews the facility's physicians failed to treat clients (review of 3 of 6 clinical records) that were hypoglycemic (low blood sugar) and being administered insulin. Insulin is a medication used to lower blood sugar levels to treat diabetes. When too much insulin is administered and blood sugar levels drop below 70 mg/dl a patient becomes hypoglycemic. Hypoglycemia may result in convulsions, unconsciousness, temporary or permanent brain damage, or even death. The facility also failed to ensure that an opthalmology follow-up appointment was made per recommendation for Client A and an annual physical examination was done for Client 25. Findings: [redacted]	W 322	1.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 1.2. A medication error report was initiated for Clients 26. 1.3. Physician reviewed the medication error reports for Client 26, and determined that the client was not adversely affected. 1.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 1.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 1.6. Physicians were notified of blood sugar level prior to administration of insulin. 1.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 1.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 1.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 1.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 1.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 1.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 1.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 322	Continued From page 157 [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. A review of Lexicomp Online indicated that Humulin R had a duration of 4 to 12 hours and a onset of 30 minutes. Humulin R can have an effect on lowering blood sugars for 4 to 12 hours and can begin lowering blood sugar within 30 minutes. [redacted]	W 322	W 322 (cont.) 1.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 1.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 1.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 1.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 1.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 1.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 322	Continued From page 158 [redacted]	W 322	W 322 (cont.) 1.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 1.20. Program Director is responsible.	11-25-13

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W 322	Continued From page 159 Humulin R is short acting insulin and may promptly lower blood sugars. Humulin R was administered 6 times when Client 26 was hypoglycemic (43 mg/dl, 45 mg/dl, 47 mg/dl, 60 mg/dl, 62 mg/dl, 66 mg/dl). During an interview on 10/15/13 at 11:30 AM, the Psych Tech stated she had administered Client 26's insulin. She also stated she thought the physician orders were to give the insulin when blood sugars were less than 70 mg/dl and then call the clinician. [redacted] there was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 26. [redacted]	W 322	W 322 (cont.) 2.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 2.2. A medication error report was initiated for Clients 42. 2.3. Physician reviewed the medication error reports for Client 42, and determined that the client was not adversely affected. 2.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 2.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 2.6. Physicians were notified of blood sugar level prior to administration of insulin. 2.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 2.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 2.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 2.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 2.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 2.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 2.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 322	Continued From page 160	W 322	W 322 (cont.) 2.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
	[redacted]		2.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			2.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			2.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			2.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			2.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 322	Continued From page 161 [redacted] The psych techs continued to administer Lantus daily when Client 42 was hypoglycemic. Client 42 had 21 hypoglycemic events from [redacted] without a Lantus dosage change. During an interview on 10/15/13 at 10:59 AM, a second Psych Tech stated she had administered Client 42's insulin. She also stated that you always give the Lantus insulin. She said that the Lantus should always be administered even with low blood sugars. [redacted] [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:15 pm Health Services Nurse 1 stated there was no documentation of daily monitoring for hypoglycemia for Client 42. [redacted]	W 322	W 322 (cont.) 2.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 2.20. Program Director is responsible.	11-25-13

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W 322	Continued From page 162	W 322	W 322 (cont.) 3.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
	[redacted]		3.2. A medication error report was initiated for Clients 43.	10-15-13
			3.3. Physician reviewed the medication error reports for Client 43, and determined that the client was not adversely affected.	10-15-13
			3.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
	A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. According to Lexicomp Online Lispro has a duration of about 5 hours. Lispro can have an effect on lower blood sugar for about 5 hours.		3.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			3.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			3.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
	[redacted]		3.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			3.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
			3.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			3.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
			3.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
			3.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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W 322	Continued From page 163	W 322	W 322 (cont.) 3.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
	[redacted]		3.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			3.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			3.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			3.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			3.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 322	Continued From page 164	W 322	W 322 (cont.)	
	[redacted]		3.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary.	11-25-13
			3.20. Program Director is responsible.	
			[redacted]	06-26-13
				10-25-13
			4.3. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client special clinic consult.	11-25-13
			4.4. IPC's will monitor client consults via monthly audit of the clinical record. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			4.5. Program 5 Management and Unit Supervisor will monitor client consults via the Behavior Intervention Review Team meeting.	11-25-13
			4.6. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
	The psych techs continued to administer the Lantus and Lispro when Client 43 was hypoglycemic.		4.7. Program Director is responsible.	
	Client 43 had 36 hypoglycemic events from			

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W 322	Continued From page 165 [redacted] with blood sugars as low as 20 mg/dl and several blood sugars in the 30s (30 mg/dl, 32 mg/dl, 32 mg/dl, 33 mg/dl, 34 mg/dl, 37 mg/dl) . On average Client 43 was hypoglycemic once every 1.6 days (57 days divided by 36 hypoglycemic events). [redacted] confusion and nervousness. There was no documented evidence in the clinical record of every shift monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of monitoring every shift for hypoglycemia for Client 43. During an interview on 10/15/13 at 1:30 PM the Medical Director stated that hypoglycemia was a significant concern for clients receiving insulin. He also stated that if blood sugars drop too low it would be an emergent situation which could lead to death. He said that for blood sugars that were around 70 mg/dl to 80 mg/dl and below he would expect the psych techs to hold the insulin and call the clinician. [redacted] There was no documented evidence in the	W 322	W 322 (cont.) [redacted]	11-02-13
			5.2. An audit of the annual physical exams was completed for all Program 5 clients.	11-08-13
			5.3. Any deficient annual physical exams were completed.	11-25-13
			5.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client annual physical examinations.	11-25-13
			5.5. IPC's will monitor client annual physical examination via monthly audit of the clinical record. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes.	11-25-13
			5.6. Program 5 Management and Unit Supervisor will monitor client consults via the Behavior Intervention Review Team meeting.	11-25-13
			5.7. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			5.8. Program Director is responsible.	

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W 322	Continued From page 166 client's clinical record that the client was seen by the [redacted] in six months. There was also no documented evidence in the client's clinical record that the physician was aware of the recommendation on [redacted] During an interview with the Unit Manager on 10/22/13 at 2:40 PM, she confirmed that the facility failed to ensure that a recommendation to return to [redacted] clinic was not conducted in six months from [redacted] She also stated that there was no documentation made from the physician indicating that he was aware of the recommendation from the [redacted] clinic on [redacted] 5.. A review of Client 25's clinical record was conducted on 10/23/13 at 11:30 AM. The client's [redacted] examination indicated that the most current examination was conducted on 4/25/12 by a Nurse Practioner. During an interview with the IPC (Individual Program Coordinator) on 10/23/13 at 11:35 AM, he confirmed that there was no [redacted] examination conduction since 4/25/12. He further stated that an annual physical examination should have been conducted in April of 2013.	W 322	W 331 1.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, document review and interviews the facility failed to ensure nursing services in accordance with clients' needs when:	{W 331}	1.2. A medication error report was initiated for Clients 26.	10-15-13
			1.3. Physician reviewed the medication error reports for Client 26, and determined that the client was not adversely affected.	10-15-13
			1.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
			1.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			1.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			1.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
			1.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			1.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
			1.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			1.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
			1.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
			1.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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{W 331}	Continued From page 167	{W 331}	W 331 (cont.) 1.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
	The care plan to monitor hypoglycemia was not implemented for 3 of 6 diabetic clients (Client 26, Client 42, and Client 43) and when 1 sampled client (Client 30) had severe ongoing open wounds and lacked evidence of consistent documentation, monitoring by the facility wound care specialist, unclear treatment orders, and lacked a detailed and consistent system for tracking wound healing. In addition, there was a failure to assess and monitor an unsampled client (Client 49) after he sustained a fall and struck his head. Findings: [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. A review of Lexicomp Online indicated that Humulin R had a duration of 4 to 12 hours and a onset of 30 minutes. Humulin R can have an effect on lowering blood sugars for 4 to 12 hours and can begin lowering		1.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 1.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 1.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 1.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 1.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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{W 331}	Continued From page 168 blood sugar within 30 minutes. [redacted]	{W 331}	W 331 (cont.) 1.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 1.20. Program Director is responsible.	11-25-13

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{W 331}	Continued From page 169	{W 331}	W 331 (cont.)	
	[redacted]		2.1. The identified staff who made the medication-error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
			2.2. A medication error report was initiated for Clients 42.	10-15-13
			2.3. Physician reviewed the medication error reports for Client 42, and determined that the client was not adversely affected.	10-15-13
			2.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
			2.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			2.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			2.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
			2.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			2.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
	The psychiatric technicians (psych techs) continued to administer Lantus and Humulin R when Client 26 was hypoglycemic. Humulin R is short acting insulin and may promptly lower blood sugars. Humulin R was administered 6 times when Client 26 was hypoglycemic (43 mg/dl, 45 mg/dl, 47 mg/dl, 60 mg/dl, 62 mg/dl, 66 mg/dl).		2.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			2.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
			2.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
	[redacted]		2.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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{W 331}	Continued From page 170 [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:15 PM, a Psych Tech stated there was no documentation of daily monitoring for hypoglycemia for Client 26. She also stated that Client 26 was observed periodically for hypoglycemia but there was no documentation indicating that daily hypoglycemia monitoring was done. The facility did not provide evidence of daily hypoglycemia monitoring for Client 26. [redacted]	{W 331}	W 331 (cont.) 2.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 2.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 2.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 2.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 2.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 2.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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{W 331}	Continued From page 171 [redacted] The psych techs continued to administer Lantus daily when Client 42 was hypoglycemic. Client 42	{W 331}	W 331 (cont.) 2.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 2.20. Program Director is responsible.	11-25-13

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{W 331}	Continued From page 172 had 21 hypoglycemic events from [redacted] without a Lantus dosage change. A review of the [redacted] There was no documented evidence in the clinical record of daily and monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 42. He also stated that Client 42 was observed periodically for hypoglycemia but there was no documentation indicating that hypoglycemia daily monitoring was done. The facility did not provide evidence of daily hypoglycemia monitoring for Client 42. [redacted]	{W 331}	W 331 (cont.) 3.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 3.2. A medication error report was initiated for Clients 43. 3.3. Physician reviewed the medication error reports for Client 43, and determined that the client was not adversely affected. 3.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 3.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 3.6. Physicians were notified of blood sugar level prior to administration of insulin. 3.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 3.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 3.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 3.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 3.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 3.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 3.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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{W 331}	Continued From page 173 A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. According to Lexicomp Online Lispro has a duration of about 5 hours. Lispro can have an effect on lower blood sugar for about 5 hours. [redacted]	{W 331}	W 331 (cont.) 3.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 3.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 3.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 3.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 3.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 3.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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{W 331}	Continued From page 174 [redacted]	{W 331}	W 331 (cont.) 3.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 3.20. Program Director is responsible.	11-25-13

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{W 331}	Continued From page 175 54 mg/dl [redacted] The psych techs continued to administer the Lantus and Lispro when Client 43 was hypoglycemic. Client 43 had 36 hypoglycemic events from [redacted] with blood sugars as low as 20 mg/dl and several blood sugars in the 30's (30 mg/dl, 32 mg/dl, 32 mg/dl, 33 mg/dl, 34 mg/dl, 37 mg/dl) . On average Client 43 was hypoglycemic once every 1.6 days (57 days divided by 36 hypoglycemic events). [redacted]	{W 331}	W 331 (cont.) [redacted]	10-22-13 10-24-13 11-23-13
			4.4. The CNS or designee was in the process of providing training to RN/HSS and ACNS/HSS on Clinical Recording Guideline #20 "Nursing Assessment".	11-25-13
			4.5. RN/ACNS will monitor staff compliance via random review of the annual and quarterly nursing assessments for Program 5 clients.	11-25-13
			4.6. Any elevated issues will be reviewed monthly via the Medical/Nursing Quarterly Management meeting, along with corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further actions taken as necessary.	11-25-13
			4.7. CNS is responsible.	

