

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 000	INITIAL COMMENTS  The following reflects the findings of the California Department of Public Health during a recertification survey.  Representing the California Department of Public Health were Health Facilities Evaluator Nurses: 16553, 09671, 22069, 21898, 27090, 22975, 22327 and 18839.  Representing the Centers for Medicare and Medicaid Services -16236.  The census on the day of entrance, 5/5/14, was 171 clients.  The number of clients in the core sample was 17.	W 000			
W 100	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.	W 100			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 100	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet the Condition of Participation of Active Treatment Services.  Findings:  The facility failed to meet the Condition of Participation (COP) of Active Treatment Services. The facility did not assure that clients received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs. The facility failed to develop individual plans structured to promote consistent implementation of training programs to teach skills and increase independence. (SeeW195).	W 100			
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, interview, record review and policy review, (for the time parameter 2/1/14-5/15/14) the facility did not meet the Condition of Participation for Governing Body and Management by failing to take responsibility and timely action to identify and resolve systemic problems of serious and recurrent nature and by not meeting the requirements for the Conditions	W 102			

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W 102	<p>Continued From page 2</p> <p>of Participation of Active Treatment Services, Condition of Participation for Client Protections, and the Condition of Participation for Health Care Services. The facility also failed to exercise, monitor and implement policies and written protocols to ensure the health and safety of all clients residing at the facility.</p> <p>These failures affected 10 of 17 core sampled clients (Client's 13, 46, 64, 68, 78, 100, 102, 119, 138, 143 ) and 46 focus sampled clients (1, 6, 7, 20, 21, 24, 25, 27, 29, 41, 43, 44, 50, 51, 54, 55, 57, 63, 66, 71, 73, 77, 82, 83, 85, 86, 88, 98, 99, 107, 112, 122, 123, 125, 129, 131, 132, 136, 139, 140, 147, 149, 152, 155, 173, and 174) and potentially all 171 clients residing at the facility.</p> <p>Findings:</p> <p>1. The Condition of Participation: Governing Body, was not met. The Governing Body failed to maintain an effective pest control system, failed to ensure maintenance was conducted and timely repairs done in the environment, failed to keep food safe during dining service and storage, failed to routinely monitor the dishwashing machine in the main kitchen to assure it was functioning properly.</p> <p>The Governing Body failed to ensure implementation of the following policies and procedures; food handling, receiving, storage, and equipment; Human Rights committee, whole person reviews, individual planning coordinator role and responsibilities, informed consent, psychotropic medications, physical, medical supports and restraints; abuse/mistreatment/neglect prevention and reporting; bowel care management, notification to</p>	W 102			

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W 102	<p>Continued From page 3</p> <p>the physician/nurse, gastrostomy tubes, and infection control. In addition, the health care record was not accurate, fall prevention assessment and MOSES nursing protocols were not implemented. (See W104, W111)</p> <p>2. The Condition of Participation: Client Protections was not met. The facility failed to maintain systems that would prohibit abuse, neglect and mistreatment of clients residing in the facility. The Governing Body failed to ensure all alleged violations were reported immediately, investigated thoroughly and corrective actions were taken. The facility failed to ensure the Human Rights Committee reviewed and monitored programs that involved risks to client protections, including the informed consent process, unnecessary drugs and active treatment, locked doors, opportunities for choice and self-management i.e., manage monies, engage in the community and appropriate dressing and grooming. The facility failed to ensure training of registry staff and employees, implement bowel care programs and intervene when clients exhibited maladaptive behaviors. This affected 6 of 17 clients in the core sample (Client's 13, 46, 64, 68, 100, 102) and 28 focused clients (Client's 1, 25, 27, 29, 41, 44, 50, 51, 57, 63, 66, 71, 82, 83, 85, 86, 88, 98, 99, 107, 122, 123, 125, 139, 147, 149, 152 and 174) (See W122)</p> <p>3. The Condition of Participation: Active Treatment Services, was not met. The facility failed to ensure the Condition of Participation of Active Treatment Services was met when individuals were not involved in activities which addressed their individualized priority needs.</p>	W 102			

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W 102	<p>Continued From page 4</p> <p>The facility did not assure individuals received a continuous active treatment program with opportunities to practice new or existing skills and to make choices in their daily routines. The facility failed to ensure data was accurate, collected, documented, and analyzed in the method and frequency required by the plan. The facility did not assure active treatment plans were implemented by trained staff, and objectives amended and revised by the qualified mental retardation professional (QMRP) / Individual Program Coordinator (IPC). The facility failed to ensure the Human Rights Committee (HRC) reviewed and monitored individual programs designed to manage behavior which involved risks to client protections and rights. This affected 9 of 17 core sample clients (Client's 13, 64, 68, 78, 100, 102, 119, 138, 143) and 23 focused clients (Client's 6, 7, 20, 24, 25, 27, 29, 44, 51, 54, 57, 73, 77, 85, 86, 107, 125, 129, 131, 132, 139, 140 and 174). (See W 195)</p> <p>4. The Condition of Participation: Health Care Services, was not met. Individuals did not receive adequate health care monitoring and services, including appropriate and timely notifications and follow-up based on their individual need for service. This affected 1 of 17 sampled clients (Client 13) and 12 focused clients (Client's 21, 27, 43, 51, 55, 85, 86, 107, 112, 155, 173 and 174). (See W318)</p> <p>The cumulative effect of these systemic problems resulted in the facility's failure to ensure the Governing Body was providing oversight and failed to ensure the provision of safe healthcare and services.</p>	W 102			
W 104	483.410(a)(1) GOVERNING BODY	W 104			

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W 104	<p>Continued From page 5</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, record and policy review, the facility's governing body failed to exercise general policy and operating direction over the facility in the following areas:</p> <ol style="list-style-type: none"> <li>1. The facility failed to exercise, monitor and implement established policies and written protocols to safeguard the health and safety of clients.</li> <li>2. An infestation of ants and tall weeds were observed in an outside client area at the day program.</li> <li>3. Swarming bees were observed in an overgrown bush at the entrance of a day program.</li> <li>4. The facility failed to ensure a safe environment when uneven pavement was observed on sidewalks used by clients and when work orders for repair of the uneven pavement were not completed timely.</li> <li>5. Food was not covered prior to serving.</li> <li>6. Dishwasher temperatures were not consistently logged.</li> <li>7. Open refrigerated food items were kept beyond 5 days.</li> </ol>	W 104			

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W 104	<p>Continued From page 6</p> <p>8. The facility failed to ensure the practice to prevent the potential spread of infection was implemented by direct and non-direct care staff.</p> <p>9. There was no wheelchair access at the curb near the clothing store requiring staff to lift wheelchairs over 2-3" curbs.</p> <p>These failures had the potential to affect the health and safety of all client's residing in the facility.</p> <p>Findings:</p> <p>1. The governing body failed to implement the following policies and written protocols:</p> <p>1a. Food Handling Techniques (See section #5 W104)</p> <p>1b. Section 300-Equipment (See section #6 W104)</p> <p>1c. Section 320- Receiving and Storage (See section #7 W104)</p> <p>1d. Informed Consent, dated March 2014. (See W122, W124)</p> <p>1e. Physical Medical Restraints, dated April 2014. (See W128, W262)</p> <p>1f. Abuse/Mistreatment/Neglect Prevention and Reporting dated February 2014. (See W149, W153, W154, W155, W156)</p> <p>1g. Bowel Care Management, dated March 2014. (See W111, W192, W252, and W331)</p>	W 104			

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W 104	Continued From page 7 1h. Psychotropic Medication "454", dated January 2014. (See W128, W312, and W316, W262)  1i. Transfer an Individual to a Community Hospital or a Community Appointment, dated November 2012. (See W206, W331)  1j. Human Rights Committee (HRC), dated September 2013. (See W128, W159, W262)  1k. HRC and Whole Person Review (WPR) Process, 2013. (See W262)  1l. Notification of Physician , MOD, and or Health Services Specialist, dated December 2013. (See W331)  1m. Gastrostomy Tubes, dated March 2014. (See W331)  1n. Nursing Protocol, Fall prevention, Assessment (See W331)  1o. General Event Reporting (GER) and Investigation System, 7/13 (See W149, W154).  1p. Client Protection & Prevention from Harm, 3/14 (See W149)  1q. Standard Precautions (See section #8 W104, W341)  1r. Assisted Feeding-Estimating Intake Procedure (See W192, W331)  1s. Informed Consents: Capacity and Consenters, 5/14 (See W263)	W 104			

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W 104	<p>Continued From page 8</p> <p>1t. Infection Control (See W341)</p> <p>1u. Section 400 Client Services-Continuous Active Treatment, 4/14 (W249)</p> <p>2. On 5/7/14, clients were observed in the day program. At 10 a.m., some of the clients were observed going outside. There were high weeds growing in the back area where the clients were allowed to spend time. The weeds in the grass area had not been pulled. Staff had the clients sit in chairs that had been lined up against the wall of the classroom. Staff did not appear to have checked the environment for safety concerns. An ant colony was observed next to where the clients were seated. An infestation of ants was observed crawling all over the balls (used for client recreation) on the ground. Large black/brown ants were observed crawling up an individual's leg.</p> <p>During an interview with the offsite staff, on 5/7/14 at 10:25 a.m., the staff member stated she did not check the environment for any safety issues prior to bringing the clients out and had not noticed the ants on the ground and offsite equipment.</p> <p>3. On 5/7/14 at 2:25 p.m. during observation of the offsite day program, an overgrown bush at the entrance of the day program was observed with many bees swarming around the bush. As the clients came out of the day program, a couple of clients were observed hitting the bush as they came out the day program door.</p> <p>On 5/8/14 at 11:20 a.m., during an interview with the unit supervisor, she stated she was not aware that there were bees there and would notify plant</p>	W 104			

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W 104	<p>Continued From page 9</p> <p>operations immediately to take care of it, because it was a serious hazard to the clients. It was possible a client could experience an anaphylactic reaction if stung and allergic to bees. (an anaphylactic reaction is a serious allergic reaction that typically causes a number of symptoms including an itchy rash, throat and tongue swelling, low blood pressure, coronary spasm, which has a rapid onset and may cause death. Bee, wasp, yellow jacket, hornet, or fire ant stings are the insects that most often trigger allergic reactions).</p> <p>4. On [REDACTED]/14, at 9:20 a.m., during observation of the offsite, one of the clients was observed to have multiple reddened scrapes on the forehead, nose, and arms. The abrasions appeared new and were not observed the previous day [REDACTED]).</p> <p>During an interview with the offsite staff, on 5/8/14, at 9:30 a.m., staff stated on [REDACTED]/14 during a walk, the client attempted to elope. The client ran away and then tripped on the uneven sidewalk pavement.</p> <p>An interview was conducted with the offsite unit supervisor on 5/8/14 at 11:20 a.m. The offsite unit supervisor stated she had reported numerous times uneven pavements to plant operation, but nothing seemed to have been done. The offsite unit supervisor stated she had an employee who tripped and fell on the uneven pavement last year, a work order was written, but the sidewalk was never fixed.</p> <p>On 5/8/14 at 11:25 a.m., a tour of the walkways used by the client was conducted with offsite Unit Supervisor 1. Multiple areas in the sidewalk around the Powers and Parmelee units were</p>	W 104			

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W 104	<p>Continued From page 10</p> <p>observed lifted. There was an area where the root of a tree had lifted and broken apart the sidewalk. Numerous clients were observed taking walks over the unsafe areas.</p> <p>During an interview with offsite Unit Supervisor 2 (US 2), on 5/8/14 at 11:30 a.m., US 2 stated that offsite staff did not do environmental rounds of the outside surrounding areas of the offsite locations.</p> <p>The plant operations work orders were reviewed. A work order dated October 30, 2013, indicated there had been a previous incident when the sidewalk was raised and a client tripped and fell. There were eight other work orders for raised sidewalks. A work order for the repair of the sidewalk between the Powers and Parmelee day programs due to the fallen or overgrown oak tree was submitted on April 8, 2014. The work order had not been completed, and the sidewalk remained obstructed by the rooted oak tree.</p> <p>5. An observation was conducted in the Farrell F Day Program on 5/7/14, starting at 10:15 a.m. At 11:15 a.m., an open cart of pre-dished up meal trays was observed near the dining area. There were bowls of jello and cubed breads and plates of turkey sandwiches observed on the pre-dished up meal trays. The meal trays were not covered to prevent cross contamination prior to serving the meals.</p> <p>An interview was conducted with the Food Service Supervisor on 5/7/14 at 12:15 p.m. He stated the plates should have been covered prior to serving the meal.</p> <p>A review of the facility policy and procedure titled,</p>	W 104			

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W 104	<p>Continued From page 11</p> <p>"Food Handling Techniques," indicated the following;</p> <p>"2.0 All Nutrition Services staff and any other employees who provide food to clients are responsible for practicing proper food handling techniques.</p> <p>3.7 Physical Contamination - Food must be handled properly to prevent contamination by foreign objects.</p> <p>3.7.1 Actions to prevent physical contamination:</p> <p>3.7.1.2 Keep food covered."</p> <p>6. During observation on 5/5/14 at 2:15 p.m. in the main kitchen of the facility, a "Weekly Dish Machine Log" was observed near the dishwashing machine.</p> <p>During a concurrent review of the log, it indicated that there were multiple days from March 2014 through May 2014, when the dishwasher temperatures were not logged. The log also indicated, "Instructions to the FST (Food service Technician): 1. Log the temperatures of each cycle of the dish machine ..."</p> <p>During a concurrent interview with Supervising Cook I, the cook reviewed the log and confirmed the missing dishwasher temperature entries on multiple occasions. He stated that whoever was running the dish washing machine should have documented the temperatures, because of a potential for an infection control issue.</p> <p>On 5/13/14 at 10:20 a.m., an interview with the ADD (Assistant Director of Dietetics) was conducted. The ADD confirmed that dishwasher temperature entries were missing from the log.</p>	W 104			

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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
(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 104	<p>Continued From page 12</p> <p>On 5/13/14 at 10:40 a.m., a review of the P&amp;P (policy and procedure) titled, "Section 300 Equipment," was conducted. The review indicated, "Purpose 1.0 This policy assures that all tableware, pots and pans are cleaned and sanitized for the safety of our clients ...Responsibility ...2.1 All employees are responsible for ensuring that all temperatures are correct and recorded ..."</p> <p>7. During observation on 5/5/14 at 2:35 p.m. in the main kitchen of the facility, opened food products such as Farina baked bread and Monterey Jack cheese were noted in Refrigerator #2. The food had been labeled with an opened date of 4/29/14, 6 days prior to the observation.</p> <p>During a concurrent interview with the Assistant Director of Dietetics (ADD), she confirmed the dates on the open food products and stated she would check the policy to confirm the discard date for the specific opened food items.</p> <p>On 5/13/14 at 10:20 a.m., an interview with the ADD was conducted. The ADD stated that the food products found in Refrigerator #2 should have been used within five days after they were opened.</p> <p>On 5/13/14 at 10:40 a.m., a review of the P&amp;P titled, "Section 320 Receiving &amp; Storage," was conducted. The review indicated, "Purpose 1.0 This procedure and attached food storage charts are designed to guide employees and supervisors in providing cost-effective, safe, high quality food to clients ...Food ...Monterey Jack ...Follow "Use By" date; or use within 5 days after opening ..."</p> <p>8. On [REDACTED]/14 at 8:08 a.m., a gastric tube (GT)</p>	W 104			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 104	<p>Continued From page 13</p> <p>(soft tube inserted through the abdominal wall into the stomach to feed people with difficulty eating) feeding was observed. The Psychiatric Technician (PT 1) and PT student brought Client 2 into the medication room [REDACTED].</p> <p>[REDACTED] The PT student reached into his pocket, put on gloves, and began to clean around the GT site. Both the student and PT 1 participated in the process of cleaning the site and then gave 750 cc's of water through the tube to Client 2. The student removed his gloves and documented the procedure, left the room and started to proceed down a hallway. The PT student did not wash his hands before or after the procedure. During a concurrent interview PT 1 stated that the student did not wash his hands. The PT1 stated she would notify the PT student to wash his hands before continuing client care.</p> <p>On [REDACTED]/14 at 7:45 a.m., a PT assistant (PTA) was observed leaving a client room walking in the hall and into to the dirty linen room. While in the dirty linen room, the PTA removed her used gloves and put them in her shirt pocket. The PTA did not wash her hands and walked to the dining area where clients were in line getting their breakfast. The PTA then went to the tray line and began to interact and assist the clients.</p> <p>A simultaneous interview was conducted with the PTA and she explained the reason she had the gloves on was because she had been cleaning a client's restroom. The PTA confirmed she did not wash her hands prior to assisting with breakfast.</p> <p>On 5/14/14, a review of the policy titled, "Standard Precautions," revised July 2013, was conducted. The following was documented in section D. Process Standards: "1. Hand washing</p>	W 104			

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

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W 104	Continued From page 14 with soap is indicated before and after each new client contact, whenever hands are soiled, after touching blood, body fluids, secretions, excretions, contaminated items and/or after gloves use." 3., ...Employees are expected to wash hands immediately after glove removal to avoid transfer of microorganisms to other clients or environments.  9. On 5/5/14 at 11 a.m., during an observation at a day program, three clients from the day program were observed going to an on campus clothing store. One of the clients was in a wheelchair and was assisted by staff. The staff explained that the clients from the day program went to the clothing store two to three times a week over the past three months. The clothing store was approximately 100 yards distance from the day program. At one point two staff had to assist the client in the wheelchair over the 2 to 3" curb. When the clients returned from the store they walked the same route having to lift the wheelchair over the curb.  A concurrent interview was conducted with the staff present who explained that was the only area to cross the street because that was where the cross walk was. The staff stated that she thought there may be wheelchair access further down the side walk but there was no cross walk.	W 104			
W 111	483.410(c)(1) CLIENT RECORDS  The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.	W 111			

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W 111	<p>Continued From page 15</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure an accurate behavior intervention plan was documented for one of three focused clients from the Human Rights Committee (HRC) Review (Client 25), and</li> <li>2. Ensure the employee completing Client 86's Psychotropic Drug Review (PDR), dated 2/24/14, signed the document.</li> <li>3. Maintain an accurate health care record that documented hydration / fluid status related to bowel care management, for five of ten focused clients (Client's 13, 27, 51, 85, 86) from 131 clients identified at high risk for constipation including one death review record (Client 174).</li> </ol> <p>These failures had the potential to result in an inaccurate representation of the clients' due to inaccurate record keeping.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the HRC minutes, dated [REDACTED]/14, revealed Client 25 was prescribed Clonazepam 1 mg daily that "did not require an approval from the committee as it was prescribed for a medical symptom." [REDACTED]</li> </ol> <p>[REDACTED] Record review revealed Client 25's behavior and objective plan for harm to self showed Clonazepam being used as a highly restrictive intervention for [REDACTED] which would require a review and approval from the HRC.</p>	W 111			

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W 111	<p>Continued From page 16</p> <p>Client 25's physician orders, dated April 2014, indicated Clonazepam [REDACTED]</p> <p>In an interview with the HRC chairperson on 5/12/14 at 11 a.m., he said the behavior intervention plan was in error.</p> <p>2. Review of Client 86's PDR, dated 2/24/14, showed the PDR was not signed by the person completing the form.</p> <p>3. During a focused record review of Client's 13, 27, 51, 85, 86 and 174, these records for the clients who were receiving bowel care management were noted to be incomplete. The documentation of each clients' hydration / fluid intake was not thoroughly and accurately documented, analyzed for discrepancies and concerns acted upon timely. Interviews confirmed the policy was not understood by staff responsible for its implementation.</p> <p>The policy titled, "Bowel Care Management," dated March 2014, indicated staff were to document and track fluid intake totals for each shift on the activity of daily living (ADL) flow sheets # DS5504 by the end of each shift. The fluid hydration totals should have been documented by cc (cubic centimeter/ a fluid measurement) on a separate row from the percentage of meal consumed.</p> <p>The policy assigned responsibility to the shift lead to ensure completion of the ADL flow sheet. The RN (registered nurse) was to provide a synthesis (combination of ideas to form a theory) of the information which included nursing actions,</p>	W 111			

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W 111	Continued From page 17 interventions, follow-up and notifications. For clients at risk for constipation a monthly/weekly review by licensed staff was required.  Fluid hydration data was not documented per policy, totaled accurately, and discrepancies in the collection were not identified by the RN / HSS (Health Services Specialist) during monitoring and quarterly review per policy.  The nightly audit worksheet from the Poppe residence showed that the ADL flow sheets were to be reviewed nightly for pertinent information.  (See W192, W252, W331)	W 111			
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 observations, interviews, record reviews, and document review, the facility failed to ensure that appropriate systems were in place that would prohibit abuse /neglect / mistreatment of clients in the facility. This affected 6 of 17 clients in the core sample (Client's 13, 46, 64, 68, 100, 102) and 28 focus clients (1, 25, 27, 29, 41, 44, 50, 51, 57, 63, 66, 71, 82, 83, 85, 86, 88, 98, 99, 107, 122, 123, 125, 139, 147, 149, 152 and 174).  1. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing abuse during the investigation and before reporting results to the administrator or	W 122			

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W 122	<p>Continued From page 18</p> <p>designated representative within 5 working days, and taking appropriate action if a violation was verified. The lack of implementation of systems caused the Condition of Participation for Client Protections to not be met. (See W153, W154, W155, W156 and W157).</p> <p>2. The facility failed to implement the policy for abuse/neglect/mistreatment. (See W149).</p> <p>3. The facility failed to ensure training of registry staff related to delivery of client care (See W189).</p> <p>4. Staff failed to provide a safe environment when they did not intervene when clients exhibited inappropriate behaviors (See W191).</p> <p>5. Staff failed to display knowledge of bowel care management on 6 of 7 units. (See W192 )</p> <p>6. Doors that were to be unlocked were locked on 3 of 7 units. (See W125).</p> <p>7. Staff failed to ensure clients were given opportunities to manage money to their fullest extent. (See W126)</p> <p>8. Clients were observed wearing ill-fitting clothing. (See W137)</p> <p>9. Clients were not provided community outings due to a broken van. (See W136)</p> <p>10. The facility failed to ensure the rights of individuals, implement their policy titled, "Informed Consent," and failed to ensure written consents were complete, specific, and time limited for procedures and failed to seek consent</p>	W 122			

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

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W 122	<p>Continued From page 19</p> <p>from the designated conservator before treatment was initiated. This affected one of three focused clients during the Human Rights Review (Client 86) and one client from the Task 2 incident review (Client 44). (See W124)</p> <p>11. The facility failed to implement policies titled, "Physical Medical Supports," dated April 2014, and "Psychotropic Medications," dated January 2014, and ensure two of three focused clients from the Human Rights Committee review were free from unnecessary drugs and provided active treatment to reduce dependency on those drugs.</p> <p>Client 29 received a non FDA (Food and Drug Administration) approved drug to target [REDACTED] behaviors and agitation, there was no identified criteria to show how the use of the drug could change in relation to the active treatment program and progression or regression of Client 29's [REDACTED] and target behaviors of [REDACTED] / agitation for which it was prescribed.</p> <p>Client 86 had [REDACTED], as needed (PRN) usage of an antipsychotic drug prescribed for anxiety [REDACTED] without an active treatment plan or Human Rights approval. (See W128)</p> <p>The cumulative effect of these systemic practices, resulted in the facility's inability to meet the requirements for the Condition of Participation: Client Protections.</p>	W 122			

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W 124 W 124	Continued From page 20 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure the rights of individuals, implement their policy titled, "Informed Consent," failed to ensure written consent was complete, specific and time limited to procedure, and failed to seek consent from the designated conservator before treatment was initiated. This affected one of three focused clients during the Human Rights Committee Review (Client 86) and one client from the Task 2 incident review (Client 44). This failure created the potential for individual rights and freedoms to be restricted without justification.  Findings:  1. Review of Client 86's consent for medical restraints and restrictives, dated [REDACTED]/13, [REDACTED] were being utilized for "personal safety and procedural anxiety" during four different medical procedures. The consent was not specific, time limited nor complete.	W 124 W 124			



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W 124	<p>Continued From page 22</p> <p>[REDACTED]</p> <p>The consent referenced the physician note dated two months prior on 10/17/13 indicating, the physician had "reviewed informed consent for these three psychotropics" on 10/17/13 with the COR. The physician's progress note referenced did not include the Mirtazapine or specify the drugs used for sedation.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>The policy titled, " Informed Consent" to Medical/Surgical / Dental procedures and / or Sedation / Anesthesia and special consents dated March 2014 indicated a "specific consent shall be obtained."</p>	W 124		

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W 124	<p>Continued From page 23</p> <p>During an interview with a Licensed Clinical Social Worker (LCSW) on 5/12/13 at 10 a.m., she indicated the consent format "had been changed" and the consents were not specific to each medical procedure and now only had to be done annually.</p> <p>2. A review of the GER (General Events Report), dated 4/7/14, indicated that Client 44's sister was her conservator but her father had been signing her current consents. Client 44 had the general "Consent for Care and Treatment" and "Consent for Restrictive Behavior/ Access Management Program" signed by her father, who was listed as Consenter of Record, on 1/7/14 and 3/20/14 respectively.</p> <p>A review of Client 44's Person Centered IPP (Individual Program Plan) Narrative, dated 1/7/14, indicated that Client 44 received the medications</p> <div style="background-color: black; width: 100%; height: 150px; margin: 5px 0;"></div> <p>The IPP also indicated that Client 44's sister was her conservator and her father was consenter of record. A review of the Letters of Conservatorship, filed in Sonoma County Superior Court on 9/4/09, indicated the client's sister and mother were her conservators and had "exclusive authority to give consent for and to require the conservatee to receive medical</p>	W 124			

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

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W 124	Continued From page 24 treatment ..."  A review of the facility's policy 440," Informed Consent: Capacity and Consenters," dated March 2014, indicated that under the section of the hierarchy of consenters, conservator was listed as the person to supersede the closest available relative when delegating responsibility for signing consents. The policy indicated, "Adults, conserved, not competent to give consent, consent forms will be given to the conservator for signature."  During an interview on 5/13/14 at 2:20 p.m. with the Licensed Clinical Social Worker (LCSW) of the unit where Client 44 resided, the social worker stated the client's mother and sister were originally co-conservators but client's mother passed away approximately three years ago. The LCSW stated that the client's father came to visit her regularly and the sister only occasionally and was sometimes difficult to contact for consents. LCSW stated that she drafted a letter to the sister requesting that the father be designated the consenter of record and that Client 44's sister did agree to that change, allowing the father to sign consents in her absence. The LCSW stated that the father has been signing all consents for Client 44 since May, 2013 although the authority to sign remained with the client's sister.	W 124			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States,	W 125			

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W 125	<p>Continued From page 25 including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients who were assessed and approved for access (ability to come and go at will) were not restricted to enter and exit unlocked units (Poppe, Stoneman, and Roadruck Units). This restriction of clients' ability to exercise their right to freedom of movement potentially affected the clients' quality of life.</p> <p>Findings:</p> <p>1. During an observation on 5/5/14 at 10 a.m. in Poppe Unit, the "Family 1" door leading to the unit's courtyard/patio was noted to be locked, preventing access to clients.</p> <p>During a concurrent interview with the Unit Supervisor (US), she confirmed that the residence was an unlocked unit. She stated that "Family 1" door was supposed to be unlocked.</p> <p>On 5/7/14 at 9 a.m., a review of the unit's "Residential Access Plan," dated 4/4/14, was conducted. The review indicated the courtyard doors should be unlocked.</p> <p>2. During an observation on 5/5/14 at 2:52 p.m. in Stoneman Unit, the front entrance door was noted to be locked. A Social Worker (SW) was observed to approach the entrance door and unlocked it using her keys to allow access to the unit.</p>	W 125			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 125	<p>Continued From page 26</p> <p>During a concurrent interview with the unit Social Worker, she stated, "It should never been locked. Everybody should know."</p> <p>On 5/7/14 at 9:45 a.m., a review of the unit's "Residential Access Plan" dated 4/14/14 was conducted. The review indicated the entrance door should be unlocked.</p> <p>3. During an observation on 5/5/14 at 10 a.m. on the Roadruck Unit, the exit door to the inner courtyard/patio was locked, preventing access to clients.</p> <p>During a concurrent interview with the licensed staff passing medications, she stated the doors were kept locked at all times. The Unit Supervisor (US), overheard staff saying that the door was kept locked and corrected the staff member. The US stated the door to the patio was kept open for the clients to access at their leisure from 9 a.m. to dusk. The US stated, "If they can walk, they have access to the patio." Staff attempted to open the door, but was not able to because it was locked. The US checked the door and verified that the door was locked. The US stated, "That door should not have been locked." The US stated a new access plan was recently implemented and perhaps not all staff were aware the unit was keeping certain doors open from 9 to dusk so the clients could go outside.</p> <p>On 5/7/14 at 9 a.m., a review of the unit's "Residential Access Plan," dated 4/14/14, was conducted. The review indicated the exit door to the inner courtyard should be unlocked daily from 9 a.m. to 5 p.m.</p>	W 125			
W 126	483.420(a)(4) PROTECTION OF CLIENTS	W 126			

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

PRINTED: 07/25/2014  
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W 126	<p>Continued From page 27</p> <p><b>RIGHTS</b></p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients were given the opportunity to manage money to their fullest extent for 1 of 17 sampled clients (Client 46). Due to this failure individual freedoms, choice, and rights were not promoted to support maximum independence.</p> <p>Findings:</p> <p>1. On 5/5/14 at 11 a.m., during an observation at a day program, three clients were observed going to an on campus clothing store. Inside, the store resembled a large retail clothing store with a large selection of new and used clothing. The clients had profound disabilities and were assisted by the staff. While at the clothing store, the clients were assisted and encouraged to shop for clothes they preferred. All three clients had chosen clothing with assistance from the day program staff.</p> <p>When the shopping was complete, one of the staff members went to the front desk and handed the clothes to the store clerk and explained these were the items that the clients would like. The clerk filled out an order form and explained to the staff that the clothes would be sent to the day program within a few days. At no time were any of the clients involved in the transaction to purchase the clothing. Only one of the clients was present</p>	W 126			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 126	<p>Continued From page 28</p> <p>at the counter and was sitting in a wheelchair with their back to the transaction between the two staff. There was no cash register at the desk.</p> <p>On 5/7/14 at approximately 2:30 p.m., during an interview with clothing store staff, staff stated no money was ever exchanged with the clients and added, instead of using money for the client's clothing selections, a requisition form was used. Staff fill out a requisition form with the clothing items that were selected for or by the clients.</p> <p>On 5/13/14 at 11:30 a.m., an interview was conducted with Client 46. Client 46's disability was mild and she was able to express herself very well. Client 46 carried her own money with her and it was documented that she liked to go to the grill by herself or with a peer and purchase a hamburger with her own money. During the interview Client 46 was asked if she would go to the on campus clothing store. She replied yes and she had been there before many times. Client 46 explained she does not use her money to buy clothing because, "It is all free."</p> <p>On 5/13/14, Client 46's Individual Program Plan (IPP) money management was reviewed. Documented in the plan was that Client 46 had earned \$2.47 per hour and understood the concept of working for money and that money had an exchange value. She recognized the denominational value of coins and bills and had safe guard skills for carrying cash. She was able to handle money without supervision.</p> <p>2. On 5/7/14 at approximately 2:30 p.m., the clothing store was visited. The clothing store was divided into two sections. One side of the store had new clothing items and the other side had</p>	W 126			