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{W 331}	Continued From page 176 [redacted] There was no documented evidence in the clinical record of every shift monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of every shift monitoring for hypoglycemia for Client 43. He also stated that Client 43 was observed periodically for hypoglycemia but there was no documentation indicating that hypoglycemia monitoring every shift was done. The facility did not provide evidence of every shift hypoglycemia monitoring for Client 43. 4. On 10/22/13 at 7:30 AM, observations were made of injuries on the arms of Client 30 as Licensed Staff applied treatment and dressings. The top of the client's right forearm had a wide linear area of scar tissue with the center portion open and raw appearing. Two other small areas approximately the size of a quarter on each arm were also opened. Staff stated that she had not provided wound care to the client recently and therefore was unable to determine if the wounds were improving or not. Staff was asked if there was a system of documenting the observations of staff, in order to monitor the wound healing progress and changes in treatment on a regular basis. Staff stated they only document in the Interdisciplinary Notes (IDN's). [redacted]	{W 331}	W 331 (cont.) [redacted] 5.2. A General Event Report was initiated for Client 49. 5.3. Program 5 NOC shift staff audited the last 24 hours of Interdisciplinary Notes for all clients to verify no client had fallen and/or struck head. The audit findings were documented on the daily report. 5.4. RN/HSS and/or ACNS contacted each Program 5 residence, via call or visit, every hour to verity no client had fallen and/or struck head, and documented via NOD report through 1700 hours. 5.5. Program 5 LOC staff discussed at huddles the need to train and implement Nursing Procedure 80 "Head Injuries, Care Of", and document on the daily report through PM shift. 5.6. Program 5 LOC staff were trained by the Unit Supervisor or designee on Nursing Procedure 80 "Head Injuries, Care Of". 5.7. Facility Bulletin 105 "Client Protections" was revised to include the following: a. Each change of shift will include a report on any clients who have fallen or struck their head on previous shift(s), and actions taken. b. Documentation of change of shift report on fall or hitting head will be on Daily Report. c. SRPT/NPIC on duty will include communication of information about clients who have fallen or have hit their head and action taken, as well as responsibility to elevate concern or seek clarification as needed, to US/AOD immediately, to ensure actions taken meet expectations. 5.8. Program 5 LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 105 "Client Protections". 5.9. Program 5 LOC staff were trained by their Unit Supervisors or designees on the Clinical Recording Guideline #2 "Temporary Conditions", and Clinical Recording Guideline #5 "Client	10-15-13 10-17-13 10-17-13 10/17/13 10/17/13 10/18/13 10/21/13 10-23-13 10-23-13

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{W 331}	Continued From page 177 [redacted] without consistent detail of the number, location, size, and characteristics of the client's wounds. An IDN, dated [redacted] described the following: [Client 30] [redacted] There was no description of the specific location impacted, size and appearance. There was no system in place to track when lesions first appeared, healed, or reopened without going through innumerable daily IDN's which were inconsistent in what was documented. Documentation by the psychologist, dated [redacted] indicated that Client 30 had already opened areas on both arms and made them bigger and his wounds had almost healed before this. This has been his pattern. The most recent Nursing Quarterly Evaluation/Assessment dated 8/10/13 did not address the client's wounds for that assessment. However the form indicated the following: [redacted] Review of physician progress notes (ppn's) dated [redacted] and [redacted] did not describe the status of the client's wounds. The notes indicated [redacted] [redacted] Only one was being used (documented) daily and there was no clarification	{W 331}	W 331 (cont.) 5.9 (cont.) Immediate Protection Plan". 5.10. Daily Report will be reviewed at the morning Program Management meeting daily, Monday through Friday. 5.11. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 5.12. Program Director is responsible.	10-23-13 10-23-13

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{W 331}	Continued From page 178 as to under which condition each was to be used. [redacted] Two facility nursing policies related to wound care were reviewed. Nursing Procedure No. 85 titled: "Emergency Wound Care" dated June 25, 2013 and Nursing Protocol No. 4 titled: "Open Wounds" dated April 22, 2013. Neither addressed on-going assessment and documentation. On 10/22/13 at 7:00 PM, during an interview, the facility's Certified Wound Care Nurse Specialist stated that she had not observed Client 30's wounds in approximately two years. Staff stated the reason was because of the client's behavior of reopening the wounds, once they were almost healed. In addition, the nurse stated that the unit staff were able to monitor and treat them. The nurse stated there was no data collection document or system for tracking wounds and that the two policies No. 4 and 85 were the only wound related policies she was aware of. The nurse added that the two treatment orders should be further clarified. 5. On 10/16/13 at 11:00 AM, during observations at a day program, un-sampled Client 49 had noticeable bruising around the left eye orbit and on the left cheekbone. During a concurrent interview, Client 49 stated that he had fallen two nights previously at home (Residence 26). ~~The client's record indicated that he had an~~	{W 331}		

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{W 331}	Continued From page 179 [redacted] During a concurrent interview, the shift lead stated that staff should have initiated the head injury protocol and notified the HSS (Health Services Specialist) at the time of the fall and communicated the incident to the next shift. During an interview on 10/16/13 at 7:30 PM, a licensed staff stated that she checked the client immediately after the fall, but didn't think the client was hurt. Staff stated that she did not know at the time, that the client had struck his head and did not notify the HSS or physician. There was no documentation until the following morning on [redacted] at 6:45 AM, when an [redacted] indicated that another licensed staff " [redacted] Two abrasions were described: [redacted]	{W 331}		

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{W 331}	Continued From page 180 Review of [redacted] on [redacted] indicated the last entry by a physician was dated [redacted] The record indicated that the RN/HSS assessed Client 49 at [redacted] eleven hours after the initial fall. The client's neurologic status and vital signs had not been monitored throughout the night. During an interview on 10/17/13 at 11:30 AM, the licensed staff who worked overnight and discovered the client's injury on [redacted] at 6:45 AM, stated that there had been no communication from the evening shift on [redacted] that Client 49 had fallen that evening. Review of Nursing Procedure No. 80 titled: "Head Injuries - Care of, " indicated under Section B Definition: #1. Trauma to the head (including the face) resulting from a blow, impact with an object, fall, etc. Section III Special Considerations: Immediate Management for Severe Injury or Injury with loss of consciousness. Subsection G: "Notify Residence Physician/HSS/Assistant Coordinator of Nursing Services." The policy for Falls N 16 titled: "First Aid for Falls and or Suspected Fractures" was the only policy received regarding falls. When asked if a General Event Report (GER) was initiated on 10/15/13, Quality Assurance Staff stated that it was not, because "it did not meet the criteria for a GER." When asked if the facility tracked client falls, Quality Assurance Staff stated that only through the GER process.	{W 331}		
W 363	483.460(j)(2) DRUG REGIMEN REVIEW	W 363		

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W 363	Continued From page 181 The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on interview and document review the facility pharmacists failed to identify irregularities in administering insulin when psychiatric technicians administered insulin to clients (review of 3 of 6 clinical records) that were hypoglycemic (low blood sugar). Insulin is a medication used to lower blood sugar levels to treat diabetes. When too much insulin is administered and blood sugar levels drop below 70 mg/dl a patient becomes hypoglycemic. Hypoglycemia may result in convulsions, unconsciousness, temporary or permanent brain damage, or even death. Findings: [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24	W 363	W 363 1.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 1.2. A medication error report was initiated for Clients 26. 1.3. Physician reviewed the medication error reports for Client 26, and determined that the client was not adversely affected. 1.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 1.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 1.6. Physicians were notified of blood sugar level prior to administration of insulin. 1.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 1.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 1.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 1.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 1.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 1.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 1.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 363	Continued From page 182 hours. Lantus can have an effect on lowering blood sugars for 24 hours. A review of Lexicomp Online indicated that Humulin R had a duration of 4 to 12 hours and a onset of 30 minutes. Humulin R can have an effect on lowering blood sugars for 4 to 12 hours and can begin lowering blood sugar within 30 minutes. [redacted]	W 363	W 363 (cont.) 1.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
			1.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			1.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			1.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			1.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			1.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 363	Continued From page 183 [redacted] The psychiatric technicians (psych techs) continued to administer Lantus and Humulin R when Client 26 was hypoglycemic. Humulin R is short acting insulin and may promptly lower blood sugars. Humulin R was administered 6 times when Client 26 was hypoglycemic (43 mg/dl, 45 mg/dl, 47 mg/dl, 60 mg/dl, 62 mg/dl, 66 mg/dl).	W 363	W 363 (cont.) 1.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 1.20. Program Director is responsible.	11-25-13

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W 363	Continued From page 184 During an interview on 10/15/13 at 11:30 AM, the Psych Tech stated she had administered Client 26's insulin. She also stated she thought the physician orders were to give the insulin when blood sugars were less than 70 mg/dl and then call the clinician. [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 26. 2. A review of the clinical record on 10/15/13 at 10:00 AM indicated Client 42 [redacted]	W 363	W 363 (cont.) 2.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 2.2. A medication error report was initiated for Clients 42. 2.3. Physician reviewed the medication error reports for Client 42, and determined that the client was not adversely affected. 2.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 2.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 2.6. Physicians were notified of blood sugar level prior to administration of insulin. 2.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 2.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 2.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 2.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 2.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 2.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 2.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 363	Continued From page 185 [redacted]	W 363	W 363 (cont.) 2.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
			2.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			2.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			2.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			2.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			2.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 363	Continued From page 186 [redacted] The psych techs continued to administer Lantus daily when Client 42 was hypoglycemic. Client 42 had 21 hypoglycemic events from 08/21/13 to 10/14/13 without a Lantus dosage change. During an interview on 10/15/13 at 10:59 AM, a second Psych Tech stated she had administered Client 42's insulin. She also stated that you always give the Lantus insulin. She said that the Lantus should always be administered even with low blood sugars. [redacted] [redacted] there was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:15 PM, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 42. [redacted]	W 363	W 363 (cont.) 2.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 2.20. Program Director is responsible.	11-25-13

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W 363	Continued From page 187 [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. According to Lexicomp Online Lispro has a duration of about 5 hours. Lispro can have an effect on lower blood sugar for about 5 hours. A review of the [redacted] rom [redacted] to [redacted] ndicated Client 43 [redacted]	W 363	W 363 (cont.) 3.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
			3.2. A medication error report was initiated for Clients 43.	10-15-13
			3.3. Physician reviewed the medication error reports for Client 43, and determined that the client was not adversely affected.	10-15-13
			3.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
			3.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			3.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			3.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
			3.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			3.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
			3.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			3.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
			3.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
			3.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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W 363	Continued From page 188	W 363	W 363 (cont.) 3.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration.	
	[redacted]		3.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR.	10-17-13
			3.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration.	10-17-13
			3.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin.	11-25-13
			3.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13
			3.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	11-25-13

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W 363	Continued From page 189 [redacted] The psych techs continued to administer the Lantus and Lispro when Client 43 was hypoglycemic. Client 43 had 36 hypoglycemic events from [redacted] with blood sugars as low as 20 mg/dl and several blood sugars in the 30s (30 mg/dl, 32 mg/dl, 32 mg/dl, 33 mg/dl, 34 mg/dl, 37 mg/dl) . On average Client 43 was hypoglycemic once every 1.6 days (57 days divided by 36	W 363	W 363 (cont.) 3.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 3.20. Program Director is responsible.	11-25-13

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W 363	Continued From page 190 hypoglycemic events). [redacted] There was no documented evidence in the clinical record of every shift monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 pm Health Services Nurse 1 stated there was no documentation of monitoring every shift for hypoglycemia for Client 43. A review of the facility policy entitled Drug Control/Medication Errors Facility Bulletin No. 46 dated December 2012 indicated "This bulletin outlines policies and procedures to assure clients receive the correct medication in the correct manner ...Monthly drug regimen reviews of all client records ...will be performed for the purpose of determining if irregularities exist in the writing, interpretation, implementation and documentation of physician's orders ...In the event that a staff pharmacist is unable to do a Drug Regimen Review[DRR], the Pharmacy Services Manager shall secure the services of a Registered Nurse to complete the review. Minimally once each quarter, the Drug Regimen Reviews must be completed by a pharmacist." During an interview on 10/16/13 at 1:00 PM, the Pharmacist stated that there were no DRR irregularities for Client 26, Client 42, and Client 43. There were no irregularities documented for clients being administered insulin while they were hypoglycemic. He acknowledged that the pharmacist should have addressed issues with	W 363		

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W 363	Continued From page 191 hypoglycemic clients being administered insulin. The hospital did not provide evidence of DRR irregularities of hypoglycemic clients (Client 26, Client 42, and Client 43) being administered insulin.	W 363	W 368 1.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to ensure safe administration of insulin when psychiatric technicians administered insulin to clients (review of 3 of 6 clinical records) that were hypoglycemic (low blood sugar). Insulin is a medication used to lower blood sugar levels to treat diabetes. When too much insulin is administered and blood sugar levels drop below 70 mg/dl a patient becomes hypoglycemic. Hypoglycemia may result in convulsions, unconsciousness, temporary or permanent brain damage, or even death. An Immediate Jeopardy was called on 10/15/13 at 5:30 PM. On 10/17/13 at 6:05 PM, after review of evidence of implementation of the corrective action plan, the survey team abated the Immediate Jeopardy. These violations caused or were likely to cause serious injury or death to patients. Findings: According to the National Coordinating Council	W 368	1.2. A medication error report was initiated for Clients 26. 1.3. Physician reviewed the medication error reports for Client 26, and determined that the client was not adversely affected. 1.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 1.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 1.6. Physicians were notified of blood sugar level prior to administration of insulin. 1.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 1.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 1.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 1.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 1.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 1.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 1.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 368	Continued From page 192 for Medication Error Reporting and Prevention, a nationally recognized organization committed to medication safety, website http://www.nccmerp.org/aboutMedErrors.html, indicates "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer..." According to Lexicomp Online, a nationally recognized drug information resource, indicates for insulin "Hypoglycemia: The most common adverse effect of insulin is hypoglycemia...Profound and prolonged episodes of hypoglycemia may result in convulsions, unconsciousness, temporary or permanent brain damage, or even death". According to the National Institute of Diabetes and Digestive and Kidney Disease, a nationally recognized diabetes education resource, website www.diabetes.niddk.nih.gov/dm/pubs/hypoglycemia, indicates, "Hypoglycemia, also called low blood glucose or low blood sugar, occurs when blood glucose drops below normal levels ...Hypoglycemia can happen suddenly ...hypoglycemia can get worse and cause confusion, clumsiness, or fainting. Severe hypoglycemia can lead to seizures, coma, and even death ...For people with diabetes, a blood glucose level below 70 mg/dL is considered hypoglycemia." [redacted]	W 368	W 368 (cont.) 1.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 1.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 1.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 1.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 1.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 1.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 368	Continued From page 193 [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. A review of Lexicomp Online indicated that Humulin R had a duration of 4 to 12 hours and a onset of 30 minutes. Humulin R can have an effect on lowering blood sugars for 4 to 12 hours and can begin lowering blood sugar within 30 minutes. A review of the diabetic record from [redacted] indicated Client 26 [redacted]	W 368	W 368 (cont.) 1.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 1.20. Program Director is responsible.	11-25-13

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W 368	Continued From page 194 [redacted]	W 368	W 368 (cont.) 2.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus.	10-15-13
			2.2. A medication error report was initiated for Clients 42.	10-15-13
			2.3. Physician reviewed the medication error reports for Client 42, and determined that the client was not adversely affected.	10-15-13
			2.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin.	10-15-13
			2.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate.	10-16-13
			2.6. Physicians were notified of blood sugar level prior to administration of insulin.	10-15-13
			2.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information.	10-15-13
			2.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593.	10-15-13
			2.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed.	10-16-13
			2.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director.	10-16-13
			2.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician.	10-16-13
			2.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration.	10-17-13
			2.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-17-13

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W 368	Continued From page 195 [redacted] The psychiatric technicians (psych techs) continued to administer Lantus and Humulin R when Client 26 was hypoglycemic. Humulin R is short acting insulin and may promptly lower blood sugars. Humulin R was administered 6 times when Client 26 was hypoglycemic (43 mg/dl, 45 mg/dl, 47 mg/dl, 60 mg/dl, 62 mg/dl, 66 mg/dl). During an interview on 10/15/13 at 11:30 AM, the Psych Tech stated she had administered Client 26's insulin. She also stated she thought the physician orders were to give the insulin when blood sugars were less than 70 mg/dl and then call the clinician. [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of daily monitoring for hypoglycemia for Client 26. [redacted]	W 368	W 368 (cont.) 2.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 2.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 2.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 2.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 2.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 2.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 368	Continued From page 196	W 368	W 368 (cont.) 2.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 2.20. Program Director is responsible.	11-25-13

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W 368	Continued From page 197 [redacted] The psych techs continued to administer Lantus daily when Client 42 was hypoglycemic. Client 42 had 21 hypoglycemic events from [redacted] 10/14/13, without a Lantus dosage change. During an interview on 10/15/13 at 10:59 AM, a second Psych Tech stated she had administered Client 42's insulin. She also stated that you always give the Lantus insulin. She said that the Lantus should always be administered even with low blood sugars. [redacted] There was no documented evidence in the clinical record of daily monitoring for hypoglycemia. During an interview on 10/17/13 at 1:15 PM, the Health Services Nurse stated there was no documentation of daily	W 368	W 368 (cont.) 3.1. The identified staff who made the medication error was removed from clinic duties pending training on Diabetes Mellitus. 3.2. A medication error report was initiated for Clients 43. 3.3. Physician reviewed the medication error reports for Client 43, and determined that the client was not adversely affected. 3.4. Physicians reviewed Physician Insulin Orders for accuracy and ease of comprehensive for all clients who were administered insulin. 3.5. The curriculum for competency training for licensed staff on diabetes mellitus was reviewed by the Medical Director and the Quality Assurance Director. It remained appropriate. 3.6. Physicians were notified of blood sugar level prior to administration of insulin. 3.7. Staff documented in the Interdisciplinary Notes contact with physician and response to information. 3.8. Blood sugar levels outside of normal range were documented in the Diabetic Record, PVL 593. 3.9. RN/HSS reviewed Health Care Objectives and plans for all ICF-GTA clients receiving insulin, and updated as needed. 3.10. Revisions were made to Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" following review by the Medical Director, Pharmacist, CNS, ACNS, Executive Director, Clinical Director, Training Officer II, and Quality Assurance Director. 3.11. PVL 593 "Diabetic Record" was revised to include column for notification of physician. 3.12. The identified staff who made the medication error received Competency Training on Diabetes Mellitus from Staff Development instructors prior to resuming medication administration. 3.13. Licensed staff received training from the Unit Supervisor or designee on the revised Nursing Procedure 68 "Care of the Client with	10-15-13 10-15-13 10-15-13 10-15-13 10-16-13 10-15-13 10-15-13 10-15-13 10-16-13 10-16-13 10-16-13 10-17-13 10-17-13

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W 368	Continued From page 198 monitoring for hypoglycemia for Client 42. [redacted] A review of the Lantus manufacturer package insert indicated that Lantus had a duration of 24 hours. Lantus can have an effect on lowering blood sugars for 24 hours. According to Lexicomp Online Lispro has a duration of about 5 hours. Lispro can have an effect on lower blood sugar for about 5 hours. [redacted]	W 368	W 368 (cont.) 3.13 (cont.) Diabetes Mellitus", revised PVL 593 "Diabetic Record", and Health Care Objectives and Plans for clients receiving insulin prior to resuming medication administration. 3.14. Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" was further revised to include clarity of the Interdisciplinary Notes when physician was contacted, the accuracy check of transcribed Physician's order (PO) to the Medication Administration Record (MAR), clarity of PO, legibility of writing on MAR, monitoring of transcription of PO to MAR. 3.15. The licensed staff received training on the further revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" from the Unit Supervisor or designee prior to resuming medication administration. 3.16. Pharmacists and RN/HSS responsible for completing Drug Regimen Reviews were trained by the Pharmacy Services Manager and CNS on the revised Nursing Procedure 68 "Care of the Client with Diabetes Mellitus" and DRR documentation to address hypoglycemic reactions to clients on insulin. 3.17. Residence NOC shift clinic staff will audit PVL 593 "Diabetic Record" and Medication Administration Records to ensure daily monitoring of hypoglycemia was documented. Immediate action will be taken via notification of the Unit Supervisor or designee, physician, and RN/HSS. Staff will be removed from medication administration duties until after the successful completion of Competency Training. 3.18. RN/HSS and/or pharmacists will audit the Medication Administration Records and PVL 593 "Diabetic Records" monthly to monitor client insulin administration and hypoglycemia. Immediate actions will be taken to correct any deficiencies noted. Staff will be removed from medication administration duties until after the successful completion of Competency Training.	10-17-13 10-17-13 11-25-13 11-25-13 11-25-13

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W 368	Continued From page 199 [redacted]	W 368	W 368 (cont.) 3.19. Any elevated issues will be reviewed monthly at the Clinical Quality Management Council meeting and Medical/Nursing Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via Quality Management Council meeting with further corrective action taken as necessary. 3.20. Program Director is responsible.	11-25-13

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W 368	Continued From page 200 [redacted]	W 368		

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W 368	Continued From page 201 66 mg/dl The psych techs continued to administer the Lantus and Lispro when Client 43 was hypoglycemic. Client 43 had 36 hypoglycemic events from [redacted] with blood sugars as low as 20 mg/dl and several blood sugars in the 30s (30 mg/dl, 32 mg/dl, 32 mg/dl, 33 mg/dl, 34 mg/dl, 37 mg/dl) . On average Client 43 was hypoglycemic once every 1.6 days (57 days divided by 36 hypoglycemic events). [redacted] There was no documented evidence in the clinical record of every shift monitoring for hypoglycemia. During an interview on 10/17/13 at 1:30 PM, the Health Services Nurse stated there was no documentation of monitoring every shift for hypoglycemia for Client 43. During an interview on 10/15/13 at 1:30 PM, the Medical Director stated that hypoglycemia was a significant concern for clients receiving insulin. He also stated that if blood sugars drop too low it would be an emergent situation which could lead to death. He said that for blood sugars that were around 70 mg/dl to 80 mg/dl and below he would expect the psych techs to hold the insulin and call the clinician. Client 26, Client 42, and Client 43 received insulin when they were hypoglycemic which would	W 368		