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W 126	Continued From page 29 donated clothes that could be selected by the clients. In a concurrent interview with staff that worked at the clothing store, they stated no money was ever exchanged with the clients. Staff stated that instead of using money for the client's clothing selections, a requisition form was used. Staff would fill out a requisition form with the clothing items selected for or by the clients.	W 126			
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.  This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to implement policies titled, "Physical Medical Restraints and Supports," dated April 2014 and "Psychotropic Medication 454," dated January 2014. The facility failed to ensure two of three focused clients (Clients 29, 86) from the Human Rights Committee review were free from unnecessary drugs and provided active treatment to reduce dependency on those drugs.  1. Client 29 received a non FDA approved drug to target [REDACTED] behaviors and agitation. There was no identified criteria to show how use of the drug could change, in relation to the active treatment program and progression or regression of Client 29's [REDACTED] disorder [REDACTED] [REDACTED]	W 128			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 128	<p>Continued From page 30</p> <p>██████████ and target behaviors of ██████████ / agitation for which it was prescribed.</p> <p>2. Client 86 had ██████████, as needed (PRN), usage of an antipsychotic drug (a drug used to favorably modify psychotic symptoms or anxiety) prescribed for anxiety ██████████ without an active treatment plan to reduce dependency on the drug or Human Rights approval for the drug use.</p> <p>Findings:</p> <p>1. During review of incident reports on 5/8/14 commencing at 8:50 a.m., for the time parameter ██████████/14 through ██████████/14, it was revealed the facility reported an injury of unknown source for Client 29 ██████████</p> <p>██████████ described as being "dark purple in color" on ██████████/14. A recommendation was made in the General Event Report (GER) to consider use of the herbal supplement "chaste berry" to ██████████</p> <p>Review of the Whole Person Review contained in the Human Rights Committee (HRC) and related Behavior Intervention Restrictive Team (BIRT) meeting minutes dated 4/24/14, Client 29's team was seeking initial approval for use of Chasteberry ██████████ and decrease injuries to sensitive areas. The HRC indicated a ██████████ consult had begun, informed written consent was current, plans appropriate, and the medication was approved.</p> <p>According to the U.S. Department of Health and</p>	W 128		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 128	<p>Continued From page 31</p> <p>Human Services, National Institutes of Health, National Center for Complementary and Alternative Medicine, Chasteberry is from the fruit of the chaste tree, native to Central Asia and the Mediterranean region. [REDACTED]</p> <p>[REDACTED]</p> <p>Chasteberry, according to the references cited, is used by women to ease menstrual problems and to stimulate breast milk. Chasteberry can cause gastrointestinal problems, acne like rashes and dizziness. Chasteberry may affect dopamine systems in the brain and individuals taking dopamine related medications, antipsychotics and Parkinson's disease medications should not take it. Chasteberry is a non FDA approved herbal supplement.</p> <p>Review of the written consent revealed a restrictive behavior management program, dated 4/29/14, for the Chasteberry (no dosage) to treat Client 29's [REDACTED] [REDACTED] targeting [REDACTED] behaviors and agitation.</p> <p>The consent indicated the anticipated benefits from the restrictive procedure were to reduce maladaptive behaviors and reduce injury with potential risks defined as a decreased independence. Less restrictive procedures attempted were listed as medication changes and changes to behavior support plans as indicated although not specified on the consent.</p> <p>[REDACTED]</p>	W 128			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 128	<p>Continued From page 33 prescribed.</p> <p>Interview with the Supervising Senior Psychologist / chair person for HRC on 5/12/14 at 11 a.m., revealed he was unaware of the potential side effects to observe for during the use of Chasteberry and was unaware of Client 29's diagnosis [REDACTED] and if the Chasteberry was contraindicated.</p> <p>Interview with two facility pharmacists on 5/12/14 at 2 p.m. revealed they were aware of the use of Chasteberry, stating several other clients in the facility were being tried on it. Both were unaware of Client 29's physical diagnoses or the potential for interactions related to his medical concerns. The pharmacists stated that no training had been provided to staff on the potential side effects of Chasteberry nor had any been requested.</p> <p>During an interview with the Individual Planning Coordinator (IPC) on 5/13/14 at 1:30 p.m., the potential side effects of the chasteberry had not been brought up during the weekly Psychotropic Drug Reviews, the IPC did not mention the potential side effects and was not aware of any training for side effects. (See W252)</p> <p>2. Record review showed that Client 86 had [REDACTED] as needed, usage (PRN) of an antipsychotic drug prescribed for anxiety [REDACTED] without an active treatment plan to try to reduce the drug usage and lacked Human Rights approval.</p> <p>[REDACTED]</p>	W 128			

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

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FORM APPROVED  
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W 128	<p>Continued From page 34</p> <p>[REDACTED]</p> <p>A consent, dated 12/12/13, indicated sedation was used for [REDACTED]</p> <p>[REDACTED]</p> <p>Interview with the HRC chairperson, on 5/12/14 at 11 a.m., revealed the HRC was unaware of the use of the antipsychotic drug [REDACTED] being used to treat for anxiety [REDACTED] and no approval had been sought for it.</p> <p>In an interview with two pharmacists on 5/12/14 at noon, they indicated anxiety was not an indication for use of an antipsychotic like [REDACTED] and they were unaware it was being used for that purpose as it was a PRN or as needed drug. The pharmacists indicated they were short staffed and the focus was on dispensing for the entire facility, intermediate care facility, skilled nursing and general acute hospital. They indicated contract pharmacists had been called in just to complete the drug regimen reviews and it must have been missed.</p> <p>Interview with the IPC, on 5/13/14 at 2:30 p.m., revealed she had been in the IPC position for 14</p>	W 128			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 128	<p>Continued From page 35</p> <p>months and was still learning the job. She could not verbalize her role, indicating the physician had prescribed the drugs.</p> <p>During interviews with the Unit Supervisor and residence nurse on 5/15/14 at 10 a.m., they said the combination of [REDACTED] and [REDACTED] with [REDACTED] restraints really calmed the individual. (The consent did not include [REDACTED] restraints for changing [REDACTED] catheter. See W124 ) They stated there was no assessment for less restrictive measures or training completed and designed to teach Client 86 how to tolerate and decrease his anxiety related to the [REDACTED] [REDACTED] catheter changes, routine blood draws or any other medical procedure the drugs were being used for.</p> <p>Review of the policy titled, "Physical Medical Restraints and Supports," dated April 2014, indicated the Individual Program Plan would address situations where sedation and restraints were necessary. Justification for the need of sedation/restraints, less restrictive alternatives attempted, and a desensitization plan to reduce the use of sedation and or restraints would be implemented.</p> <p>Review of the policy titled, "Psychotropic Medication 454," dated January 2014, indicated there would be no PRN (as needed) orders for psychotropic medications. Orders not part of the WPR approved monthly medication plan would be on a one time administration (STAT) basis only, with one repeat dose if the client's condition had not sufficiently improved. Frequent multiple uses of STAT medication had to be incorporated into a Behavior Management Plan and have WPR review and approval.</p>	W 128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 128	Continued From page 36	W 128			
W 136	<p>Review of the HRC policy titled "Human Rights Committee," dated September 2013, revealed the HRC should have reviewed Client 86's medical restrictives, restraints and sedation to assure it was the least restrictive intervention and had the required fading plan (a behavior modification plan designed to gradually reduce the need for the restraints).</p> <p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure community outing opportunities were provided to the clients at the day program as a result of not maintaining the van used for client transportation. This failure limited clients ability to engage in a variety of activities and potentially diminished learning opportunities in the community.</p> <p>Findings:</p> <p>An interview was conducted with the offsite day program staff on 5/12/14 at 10:45 a.m. Staff stated they had not taken the clients on outings to the community in about six months, because they did not have transportation. The last community outing was to the pumpkin patch in the Fall, approximately October of 2013.</p>	W 136			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 136	Continued From page 37 An interview was conducted with the offsite day program supervisor on 5/12/14 at 10:50 a.m. The supervisor stated they had not taken the clients to any community outings because the day program van was broken, but they did take the clients on tram rides around the facility grounds every Wednesday. The supervisor stated he could not remember when the last outing to the community occurred. It was sometime in October or November 2013. The supervisor stated the van had not been functional for about six months.	W 136			
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS  The day program outing records were requested and reviewed. There were two off-campus requests. One was dated 10/22/13, to the pumpkin patch in Sonoma and the other was dated 11/14/13, to Sonoma. There was no specific destination written on the request form.  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the clients were provided personal clothing that fit appropriately. This affected 2 of 17 sampled clients (Clients 64 & 68) and 2 clients outside of the core sample ( Clients 66 & 71), [REDACTED]. This failure resulted in lack of provision to clients, the right to use appropriate clothing, potentially negatively affecting self esteem and dignity.	W 137			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 137	<p>Continued From page 38</p> <p>Findings:</p> <p>On multiple days of the survey (May 5 through May 14, 2014), clients were observed wearing pants which were either too long or too short and did not fit appropriately.</p> <p>5/5/14 at 3 p.m., Client 66 was observed wearing blue sweat pants that were dragging on the floor.</p> <p>5/6/14 at 9:30 a.m., Client 66 was observed wearing blue sweatpants that were too long and dragged on the floor.</p> <p>5/6/14 at 9:45 a.m., a [REDACTED] client was observed in the front of the unit with staff, waiting for the tram to pick them up [REDACTED]. The [REDACTED] client was wearing pants that were too long.</p> <p>5/6/14 at 10 a.m. the physical therapist was observed working with Client 71. The physical therapist had Client 71 walk up and down the stairs at the front entrance of the unit. Client 71 had pants which seemed too big and too long for [REDACTED] size.</p> <p>5/6/14 at 11:25 a.m., Client 68 was walking around in pants that were too long.</p> <p>5/7/14 at 7:50 a.m., Client 64 was observed on the unit wearing pants that were too short for [REDACTED] height. Client 64 was wearing black shoes with white socks that stood out and looked awkward because [REDACTED] pants were so short.</p> <p>5/7/14 at 8 a.m., Client 66 was wearing blue</p>	W 137			

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

PRINTED: 07/25/2014  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 137	<p>Continued From page 39</p> <p>sweatpants that were too long and dragging on the floor.</p> <p>5/7/14 at 8:15 a.m., Client 68 was observed wearing pants that were too long. The pants were cuffed unevenly in a sloppy manner.</p> <p>5/7/14 at 10 a.m., Client 71, was observed at the day program wearing pants that dragged on the floor.</p> <p>5/7/14 at 1:30 p.m., Client 68 and Client 64 were observed at their day program. Client 68 had pants that were cuffed because they were too long for [REDACTED] height. One cuff was about two inches in width and the other leg was approximately 5 to 6 inches in width. Client 64's pants were too short for [REDACTED] size.</p> <p>5/8/14 at 11 a.m., Client 68 was wearing pants that were too long for his size. A second [REDACTED] client was observed wearing pants that hung too low and the client kept stepping on the back of the pants.</p> <p>5/8/14 at 3 p.m., Client 66 was observed wearing blue sweatpants that were ripped at the bottom and were dirty. The pants were dragging on the floor.</p> <p>On consecutive days of the survey (5/5/14 through 5/8/14), Client 66 was observed wearing blue sweat-type pants made of a cotton material that appeared dirty. The pants had padding near the knees and did not fit properly. On multiple observations the pants were observed dragging on the floor as Client 66 wheeled himself around in [REDACTED] wheelchair. The pants were observed to have several rips and torn areas at the edges of</p>	W 137			

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W 137	<p>Continued From page 40 the pants from dragging on the floor.</p> <p>On 5/8/14, at 4:25 p.m., an interview was conducted with the unit supervisor (US 3) regarding the observations of the clients' clothing, including Client 66. [REDACTED]</p> <p>[REDACTED]</p> <p>Client 66 was wearing a pair of blue sweat pants that had multiple tears at the bottom from being dragged on the floor and caught on the wheelchair because they were too long. US (Unit Supervisor) 3 agreed that Client 66's pants were too long and had not previously noticed that the pants dragged on the floor.</p> <p>The observations of Client 66 wearing [REDACTED] blue pants with tears at the bottom for four consecutive days on the unit and at the day program was shared with the US and Senior Psychiatric Technician (SPT 1), on 5/8/14 at 4:30 p.m. From 5/5/14 to 5/8/14 several staff members on both shifts, and at the day program interacted with Client 66. The SPT stated Client 66 had multiple pairs of blue sweat pants. Client 66's closet and clothing was inventoried. Client 66 did have multiple pairs of blue sweat pants that were too long and had tears at the bottom.</p> <p>A concurrent interview was conducted with US 3 and SPT 1 on 5/12/14, at 2 p.m. The US stated that the client's pants were taken to the tailor to get fitted appropriately. [REDACTED]</p>	W 137		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2014  
FORM APPROVED  
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W 137	Continued From page 41   The SPT stated the tailor measured Client 66 and cut 6 inches off the bottom of his pants. US 3 stated her staff needed to pay more attention to how the clients were dressed and the clients' clothes fit properly. The US stated the facility did not have a policy for providing the clients with appropriate personal clothing. US 3 stated it was her responsibility to ensure the clients were provided with clothes that fit correctly and staff monitored the clients for appropriately fitted clothing.  The SPT 1 was told about Client 64 wearing pants that were approximately four to five inches above the ankle. SPT 1 stated some clients liked wearing short pants. The SPT was asked if he would dress like Client 64 and wear "high water pants with white socks and black shoes." The SPT laughed and said, "No, Never."	W 137			
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 document review and interviews, the facility failed to implement its policies that prohibit abuse, neglect or mistreatment of clients when 15 out of 50 General Event Reports generated, during the time frame of 2/1/14 - 5/15/14, were found to have deficiencies in: reporting timely to the facility Administrator or the California Department of Public Health; evidence of thorough investigations; protections put in place	W 149			

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

PRINTED: 07/25/2014  
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W 149	<p>Continued From page 42</p> <p>to prevent further harm; a police report to the Administrator within 5 days of the incident determining if abuse had occurred; and corrective actions taken to prevent recurrence of the event. These failures increased the risk of client abuse.</p> <p>Findings:</p> <p>1. A review of facility incidents of allegations of abuse, neglect, mistreatment or exploitation, and injuries of unknown origin was conducted for incidents generated between 2/1/14 - 5/15/14. Six General Event Reports (GER) were found not to have been reported either to the Administrator immediately or to California Department of Public Health (CDPH) within 24 hours. (See W 153)</p> <p>A review of facility policy 346, "General Event Reporting (GER) &amp; Investigation System," dated July 2013, indicated notification to the Executive Director/Designee is to be " Immediate notification via the AOD/Department Head using the Administrative Notification process (Switchboard) for the following types of incidents, including but not limited to: Alleged/suspected abuse or neglect, including client-to-client aggressive acts; alleged/suspected violation of clients' rights; injuries of unknown origin; elopements ..."</p> <p>Facility policy 346 indicated CDPH must be notified "within 24 hours, including weekends and holidays of all: Alleged/suspected abuse/neglect, including client-to-client aggressive acts. Written notification must be submitted to CDPH within 24 hours, or the following work day if incident occurs on a weekend/holiday of: deaths, serious injuries, injuries of unknown origin ..." However, State of California Title 22, section 76551(a) Unusual</p>	W 149			

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

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W 149	<p>Continued From page 43</p> <p>Occurrences indicates that "...unusual occurrences which threaten the welfare, safety or health of clients, personnel or visitors shall be reported by the facility within 24 hours ...to the Department." The distinction of when to report different types of incidents in this policy does not meet the requirements of Title 22 in regards to reporting to CDPH.</p> <p>During an interview with the Director of Quality Assurance on 5/6/14 at 10:25 a.m., she stated "immediately" is defined as within the hour of the occurrence. In additional interviews occurring throughout the survey, she acknowledged that the reports were late to either the Administrator or to CDPH.</p> <p>2. A review of facility incidents of allegations of abuse, neglect, mistreatment or exploitation and injuries of unknown origin was conducted for incidents generated between 2/1/14 - 5/15/14. Six incidents were found to not be thoroughly investigated. (See W 154).</p> <p>A review of facility policy 346 indicated that staff are to immediately report to the Office of Protective Services (OPS) any incidents of: "alleged/suspected abuse or neglect, including client-to-client aggressive acts; death ... an injury to the genitals when the cause of the injury is undetermined ..." Then, "Depending on the type of incident, as the situation warrants, OPS police officers function as the designated investigator to conduct a preliminary investigation. All allegations of abuse will be forwarded to a Supervising Special Investigator I and/or an OPS investigator for review and follow up to ensure a thorough investigation is completed."</p>	W 149			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 149	<p>Continued From page 44</p> <p>In multiple interviews with facility OPS management during the survey, he acknowledged that investigations were not thorough and/or complete.</p> <p>3. A review of facility incidents of allegations of abuse, neglect, mistreatment or exploitation and injuries of unknown origin was conducted for incidents generated between 2/1/14 - 5/15/14. One incident indicated that a staff member who allegedly abused a client was not removed from client contact when he attended a training session on the unit where the alleged abuse had occurred. (See W 155)</p> <p>A review of facility policy 413, "Abuse/Mistreatment/Neglect Prevention," indicated under Investigation Instructions, Section 3.2.1 "Pending completion of the investigation, the person about whom the allegation is made may be placed on administrative leave or moved to a non-clinical work area ..." Section 3.3 indicated that "During the course of an investigation, when sufficient evidence is obtained which suggests there is a factual basis to any alleged incident, the staff ...involved may be restricted from client contact ...through reassignment or leave."</p> <p>During an interview with the Clinical Director on 5/7/14, she stated she was unaware that the staff had worked on the involved residence and would have removed the staff member if she had known that he was on the unit for training.</p> <p>4. A review of facility incidents of allegations of abuse, neglect, mistreatment or exploitation and injuries of unknown origin was conducted for incidents generated between 2/1/14 - 5/15/14.</p>	W 149			