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W 368	Continued From page 202 further lower blood sugar and expose them to the risk of severe hypoglycemia that could lead to organ damage or death.	W 368		
W 378	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of temperature. This STANDARD is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the safe storage of refrigerated medications when temperature excursions, temperatures not within 36 degrees Fahrenheit to 46 degrees Fahrenheit, were not acted upon. Findings: A review of the facility policy entitled Drug Control/Medication Errors dated 12/12 indicated " Drugs are stored at proper temperature ...Refrigerator temperature is maintained thermostatically between 36 degrees Fahrenheit and 46 degrees Fahrenheit. " An observation 10/16/13 at 10:50 AM of the Pharmacy medication refrigerator revealed that the thermometer indicated temperatures as low as 35 degrees Fahrenheit (F). The refrigerator had several vaccines stored inside which included Tetanus, Hepatitis A, Hepatitis B, Rabies, and Pneumococcal. Vaccines that are not appropriately stored (below 36 F and above of 46 F) may reduce in potency.	W 378	W 378 1. Pharmaceutical Consultant II from CDPH confirmed that the identified vaccines stored in the pharmacy refrigerator were not adversely affected by the deviation from the temperature range noted on the log, and the vaccines did not need to be discarded. 2. The pharmacy temperature log was modified with instructions on what to do if the temperature is out of range. 3. Pharmacy staff were trained by the Pharmacy Services Manager or designee on the use of the revised log. 4. A purchase order was submitted for new pharmaceutical grade refrigerators and freezer with product temperature sampling, continuous temperature monitoring, web-based access to temperature data, tamper-proof data integrity, and high/low temperature alarm system. 5. Pharmacists will monitor the temperature log via rounds at least monthly. Any concerns will be elevated to the Pharmacy Services Manager for further actions. 6. Issues requiring further actions will be reviewed monthly at the Administrative Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 7. Pharmacy Services Manager is responsible.	10-16-13 11-20-13 11-20-13 11-25-13 11-25-13 11-25-13

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W 378	Continued From page 203 A review of the Porterville Developmental Center temperature log indicated " If the refrigerator temperature is below the 36 to 46 F range ...adjust the thermostat and retake the temperature in one hour ...If the second refrigerator ...reading is outside ...the ...range, call Plant Operations and fill out a work order for repair. Until repaired, all heat labile medications MUST be stored in an alternate refrigerator and/or freezer." The log indicated the following temperature excursions without any documented action taken for the excursion: 33F-August 27, 2013 35F-October 14, 2013 35F-October 15, 2013 During an interview on 10/16/13 at 11:15 AM, the Pharmacy Manager stated it did not appear that there was any follow up on the above documented temperature excursions. He also stated that he would follow up to ensure that action is taken and documented when refrigerator temperature excursions occur. The facility did not provide evidence that the refrigerator temperatures excursions were acted upon.	W 378	W406 (See also W407, W436, and W454) Porterville Developmental Center is committed to the health and well-being of the clients served and in the implementation of systems to ensure that the Condition of Participation for Physical Environment is met. Specific plans of correction related to the corrective actions below are addressed under the appropriate tags.	
{W 406}	483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. This CONDITION is not met as evidenced by: Based on observation, document review and interviews, the Condition of Participation for Physical Environment was not met.	{W 406}	W406 #1 (See also W407, W436, and W454) - All food in the kitchens on units 5, 6, 21, 23, 25, 26, and 36 that originated from the Main Kitchen were discarded. Emergency food plan was immediately activated. - The use of the Main Kitchen was suspended, and a satellite kitchen was set up to be used for food preparation until the grout issues were resolved. - Facility Vector Control immediately sprayed kitchen areas on units 5, 6, 21, 23, 25, 26, 36, Main Kitchen, and the satellite kitchens. - All floor surfaces, utensils, dishes, kitchen surfaces in kitchens on units 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen were cleaned. - Facility Vector Control laid traps in the kitchen areas on units 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen. - Outside consultant from Department of Public Health, Environmental Science division (DPH-EVS) was contacted. - Outside consultant from DPH-EVS advised the facility and provided a written summary of the actions discussed. - Emergency contracts with outside Vector Control company was established for treatment services. - Acting Director of Dietetics developed new Dietetics Procedure L-19 "Production - Cleaning Procedure" on the sanitation process to be used prior to and after food preparation. Dietetics	10-14-13 10-14-13 10-14-13 10-15-13 10-15-13 10-15-13 10-17-13 10-22-13 10-23-13

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{W 406}	Continued From page 204 Findings: The Central Kitchen and the residence kitchens were not maintained in a sanitary manner and there was an ineffective pest control program in place. An Immediate Jeopardy was called on 10/14/13 and abated on 10/23/13. These failures resulted in a potential infection control problem due to the contamination of food served to clients and infestation throughout the whole facility if the pests were not adequately controlled. The facility did not provide oversight for the kitchen in the Blue Heron. There were no systems in place to ensure that the potentially hazardous food (chicken salad) was cooled properly and was not held at unsafe temperatures. An Immediate Jeopardy was called on 10/18/13 and was abated on 10/18/13. These failures had the potential to affect clients and all individuals who ate at the Blue Heron with serious food-borne illness which could result in serious nausea, vomiting, dehydration and even death. The facility did not implement Step 12 in the plan of correction for the annual recertification survey in July, 2013, for W 406, when there was no evidence provided that all the clients in Program 5 were assessed for appropriate placement based on their ages, developmental and social levels. The facility did not implement the plan of correction for the annual recertification survey in July, 2013, for the required adaptive equipment needed by Client 21.	{W 406}	W406 #1 (See also W407, W436, and W454) (cont.) Procedures E-10 "Presentation - Cleaning Procedure" and D-10 "Production - Food Storage/Receiving Procedure" were revised. - Dietetics staff were trained by the Acting Director of Dietetics or designee on the new and revised procedures. - Supervising Housekeeping Supervisor III developed procedure for "Housekeeping Vector Control". - Janitorial staff were trained by the Supervising Housekeeping Supervisor III or designee on the new procedure "Housekeeping Vector Control". - Facility Bulletin 144 "Pest and Animal Control" was revised. - Dietetics staff, janitorial staff, and Program 5 staff were trained by their supervisors or designees on the revised Facility Bulletin 144 "Pest and Animal Control". - Dietetics Supervisors, Housekeeping Supervisors and Unit Supervisors will monitor unit environment and staff compliance via daily rounds. Program Management and Quality Assurance will monitor via monthly rounds. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. W406 #2 (See also W407, W436, and W454) (cont.) - Acting Director of Dietetics provided on-site training to the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling and set up/service of cold food items. - Acting Director of Dietetics reviewed the system for tracking food temperatures and food	10-23-13 10-23-13 10-23-13 10-23-13 11-25-13 11-25-13 11-25-13 10-18-13 10-18-13

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			W406 #2 (See also W407, W436, and W454) (cont.) temperature log, and provided training to the Blue Heron staff. Acting Director of Dietetics also conducted an environmental check of the Blue Heron, and identified areas that needed to be corrected	
			- Director of Central Program Services who oversee the Blue Heron set expectation for the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling, set up/service of cold food items, and food temperature log.	10-18-13
			- Program 5 LOC staff were trained by their Unit Supervisors or designees on Infection Control Guideline 3.14 "Food-borne Illnesses".	10-20-13
			- Food Services Supervisors will monitor Blue Heron food preparation and service of cold foods no less than twice per week.	10-20-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W406 #3 (See also W407, W436, and W454)	
			- A review of assessment information for clients residing in Program 5 was conducted to ensure appropriate placement based on developmental and functioning levels, and social/medical needs.	11-24-13
			- An IPP review and/or Emerging Risk Notification/Evaluation meeting was held to address each Program 5 client's placement. Any clients identified as requiring further assessment for possible alternate placement was referred to the Interdisciplinary Team.	11-24-13
			- Program Director will monitor and review the assessment process and Interdisciplinary Team recommendations for appropriateness of placement.	11-24-13
			- Program Management will conduct monthly	11-24-13

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			W406 #3 (See also W407, W436, and W454) (cont.) review of the unit population/client grouping via the Overview System Comprehensive Assessment of Risk (OSCAR) meetings. - Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13
			W406 #4 (See also W407, W436, and W454) - Unit LOC staff were trained by the Unit Supervisor or designee on Client 21's Approaches & Strategies regarding adaptive equipment.	11-25-13
			- Program 5 IPC's were trained by the Program Assistant or designee on monitoring client use of adaptive equipment.	11-25-13
			- IPC's will monitor client use of adaptive equipment via rounds at least monthly.	11-25-13
			- Senior PT/Nursing Person In Charge will ensure daily adaptive equipment check had been completed.	11-25-13
			- Unit Supervisor and/or Senior PT will monitor client adaptive equipment use at meals at least monthly.	11-25-13
			- Any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	11-25-13

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{W 406}	Continued From page 205 These failures resulted in the Condition of Participation for Environmental Services to be determined to be not met.	{W 406}		
	See W 407, W 436, and W 454			
{W 407}	483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to provide documented evidence that all clients in Program 5 were assessed for appropriate placement. Findings: A review of the Plan of Correction that was received in the CDPH office on 9/6/13 indicated that Step 12 of the correction plan for W 102, W 122, W 127, and W 407, stated that " All clients in Program 5 were assessed by the ID Teams for appropriate housing based on ages, developmental levels and social needs. Teams reviewed client assessments to ensure the assessments are current, valid and accurate. " A spread sheet was presented as evidence that all the clients had been assessed. The spread sheet listed each client's name, date of assessment, unit, age, the different assessments used to verify the assessment of correct placement, whether clients had a history of sexual behaviors or of being victimized and	{W 407}	W 407 1. A review of assessment information for clients residing in Program 5 was conducted to ensure appropriate placement based on developmental and functioning levles, and social and medical needs. 2. An IPP review and/or Emerging Risk Notification/Evaluation meeting was held to address each Program 5 client's placement. 3. Any client identified as requiring further assessment for possible alternate placement was referred to the Interdisciplinary Team. If alternate placement was identified, an IPP review was held upon receipt of the assessment to discuss finding and address any recommendations. 4. Program Director will monitor and review the assessment process and Interdisciplinary Team recommendations for appropriateness of placement. 5. Program Management will conduct monthly review of the unit population/client grouping via the Overview System Comprehensive Assessment of Risk (OSCAR) meetings. 6. Program OSCAR meeting reports will be reviewed monthly at the Clinical Quality Management Council meetings. Any elevated issues will be reviewed by the Governing Body via Quality Management Council meeting with further corrective action taken as necessary. 7. Clinical Director is responsible.	11-24-13 11-24-13 11-24-13 11-24-13 11-24-13 11-24-13

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{W 407}	Continued From page 206 columns for the unit supervisor and program director to fill in dates when all the assessments were complete and had been reviewed. All of the dates for unit supervisors and program director were blank except for the spread sheet for Residence 21, which had unit supervisor review dates of 6/23/13. There were several dates of different assessments used for evaluating clients that were more than two years old on each spread sheet except for that of Residence 26. In an interview with Program Management staff on 10/23/13 at 11:00 AM, she stated that the spread sheet was the only evidence the facility had for verification that all assessments had been completed by the correction plan date of 6/28/13. Program Staff stated that all the unit supervisors had reviewed the spreadsheets and that all the assessments were current, accurate and valid. She stated that the spreadsheet was used to determine who would be moved to which residence. When questioned why the dates of some assessments were more than two years old, Program Staff could not explain why that was except to say she thought those dates had just not been updated. She stated that she was sure that more current assessments had been used to evaluate clients for appropriate placement. Program Staff could not explain why there was no documentation of review dates by the unit supervisor or herself noted on the spread sheets. When asked what evidence Program Staff could provide to verify that all clients, not just those who had been moved to different residences, had been assessed, she stated that the spreadsheet was the evidence. When asked how the spread sheet provided evidence of assessment, she could not explain that idea.	{W 407}		

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{W 407}	Continued From page 207 In an interview with Facility Management on 10/23/13 at 12:00 PM, she stated that the facility had evidence that the 20 clients who had moved to different residences had all been assessed; however, she had checked with unit supervisors and different members of the Interdisciplinary Teams and they had not kept any evidence of assessments being done on clients who were not moved off of the residences. On 10/24/13 at approximately 8:00 AM, facility management provided e-mails from Interdisciplinary team members sharing information concerning client assessments for seven named clients. There were also several e-mails that showed general information of assessments were being done on the residences but did not list specific clients being assessed. Reports also were provided that showed general client groupings according to residence but still did not document individual client assessments.	{W 407}	[redacted]	11-25-13 11-25-13
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on document review and observation, the facility failed to implement the plan of correction for the previous recertification survey of July, 2013 when 1 sampled client, (Client 21) was not provided the required adaptive equipment.	{W 436}	3. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client use of adaptive equipment. 4. IPC's will monitor client use of adaptive equipment via rounds at least monthly for client observation. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 5. Senior PT/NPIC will ensure daily adaptive equipment check had been completed. 6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor client adaptive equipment use at least monthly, and document any findings. 7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 8. Program Director is responsible.	11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 436}	Continued From page 208 Findings: A meal observation for Client 21 on 10/21/13 at 6 PM and on 10/22/13 at 12:00 PM was conducted. During these observations, Client 21 was not provided with ~~non-skid plate mat~~.	{W 436}	W 454 1.1. All food in the ICF-GTA residence kitchens that originated from the Main Kitchen were discarded.	10-14-13
			1.2. Emergency food supplies with associated menu changes were implemented immediately.	10-14-13
			1.3. All 2000-hour client snacks for 10/14/13 not packaged in cans were substituted with alternative food items not from the Main Kitchen.	10-14-13
{W 454}	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, client and staff interviews and facility documents, the facility failed to: a. Follow manufacturer's instructions on the use of the chemical pesticide, failed to provide guidance on the effective management of the cockroaches by failing to ensure that the cracks in the floors and walls were sealed to prevent the harboring of the cockroaches. The different departments failed to bring attention to the problem by failing to inform the infection control committee. In addition the facility failed to follow its guidelines by failing to contract with an outside vendor when the pest services were necessary. Immediate jeopardy was declared on 10/14/13 at 5:40 pm. A corrective action plan was provided by the facility administrator on 10/14/13 at 8:42 PM. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate Jeopardy on 10/23/13 at 4:00 PM.	{W 454}	1.4. All canned supplements designated for client snack orders were sanitized with alcohol wipes prior to being distributed to clients.	10-14-13
			1.5. The use of the Main Kitchen was suspended until the grout issue in the Main Kitchen had been corrected and the pest infestation had been eradicated. A satellite kitchen was designated for use on residence 22 to be used for food preparation until the Main Kitchen returned to use.	10-14-13
			1.6. Facility Vector Control immediately sprayed kitchen areas on residences 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen on residence 22.	10-14-13
			1.7. Janitorial staff completed extensive deep cleaning of all floor surfaces in all kitchen areas on residences 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen on residence 22.	10-15-13
			1.8. All utensils, dishes and surfaces on all kitchens on residences 5, 6, 21, 23, 25, 26, 36, the Main Kitchen, and the satellite kitchen on residence 22 were cleaned prior to use.	10-15-13
			1.9. The two identified drains in the Main Kitchen were covered with wire netting.	10-15-13
			1.10. Any paper goods not stored in sealed containers were discarded.	10-15-13
			1.11. Identified water leaks on residences 21 and 23 were repaired.	10-15-13
			1.12. Facility Vector Control laid traps in the Main Kitchen, the satellite kitchen on residence 22, and the kitchen area on residences 5, 6, 21, 23, 25, 26, and 36. Each trap was marked with date and location.	10-15-13

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{W 454}	Continued From page 209 b. Ensure that there was an effective system to ensure that food was stored at the appropriate temperatures to prevent the growth of microorganisms that could result in food borne illness. The Blue Heron, a contract food vendor, did not cool down cooked chicken used in the preparation of a chicken salad according to recognized food safety standards. Cooked potentially hazardous foods that are subject to time and temperature control for safety are best cooled rapidly within 2 hours from 135 to 70 degrees Fahrenheit(F) and within 4 hours to approximately 41 degrees F. The total cooling time from 135 degrees to 41 degrees F should not exceed 6 hours. The facility failed to provide any oversight on the operation of sanitary and safe food service operation. Immediate Jeopardy was declared on 10/18/13 at 11:20 AM. A corrective action plan was provided by the facility administrator on 10/18/13 at 1:15 PM.. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate jeopardy on 10/18/13 at 1:15 PM. c. Ensure that reheated eggs was at a temperature to limit the growth of microorganisms. Section 3-403.11 of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds"; Findings:	{W 454}	W 454 (cont.) 1.13. Outside consultant from the Department of Public Health, Environmental Science division (DPH-EVS) was contacted 1.14. All prepared food in the Main Kitchen and all dry goods in the plastic bins in the Main Kitchen were discarded. 1.15. Outside consultant from DPH-EVS advised the facility during the tour of the Main Kitchen, satellite kitchen on residence 22, and one residence kitchen. 1.16. A written report providing a summary of discussed actions was received from the outside consultant from DPH-EVS. 1.17. Two outside Vector Control companies (Orkin Pest Control and Eco Lab Pest Services) were toured through the Main Kitchen and residence kitchens, and requested to provide contract bid for treatment services. 1.18. Bids were received from outside Vector Control companies for treatment services. 1.19. Emergency contract was completed for Orkin Pest Control to provide emergency clean-out services for the Main Kitchen and the kitchens on residences 5, 6, 21, 22, 23, 25, 26, and 36. Orkin Pest Control started services for the Main Kitchen and then progressed to the residence kitchens. 1.20. The Main Kitchen, the satellite kitchen on residence 22, and the kitchen on residences 5, 6, 21, 23, 25, 26, and 36 received daily pest treatments in accordance with manufacturer's recommended use until the contract with the outside Vector Control services took effect. 1.21. Acting Director of Dietetics developed new Dietetics Procedure L-19 on the sanitation process to be used prior to and after food preparation. Dietetics Procedures E-10 and D-10 were revised. Staff on duty were trained on the new and revised procedures by the Acting Director of Dietetics or designee.	10-15-13 10-16-13 10-17-13 10-17-13 10-17-13 10-21-13 10-22-13 10-23-13 10-23-13

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{W 454}	Continued From page 210 1. During the tour of the facility central kitchen on 10/14/13 at approximately 3:50 PM, a food mixer with bowl attached was found to contain several black specks resembling coffee grounds. In addition, there was a dead brown colored insect in the bowl. A few minutes later, three small (baby) roaches were found crawling on the counter next to the mixer. Closer observation revealed a dead roach next to the cutting boards stored on the counter. Underneath the counter were approximately nine dead roaches. At least one of the roaches had an egg case attached to its abdomen. Continued tour of the kitchen revealed a pool of water on the floor next to the ice machine. There was a piece of blue plastic with foam that appeared to be the battery cover of unidentified electrical equipment on the window sill in the kitchen. The cover had light brown markings that resembled dried roach urine. On the foam were dark brown specks that resembled coffee grounds. A tour of the dish room revealed two more dead roaches. There was also water on the floor in the dish room. There were several broken floor tiles and grout lines throughout the kitchen. At approximately 4:15 PM in an area designated as the butcher shop, a dead roach was found in a corner of the walk-in refrigerator. This refrigerator is used to store food items prepared ahead for use the following day. There were rodent droppings inside a closet used to store brooms and staff jackets and sweaters. The amount of droppings covered approximately one quarter of this bottom of the closet. There	{W 454}	W 454 (cont.) 1.22. Supervising Housekeeper III developed procedure for "Housekeeping Vector Control". Staff on duty were trained on the new procedure by the Supervising Housekeeper III or designee. 1.23. Facility Bulletin 144 "Pest and Animal Control" was revised. 1.24. Dietetics staff and janitorial staff were trained by their supervisors or designees on the revised Facility Bulletin 144 "Pest and Animal Control". 1.25. Program 5 LOC staff and CPS LOC staff were trained by their Unit Supervisors or designees on the revised Facility Bulletin 144 "Pest and Animal Control". 1.26. Janitorial staff will inspect daily for signs of pests, and report positive findings to Facility Vector Control via work order. 1.27. Dietetics staff will inspect daily for signs of pests, and report positive findings to Facility Vector Control via work order. 1.28. Facility Vector Control will inspect traps, document findings in the Vector Trap log, and replace with new traps as needed. 1.29. Dietetics Supervisors will monitor production and presentation processes to ensure sanitation procedure had been followed. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by the Dietetics Supervisors on procedures applicable to the deficiencies found during rounds. 1.30. Housekeeping Supervisors will monitor janitorial staff compliance via rounds. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by the Housekeeping Supervisors on the applicable procedure. 1.31. Unit Supervisor, Program Management, and Quality Assurance will monitor unit environment and signs of pest via rounds	10-23-13 10-23-13 12-13-13 12-13-13 10-23-13 10-23-13 10-23-13 10-23-13 10-23-13

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{W 454}	Continued From page 211 was a mouse bait trap. There were no mice caught in the bait trap, but there were other insects in the trap. All the identified roaches were the German cockroaches. The Supervising Cook (SC) and the Acting Director of Dietetics (ADD) were present during all the observations. The SC and ADD were informed that the kitchen had a roach infestation. They both stated the kitchen is sprayed to keep down the roaches and that the frequency of spraying had just been increased to once a month. They both explained that the dietetics department was responsible for cleaning food equipment and counters and that the Housekeeping department was responsible for the floors. It was unclear who was responsible for cleaning the nine roaches found underneath the cabinets. According to the University of California Agriculture and Natural Resources Pest Notes Publication 746, May 2007 on Cockroaches state "Live and dead cockroaches, cast skins, egg capsules and droppings ...are evidence of an infestation." Immediate Jeopardy was declared on 10/14/13 at 5:40 PM. A corrective action plan was provided by the facility administrator on 10/14/13 at 8:42 PM. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate Jeopardy on 10/23/13 at 4:00 PM. At approximately 6:00 PM, the survey team conducted a check of all the patient area kitchens. Three of the five residences (Residences 21, 23, 36) had either live or dead	{W 454}	W 454 (cont.) 1.31 (cont.) on the residences. Immediate actions will be taken to correct any deficiencies observed during rounds, and findings will be documented. 1.32. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 1.33. Administrative Services Director is responsible.	10-23-13