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

PRINTED: 07/25/2014  
FORM APPROVED  
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W 149	<p>Continued From page 45</p> <p>Two incidents were found to not have been reported to the Administrator within 5 working days by facility police. (See W 156)</p> <p>A review of facility policy 346 indicated that the initial determination to rule out abuse was to be done within 5 days. Section 6.1 indicated that, "Within 5 days of identifying an injury of known or unknown origin, the combination of Level I and Level II GER reviews, along with OPS documentation (OPS Daily Police Activity Log entry, Police Report, or entry on the GER) will be utilized to make an initial determination to rule out abuse. Preliminary status of abuse determination will be documented on the GER by OPS Investigators relative to their initial findings. When indicated, the case will be referred for further investigation."</p> <p>During an interview with the Administrator on 5/6/14 at 3:10 p.m., she indicated that a new process was also initiated after her arrival to track the results of facility investigations.</p> <p>5. A review of facility incidents of allegations of abuse, neglect, mistreatment or exploitation and injuries of unknown origin was conducted for incidents generated between 2/1/14 - 5/15/14. One incident was found in which the facility did not take corrective action in response to an injury of unknown origin. (See W 157)</p> <p>A review of facility policy 410, "Client Protection &amp; Prevention From Harm," dated March, 2014, indicated that weekly Client Protection meetings would occur and GER's, along with other sources, would be reviewed prior to the meetings. The findings will be analyzed for patterns and trends and "The residence manager is responsible for</p>	W 149			

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

PRINTED: 07/25/2014  
FORM APPROVED  
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W 149	Continued From page 46 tracking all action items until completed." Policy 346 indicated that Level III review would be completed by the Quality Assurance Department. This review would include "Analysis of the internal investigation and action plans by the Quality Assurance Office, Special Investigators, and OPS Police. From the analysis, it may be concluded that additional assessment or investigation by other personnel or departments will be necessary." When clinical issues are identified by Quality Assurance in a Level III review, " they will be brought to the attention of the Program manager and Department Head for further analysis and disposition."	W 149			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure that 6 of 22 incidents were reported to either the facility Administrator or to California Department of Public Health within the designated time frames. Failure to report timely	W 153			

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W 153	<p>Continued From page 47</p> <p>may result in ongoing abuse therefore, places the clients at greater risk of harm.</p> <p>Findings:</p> <p>1. During review of facility incidents of allegations of abuse, neglect, mistreatment and exploitation on 5/8/14 commencing at 9:00 a.m., for the time parameter 2/1/14 through 5/15/14, it was revealed the facility reported an allegation of physical abuse for Client 149 on 2/14/14 at 10:10 p.m. An Inter-Disciplinary Note (IDN) written on 2/13/14 was discovered by a Senior Psychiatric Technician (SPT) on 2/14/14 who reported the IDN (Interdisciplinary note) note written by another PT from the day before stated, "I will talk to [SPT] about you have pushed me, tomorrow morning."</p> <p>In an interview with the Office of Professional Services Interim Commander and the Director of Quality Assurance (DQA) on 5/8/14 at 4:10 p.m., it was acknowledged the report was not reported immediately to the administrator and was reported late.</p> <p>2. On 5/15/14 at 1:30 p.m. a General Event Report (GER) was reviewed for Client 50 completed on 5/14/14. On 5/12/14, a representative from the [REDACTED] Regional Center received a letter from Client 50's sister alleging two staff members physically abused her brother. The incident allegedly took place on [REDACTED]/14 wherein a staff member hit Client 50 in the head and stomach and another person allegedly kicked her brother's leg and [REDACTED]</p> <p>The notification to the facility was sent via e-mail</p>	W 153			

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

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W 153	<p>Continued From page 48</p> <p>by the [REDACTED] Regional Center to Client 50's Social Worker who did not open the correspondence until [REDACTED]/14, the date on which the incident was reported.</p> <p>On 5/14/14 at 1:40 p.m. the SCC (Standards Compliance Coordinator) was asked if the facility had written service agreements with outside entities such as the Regional Center to ensure immediate phone notifications get made to the facility when any allegation of abuse, neglect, mistreatment and exploitation needs to be reported. The SCC stated she wasn't aware of a specific policy and explained she would research the matter further.</p> <p>In a follow-up interview with the DQA on 5/15/14 at 7:15 p.m., to determine what facility action had been taken in response to the late notification received by the facility via e-mail, the DQA explained the Facility Director would be in communication with the Executive Director of the Regional Center to discuss the issue.</p> <p>3. A review of the GER (General Event Report) was conducted on 5/12/14 for an incident that occurred on 4/16/14 at 3:30 p.m. The GER indicated that Client 41 was very agitated at not going to the bus ride and hit a few of [REDACTED] peers. The incident was reported to CDPH (California Department of Public Health) Licensing and Certification on 4/17/14 at 4:44 p.m. via email.</p> <p>During an interview with the Director of Quality Assurance on 5/12/14 at 3:30 p.m., she confirmed that the incident was not reported within 24 hours.</p>	W 153			

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

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W 153	<p>Continued From page 49</p> <p>4. A review of the GER was conducted on 5/13/14 for an injury of unknown origin that occurred on [REDACTED]/14 at 5 p.m. The GER indicated that Client 152 was observed to have a bruise on her leg. The incident was reported to CDPH on [REDACTED] via email. The injury of unknown origin was not reported to CDPH within 24 hours.</p> <p>During an interview with the Standards Compliance Coordinator on 5/14/14 at 1 p.m., she explained per facility's policy 346 written notification must be submitted to CDPH within 24 hours, or the following work day if incident occurred on a weekend/holiday for injury of unknown origin. The day of the incident was on a Saturday. She stated a notification was sent on 5/14/14 at 12:18 p.m. regarding the revision of the facility's policy 346 to state all injuries of unknown origin must be reported to CDPH within 24 hours on a 24/7 basis.</p> <p>5. During review of facility incidents of allegations of abuse, neglect, mistreatment and exploitation for the time frame between 2/1/14 - 5/15/14, the facility did not report an incident immediately to the Administrator. The incident involved an allegation of psychological abuse by Client 147 against staff. The GER (General Events Report) was initiated on 2/6/14 at 11:30 a.m. and was not reported to the executive director until 4:34 p.m., five hours after the allegation of abuse was made.</p> <p>During an interview on 5/6/14 at 10:25 a.m. with the Director of Quality Assurance, she stated when an allegation of abuse was made, staff were to make sure the client was safe, report the incident to facility police and then immediately report the incident to the Administrator. She</p>	W 153			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 153	Continued From page 50 defined "immediately" as within the hour of the abuse allegation being made. During an interview with the Director of Quality Assurance on 5/12/14 at 4:00 p.m., she acknowledged the facility was late in reporting to the Administrator in this instance.  6. During review of facility incidents of allegations of abuse, neglect, mistreatment and exploitation for the time period of 2/1/14-5/15/14, it was revealed the facility failed to report two incidents regarding an injury of unknown origin to the California Department of Public Health (CDPH) within 24 hours. Client 122 was noted to have a bruise [REDACTED] on 4/13/14 at 9 a.m. It was not reported to CDPH until 4/14/14 at 4:48 p.m. Client 123 was noted to have an open area on the inside of his cheek on 4/9/14 at 8:05 a.m. and it was not reported to CDPH until 4/11/14.  During an interview with the Director of Quality Assurance on 5/12/14 at 4:00 p.m., she confirmed that the incidents were not reported within 24 hours to CDPH.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure all incidents of abuse, neglect, mistreatment or exploitation between the dates of 2/1/14 - 5/15/14 were thoroughly investigated when 7 of 50 reviewed incidents	W 154			

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W 154	<p>Continued From page 51</p> <p>(Clients 50, 63, 66, 99, 100, 102 and 149) lacked thorough investigation by facility police. One investigative report failed to address the issue of late reporting. These failures increased the risk that deficiencies might not be substantiated and corrective measures taken, due to lack of thorough investigations.</p> <p>Findings:</p> <p>1. During review of facility incidents of allegations of abuse, neglect, mistreatment and exploitation on 5/7/14 commencing at 8:30 a.m., for the time parameter 2/1/14 through 5/15/14, it was revealed the facility reported and investigated an allegation of physical abuse for Client 50 on 2/13/14, wherein it was reported by a relative Client 50 was kicked in the stomach [REDACTED] and the person would not let Client 50 wear [REDACTED] clothes.</p> <p>Per investigation completed on 2/17/14, the allegation was determined to be unfounded due to Client 50's recanting the allegation of physical abuse. Client 50 indicated the incident did not happen and he imagined it. The investigation was absent any disposition with respect to the second component of the allegation stating Client 50 was not allowed to wear [REDACTED] clothes.</p> <p>In addition to this not being addressed in the investigation, there was no evidence interviews had been conducted with any other potential witnesses to address either aspect of the allegation.</p> <p>Per interview with the Office of Protective Services (OPS) Interim Commander, Lieutenant (LT) on 5/7/14 at 9:45 a.m. the LT reviewed the</p>	W 154			

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W 154	<p>Continued From page 52</p> <p>case file and acknowledged the second part of the allegation was not addressed in the report and no other potential witnesses were identified as being interviewed with respect to the allegation of Client 50 being kicked in the stomach.</p> <p>2. During review of facility incident reports on 5/6/14 commencing at 11:15 a.m., it was revealed the facility reported an allegation of potential psychological abuse on [REDACTED]/14 wherein two clients who lived in the Poppe residence, Clients 100 and 102 may have been the victims of psychological abuse due to a verbal exchange which occurred between two direct care staff members. The two clients had episodes of [REDACTED] considered to be uncharacteristic for them and there was speculation they were upset about the employee altercation in the residence on [REDACTED]/14.</p> <p>Review of the investigative report indicated the focus of the investigation centered on the employee misconduct and was deemed inconclusive. Multiple comments were made with respect to employee actions, but there was no evidence of investigation on the core of the allegation to determine if potential psychological abuse had occurred.</p> <p>In an interview with the LT. of OPS, on 5/7/14 at 9:45 a.m., it was acknowledged the focus of the investigation was on the employee interactions.</p> <p>3. During review of facility incidents of allegations of abuse, neglect, mistreatment and exploitation on 5/8/14 commencing at 9:00 a.m., for the time parameter 2/1/14 through 5/15/14, it was revealed the facility reported an allegation of physical abuse for Client 149 on [REDACTED]/14 at 10:10</p>	W 154			

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

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FORM APPROVED  
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W 154	<p>Continued From page 53</p> <p>p.m. An Inter-Disciplinary Note (IDN) written on [REDACTED]/14 was discovered by a Senior Psychiatric Technician (SPT) on 2/14/14 who reported that the IDN note written by another PT the previous day stated, "I will talk to [SPT] about you have pushed me, tomorrow morning."</p> <p>Review of the investigative report revealed the investigation did not identify the issue of late reporting by the PT who documented the allegation of abuse in an IDN note on [REDACTED]/14.</p> <p>During an interview with the LT. of OPS and the Director of Quality Assurance (DQA) on 5/8/14 at 3:15 p.m. it was acknowledged the investigative report did not address the late reporting issue.</p> <p>4. During review of facility reports on 5/8/14 commencing at 8:50 a.m., generated for injuries of unknown source that occurred during the time parameter 2/1/14 through 5/15/14, it was revealed the facility reported and investigated an injury sustained by Client 66 on [REDACTED]/14. Client 66 was discovered with discoloration to his lower back at 7:30 a.m. described as a 5 centimeter x 5 centimeter bruise that was blue, purple and red in color.</p> <p>A GER was initiated and the injury was investigated by OPS. Documentation from the GER evinced (showed evidence) Client 66 was wheelchair dependent, could self-transfer, was known to rock violently sometimes while in a chair and received medication that might cause Client 66 to easily bleed.</p> <p>The OPS investigation was reviewed to determine if rudimentary interrogatories (basic inquiries) were made such as: who worked with</p>	W 154			

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

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W 154	<p>Continued From page 54</p> <p>Client 66 throughout the shifts prior to discovery of the injury? Who bathed and dressed Client 66 the evening before? What time did Client 66 retire for the evening? What occurred from the time Client 66 went to bed and the discovery of the bruise? When was the last time Client 66 was seen without a bruise? The investigation was absent of any timeline or these basic questions.</p> <p>Per interview with the LT. of OPS on 5/8/14 at 3:15 p.m. it was acknowledged the investigative report did not address any of those queries.</p> <p>5. During review of the facility incidents of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin on 5/8/14, for the time parameter of 2/1/14 through 5/15/14, it was revealed the facility reported and investigated an injury of unknown origin for Client 99 that occurred on 4/1/14.</p> <p>Review of the GER indicated on [REDACTED]/14 at 10:20 a.m., Client 99 appeared restless and agitated. The facility staff observed Client 99's left middle finger was swollen. The level 1 review indicated the incident happened at the Lux offsite. The client was [REDACTED] received constant supervision (staff must be in the immediate area and must make visual contact at least every 5 minutes) when [REDACTED] was off his residence, and individual supervision (staff must be able to see the clients at all times and be in close enough proximity to protect them and others from injury) when going on walks. Client 99 was walked over to the offsite by a familiar staff the day of the incident. The staff who worked recently with the client were interviewed. The staff who were interviewed stated they were not aware of the injury, and that they did not observe</p>	W 154			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 55</p> <p>any client to client unwanted interaction, or any staff to client unwanted interaction. █ possibly sustained his injury by bumping into something in █ environment although the incident was unobserved by staff working with the client. All the staff were interviewed during the facility's internal investigation did not include the staff who escorted the client to his offsite from his residence on the day of the incident. The facility was not able to provide documented evidence that during the internal investigation the familiar staff who escorted the client had been interviewed.</p> <p>During an interview with the Standards Compliance Coordinator on 3/8/14 at 4 p.m., she confirmed that there was no documented evidence to show that the staff who escorted Client 99 from his residence to Lux offsite that morning of the incident had been interviewed.</p> <p>A review of the facility's Policy and Procedure 346 titled, "General Event Reporting and Investigation System," with the effective date of July 2013, indicated appropriate and thorough investigation of each incident.</p> <p>6. During review of the facility incidents of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin on 5/14/14, for the time parameter of 2/1/14 through 5/15/14, it was revealed the facility reported and investigated an injury of unknown origin for Client 63 that occurred on █/14. The incident was not thoroughly investigated due to the following:</p> <p>a. A review of the GER indicated on █/14 at 1:15 p.m., Client 63 went to church with a staff member and four other individuals. At 2:55 p.m.,</p>	W 154			

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

PRINTED: 07/25/2014  
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W 154	<p>Continued From page 56</p> <p>it was discovered that Client 63 had wandered off. Initial search was started, the operator was called and the police were notified. The missing client was discovered 12 minutes later sitting outside the main storeroom.</p> <p>The level 1 review indicated that a PTA (Psychiatric Technician Assistant / Aide) went to church with Client 63 and four peers. One of the mothers of her peers also went to church with them. The PTA indicated the client and her peers were in church when client needed to use the restroom. The PTA took Client 63 to the restroom and returned to the church service. The PTA reported later into the service she was bending down to adjust peer's foot pedal on his wheelchair. Client 63 was sitting next to her on the opposite side and PTA did not see Client 63 get up and walk out of the room. The PTA then went to find the missing client. The PTA had the tram driver call the operator at 3:01 p.m. The client was found sitting on a bench in front of the main storeroom at 3:07 p.m.</p> <p>Client 63 was on close supervision (staff must be in the immediate area and must make visual contact at least every 5 minutes) on grounds. There was no documentation to show when Client 63 was last seen prior to 2:55 p.m. when she was observed missing.</p> <p>During an interview with the Standards Compliance Coordinator on 5/15/14 at 10 a.m., she acknowledged there was no documentation on the facility's internal investigation the level of supervision was maintained for Client 63 at the time of the incident.</p> <p>b. The OPS (Office Of Protective Services)</p>	W 154			

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W 154	<p>Continued From page 57</p> <p>incident report was reviewed on 5/14/14 at 9 a.m. The investigation report indicated PTA reported Client 63 went to the bathroom during church services in the Wagner building. The PTA said she went to fix another client's foot rest on ■ wheelchair and when she went to check on Client 63 ■ was gone. Fire and Police searched for the missing client. Firefighter located the client in a chair next to the loading dock of the main storeroom. Client 63 was missing for 12 minutes.</p> <p>On 3/23/14 at 3:01 p.m., the OPS investigator was dispatched to look for the missing client. At 3:15 p.m. the investigator spoke with the PTA who was working with the missing client at the time of the incident. At 3:35 p.m., the investigator attempted to interview Client 63 but the client just stared at the ground and did not answer the question. PTA told the investigator that the client was non-verbal.</p> <p>On 3/25/14 at 9:55 a.m., another interview was conducted with the PTA who was working with the client. She said that Client 63 was on close supervision when she was on the grounds (Facility property) and constant supervision (staff must be able to see and/or hear each individual and be in close enough proximity to intervene as necessary) when she is out in the community (Off Facility property).</p> <p>There was no specific timeframe as to when Client 63 was in the bathroom. There was no documented timeframe when client was last seen from the time she was missing. There was no documentation in OPS investigation indicating who was in the vicinity during the incident and there was no other possible witnesses interviewed. The only person who was</p>	W 154			

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

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W 154	Continued From page 58 interviewed was the PTA who worked with the client during the incident.  During an interview with the OPS Commander at 5/14/14 at 10:50 a.m., he stated that the OPS investigation should have asked who was in the vicinity at the time of the incident and should have interviewed other possible witnesses. He also acknowledged that timeframe should have been more specific timeframe included during the investigation. The OPS Commander stated that the investigation was not thoroughly investigated.	W 154			
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must prevent further potential abuse while the investigation is in progress.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure protection from further potential harm was provided, during the investigation of one allegation of physical abuse, reported during the time period of 1/1/14 through 5/15/14. This affected one focused client (Client 50).  Findings:  During review of facility incident reports on 5/7/14 commencing at 1:30 PM, it was revealed the facility reported an allegation of abuse on 1/22/14 for Client 50 wherein it was alleged Client 50 was struck on the back of the head by a person named "[Staff's first name]." Per investigative report, it was documented a staff member with that first name had worked in Client 50's residence on 1/16/14 and 1/17/14 for training, but had not been removed from client contact while	W 155			

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

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OMB NO. 0938-0391

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W 155	Continued From page 59 investigation into the incident was still ongoing.	W 155			
W 156	Per interview with the Clinical Director on 5/7/14 at 2:00 PM, it was revealed she was initially unaware the staff member had worked in the residence and would have removed the employee from all client contact had she been aware the staff member was in the unit for training. 483.420(d)(4) STAFF TREATMENT OF CLIENTS  The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.  This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure that the results of an investigation of psychological abuse was reported to the facility Administrator within five working days. This failure increased the risk that abuse could be ongoing and/or go undetected during the lapse in time.  Findings:  During review of facility incident reports on 5/6/14 commencing at 11:15 a.m., it was revealed the facility reported an allegation of potential psychological abuse on 2/22/14 wherein five clients who lived in the Poppe residence may have been the victims of psychological abuse due to a verbal exchange that occurred between two direct care staff members.  General Event Reports (GERs) were generated for five clients on the day of occurrence, for	W 156			

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W 156	Continued From page 60 fourteen clients, GERs were generated on 2/24/14 and one client was added to the investigation on 2/25/14.  For the first five clients, Clients 82, 83, 86, 88 and 98 whose GERs were generated on 2/22/14 there was evidence the results of the investigation were reported to the Facility Director (FD) on 3/3/14 one day beyond the 5th working day.  Per interview with the FD on 5/6/14 at 3:10 p.m., it was revealed the facility initiated a process after her arrival to track the results of facility investigations. The Facility Director explained the facility used an "SDC Staff Disposition Cover Page" attached to the preliminary police reports or police entry logs as evidence of receipt of status results.  For the five clients who may have been the victims of psychological abuse, the disposition cover page was signed by the Supervising Special Investigator II on 3/3/14. The FD also made an entry in the GERs for the first five clients on 3/3/14 indicating receipt of the preliminary results of this investigation.	W 156			
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS  If the alleged violation is verified, appropriate corrective action must be taken.  This STANDARD is not met as evidenced by: Based on interview and review of facility reports the facility failed to take corrective action in response to an injury of unknown source sustained by one focused client (Client 1). This failure increased risk of harm to the client due to	W 157			

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W 157	Continued From page 61 lack of intervention.  Findings:  During review of facility reports on 5/8/14 commencing at 8:50 a.m. generated for injuries of unknown source that occurred during the time parameter 2/1/14 through 5/15/14 it was revealed the facility reported and investigated an injury sustained by Client 1 on [REDACTED]/14. Client 1 was discovered with a small open area on top of his head requiring first aid as treatment.  Recommendations were documented in the General Event Report (GER) including one from the Risk Manager (RM) who recommended a "physical therapy consult to watch him walk, stand and sit" [REDACTED]  The Director of Quality Assurance (DQA) was asked to verify when the consult had been completed and evidence was presented in the form of a handwritten request for an updated PT evaluation made on 5/8/14. Per follow-up interview with the RM to determine the status of the PT assessment the RM verified the request had just been made.	W 157			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
(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 159	<p>Continued From page 62</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review for the time parameter 2/1/14 through 5/15/14, the facility failed to ensure each client's active treatment program was integrated, coordinated and/or monitored by a Quality Intellectual Disability Professionals/Individual Planning Coordinator (QIDP/IPC). This affected six focused clients. (Client's 25, 29, 86, 107, 125 and 136)</p> <ol style="list-style-type: none"> <li>Client 25 had a hearing aide which staff held and there was no training plan or timely follow up to her stated desire to hear better and recommendations from the team for audiologist review.</li> <li>Two focused clients identified with changes in condition did not have an individual plan which identified and designed a program plan responsive to those needs. (Client's 107 and 125)</li> <li>Client 29's data collection for self injurious behaviors was inaccurate, the recorded frequency was zero despite evidence otherwise during the Task 2 review.</li> <li>Client 86 was receiving an antipsychotic drug for anxiety with [REDACTED], with no Human Rights Approval, unspecific consent and without a fading or desensitization plan to increase independence.</li> <li>Client 136's IPC failed to ensure discussion of gradual dose reductions occurred and failed to ensure recommendations for objectives be incorporated into the IPP and the viability of success towards achieving objective.</li> </ol> <p>These failures had the potential to result in the</p>	W 159			

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

PRINTED: 07/25/2014  
FORM APPROVED  
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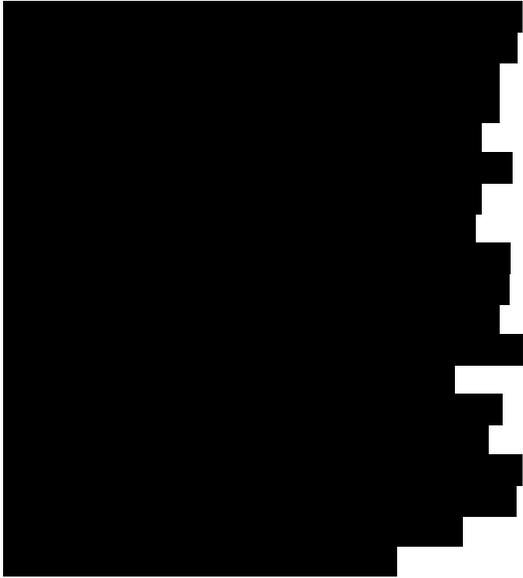
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W 159	<p>Continued From page 63</p> <p>lack of progression towards the clients achievement of his/her established goals.</p> <p>Findings:</p> <p>Review of the general statement of duties for the Individual Program Coordinator (IPC) and role / responsibilities of the IPC, revealed that their activities should be directed toward maintaining the Active Treatment cycle of assessing, planning, monitoring, and taking action on behalf of the individual to enhance his/her independence.</p> <p>The IPC was to have the ability to gather and analyze data. On at least a monthly basis, the IPC was to observe individuals, review data and progress and revise programs and ensure discrepancies between medical, dietary, and programs were resolved. The IPC was also to ensure a follow- up of recommendations for services, equipment, adequate equipment and assistive devices were present.</p> <p>The IPC was to provide leadership in the identification of an individual's strengths, interests, needs, ...and facilitate a team process.</p> <p>Review of the policy titled, "Human Rights Committee," (HRC) dated September 2013, and Whole Person Review (WPR) Process 2013, revealed the IPC was responsible for assuring the Human Rights Committee reviewed a plan containing restrictive interventions.</p> <p>1. On 5/11/14 a review of Client 25's HRC review revealed the Person Centered Individualized Plan, dated 1/28/14, indicated [REDACTED] had a hearing loss. According to the documentation, during the</p>	W 159			

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W 159	<p>Continued From page 64</p> <p>planning meeting Client 25 was asked if [REDACTED] would like to "hear better," to which [REDACTED] replied "yes."</p> <p>The level of care staff indicated Client 25 used to have a hearing aide and that a year and a half later; staff "still had it." Client 25's teacher indicated the trial of the hearing aide was troublesome, as it had ringing problems and did not fit Client 25 [REDACTED]. The Interdisciplinary team (IDT) agreed the physician would set up a conference with the audiologist.</p> <p>A review of the Individual Planning Coordinator (IPC) notes [REDACTED] revealed no discussion of the follow-up for Client 25's hearing aide.</p> <p>In an interview on 5/14/14 at 1 p.m, Client 25's IPC indicated she did not know where the hearing aide was or if the audiologist was made aware of the teams recommendation and re-evaluated Client 25.</p> <p>2a. Record review beginning on 5/7/14 revealed Client 107 was transferred to an outside acute care hospital for surgery on [REDACTED]</p> <p>Review of a special meeting, dated 4/9/14, revealed the team agreed benefits of the [REDACTED] surgery outweighed its risk of [REDACTED] obstruction and the family had provided consent for the procedure. The team indicated Client 107 would "most likely require one to one supervision."</p>	W 159			

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W 159	<p>Continued From page 65</p>  <p>Client 107's family expressed concern that he would need to be watched closely during the planned surgery and should be provided familiar staff as ■ might be afraid. The team assured the family, Client 107's supports would be discussed prior, during and after the procedure.</p> <p>The special meeting to discuss Client 107's planned surgery failed to discuss the concerns and positive interactions identified in the home residence and how they would be proved while at the acute care hospital.</p> <p>2b. Client 125's "review of the individual program plan meeting" dated 3/6/14, indicated a significant change in condition resulting in the agreement to provide palliative (comfort care) and hospice care (Care designed to give supportive care to people in the final phase of a terminal illness and focus</p>	W 159		
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W 159	<p>Continued From page 66 on comfort and quality).</p> <p>A nursing care plan developed 3/7/14 identified physical, emotional and spiritual needs, pain, increased supervision and equipment. However, the individual program planning failed to discuss current active treatment objectives (using a walker, napkin, toothbrushing, reaching for preferred items) in response to Client 125's change in condition.</p> <p>In an interview with the Standards Compliance Coordinator, on 5/8/14 at 7:30 a.m., she confirmed the client's plans should contain needed supports during a hospital transfer or significant change in condition.</p> <p>3. Review of Client 29's behavior data collection for targeted behavior of self injurious behaviors (SIB) revealed no target behavior had occurred during the months of November, December, January, February, March or April 2014.</p> <p>Review of the Individual Planning Coordinator (IPC) note dated 4/10/14 for the month of March 2014 confirmed the data for SIB had been zero (Jan, Feb, March).</p> <p>However, during a review of the facility system to prevent abuse, neglect and mistreatment, incidents were noted related to Client 29's SIB target behavior resulting in bruises in [REDACTED] area.</p> <p>IPC interview on 5/13/14 at 1:30 p.m. revealed it was the psychologist's area to chart and analyze data for behavior. She stated she had been at a special conference on 4/17/14 to discuss Client 29's bruising, but they did not think to review or</p>	W 159			

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W 159	<p>Continued From page 67</p> <p>revise the data collection. The IPC did not verify data based on the client's actual behaviors.</p> <p>4. Client 86 had [REDACTED], as needed (PRN) usage of an antipsychotic drug used for anxiety [REDACTED] without an active treatment plan or Human Rights Committee (HRC) approval.</p> <p>Physician orders, dated 5/6/14, revealed orders for the use of [REDACTED]</p> <p>A consent, dated 12/12/13, indicated sedation was used for [REDACTED] changing of the [REDACTED] catheter, routine laboratory blood draws and oral sedation, but did not specify the drugs to be used.</p> <p>Psychotropic Drug Reviews, dated 2/24/14 and 4/21/14, did not reflect the usage of the antipsychotic drugs used for anxiety during [REDACTED] changes of the [REDACTED] catheter, blood draws or dental procedures.</p> <p>An interview with the HRC chairperson on 5/12/14 at 11 a.m. revealed the HRC was unaware of the use of the antipsychotic drug [REDACTED] being used to treat for anxiety for [REDACTED] and no approval had been sought for it.</p> <p>During interviews with the Unit Supervisor and residence nurse on 5/15/14 at 10 a.m., they said the combination of [REDACTED] and [REDACTED] with [REDACTED] restraints really calmed the individual. They verified there was no assessment or training completed and designed to teach Client 86 how to tolerate and decrease his anxiety related the [REDACTED] catheter changes, routine</p>	W 159			

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

PRINTED: 07/25/2014  
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W 159	<p>Continued From page 68</p> <p>blood draws or any other medical procedure [REDACTED]</p> <p>Review of the policy titled, "Physical Medical Restraints and Supports," dated April 2014, revealed the Individual Program Plan would address situations where sedation and restraints were necessary. Justification for the need of sedation/restraints, less restrictive alternatives attempted, and desensitization plan to reduce the use of sedation and or restraints would be implemented.</p> <p>Review of the policy titled, "Psychotropic Medication 454," dated January 2014, indicated there would be no PRN (as needed) orders for psychotropic medications. Orders not part of the WPR approved monthly medication plan would be on a one time administration (STAT) basis only, with one repeat dose if the client's condition has not sufficiently improved. Frequent multiple uses of STAT medication were to be incorporated into a Behavior Management Plan and have WPR review and approval.</p> <p>Review of the HRC policy titled, "Human Rights Committee," dated September 2013, revealed the HRC shall review medical restrictives, restraints and sedation to assure it is the least restrictive intervention and has the required fading plan.</p> <p>Interviews with IPC's on 5/12/14 starting at 11 a.m. revealed a lack of knowledge related to the role of the IPC, their supervisor confirmed many IPC's were new and learning.</p> <p>5. During review of facility incident reports on 5/12/14 commencing at 1:20 p.m., it was revealed the facility completed a General Event</p>	W 159			

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W 159	<p>Continued From page 69</p> <p>Report (GER) on Client 136 for person to person abuse on 3/21/14 when Client 136 hit Client 131 lightly on the head.</p> <p>Record review for Client 136 on 5/13/14 commencing at 1:40 p.m. revealed an Individual Program Plan (IPP) meeting dated 4/21/14 which identified the use of three medications for behavior management: [REDACTED] [REDACTED] All three medications were currently prescribed as of [REDACTED]/14.</p> <p>A statement regarding the facility plans for a potential reduction in behavior altering medication was developed. It stated, "When aggression reaches 0 for 24 consecutive months a medication decrease will be considered."</p> <p>The psychologist for Client 136 was interviewed on 5/13/14 at 2:20 p.m. and was questioned about the use of three medications to ameliorate the identified target behaviors of self-injurious behavior (SIB) and aggression. When the psychologist was asked to identify the target behavior to which the medications were linked, the psychologist stated, "aggression." When the psychologist was asked to offer an opinion as to which of the three medications was working, the psychologist stated, "all three."</p> <p>Per follow-up interview with the HSS (Health Services Specialist) to determine the last time a reduction had occurred in any of the three behavior altering medications, the HSS reviewed the medication database and concluded the medications and dosages were essentially the same for five years except for a period of time when [REDACTED] was increased and subsequently decreased back to its previous</p>	W 159			

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

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W 159	Continued From page 70 level.  In an interview with the facility's Chief Psychologist (CP) on 5/14/14 at 3:45 p.m. it was revealed and stated, Client 136 had a medication reduction in [REDACTED] last year. When the CP was asked to comment on the behavioral objective requiring 0 incidents of aggression for 24 months before a medication reduction would be considered, the CP stated that was "indefensible" (incapable of being justified).  In an interview with the Supervisor of the Quality Intellectual Disability Professionals (QIDPs) on 5/15/14 at 11:25 a.m., to ascertain QIDP responsibility in addressing recommendations for objectives to be incorporated into the IPP and the viability of success towards achieving objectives, the supervisor explained QIDPs monitor client plans for progress and the development of behavioral objectives rested with the psychologist.  In a follow-up interview with the Chief Psychologist (CP) on 5/15/14 at 11:45 a.m. the CP was asked his opinion about professional responsibility related to the establishment of objectives for the IPP. The CP concurred with the QIDP (Qualified Intellectual Disabilities Professional) supervisor that psychologists would make recommendations with respect to behavioral objectives, but ultimately the inter-disciplinary team had the responsibility for acceptance of any behavioral objective recommendations.	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with	W 189			