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{W 454}	Continued From page 212 roaches. Roaches had been identified at the previous survey in Residence 21. One residence (Residence 23) had both roaches and mice droppings. According to the booklet titled "Effective Management of Cockroach Infestations" by the County of Los Angeles Vector Management Program, "the German cockroach is the most common of the cockroach species". This species reproduces more rapidly than the other common pest cockroaches. German cockroaches are believed to be capable of transmitting disease causing organisms such as Staphylococcus spp., Streptococcus spp., hepatitis virus, and coliform bacteria. They also have been implicated in the spread of typhoid and dysentery. They prefer food preparation areas, kitchens, and bathrooms because they favor warm, humid areas that are close to food and water. An interview was conducted on 10/15/13 at approximately 10:00 AM with the Pest Control Technician (PCT). He stated that he used a certain chemical (ULD BP300) to spray the kitchen and that lately he needed to spray more frequently. He also stated he wanted to check if he could spray more frequently because of the continued problems with the roaches. He provided no explanation about the presence of mice droppings in the closet in the butcher room. He further acknowledged that no other approaches (such as use of baits) had been attempted other than chemical spraying. He indicated that he kept a record of these sprayings in a log. According to the University of California Agriculture and Natural Resources Pest Notes	{W 454}	W 454 (cont.) 2.1. Chicken salad was discarded from the Blue Heron. 2.2. Effective 6:30 pm, Blue Heron sold only pre-packaged, ready-to-eat food items and food items prepared on the grill. 2.3. All prepared food at the Blue Heron were discarded. [redacted] 2.5. No other clients were affected. 2.6. Acting Director of Dietetics provided on-site training to the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling and set up/service of cold food items. 2.7. Acting Director of Dietetics reviewed the system for tracking food temperatures and food temperature log, and provided training to the Blue Heron staff. 2.8. Acting Director of Dietetics conducted an environmental check of the Blue Heron, and identified areas that needed to be corrected. 2.9. The Blue Heron Manager/Vocational Instructor was verified to be currently certified as Food Safety Manager. 2.10. Acting Director of Dietetics and Food Services Supervisor II conducted follow-up check to ensure identified areas had been corrected. 2.11. Director of Central Program Services set expectations for Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling, set up/service of cold food items, and food temperature log. 2.12. The Blue Heron Manager/Vocational Instructor reviewed and updated the Food Storage Manual at the Blue Heron. 2.13. Blue Heron staff completely sanitized all surfaces, utensils, and dishes prior to re-opening	10-17-13 10-17-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13

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{W 454}	Continued From page 213 Publication 746 , May 2007, chemical control alone does not irradicate the problem of roach infestation. Review of the log titled "Pest Control Spray at Main Kitchen & Stores" showed that the PCT documented that he "fogged" (the spraying of insecticides into air to form a fog) the MK (central kitchen) on "9/27/13" and sprayed MK, Dietetics, Warehouse and Doc [sic] on "10/2/13" and "10/9/13". On the log titled "Pest Control Trap Locations at main Kitchen & Stores" the kitchen, warehouse, dock and dietetics were listed but only one mouse trap was observed when the initial tour was conducted on 10/14/13. At approximately 1:45 PM on 10/15/13, several men were observed in the kitchen sealing the floor grout lines. The mason was interviewed on whether he had been asked in the past by the PCT or the kitchen staff to seal grout lines and broken floor tiles. He stated that he had never been asked to fix any floor tiles or masonry in the kitchen. According to the Los Angeles County booklet the integrated approach is the most effective means of controlling a cockroach infestation and preventing its reoccurrence. Suggestions include reducing food and water sources, eliminating hiding places, consider using baits, avoid sprays if possible, and use traps to monitor population. The PCT had not advised the dietetic service staff or implemented one of the important strategies in eliminating the hiding spaces of the roaches, by sealing the cracks in the kitchen. On 10/15/13, there were approximately 10 dead roaches under the dish machine in Residence 26.	{W 454}	W 454 (cont.) 2.14. Monitoring of the Blue Heron food preparation and service of cold foods was completed. 2.15. Program 5 LOC staff were trained by the Unit Supervisor or designee on Infection Control Guideline 3.14 "Food-borne Illnesses". 2.16. Food Services Supervisor will monitor Blue Heron food preparation and service of cold foods no less than twice per week, and document the visit in the Visitor Log at the Blue Heron. Any issues identified will be elevated to the Director of Central Program Services. 2.17. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 2.18. Acting Director of Dietetics and Director of Central Program Services are responsible.	10-18-13 10-20-13 10-20-13 10-20-13

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{W 454}	Continued From page 214 Housekeeping had cleaned the area prior to the observation. Baits were placed in all the client area resident kitchens the evening of 10/15/13. A check of all these areas the morning of 10/16/13 revealed the presence of roaches (live or dead) in Residences 5 and 6. Water was observed leaking in two different parts of the dish machine. All three employees working in the dish room denied observing it. The SC stated that he also had not observed it and that no food service worker had brought it to his attention. The dried-on white residue, evidence of hard water stains, indicated that it was not a new problem. The water would provide moisture for the roaches. There were food particles floating in the water in the floor drain. This would be additional sources of food for the cockroaches. On 10/16/13 at approximately 1:30 PM, the consultant who had conducted a tour of the facility and the surveyor were provided the container of the chemical pesticide used by the PCT to spray the kitchen. The manufacturers' instructions attached to each container suggested the use of the chemical pesticide daily "if retreatment is necessary". The PCT had not read these instructions and was not aware of the recommended frequency. He had been using the product with other chemicals since May 2013. He had fogged in July and also in September. He may have also sprayed with it "10/2/13" and "10/9/13". Residence 6 had one roach on the glue bait at 7:30 PM. On 10/17/13 at approximately 9:00 AM, there was	{W 454}	W 454 (cont.) 3.1. Acting Director of Dietetics set the following expectations at the Dietetics Services October Monthly Mandatory Meeting with the Dietetics staff on duty: a. Thermometers need to be calibrated regularly - at least once a month and at any conflict. b. Dimple needs to be submerged in the center of food to allow for accurate temperature reading c. Need to put thermometer in at an angle to allow for accurate reading of thermometer d. If for any reason you think that your thermometer may not be reading accurately/ is broken, a supervisor should be contacted for a replacement. e. In an emergency situation where ready-to-eat food may have been delivered frozen, cooking times may deviate from the standard length of time f. Food to be reheated to 165 degrees F and held at 140 degrees F or above 3.2. No negative impact was observed to the clients on Unit 6. 3.3. Unit Supervisor or designee was in the process of arranging a Unit Government meeting to discuss food substitutions and preferences with the clients. The anticipated date of the meeting was 12/9/13. 3.4. Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the residence kitchens. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by Food Services Supervisor on the applicable procedures. 3.5. Any elevated issues will be reviewed at the Administrative Quality Management Council meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-25-13 10-25-13 11-25-13 11-25-13 11-25-13

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{W 454}	Continued From page 215 one live roach crawling against the wall and one dead roach against the same wall. The bait that had been placed near the heating unit underneath the dish machine in Residence 6 had three insects stuck on it. On 10/17/13 at approximately 9:10 AM, the food service worker (FSW) was asked what procedure was to be taken when a roach was identified in the kitchen and if she could state whether the residence kitchen had been sprayed earlier that week. She stated that she could not state whether the kitchen was sprayed. But the kitchen had been sprayed based on a schedule posted on the bulletin board. The posted schedule was dated September 2013. At approximately 9:30 AM, there was an adult roach running across the floor towards the hand washing sink in Residence 5, there was another roach crawling on the wall below the dishwashing machine area next to bait. The bait had one dead adult roach. There were two or three roaches squashed on the door frame jam in the janitorial closet. FSW was not sure if the residence kitchen had been sprayed. The posted schedule was September 2013. At approximately 12:30 PM on 10/17/13, the bait in Residence 36 had a baby roach. At approximately 1:00 PM a tour of the facility central kitchen was conducted by a third party pest control company. The technician identified two other types of cockroaches in the oven area. He found two American cockroaches and one Oriental roach and several German roaches on the glue bait behind the oven. He explained that the chemical pesticides needed to be applied as directed by the manufacturer because some of the cockroaches develop immunity and become	{W 454}	W454 (cont.) 3.6. Acting Director of Dietetics is responsible. 4.1. A Special IPP was held for Client 7 to review and update his Approaches & Strategies and Desired Outcomes & Milestones to include staff intervention for proper sink faucet use. 4.2. The training objectives for Program 5 clients were reviewed by the Interdisciplinary Teams. Clients identified as needing revisions to their training objectives were referred back to the Interdisciplinary Team for recommendations. 4.3. Unit 5 LOC staff were trained by the Unit Supervisor or designee on Client 7's updated Approaches & Strategies, Desired Outcomes & Milestones, Client 7's Independent Living Assessment, Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing Techniques", and Nursing Protocol 5 "Blood and Body Fluid Precautions (Standard Precautions)". 4.4. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client training needs. 4.5. IPC's will monitor client training assessments and objectives via rounds at least monthly. Any concerns will be elevated to the Unit Supervisor, and documented in the monthly IPC notes. 4.6. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor staff compliance during rounds at least monthly, and document any findings. 4.7. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 4.8. Program Director is responsible.	11-14-13 11-20-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 454}	Continued From page 216 ineffective. Review of various inter-departmental communications between dietetics staff and the pest control and housekeeping staff, and training attendance logs showed that the facility was aware of the problem with the roaches and mice. Review of the facility Infection Control Guideline titled "Housekeeping/Janitorial" dated June 2010 stated the "Environmental services department is responsible for maintaining a safe, clean and orderly interior of all residential units, program offices, class rooms, public buildings and special designated areas." The Infection Control Guideline, titled Plant Operations/ Vector control/Animal Control, dated April 2009, under the heading Plant Operations, places responsibility for inspecting all buildings and grounds for evidence of infestation of such vectors as ants, cockroaches, mice, rats, flies, bats and other vector problems on the Plant Operations. The guideline further states that Plant Operations will contract with an outside vendor to provide pest/vector services when necessary. With documented evidence of the roach problem going on for over two years and the in-house attempts at controlling not being effective, the facility failed to follow its own guidelines. There was no evidence that Plant Operations, Housekeeping, or Dietetics identified the problems of the roach infestation and the presence of mice or shared information with the infection control committee. Review of the Infection Control minutes from May 2013 through September 2013 did not show that any pest control issues had been brought forward for	{W 454}	W 454 5.1. The identified towels were removed from the folded pile and placed in dirty laundry. 5.2. Program 5 Management identified clients in the program who may have unaddressed issues or behaviors that impact infection control or cross contamination. A special IPP or Emerging Risk Notification/Evaluation meeting was held for any identified client to ensure the issues/behaviors have been addressed. 5.3. Unit 23 LOC staff were trained by the Unit Supervisor or designee on [redacted] his Approaches & Strategies. 5.4. Program 5 Group Leaders were trained by the Unit Supervisor or designee on the Independent Living Assessments to ensure they address client's hygiene abilities during the assessment process, and make recommendations as needed. 5.5. Program 5 IPC's were trained by the Program Assistant or designee on monitoring client activities that may compromise their health or the health of others due to inflection control concerns. 5.6. Program 5 LOC staff were trained by their Unit Supervisors or designees on Nursing Procedure 42 "Oral Hygiene", Nursing Procedure 53 "Handwashing", and Nursing Protocol 5 "Blood and Body Fluid Precautions". 5.7. Unit Supervisor and/or Senior PT, Program Management, and Quality Assurance will monitor for possible infection control issues during rounds at least monthly, and document any findings. 5.8. Rounds findings and any issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meeting, along with any corrective plans. Governing Body will monitor via monthly Quality Management Council meetings with further corrective actions taken as necessary. 5.9 Program Director is responsible.	10-15-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13 11-25-13