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W 189	<p>Continued From page 71</p> <p>initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure that training was conducted to a registry staff regarding appropriate use of a wheelchair for 1 client (Client 99) outside of the core sample;</li> <li>2. Ensure a sampled client (Client 143) observed in a day room, was not observed with soiled pants;</li> <li>3. Ensure an additional client outside the core sample (Client 139) was not observed with soiled pants.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. A review of the facility's GER was conducted on 4/12/14 for an incident that occurred on 3/5/14 at 2 p.m. The GER indicated Client 99 was observed coming from the worksite sitting in a wheelchair within a pinpoint seatbelt. Per the GER, Client 99 was placed in a wrong wheelchair with unfamiliar staff.</li> </ol> <p>A review of Client 99's Objective and Plans, dated 3/5/14, indicated [REDACTED] Nothing was mentioned regarding the use of a pinpoint seatbelt.</p>	W 189			

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W 189	<p>Continued From page 72</p> <p>An interview was conducted with the US (Unit Supervisor) on 4/13/14 at 1:34 p.m. The US stated that she was the one who observed the client using a wrong wheelchair with a pinpoint seatbelt in place. She further stated that Client 99 had [REDACTED] own wheelchair and used a seatbelt for safety. [REDACTED]</p> <p>The Unit Supervisor also stated that it was a registry staff that placed Client 99 in the wrong wheelchair. She confirmed that the registry staff was not given training regarding specific adaptive equipment for Client 99.</p> <p>2. An observation was conducted on the Brent Unit on [REDACTED]/14, starting at 8:15 a.m. From 9:15 to 9:35 a.m., Client 143 was observed in Room [REDACTED] (Sensory Room) with a [REDACTED] peer. Client 143 was noted lying down in the couch holding strings and flipping it with his hands. The television was on, showing a court TV show. The client did not show interest in watching television. Both clients were left alone in the room with no staff. Client 143 was wearing [REDACTED] shorts. The shorts were noted soiled with large brown area at the back of the shorts. There was no staff present in the room to provide intervention.</p> <p>On 5/8/14 at 9:35 a.m., the Acting US (Unit Supervisor) was interviewed. She was informed of the two clients being left alone with no activity and Client 143 being soiled. She stated, "This is their quiet time activity." She confirmed, Client 143 was soiled and needed to be changed.</p> <p>3. An observation was conducted on the Brent Unit on [REDACTED]/14, starting at 8:25 a.m. [REDACTED]</p>	W 189			

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

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W 189	Continued From page 73 [REDACTED] Client 139 was observed pacing the hallway wearing [REDACTED] pants. The client was noted restless pacing in and out of [REDACTED] room and towards the nursing station. The client's pants were noted to be soiled from both thigh areas all the way down to [REDACTED] ankle area. Several staff were observed passing by the client and did not provide interventions.  An interview was conducted with the US on 5/14/14 at 10:45 a.m. The US confirmed the finding and stated the staff assigned to Client 139 was attending to another client. She stated other staff should have provided care to the client.	W 189			
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, staff interview, and record review, the facility failed to provide training to its employees that was focused on the skills and competencies directed toward Client 57's individual behavioral needs. The facility staff did not demonstrate the necessary skills and interactions needed to decrease the inappropriate behavior demonstrated by Client 57.  Findings:  On [REDACTED]/14, at 11:30 a.m., Client 57 was observed walking around the hallways. Client 57 suddenly went after the federal surveyor, and attempted to grab her hair. The a.m. Senior Psychiatric Technician (SPT) was observed sitting in a chair in front of the nursing station where the incident occurred. The SPT did not do anything about the	W 191			

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

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W 191	<p>Continued From page 74</p> <p>incident. The SPT did not attempt to stop Client 57 and did not address the negative behavior.</p> <p>At 11:40 a.m., Client 57 went to the nurse's station and threw paper with a brown matter at the desk. The office technician stated not to touch it, because it had feces. The client attempted to touch the US. In a concurrent interview with the US, the US stated that Client 57 had open behavior problems for intrusive behaviors, unwanted touching of female hair, [REDACTED]. The US stated that all staff were aware of how to handle Client 57's behaviors, because it is detailed on the Windows (A document that contained information about the clients). The Windows document was reviewed with the US. The Windows document did not provide interventions for staff to use when they saw Client 57 trying to grab or touch females' hair. The US verified that the Windows did not contain the interventions for dealing with Client 57's intrusive behavior. The US stated that the Windows was not complete and would have the document updated to include all information needed for staff to know what to do when Client 57 exhibited his negative behaviors of inappropriate touching. The US stated she would talk to the psychologist about Client 57's behavior.</p> <p>An interview was conducted with the SPT on 5/7/14 at 2:35 p.m. The SPT stated he was in charge of the a.m. shift. The SPT was asked about Client 57's behaviors. The SPT stated he did not know them all but he did have his Windows in his pocket that would list all of the client's behaviors. The SPT stated that Client 57 [REDACTED]. The SPT did not know that</p>	W 191			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 191	<p>Continued From page 75</p> <p>intrusiveness and inappropriate hair/head touching was one of Client 57's behavior problems.</p> <p>On [REDACTED]/14, at [REDACTED] Client 57 was observed walking around the hallways. [REDACTED] Client 57 continued to pace around the hallway and nurse's station. There was no staff observed providing supervision of the clients in the hallways. The Office Technician and Occupational Therapist were behind the nurse's station. Client 57 suddenly attempted to grab the federal surveyor's hair. No staff intervened. Minutes later, Client 57 attempted two additional times to grab the females' hair. In the last attempt, Client 57 grabbed the surveyor's name badge and it was thrown over the nurse's station. Both facility staff members that were behind the nurse's station did nothing. The Occupational Therapist was observed leaving the nurse's station and attempting to walk away from the incident. The Occupational Therapist was stopped and asked why he did nothing about Client 57 aggressive behavior. The Occupational Therapist stated, "I'm not a behavior specialist." The Occupational Therapist further stated that Client 57 was done by the time he came out of the nursing station. The Occupational Therapist stated he was not aware of Client 57's behaviors.</p> <p>Minutes later, the US came to the nurse's station and Client 57 attempted to grab her hair. The US stated the Occupational Therapist did not work on the unit. The OT was there to file documents in the records, and was not familiar with the clients. The US stated she did not provide information regarding client behaviors to all staff that came onto the unit.</p>	W 191			

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W 191	<p>Continued From page 76</p> <p>On [REDACTED]/14 between 9:40 a.m. and 12 p.m. no structured activity was observed for Client 57. When Client 57 first arrived to the classroom [REDACTED] walked around moving chairs for a few minutes. For the rest of the morning Client 57 was left to do whatever [REDACTED] wanted. Client 57 walked around the classroom and at times pushed the chair against the table.</p> <p>At approximately 10:50 a.m., Client 57 walked behind Client 78 and pushed [REDACTED] off her chair. Staff did not intervene or redirect Client 57.</p> <p>In an interview with the teacher, on 5/7/14, at 11:15 a.m., the teacher stated they did not have assigned seating in the classroom. The teacher stated the clients could sit wherever they wanted to. The teacher further stated that if they did not let Client 57 do what [REDACTED] wanted, Client 57 would get upset in class, and they did not want that to happen. The teacher stated, "The more you intervene, he more [REDACTED] will escalate."</p> <p>From 11 a.m. to 12 p.m., [REDACTED] was left to do whatever he wanted. Client 57 walked around the classroom, picking things off the floor, and at times pushed in the chair against the table. There were no structured activities observed with Client 57.</p> <p>On 5/8/14, during the day program observation, Client 57 was observed walking around the classroom and not engaged in any type of structured activity.</p> <p>On [REDACTED]/14 at 9:40 a.m. Client 57 was inappropriate and intrusive, as [REDACTED] tried to grab females' hair. The offsite staff did nothing about it. At 9:47 a.m., Client 57 again tried to touch a</p>	W 191			

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W 191	<p>Continued From page 77</p> <p>female's hair. The classroom teacher laughed and ignored the behavior. [REDACTED]</p> <p>[REDACTED] At 9:55 a.m., Client 57 attempted a third time to grab the female's hair. Staff threw a ball at Client 57 to distract him [REDACTED]</p> <p>[REDACTED]</p> <p>On 5/7/14 and 5/8/14 [REDACTED] During lunch observation, Client 57 was not observed wiping the table after the clients ate. Staff was observed wiping the table after the clients were done eating.</p> <p>Client 57's day program objectives were reviewed. The offsite objectives for Client 57's were to wipe down table after lunch and wash hands after using restroom. [REDACTED]</p> <p>[REDACTED]</p> <p>The offsite "Windows" was reviewed. Under Alerts, it indicated "May touch hair, [REDACTED] Under Behaviors, the window indicated that Client 57 had Intrusive behaviors of unwanted touching of hair/head. The Windows did not list interventions for staff to implement when Client 57 exhibited the behavior of the unwanted and inappropriate touching of female hair/head.</p> <p>On 5/8/14, at 10:15 a.m., an interview was conducted with Client 57's psychologist. [REDACTED] Client 57 [REDACTED] did [REDACTED]. The psychologist stated it was important that Client 57 be allowed to do [REDACTED] rituals. As the Client 57 paced around the classroom, the psychologist stated, "That is part</p>	W 191		

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W 191	Continued From page 78 of [REDACTED] active treatment."  In an interview with the US, on 5/8/14, at 9 a.m. the US stated that they had a special meeting to discuss Client 57's intrusive behavior of touching females' hair. The US stated the team had implemented a new Behavior Support Plan.  The Behavior Support Plan, dated 5/8/14, was reviewed. The Plan was two pages long and addressed target behavior [REDACTED]. The plan did not address Client 57's intrusive behaviors of unwanted and inappropriate touching of females' hair. The previous Behavior Support Plan, dated [REDACTED] 2014, [REDACTED], of [REDACTED] did not address inappropriate touching of female hair. The most current IPP for Client 57 was from [REDACTED], 2013. The IPP indicated that Client 57 had a behavior that consists of unwanted touching of females' hair, [REDACTED]. The IPP further indicated, "Data collection for this behavior began in 10/12. During the past seven months (10/12 - 4/13), ratings of intrusive behavior were an average of 434 incidents per month. This was baseline data and no objective was set..." The IPP did not address an intervention or give a detailed plan to address the behavior that consists of unwanted touching of females' hair, [REDACTED].	W 191			
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			

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W 192	<p>Continued From page 79</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record reviews the facility failed to ensure an identified concern by the facility in staff competency. Documentation and implementation of clients' hydration and fiber needs related to their risk of constipation was not thoroughly understood by staff, documented and analyzed for discrepancies and acted upon timely.</p> <p>The facility failed to implement their policy titled, "Bowel Care Management" dated March 2014, placing five of ten focused clients (Clients 27, 51, 85, 86 and 174) of 131 and one death review client identified to be at high risk of constipation for complications including abdominal pain, discomfort, frequent use of laxatives, fecal impaction, bowel obstruction, and /or delayed gastric emptying, emesis and secondary aspiration and acute hospital transfers. This affected 1 of 17 sampled clients (Client 13) and 5 focused clients (Clients 27, 51 85, 86, and 174). See W331</p> <p>Findings:</p> <p>1. Review of the IPP (Individual Program Plan) on 5/14/14 indicated that Client 174 was at risk for bowel obstruction and constipation and [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	W 192			

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W 192	<p>Continued From page 80</p> <p>[REDACTED]</p> <p>Staff were to document total fluid intake every shift on the daily care flow sheet #5504 and were to notify HSS/ACNS if daily intake was less than 50% of baseline.</p> <p>Review of the daily care flow sheet for 2/14 contained a section for documenting fluids which instructed staff to record ccs (cubic centimeters/unit of measure) of fluids taken in the a.m. and p.m.</p> <p>On 2/1/14, 2/2/14 and 2/3/14 there were what appeared to be 6 entries that documented fluid intake for the a.m. and p.m. shifts, the majority of entries were illegible.</p> <p>On [REDACTED] 14 Client 174 was admitted to the facility GACH for pre- procedure care [REDACTED] and returned to his home unit on [REDACTED] /14.</p> <p>Aside from one IDN shift entry that documented 1,680 cc's of fluid intake on [REDACTED] /14 at 2 p.m., there was no further documentation of fluid intake for the next 7 days, upon which time Client 174 was hospitalized [REDACTED]</p> <p>The daily care flow sheet also contained a section entitled, "Eating," and included documentation of nourishments for 8 ounces of prune juice at breakfast and Carnation Instant Breakfast at breakfast, lunch and dinner. The majority of fluid entries were illegible, resulting in staff being unable to determine the actual amount of nourishments that were actually consumed by the client.</p>	W 192		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 192	<p>Continued From page 81</p> <p>During an interview with the ACNS (Asst. Coordinator of Nursing Service) on 5/12/14 at noon revealed the facility had identified a systems concern with staff competency, documentation, and implementation of clients' hydration and fiber needs related to their risk of constipation. The facility revised their policy titled, "Bowel Care Management," dated March 2014, and provided training with on-going audits.</p> <p>In an interview with the CNS (Coordinator of Nursing Services) on 5/15/14 at 12 p.m., the CNS stated the policy was revised and stated staff training was provided. The CNS also stated that any high risk client required fluid tracking every day. The CNS further stated that the flow sheet should be filled in.</p> <p>Review of the policy titled, " Bowel Care Management" dated March 2014 revealed staff were to: Encourage fluids and ensure adequate fluid intake. Provide diet as ordered with encouragement of foods high in fiber when not contra-indicated. Monitor bowel movements and document results on ADL flow sheet.</p> <p>Additionally for clients who were identified as at HIGH RISK for CONSTIPATION: Hydration totals by cc (fluid measurement) would be tracked and documented on the activities of daily living (ADL) flow sheet each shift on a separate row than percentage of meal consumed. Licensed staff were to review daily total fluid intake to ensure standard hydration goal of 6-8 glasses, or 1440-2000 cc/day was met. When</p>	W 192			

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W 192	<p>Continued From page 82</p> <p>daily hydration goal is not met additional fluids should be offered and encouraged. Notify CRN/HSS/ACNS if daily intake is less than 50% of baseline.</p> <p>Staff were to document: ADL flow sheet form #DS5504 by the end of each shift. Shift lead was to ensure completion. The PT / LVN was to document observations of signs and symptoms, deviations form usual condition. RN was to provide a synthesis of subjective and objective information which included nursing actions, interventions, follow-up and notifications. For clients at risk for constipation a monthly/ weekly review by licensed staff was required .</p> <p>On 5/14/14 a request was made to QA for a list of clients identified to be at high risk for constipation. A list of 131 clients was received. Client's 8, 32, 46, 67, 75, 86, and 133 were chosen with descriptions of constipation other, constipation unspecified, constipation slow transit for focus review for implementation of the revised policy.</p> <p>2. Client 86's Medical History, dated 1/17/14, indicated he had chronic constipation and a [REDACTED] catheter [REDACTED]. The facility protocol for individuals with a [REDACTED] catheter was to monitor and document daily fluid input and urinary output (I &amp; O).</p> <p>Client 86's I &amp; O and flow sheets showed inconsistencies. For example: On 3/18/14 the a.m. fluid documented on the flow sheet was 720 cc's at breakfast and lunch and 240 cc prune juice at breakfast and lunch. The I &amp; O sheet showed for breakfast and lunch; 720 cc, 720 cc</p>	W 192			

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

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W 192	<p>Continued From page 83 and 240 cc to equal 1680 however the total documented was 1440 cc. When asked if the total fluid consumed on the flow sheet included the prune juice served with meals, the nurse was not sure.</p> <p>Other inconsistencies for Client 86's fluid intake documentation were: On 3/29/14 the daily fluid total was not calculated. On 4/4/14 the I &amp; O for the a.m. shift was 240, plus 150, plus 480 to equal 870 cc and the PM shift was 720 plus 400 cc equaling 1120ccs. The daily total was not 1990 (the sum of 870 cc and 1120 ccs) it was documented to be 2310 ccs consumed.</p> <p>There was no identification of what Client 86's daily estimated fluid needs were on the I &amp; O or ADL flow sheets. There was no signature of the person totaling the fluid on the I &amp; O sheets.</p> <p>The quarterly nursing evaluation dated 4/3/14 indicated Client 86's bowel pattern was normal but 5 PRN's for bowel care had been given. Client 86's [REDACTED] was prescribed and "extra fluids encouraged." The ADLs were recorded as usual. There was no synthesis of Client 86's intake of fluids and urinary output by the nurse. The Psychotropic Drug Review dated 4/21/14 indicated more frequent PRN's for bowel care - March showed 6 PRN's and 3 in April 2014.</p> <p>A monthly summary dated 5/9/14 indicated Client 86 was at "High Risk for Constipation" but there was no reference of his fluid intake or fiber, how staff encouraged fluids or fiber or if his daily goals of fluid were met.</p> <p>The annual nutritional assessment dated 1/9/14</p>	W 192			

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W 192	<p>Continued From page 84</p> <p>estimated Client 86's daily fluid requirements to be 2651 cc with a recommendation to increase clear fluids.</p> <p>In an interview with the residence nurse and Health Services Specialist, on 5/15/14 starting at 8 a.m., they were unable to verbalize how to access the information regarding daily fluid requirements for Client 86. Both thought that the fluid requirements would be found in the physician orders, but when orders were accessed on the computer, the nurses were unable to find any specific information. The nurse said the plan of care for Client 86's constipation concern did not include daily fluid requirements. When asked how the nurse communicated to the staff the need for increased fluids or fiber in the diet, she indicated the ordered diet met all Client 86's needs. When asked if a lack of fluid or fiber in the diet could be related to Client 86's need for PRN's to stimulate bowel, she replied, there was no correlation. The nurse indicated she had been trained in the new Bowel Care Management protocol.</p> <p>3. Client 85 </p> <p>The nutritional evaluation, dated 2/3/14, estimated his fluid needs to be 2245 cc daily with recommendations to drink only 2 ounces at a time. The ADL sheet for May 2014 showed staff documented Client 85 drank a low of 1354 cc to 2199 cc daily.</p>	W 192			

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

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OMB NO. 0938-0391

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W 192	<p>Continued From page 85</p> <p>In an interview with the residence nurse and Health Services Specialist on 5/15/14 starting at 8 a.m., they were unable to verbalize how to access the information regarding daily fluid or fiber requirements for Client 85; see interview above.</p> <p>4. A review of Client 13's "Objectives - Expected Outcomes" was conducted on 5/14/14. listed as "Objective 1. [Clients Name] will be free of complication related to constipation evidenced by having a bowel movement every 2-3 days". The objective contained steps to implement the plan. "Step 3 "Encourage fluids. Document total fluid intake every shift on a daily care flow sheet #5504 per NP A405. Notify HSS (Health Services Specialist) / CRN (Clinical Registered Nurse) /MD if daily intake is less than 50% of baseline."</p> <p>On 5/14/14 at 5:30 p.m., a review of Client 13's Individualized Daily Care Flow Sheet (DCFS) DS 5504 was conducted. An inadequate amount of fluid intake was recorded from 5/1/14 through 5/14/14. On six out of 14 days for the month of May 2014 the documentation recorded as 300 cc's per day (equivalent to about 10 ounces of fluid per day). Documented was 100 for Breakfast 100 for lunch and 100 for dinner, for May 1, 2, 3, 4, 10 and 11, 2014.</p> <p>The month of March and April listed inconsistencies in the documentation of fluid consumed. The month of March 2014, fluid intake was listed on 3/1/14, as breakfast 80, lunch "S". The intake for 3/2/14 was written the same as Breakfast 100 and lunch "S". On April 2014, the Breakfast was 100, Lunch "S" and dinner 100. On April 15 the documentation was recorded as Breakfast 100, Lunch "S".</p>	W 192			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 192	<p>Continued From page 86</p> <p>The DCFS document contained a legend that listed abbreviations for "Care completed as planned" The letter S was an abbreviation for the word self. It was not an indication of cc's consumed.</p> <p>The policy titled "Assisted Feeding Estimating Intake Procedure," A405 revised 10/2013 section III, was reviewed on 5/15/14 and documented in Section III,. "Estimating Fluid Consumed By Clients - standard recommendation is 6-8 glasses or 1440-2000 ml (cc) per day for the average sized person"...</p> <p>Further review of the clinical record there was no documentation that addressed the inadequate fluid intake, for the days recorded as 300ccs' per day.</p> <p>On 5/15/15 at 2 p.m., during an interview with the Unit supervisor, she stated that the staff who are documenting 100 must mean 100% of fluids per meal consumed. The unit supervisor confirmed that the DCSF form should contain the amount of cc's of fluid consumed per shift, and not the percent of meals.</p> <p>5. A review of Client 51's medical record indicated [REDACTED] constipation [REDACTED]. A review of the dietary assessment indicated that her fluid requirements were calculated to be 2476 cc/day.</p> <p>During an interview with a Clinical Nurse on 5/15/14 at 11:50 a.m., he was unable to demonstrate or verbalize how to access the information regarding fluid requirements for Client 51. He thought that the fluid requirements would be found in the dietary orders, but when he</p>	W 192			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 192	<p>Continued From page 87</p> <p>accessed those orders on the computer, he was unable to find any specific fluid requirement information so he stated that [REDACTED] would be on standard requirements which would be about 2000 cc/day. Even when he was told by the surveyor that the fluid requirements could be found on the dietary assessment he still did not find the section listing Client 51's specific fluid requirements. The surveyor had to point it out to him.</p> <p>When asked what he would do if Client 51 did not meet [REDACTED] fluid requirements for the day, he stated that [REDACTED] could be offered other fluids but could only name a few sources of supplemental fluids, such as juice, soda, coffee or tea. He was unable to verbalize other common, and more nutritious, sources of fluids available such as Jell-O, pudding, soups, ice cream, popsicles, etc., even with prompting by the surveyor.</p> <p>He stated that he was trained on the new bowel care policy by the ACNS and then he trained the rest of the staff on the unit. He stated that he could not remember if there had been a post-test for the training received. He stated some training has post-tests and some training does not. He stated that as per the new policy, all clients on the unit had been assessed and were monitored for bowel problems and bowel care needed.</p> <p>When Client 27's record was randomly pulled for review and the Activities of Daily Living (ADL) sheet was reviewed, it was noted that there was no documentation of any bowel monitoring being done. The ADL sheet in Client 27's record did not even have any space for bowel monitoring and was completely different from the ADL sheets in other clients' records. The Clinical Nurse could</p>	W 192			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 192	Continued From page 88 not explain why Client 27 did not have the correct sheet in his medical record.	W 192			
W 195	483.440 ACTIVE TREATMENT SERVICES  The facility must ensure that specific active treatment services requirements are met.  This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Condition of Participation of Active Treatment Services was met when individuals were not involved in activities which addressed their individualized priority needs.  The facility did not assure individuals had opportunities to practice new or existing skills and to make choices in their daily routines. The facility failed to ensure data was accurate, collected, documented, and analyzed in the method and frequency required by the plan. The facility did not assure active treatment plans were implemented by trained staff, and objectives amended and revised by the qualified mental retardation professional (QMRP) / Individual Program Coordinator (IPC). The facility failed to ensure the Human Rights Committee (HRC) reviewed and monitored individual programs designed to manage behavior which involved risks to client protections and rights. This affected 9 of 17 core sample clients (Client's 13, 64, 68, 78, 100, 102, 119, 138, 143) and 23 of 57 focused clients (Clients 6, 7, 20, 24, 25, 27, 29, 44, 51, 54, 57, 73, 77, 85, 86, 107, 125, 129, 131, 132, 139, 140 and 174) as evidenced by the following:	W 195			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 195	<p>Continued From page 89</p> <ol style="list-style-type: none"> <li>The facility failed to ensure four of 17 sampled clients (100, 102, 119 and 143), and five focused clients (Client's 129, 131, 132, 139 &amp; 140) at the LUX day program, Stoneman and Poppe residences received a continuous active treatment program. (See W196)</li> <li>The facility failed to ensure two focused clients identified with changes in health had an individual program plan which identified and designed programs responsive to their changing needs. (Client's 107 and 125) (See W206)</li> <li>The facility failed to ensure behavior objectives were stated separately in a single behavioral outcome for one of three HRC focus reviews (Client 86). (See W229)</li> <li>The facility failed to ensure one of 17 sampled clients (Client 100) behavior in the dining room was identified and a training program was formulated to promote the client's ability to function. (See W238)</li> <li>The facility failed to develop a program plan that addressed an individual client need for Client 20 addressing the personal hygiene necessary to reduce the risk of developing urinary tract infections (UTI's). Client 73, with a behavior plan [REDACTED], did not have any interventions listed in the plan that addressed this behavior. This affected two focus clients (Clients 20 and 73). (See W242)</li> <li>The facility failed to ensure opportunities for choice and self management related to food preparation and for making choices to foster greater independence for two of 17 sampled clients (Client's 138 and 143) and five additional</li> </ol>	W 195			

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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 195	<p>Continued From page 90 clients. (See W247)</p> <p>7. The facility failed to ensure a continuous active treatment program was provided for four of 17 sampled clients (Client's 64, 78, 100 and 138) and 8 clients outside the core sample (6, 7, 24, 54, 57, 77, 102, and 119) (See W249)</p> <p>8. The facility failed to ensure data was accurate, collected, documented, and analyzed in the method and frequency required by the plan. This affected 1 of 3 focused clients from the HRC review (Client 29), 1 of 17 sampled clients (Client 13) and 4 of 10 focused clients (Client's 27, 51, 85 and 86) from 131 clients identified by the facility to be at high risk for constipation, and one death review (Client 174). (See W252)</p> <p>9. The facility failed to ensure the individual program plan was reviewed and revised for one of three focused clients who had human rights committee reviews. During review of the human rights committee review when Client 86 had successfully completed an objective [REDACTED] for which highly restrictive interventions (antipsychotic drugs) were employed, the review and revision were not done. (See W255)</p> <p>10. The facility failed to ensure the HRC reviewed and monitored individual programs designed to manage behavior which involved risks to client protections and rights. This was evident for one of three focused clients of the HRC review. Client 86 had [REDACTED], as needed, usage (PRN) of an antipsychotic drug used for anxiety [REDACTED] without an active treatment plan or HRC approval. Client 86 also received</p>	W 195			

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W 195	Continued From page 91 drugs for the management of inappropriate behavior for which there were no long term plan and objectives to decrease these behavioral restrictive interventions, i.e., drugs to modify behavior. (See W262)  11. The facility's specially constituted committee (HRC) failed to ensure written consents were obtained by all co-conservators for programs to manage inappropriate behaviors, or containing the administration of behavior altering medications prior to implementation for one of 17 sampled clients (Client 68) and two focused clients (Client's 44 and 131). (See W263)  The cumulative effect of these systemic problems resulted in the facility's failure to ensure that active treatment objectives and programs were provided.	W 195			
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, interview, and record review, the facility failed to ensure 4 of 17 sampled clients (Client's 100, 102, 119 and 143)	W 196			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 196	<p>Continued From page 92</p> <p>and multiple focused clients (Client's 129, 131, 132, 139 &amp; 140) at the LUX day program, Poppe and Stoneman residences received a continuous, consistently implemented program consisting of supports and services which met health related and training needs. These failure had the potential for a decline in the client's functional abilities.</p> <p>Findings:</p> <p>1a. On █/14 at 9:50 a.m., Client 102 was observed sitting by himself in █ without activities for 10 minutes. On 5/7/14, he was observed from 8:15 a.m. through 9:10 a.m. in his room without any activities.</p> <p>On █ 14 at 10 a.m., an observation in █ of the Lux Day Program was conducted. Five clients were observed inside the room with one staff. Clients were observed sitting on a chair from 10 a.m. through 11:55 a.m. without being engaged in any activities. At 11:55 a.m., Client 102 arrived in the room. Staff was observed entering and exiting the room. There was no staff observed in room 127 from 12:05 p.m. through 12:15 p.m. Client 102 was observed from 11:55 a.m. through 1:25 p.m., sitting on a couch and not engaged in any activities.</p> <p>On █/14, Client 102 was observed sitting on a chair in █ of Poppe unit from 9 a.m. through 9:30 a.m. without any activities. █ was observed in █ of Lux Day Program sitting on a couch from 9:40 a.m. through 10:40 a.m. There was no staff observed inside the room from 9:40 a.m. through 10:07 a.m. Client 102 remained seated in the room without any activities observed for an hour.</p>	W 196			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 196	<p>Continued From page 93</p> <p>On 5/14/14 at 10:40 a.m., a review of Client 102's Individual Plan Skill/Behavior Development Objectives and Plan, dated 4/17/13, was conducted. The review indicated that he should be involved in an adult living task by helping the staff in folding towels and bringing the laundry in and out.</p> <p>1b. On [REDACTED]/14, Client 100 was observed in the group room of Poppe unit. [REDACTED] was observed sitting on a couch from 9:30 a.m. through 10 a.m., without any activities. On [REDACTED]/14, an observation from 10 a.m. through 11:55 a.m. in [REDACTED] of Lux Day Program was conducted. Client 100 was observed sitting on a chair without being engaged in any activities.</p> <p>On 5/8/14, Client 100 was observed with two other [REDACTED] clients in room 151 of Poppe residence from 9 a.m. through 9:30 a.m. There were no activities observed during a half an hour of observation of the clients. [REDACTED] was observed in room [REDACTED] of the Lux Day Program on the same day with three female clients, five male clients, and one staff. Client 100 was observed without activities from 9:40 a.m. through 10:40 a.m. The staff started engaging the clients at 10:17 a.m., one at a time.</p> <p>On 5/14/14 at 10:40 a.m., a review of Client 100's "Review of the Individual Program Plan" (IPP), dated 2/13/14, was conducted. The review indicated that her offsite objectives were independence, [REDACTED] and [REDACTED]</p>	W 196			

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 196	<p>Continued From page 94</p> <p>On 5/14/14 at 4:30 p.m., an interview with Poppe unit's Individual Program Coordinator A (IPC A) was conducted. She stated that she visited the day program at least once a week for 30 minutes. She also stated that clients had objectives in the day program and staff should have been engaging clients with activities. IPC A stated that she observed lack of staff in the day program and it was difficult to engage clients in activity, especially when a staff was watching two rooms at the same time. She further stated, "I felt bad for the clients, they're not being engaged and just sitting there."</p> <p>2a. On 5/5/14 at 3:15 p.m., Client 119 was observed in [REDACTED] of the Stoneman unit. [REDACTED] was observed curled up in a chair with [REDACTED] head resting on [REDACTED] arms. [REDACTED] was observed from 3:15 p.m. through 5:45 p.m. in the same position, without any activities.</p> <p>On 5/7/14 at 9:54 a.m., an observation in [REDACTED] of Lux Day Program was conducted. Client 119 was observed with three male clients, a female peer, and one staff in [REDACTED]. Client 119 was observed slouched in a chair with [REDACTED] head resting on [REDACTED] arms from 10 a.m. through 11:02 a.m. A wooden square board with items on it was the only table activity observed. The staff was observed to involve the client one time, in an activity at 10:42 a.m. by having [REDACTED] touch a green vibrating pillow, but Client 119 refused to engage. She remained slouched in a chair with [REDACTED] head resting on her arms.</p> <p>Three male clients were observed sitting in a chair without any involvement in any activities. One female client was observed rocking back and forth in a chair, without any activities. At</p>	W 196			