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{W 454}	Continued From page 217 discussion and/or resolution. The facility failed to develop an effective pest control program. The PCT failed to follow manufacturer's instructions on the use of the chemical pesticide, failed to provide guidance on the effective management of the cockroaches by failing to ensure that the cracks in the floors and walls were sealed to prevent the harboring of the cockroaches. The different departments failed to bring attention to the problem by failing to inform the infection control committee. In addition the facility failed to follow its guidelines by failing to contract with an outside vendor when the pest services were necessary. 2. At approximately 11:10 AM on 10/17/13, a tour of the Blue Heron, a contracted canteen, on the Porterville Developmental Center campus was conducted. A randomly-observed client was observed eating a chicken sandwich out in the dining area. A tour of the kitchen was conducted. There was a sandwich bar in the kitchen that opened to a service window in the dining area. There were items used to make sandwiches such as onions, tomatoes, mayonnaise, chicken salad, tuna salad, etc. A request was made to test the temperature of the potentially hazardous foods on the sandwich bar. Potentially hazardous foods are foods that require time and temperature control for food safety. These were the chicken salad and tuna salad. The chicken salad was 46.7 degrees Fahrenheit (F) and the tuna salad was 40.8 degrees F. The recommended holding temperature for cold food is 41 degrees F and	{W 454}		

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{W 454}	Continued From page 218 below. The Food Instructor (FI) who was responsible for managing the kitchen asked another employee to take some of the chicken salad out and returned the scooped out portion into another refrigerator. The original container was never removed from the sandwich bar. A few minutes later, the chicken salad was rechecked and the temperature was 43.3 degrees F. As the tour continued, another container was found in the reach-in refrigerator containing a larger amount of the chicken salad. The temperature of the chicken salad in the refrigerator was 48.7 degrees F. The FI was interviewed on the process and meal preparation method for the chicken salad. She indicated that the chicken salad was prepared from chicken breasts cooked in a crock pot from 10 AM to 4 PM the day before, 10/16/13. She stated that the chicken breasts were then placed in a metal container, pulled apart, and placed on ice until it reached 70 degrees F, which was approximately about 1-1/2 hours later. The metal container with the chicken was then placed in the refrigerator for further cooling. The FI stated the Blue Heron closed at 5:30 PM but there was another staff present until 7 PM. When interviewed, the FI stated this employee had no temperature cooling/monitoring responsibilities. FI stated in an interview on 10/17/13 at approximately 11:30 AM that they had cooling logs. A review of the temperature log that was presented indicated that the temperature of the chicken had not been recorded and the form presented was not an actual cooling log. There were only two items regularly monitored for	{W 454}		

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{W 454}	Continued From page 219 temperature from July 2013 till October 2013. These two items were chili and cheese. Section 3-401.14 (E) of the 2009 Food Code stated that "Raw animal foods that are cooked using a non-continuous cooking process shall be cooled according to the time and temperatures parameters specified for cooked potentially hazardous food" (Time/Temperature Control for Safety Food). The (Time/Temperature Control for Safety Food) is cooling within 2 hours from 135 degrees F to 70 degrees F and within a total of 6 hours from 135 degrees F to 41 degrees F. In addition, Section 3-401.14 (F) (2) of the 2009 Food Code required that raw foods be prepared and stored according to written procedures that are maintained in the food establishment and are available to the regulatory authority on request. The FI pointed to a column that showed how all the items that had been cooled were 70 degrees. When the FI was asked the significance of 70 degrees Fahrenheit, she stated that when food was cooled they monitor to make sure it reaches 70 degrees. When asked if any further steps were monitored she stated " No ". The FI and the food manager, stated they had food safety certifications but neither was able to state that the correct process of cooling to include the further cooling to 40 degrees Fahrenheit. The FI and canteen manager were not able to show previous cooling logs and knowledge on the proper cooling process. The Blue Heron had stopped monitoring the cooling of the Chicken after 5:30 PM. They were not able to state if the food had cooled down to the proper temperature. Temperatures were not taken before additional items such as the	{W 454}		

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{W 454}	Continued From page 220 mayonnaise, apple and nuts were added on 10/16/13. The appropriate time to check that the chicken had cooled down to 41 degrees Fahrenheit or below was prior to the addition of those other ingredients. Therefore, the possibility existed that the food may have been in the danger zone for over 16 hours. Review of the facility document titled Canteen Lease, dated June 4, 2013, between the facility and the food vendor, Blue Heron, was conducted. Included in the terms of the lease was the requirement that the Administrative Services Director of the facility had the right to regulate the operations of Blue Heron as they affect the "...safety and conduct of the facility." In addition, the lease had the Blue Heron "comply with all rules and regulations" adopted by the facility. At approximately 11:46 AM on 10/17/13, the Acting Director of Dietetics (ADD) was interviewed on the dietetics department's responsibility for oversight for food safety at the Blue Heron. She stated that there was no affiliation with the Blue Heron as it was managed by a separate entity. In an interview at approximately 1:12 PM on 10/17/13, the facility staff in charge of the contract was interviewed. She stated that she does not provide any oversight to the Blue Heron but included them in training provided to staff. She stated that the food manager was certified in food safety. Improper cooling is a major factor in causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that	{W 454}		

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{W 454}	Continued From page 221 may survive the cooking process. All persons, including those with compromised immune systems, are at increased risk of food borne illness such as Salmonella, Norovirus, Clostridium Perfringens, E. Coli, when food is not held at the appropriate temperature. Some of symptoms include fever, diarrhea and vomiting and in some cases death. Immediate jeopardy was declared on 10/18/13 at 11:20 AM. A corrective action plan was provided by the facility administrator on 10/18/13 at 1:15 PM. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate jeopardy on 10/18/13 at 1:15 PM. The facility failed to provide oversight to the contracted service. There was lack of supervision and monitoring of the food service activities by the staff of the PDC. The food vendor failed to put a system in place to ensure that food was cooled in a manner consistent with recognized food standards. 3. According to the breakfast menu on 10/16/13, the following items were offered: Juice, pancakes with syrup, egg patty, cold cereal, toast with jelly and milk. At approximately 8:12 AM on 10/16/13, Client 5 was overheard stating, "This [expletive] is cold". The client told the residence staff present that his food was cold. The food service worker (FW) serving the food felt the eggs and pancakes and agreed it was cold. She took the temperature and stated it was 80 degrees Fahrenheit (F).	{W 454}		

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{W 454}	Continued From page 222 FW then proceeded to return the items to the oven to reheat. A few minutes later FW pulled out the food but was not observed to recheck the food temperatures prior to serving the Clients. Section 3-403.11 of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds." The facility failed to ensure that the food was either cooled or reheated to the appropriate temperature to prevent the growth of microorganisms or toxin formation. The facility failed to put systems in place to ensure that staff consistently practiced safe food production procedures. [redacted] On 10/17/13 at 7:25 AM, with staff present, Client 7 was observed preparing to brush his teeth. Client 7 squeezed a large amount of toothpaste onto his toothbrush prior to brushing his teeth. The excess toothpaste dropped off of the toothbrush into the sink. Client 7 proceeded to scoop up the excess toothpaste with his toothbrush from the side of the sink and continued to brush his teeth Client 7 then put his mouth directly under the faucet to rinse his mouth. There was no staff intervention or redirection provided.	{W 454}		

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{W 454}	Continued From page 223	{W 454}		
	5. A day program observation on 10/15/13 at 9:25 AM in room 161 of residence 22, was conducted. Client 39 was folding towels on the table. The day program staff was standing beside Client 39 and was providing the towels to be folded to Client 39 and another client on the same table. While folding the towels, Client 39 was observed to have wiped each folded towel across his nose and mouth and then placed them on the folded pile. There was no intervention from the two staff in the room from 9:25 a.m. to 10:15 a.m. The folded towels were place inside the plastic bin. The staff stated to the group that the towels will be distributed to the units for use. At 10:30 AM, while the clients were having snacks, the staff was informed of the observation and that no intervention was implemented. The staff stated that the bin of folded towels would be sent back to the laundry.			
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that an order to hold supplement and prune product was communicated to kitchen staff for one of 19 sampled clients (Client A). Findings:	W 463	W 463 1. New profile for Client A was immediately sent to the unit to update the meal profile. 2. Food Services Technician was trained by the Food Services Supervisor on the importance of notifying Food Services on the unit of any dietary changes. 3. Client meal profile cards were audited to ensure accuracy. No other issues were noted. 4. Food Services Technicians were trained by the Food Services Supervisors regarding updating the meal profile. 5. Food Services Supervisor will monitor staff compliance and the use of correct meal profile during rounds at least monthly, and document any findings. 6. Any elevated issues will be monitored monthly at the Administrative Quality Management Council meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further actions taken as necessary. 7. Acting Director of Dietetics is responsible.	10-16-13 10-28-13 11-25-13 11-25-13 11-25-13 11-25-13

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W 463	Continued From page 224 During breakfast observation on 10/16/13 at 8:15 AM, Client A was observed eating his breakfast. There was no [redacted] given or offered to the client during his breakfast. A review of the Client Meal Profile which was located in the kitchen indicated for Client A, an [redacted] with breakfast must be given or offered to the client. An interview was conducted with the food service staff on 10/16/13 at 8:25 AM. She stated that the client should been given his [redacted] but she forgot. She also stated that [redacted] can be used as a substitute if there was no [redacted] available. She confirmed that those items should have been given or offered as per the Client Meal Profile. [redacted] In an interview with the Dietician on 10/25/13 at 9:45 AM, she stated that the order for [redacted] was on hold. The dietician provided this writer with an order dated 10/15/13. The order indicated that staff were to hold both the [redacted] and the supplement. The dietician was informed that kitchen staff and the Resident Manager were not aware of the new order and the Client Meal Profile was not updated. The dietician confirmed that the new	W 463		

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W 463	Continued From page 225 order should have been communicated with the dietary staff and the staff working for Client A. She also confirmed that the Meal Profile for Client A should have been updated.	W 463		
W 466	483.480(a)(6) FOOD AND NUTRITION SERVICES Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity. This STANDARD is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the facility failed to ensure that the diets provided to clients were evaluated to ensure that they was well-balanced. The facility had not conducted a nutrient analysis of their different diets to ensure they met the latest edition of the recommended dietary allowances of the Food Nutrition Board. Finding: During interviews with the Acting Director of Dietetics (ADD) on October 16, and 17, 2013 at 11:46 AM, she indicated that the facility had not conducted a nutrient analysis of the regular, modified and emergency menus. She explained that she could not do the nutrient analysis based on the limited number of staff the facility had. She explained that the facility had only one full-time registered dietitian (RD) who was responsible for clinical nutrition and assessments. In addition,	W 466	W 466 1. A purchase order was submitted for the acquisition of the nutrient analysis software. 2. Acting Director of Dietetics developed plan for completion of nutrient analysis once the software has been received. 3. Acting Director of Dietetics and Assistant Director of Dietetics will monitor the completion of the menu nutrient analysis project via auditing the software. 4. Any elevated issues will be monitored monthly at the Administrative Quality Management Council meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further actions taken as necessary. 5. Acting Director of Dietetics is responsible.	10-29-13 10-29-13 11-25-13 11-25-13

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W 466	Continued From page 226 there were two other part-time contract RDs. She acknowledged that her responsibilities as the director have not allowed her to conduct the analysis. Review of two contracts dated 3/6/13 revealed two additional dietitians had been hired on a consultant basis. The combined hours provided by both RDs were not equivalent to a full time employee. Their scope of work was limited to client assessments, clinical record progress reports and treatment plans, consultation, in service education and client education and inspections. The severe shortage of RDs resulted in the failure of the facility to ensure that the nutrient analysis of the menus was completed. It is unclear whether the food provided by the facility meets the requirements of the Food Nutrition Board.	W 466	W 473 1.1. Chicken salad was discarded from the Blue Heron. 1.2. Effective 6:30 pm, Blue Heron sold only pre-packaged, ready-to-eat food items and food items prepared on the grill. 1.3. All prepared food at the Blue Heron were discarded. 1.4. A ~~Client Immediate Protection Plan~~ was ~~initiated for Client 5. Client 5 was assessed~~ by ~~RN/HSS, and was monitored for signs and symptoms of food poisoning, i.e. abdominal pain, diarrhea, fever, and vomiting.~~ 1.5. No other clients were affected. 1.6. Acting Director of Dietetics provided on-site training to the Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling and set up/service of cold food items. 1.7. Acting Director of Dietetics reviewed the system for tracking food temperatures and food temperature log, and provided training to the Blue Heron staff. 1.8. Acting Director of Dietetics conducted an environmental check of the Blue Heron, and identified areas that needed to be corrected. 1.9. The Blue Heron Manager/Vocational Instructor was verified to be currently certified as Food Safety Manager. 1.10. Acting Director of Dietetics and Food Services Supervisor II conducted follow-up check to ensure identified areas had been corrected. 1.11. Director of Central Program Services set expectations for Blue Heron staff on Dietetics procedures associated with sanitation, safe cold food handling, set up/service of cold food items, and food temperature log. 1.12. The Blue Heron Manager/Vocational Instructor reviewed and updated the Food Storage Manual at the Blue Heron. 1.13. Blue Heron staff completely sanitized all surfaces, utensils, and dishes prior to re-opening	10-17-13 10-17-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13 10-18-13
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation, client and staff interviews and facility documents, the facility failed to ensure that there was an effective system to ensure that food was stored at the appropriate temperatures to prevent the growth of microorganisms that could result in food borne illness. The Blue Heron, a contract food vendor, did not cool down cooked chicken used in the preparation of a chicken salad according to recognized food safety standards. Cooked potentially hazardous foods that are subject to time and temperature	W 473		

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W 473	Continued From page 227 control for safety are best cooled rapidly within 2 hours from 135 to 70 degrees Fahrenheit (F) and within 4 hours to approximately 41 degrees F. The total cooling time from 135 degrees to 41 degrees F should not exceed 6 hours. The facility failed to provide any oversight on the operation of sanitary and safe food service operation. Immediate jeopardy was declared on 10/18/13 at 11:20 AM. A corrective action plan was provided by the facility administrator on 10/18/13 at 1:15 PM. After review of evidence of implementation of the corrective action plan, the survey team abated the Immediate jeopardy on 10/18/13 at 1:15 PM. In addition, a dietary employee was not observed to ensure that reheated eggs was at a temperature to limit the growth of microorganisms.Section 3-403.11of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds." Findings: 1. At approximately 11:10 AM on 10/17/13, a tour of the Blue Heron, a contracted canteen, on the Porterville Developmental Center campus was conducted. Sampled Client 5 was observed eating a chicken sandwich out in the dining area. A tour of the kitchen was conducted. There was a sandwich bar in the kitchen that opened to a service window in the dining area. There were items used to make sandwiches such as onions,	W 473	W 473 (cont.) 1.14. Monitoring of the Blue Heron food preparation and service of cold foods was completed. 1.15. Program 5 LOC staff were trained by the Unit Supervisor or designee on Infection Control Guideline 3.14 "Food-borne Illnesses". 1.16. Food Services Supervisor will monitor Blue Heron food preparation and service of cold foods no less than twice per week, and document the visit in the Visitor Log at the Blue Heron. Any issues identified will be elevated to the Director of Central Program Services. 1.17. Issues requiring further actions will be reviewed monthly at the Clinical Quality Management Council meetings, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary. 1.18. Acting Director of Dietetics and Director of Central Program Services are responsible.	10-18-13 10-20-13 10-20-13 10-20-13

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W 473	Continued From page 228 tomatoes, mayonnaise, chicken salad, tuna salad, etc. A request was made to test the temperature of the potentially hazardous foods on the sandwich bar. Potentially hazardous foods are foods that require time and temperature control for food safety. These were the chicken salad and tuna Salad. The chicken salad was 46.7 degrees Fahrenheit (F) and the tuna salad was 40.8 degrees F. The recommended holding temperature for cold food is 41 degrees F and below. The Food Instructor (FI) who was responsible for managing the kitchen asked another employee to take some of the chicken salad out and returned the scooped out portion into another refrigerator. The original container was never removed from the sandwich bar. A few minutes later, the chicken salad was rechecked and the temperature was 43.3 degrees F. As the tour continued, another container was found in the reach-in refrigerator containing a larger amount of the chicken salad. The temperature of the chicken salad in the refrigerator was 48.7 degrees F. The FI was interviewed on the process and meal preparation method for the chicken salad. She indicated that the chicken salad was prepared from chicken breasts cooked in a crock pot from 10 AM to 4 PM the day before, 10/16/13. She stated that the chicken breasts are then placed in a metal container, pulled apart, and placed on ice until it reached 70 degrees F, which is approximately about 1-1/2 hours later. The metal container with the chicken was then placed in the refrigerator for further cooling. The FI stated the Blue Heron closed at 5:30 PM but there was another staff present until 7 PM. When interviewed on the	W 473	W 473 (cont.) 2.1. Acting Director of Dietetics set the following expectations at the Dietetics Services October Monthly Mandatory Meeting with the Dietetics staff on duty: a. Thermometers need to be calibrated regularly - at least once a month and at any conflict. b. Dimple needs to be submerged in the center of food to allow for accurate temperature reading c. Need to put thermometer in at an angle to allow for accurate reading of thermometer d. If for any reason you think that your thermometer may not be reading accurately/ is broken, a supervisor should be contacted for a replacement. e. In an emergency situation where ready-to-eat food may have been delivered frozen, cooking times may deviate from the standard length of time f. Food to be reheated to 165 degrees F and held at 140 degrees F or above 2.2. No negative impact was observed to the clients on Unit 6. 2.3. Unit Supervisor or designee was in the process of arranging a Unit Government meeting to discuss food substitutions and preferences with the clients. The anticipated date of the meeting was 12/9/13. 2.4. Food Services Supervisor will monitor staff compliance when completing meal checks and rounds assessments of the residence kitchens. Immediate actions will be taken to correct any deficiencies observed during rounds. Staff will be re-trained by Food Services Supervisor on the applicable procedures. 2.5. Any elevated issues will be reviewed at the Administrative Quality Management Council meeting, along with any corrective plan. Governing Body will monitor via monthly Quality Management Council meeting with further corrective actions taken as necessary.	10-25-13 10-25-13 11-25-13 11-25-13 11-25-13

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W 473	Continued From page 229 responsibilities of this employee, the FI acknowledged he had no temperature cooling/monitoring responsibilities. FI stated in an interview on 10/17/13 at approximately 11:30 AM that they had cooling logs. A review of the temperature log that was presented indicated that the temperature of the chicken had not been recorded and the form presented was not an actual cooling log. There were only two items regularly monitored for temperature from July 2013 till October 2013. These two items were chili and cheese. Section 3-401.14 (E) of the 2009 Food Code stated that "Raw animal foods that are cooked using a non-continuous cooking process shall be cooled according to the time and temperatures parameters specified for cooked potentially hazardous food" (Time/Temperature Control for Safety Food). The (Time/Temperature Control for Safety Food) is cooling within 2 hours from 135 degrees F to 70 degrees F and within a total of 6 hours from 135 degrees F to 41 degrees F. In addition, Section 3-401.14 (F) (2) of the 2009 Food Code requires that the raw foods be prepared and stored according to written procedures that are maintained in the food establishment are available to the regulatory authority on request. The FI pointed to a column that showed how all the items that had been cooled were 70 degrees. When the FI was asked the significance of 70 degrees Fahrenheit, she stated that when food was cooled they monitor to make sure it reached 70 degrees. When asked if any further steps were monitored she stated "No". The FI and the food manager stated they had food safety	W 473	W473 (cont.) 2.6. Acting Director of Dietetics is responsible.	

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W 473	Continued From page 230 certifications but neither was able to state that the correct process of cooling to include the further cooling to 40 degrees Fahrenheit. The FI and canteen manager were not able to show previous cooling logs and knowledge on the proper cooling process. The Blue Heron had stopped monitoring the cooling of the Chicken after 5:30 pm. They were not able to state if the food had cooled down to the proper temperature. Temperatures were not taken before additional items such as the mayonnaise, apple and nuts were added on 10/16/13. The appropriate time to check that the chicken had cooled down to 41 degrees Fahrenheit or below was prior to the addition of those other ingredients. Therefore, the possibility exists that the food may have been in the danger zone for over 16 hours. Review of the facility document titled Canteen Lease dated June 4, 2013 between the facility and the food vendor, Blue Heron was conducted. Included in the terms of the lease is the requirement that the Administrative services Director of the facility had the right to regulate the operations of Blue Heron as they affect the "...safety and conduct of the facility." In addition, the lease had the Blue Heron "comply with all rules and regulations" adopted by the facility. At approximately 11:46 AM on 10/17/13, the Acting Director of Dietetics (ADD) was interviewed on the dietetics department's responsibility for oversight for food safety at the Blue Heron. She stated that there was no affiliation with the Blue Heron as it was managed by a separate entity.	W 473		

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W 473	Continued From page 231 In an interview at approximately 1:12 PM on 10/17/13, the facility staff in charge of the contract was interviewed. She stated that she does not provide any oversight to the Blue Heron but includes them in training provided to staff. She stated that the food manager was certified in food safety. On 10/18/13 at 12:10 PM a Blue Heron dietary staff stated, "We don't have a cool down log." Improper cooling is a major factor in causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that may survive the cooking process. All persons including those with compromised immune systems are at increased risk of food borne illness such as Salmonella, Norovirus, Clostridium Perfringens, E. Coli, when food is not held at the appropriate temperature. Some of symptoms include fever, diarrhea and vomiting and in some cases death. The facility failed to provide oversight to the contracted service. There was lack of supervision and monitoring of the food service activities by the staff of the PDC. The food vendor failed to put a system in place to ensure that food was cooled in a manner consistent with recognized food standards. 2.According to the breakfast menu on 10/16/13, the following items were offered: Juice, pancakes with syrup, egg patty, cold cereal, toast with jelly and milk. At approximately 8:12 AM on 10/16/13, Client 5 was overheard stating, "This [expletive] is cold".	W 473		

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W 473	Continued From page 232 The resident told the Residence staff present that his food was cold. The food service worker (FW) serving the food felt the eggs and pancakes and agreed it was cold. She took the temperature and stated it was 80 degrees Fahrenheit (F). FW then proceeded to return the items to the oven to reheat. A few minutes later, FW pulled out the food but was not observed to recheck the food temperatures prior to serving the clients. The randomly-observed client continued to eat his cold cereal but left the dining room without eating the pancakes and egg patty. A few minutes later, FW 2 pulled out the food but was not observed to recheck the food temperatures prior to serving the clients. A review of the menu for 10/16/13, which included documentation of food temperatures for breakfast items, showed the initial food temperature (taken at the beginning of service) of the pancakes as 166 degrees and the egg patty as 160 degrees F. Section 3-403.11of the 2009 Food Code states that "potentially hazardous food (time/temperature control for food safety) that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds." The facility failed to ensure that the food was either cooled or reheated to the appropriate temperature to prevent the growth of microorganisms or toxin formation. The facility failed to put systems in place to ensure that staff	W 473		

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W 473	Continued From page 233 consistently practiced safe food production procedures. Th facility failed to serve food at the appropriate temperatures. One randomly-observed cleint left the dining room without eating his pancakes and eggs for breakfast as a result of being served cold food. This failure resulted in a significant loss of calories and protein for this client.	W 473		