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

PRINTED: 07/25/2014  
FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 196	<p>Continued From page 95</p> <p>11:09 a.m., the same staff engaged another client in touching the green vibrating pillow. There were very minimal activities and coaching observed in [REDACTED] of Lux Day Program.</p> <p>2b. During a concurrent observation in [REDACTED], four female clients and two male clients were observed. One female client was observed rocking back and forth in a chair, without any activities. A staff started reading a book to the clients in the room. There were no interactions or interest observed in the activity provided by the staff. There was minimal coaching observed in the room. Only one client was observed engaged in an activity where he was seen in front of a monitor and tapping his foot to the sound of the music. The rest of the clients in the room were observed sitting in their chairs from 9:54 a.m. through 11:21 a.m., not engaged in any activities.</p> <p>On 5/13/14 at 10 a.m., a review of the clients' objectives in [REDACTED] and [REDACTED] were conducted. The objectives identified and documented were inconsistent with what was observed in the rooms. The objectives that were documented, were not implemented during the observation.</p> <p>On 5/14/14 at 3:40 p.m., an interview with the Stoneman unit's Individual Program Coordinator B (IPC B) was conducted. She stated that she visited the day program at least twice a month and spent about half an hour on each visit. She also stated that she conducted observations in the day program and confirmed that clients were not engaged enough.</p> <p>3. Client 143 was observed along with five other clients (Client's 129, 131, 132, 139 and 140) at [REDACTED] home from 9:45 a.m. to 10:30 a.m. and again</p>	W 196			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 196	<p>Continued From page 96</p> <p>at 11 a.m. to 11:20 a.m. There was no structured activity for the clients. During observations from 9:45 a.m. to 10:30 a.m., Client's 131 and 139 were observed in the hallway. Client 131 propelled [REDACTED] wheelchair up and down the hallway with no meaningful activity. Client 131 stood near the nurse's station and paced back and forth with no meaningful activity. Client 143 sat in the couch either lying or sitting holding a string which [REDACTED] was flipping with his hands. The clients did not receive consistent staff attention. One staff played the piano while the clients either slept or paced in and out of the day room. The clients were not engaged in other activities.</p> <p>From 11 a.m. to 11:20 a.m., the clients remained in the day room. One staff continued to play the piano. Client 131 continued pacing near the nursing station, Client 129 was pacing inside the day room chewing on a towel, Client 132 was lying down on the couch with eyes closed, Client 143 continued to hold the strings and flipping it in the air with his hands. One staff brought out a Whale Book and started to read to the clients. There were no other activities offered to the clients.</p> <p>During an interview with the RN (Registered Nurse), she stated the clients did not attend the [REDACTED] celebration due to behavior.</p> <p>An interview was conducted with the PT (Psychiatric Technician) on 5/13/14 at 10:35 a.m. She stated the clients who did not attend the [REDACTED] celebration should have been provided activities according to the calendar activity that day. She stated Client 143 did not attend due to his behavior of [REDACTED]. A concurrent review of the wall</p>	W 196			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 196	Continued From page 97 calendar was conducted with the PT. The calendar did not specify specific activities for the clients.        	W 196			
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN  Each client must have an individual program plan	W 206			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 206	<p>Continued From page 98</p> <p>developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:</p> <p>(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and</p> <p>(ii) Designing programs that meet the client's needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure two focused clients (Client's 107 and 125), identified with changes in health, had an individual program plan which identified and designed programs responsive to their changing needs.</p> <p>Findings:</p> <p>1. Record review on 5/7/14 revealed Client 107 was transferred to an outside acute care hospital for surgery [REDACTED]</p> <p>[REDACTED] There was no interdisciplinary note or physician note written at the time of transfer or within 24 hours of transfer showing Client 107's physical or emotional condition, supports or services required to meet [REDACTED] needs during hospitalization, how [REDACTED] was transferred/transported or who accompanied [REDACTED]</p> <p>Interview with the Unit Supervisor (US) on 5/7/14 at 10 a.m. indicated Client 107's surgery was planned, a transfer packet was completed and a special conference was held. Further interview determined the transfer information was not in Client 107's clinical record. A request for the transfer information was not received from the</p>	W 206			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 206	<p>Continued From page 99 facility as of 5/15/14.</p>  <p>Client 107's family expressed concern that he would need to be watched closely during the planned surgery and should be provided familiar staff as he may be afraid. The team assured the</p>	W 206		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 206	<p>Continued From page 100</p> <p>family, Client 107's supports would be discussed prior, during and after the procedure.</p> <p>The special meeting to discuss Client 107's planned surgery failed to discuss the concerns and positive interactions identified in the home residence and who, what and how theses supports would be provided while at the acute care hospital.</p> <p>2. During review of Client 125's individual program plan meeting dated 3/6/14, indicated a significant change in condition (a substantial modification in a patient's physical, mental, emotional, cognitive, or functional status that requires a new assessment and notification of the patient's attending physician, family, or guardian) resulting in the agreement to provide palliative (specialized medical care for people with serious illnesses which focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness) and hospice (designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) care.</p> <p>A nursing care plan developed 3/7/14 identified physical, emotional and spiritual needs, pain, increased supervision and equipment. The individual program planning failed to discuss current active treatment objectives [REDACTED] in response to Client 125's change in condition.</p> <p>The monthly Individual Program Coordinator notes dated 4/28/14, documented Client 125's expected decline in established objectives although it did not recommend new objectives</p>	W 206			

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W 206	Continued From page 101 that would meet [REDACTED] current needs.  Interview with the US on 5/7/14 at 10 a.m. revealed Client 125 participated in his program when [REDACTED] felt up to it and was still welcome to go to day program. The US confirmed new active treatment objectives had not been identified for Client 125.	W 206			
W 229	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN  The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.  This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure behavior objectives were stated separately for each behavioral outcome for one of three (Client 86) Human Rights Committee (HRC) focus reviews. This failure had the potential for a decline in behavioral outcomes for Client 86.  Findings:  Record review revealed Client 86 had a behavior objective and plan to reduce incidents of hitting [REDACTED] self in the face and/or loud vocalizing. [REDACTED]  The behavior objectives and plan for hitting [REDACTED] self in the face and/or loud vocalizing showed Client 86's restrictive interventions included two antidepressants and an antipsychotic (a	W 229			

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W 229	Continued From page 102 medication [or another measure] that is believed to be effective in [REDACTED] keyed to these two different behaviors.  In an interview on 5/12/14 at 1:45 p.m. with the residence psychologist she indicated sometimes, but not always, Client 86's loud vocalizing accompany incidents of hitting [REDACTED] face and history has shown it was usually when [REDACTED] was uncomfortable. She verified there was no way to evaluate which behavior had occurred through the current collection of data.  There was no direction in the behavior plan to delineate the collection of data related to episodes of hitting and/or being loud. The risks of being loud do not outweigh the risks of the highly restrictive interventions.	W 229			
W 238	483.440(c)(5)(v) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the inappropriate client behavior(s), if applicable.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 17 sampled clients (Client 100) behavior in the dining room was identified and a written training program was formulated to promote the client's ability to function. This failure had the potential to result in a decline in the client's functional ability.  Findings:	W 238			

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

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W 238	<p>Continued From page 103</p> <p>During meal observation on █/14 at 11:55 a.m., in the dining room of the Poppe unit, Client 100 was observed sitting next to a staff, with three other clients. Client 100 was observed with █ left arm across █ neck and █ left hand inside her right sleeve. █ picked up █ drinking cup using █ right hand and placed it in between █ left arm, and then █ proceeded to drink from the cup while █ left arm was still across █ neck. The staff sitting next to Client 100 observed what the client did, but did not redirect the client on how to properly drink from the cup.</p> <p>During a concurrent interview with the unit's Senior Psychiatric Technician B, she stated that Client 100 could hold a drinking cup and required prompting during meal times.</p> <p>On █/14 at 7:55 a.m., a breakfast observation was conducted in the dining room of the Poppe unit. Client 100 was observed with the same staff and three other clients at a dining table. Client 100 was again observed with █ left arm across her neck and █ left hand inside █ right sleeve. █ was also observed picking up █ drinking cup using █ right hand and drank directly from the cup without placing it in between █ left arm. When █ attempted to pick up █ drinking cup using █ right hand and attempted to place it in between █ left arm, the staff prompted █ immediately.</p> <p>On █/14 at 9:30 a.m., a review of Client 100's Individual Program Plan (IPP) Narrative dated 5/21/13 was conducted. The review indicated under "1.5 Eating/Dining/Meal Preparation" that █ will place █ hand in █ lap during dining. However, this training was discontinued and was replaced with a new training by pouring █ own</p>	W 238			

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

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W 238	Continued From page 104 drink. There was no training plan or objective found in the IPP that addressed the behavior that was observed.  On 5/14/14 at 4:30 p.m., an interview with the unit's Individual Program Coordinator A (IPC A) was conducted. She stated that Client 100 [REDACTED] and could hold a cup. She stated that she had never seen the behavior of Client 100 before during dining and felt that it was something new. She also stated that staff was not reporting what they had been observing during meal times. IPC A indicated that there was no training plan for the client's behavior that was observed. She further stated that the staff who observed the behavior should have intervened and redirected the client.  On 5/14/14 at 5 p.m., a review of the facility's Policy and Procedure (P&P) titled "Section 400 Client Services" with an effective date of 8/2013 was conducted. The review indicated, "7.0 Individual Program Plan (IPP) Development Guidelines 7.1 The Individual Program Plan (IPP) is developed, and specific client training plans and objectives are established based on professional comprehensive functional assessment, and on individual preferences, strengths, and needs ..."	W 238			
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,	W 242			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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W 242	<p>Continued From page 105</p> <p>bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Develop a program plan that addressed an individual client need that included a specific type of personal hygiene training necessary to reduce the risk of developing urinary tract infections (UTI's) for 1 focused client (Client 20).</li> <li>2. The facility failed to ensure that active treatment was provided to allow training in personal skills and to increase independence for 3 focused clients (Client's 6, 7 and 24).</li> <li>3. A focused client (Client 73) with a behavior plan for public disrobing did not have any interventions listed in the plan that addressed this behavior.</li> </ol> <p>These failures had the potential to result in the inability of the clients to reach his/her maximum functional and/or developmental capability.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On [REDACTED]/14 at 8:30 a.m., an observation of Client 20 was conducted [REDACTED] [REDACTED] [REDACTED] The nurse administering the medication explained that Client 20 was prone to [REDACTED]</li> </ol>	W 242			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 242	<p>Continued From page 106</p> <p>[REDACTED]</p> <p>An interview was conducted with the Unit Supervisor (US) on 5/14/14 at 5 p.m., and she explained that Client 20 was prone to [REDACTED] and that [REDACTED] required a specific way to be cleaned after using the restroom. The US added Client 20 was checked every two hours to ensure [REDACTED] was clean. The client was able to use the restroom by [REDACTED] self so [REDACTED] needed to be checked every two hours. The US stated, Client 20 had never been trained on how to clean [REDACTED] self and stated that was something we could do.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>2. On [REDACTED]/14, at 6:35 a.m., an observation was conducted on the Cohen unit. A direct care staff (DCS 1) was observed working with Client 7. The client was dressed sitting in a chair in [REDACTED] bedroom. DCS 1 was in the restroom cleaning the client's dentures and applying denture cream on the upper denture. DCS 1 handed the dentures to the client and the client put on [REDACTED] upper denture. Next, DCS 1 put lotion on the client's hands. As Client 7 started to rub [REDACTED]</p>	W 242		
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W 242	<p>Continued From page 107</p> <p>hands, DCS 1 rubbed the lotion on the client's hands and arms.</p> <p>During further observation, DCS 1 got a wet wash cloth and dampened and brushed Client 7's hair while [REDACTED] sat in the chair. DCS 1 finished by placing braids in the client's hair. The client sat in [REDACTED] chair the entire time smiling with the interaction [REDACTED] was having with DCS 1.</p> <p>A review of the Client 7's Approaches and Strategies (tool - developed by the IDT [interdisciplinary team] based on the client's needs and learning abilities was reviewed. The written document directed the staff and client in the implementation of the active treatment program. Contained in the section, "Activities of Daily Living Involving Care: Dental. "The care directives were,"Requires some assistance with oral hygiene. Is able to brush [REDACTED] teeth and apply adhesive with reminders from staff." Documented under " Hygiene &amp; Grooming: ..., Can independently brush [REDACTED] hair, apply deodorant and clean [REDACTED] glasses."</p> <p>[REDACTED]</p> <p>During further morning care observations on [REDACTED] 14 at 6:48 a.m., DCS 1 began morning care with Client 6. After waking up, Client 6 used the restroom. While the client was in the restroom DCS 1 washed the dentures and put on denture cream and handed the dentures to Client 6. After the client put in [REDACTED] own dentures DCS 1 took [REDACTED] electric razor and shaved [REDACTED], took a wash cloth</p>	W 242		

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W 242	<p>Continued From page 108</p> <p>and washed [redacted] face, wiped the sleep from [redacted] eyes, and combed [redacted] hair while [redacted] remained seated in [redacted] chair near [redacted] bed. No observations were made of efforts to promote Client 6's independence by encouraging or teaching the client to wash [redacted] face or comb [redacted] hair [redacted] self. After completion, Client 6 gathered [redacted] dirty linen with some minor assistance from DCS 1 and took them down the hall and put [redacted] dirty linen away.</p> <p>A review of the Client 6's Approaches and Strategies was conducted on 5/14/14. The plan section revealed, "Dental requires some assistance with oral hygiene. Requires assistance to put denture paste on dentures. Documented in the plan for "Hygiene &amp; Grooming: requires some assistance with hygiene and grooming ..., May require assistance for his hair to be combed neatly." [redacted]</p> <p>[redacted] The plan did not address shaving or face washing.</p> <p>On [redacted] 14 at 7 a.m., DCS 1 was observed to continue with care and began to help Client 24 who shared a room with Client 6. Client 6 woke up and went to the restroom. As the client was in the restroom, DCS 1 changed the client's linen on [redacted] bed. Client 6 then sat on [redacted] bed and DCS 1 went to the client's closet and picked out clothes and asked [redacted] if that was what [redacted] wanted. Client 24 agreed and DCS 1 then approached the client and started to put [redacted] shirt on by placing [redacted] head through the opening and DCS 1 walked back to the closet allowing the client to complete the procedure by placing [redacted] arms through [redacted] sleeves and pulling [redacted] own shirt down. She encouraged the client to go the restroom and wash [redacted] own glasses and do [redacted] oral care. Client</p>	W 242			

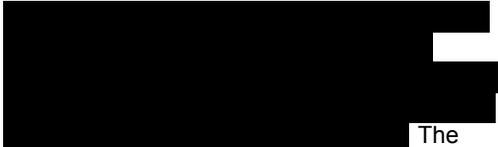
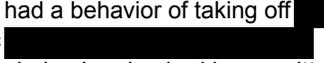
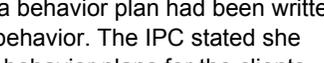
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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W 242	<p>Continued From page 109</p> <p>24 was able to follow the direction and brushed █ own teeth and washed █ glasses. Both Client 24 and DCS 1 took █ linen and walked to the dirty linen room located at the end of the hall.</p> <p>A review of Client 6's Approaches and Strategies was conducted on 5/14/14. Documented for "Dressing," "Is able to dress █ self."</p> <p>On 5/13/14, at 7:20 a.m., an interview was conducted with DCS 1. She explained that she was a teacher's assistant and would come over and help Client's 6 and 7. She added that she would help other clients if needed. DCS 1 was asked about training objectives for the clients. She stated she knew that Client 24 had a new objective to wash █ glasses. She was not able to state any training objectives for Clients 6 and 7.</p> <p>3. On █/14, Client 73 was observed at the day program. At 10:45 a.m., Client 73 took █ blouse off in front of █ peers and offsite supervisor. █. The supervisor did not redirect the client or attempt to teach the client not to disrobe. The supervisor called the day program staff to come and assist Client 73.</p> <p>An interview was conducted with staff on 5/7/14 at 10:55 a.m. and staff stated Client 73 had a behavior plan for public disrobing.</p> 	W 242			

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

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W 242	Continued From page 110   The behavior plan did not include interventions for the behavior of public disrobing.  An interview was conducted with the psychologist on 5/7/14. The psychologist stated that Client 73 had a behavior plan for public disrobing. The psychologist reviewed the behavior plan and confirmed that there were no interventions for the disrobing. The psychologist stated the plan should have included interventions to prevent the behavior and steps for staff to follow when Client 73 exhibited disrobing in public.  An interview was conducted with the Individual Program Coordinator (IPC) on 5/7/14. The IPC stated Client 73 had a behavior of taking off  clothes in public  The IPC stated a behavior plan had been written to address this behavior. The IPC stated she reviewed all the behavior plans for the clients. The IPC stated she was not aware that Client 73's behavior plan did not include interventions for the behavior.	W 242			
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN  The individual program plan must include opportunities for client choice and self-management.  This STANDARD is not met as evidenced by: Based on observation, staff interviews and clinical record review, the facility failed to ensure	W 247			

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W 247	<p>Continued From page 111</p> <p>opportunities for choice and self management related to food preparation and for making choices to foster greater independence for 2 of 17 sampled clients (Clients 138, 143) and 5 additional clients.</p> <p>Findings:</p> <p>1. On [REDACTED]/14 starting 10:15 a.m. Client 138 and 143 were observed at Farrell F Day Program.</p> <p>[REDACTED]. At 11 a.m., a PTA (Psychiatric Technician Aid) was observed setting up the dining table. The PTA placed the following items on the dining table; placemats, napkins, utensils, cup and clothing protectors.</p> <p>During a concurrent interview with the PTA, he was asked if any of the clients were able to set up the dining table. The PTA stated several of the clients in the room were capable of setting up the dining table. When asked if Client 138 and 143 were capable of setting up the dining table, he stated, "Yes, they are capable." He stated he should have let the clients set up the dining table. The PTA was observed to remove the items he placed on the dining table. The PTA proceeded to verbally prompt Client 143 to set up the dining table using hand over hand technique.</p> <p>The record for Client 138 [REDACTED] indicated Client 138's current vocational objectives included, "Will bring napkin to dining table 3/5x p/w (three out of five times per week) for 6 cm (six consecutive months)."</p> <p>The record for Client 143 was reviewed on</p>	W 247			

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

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W 247	<p>Continued From page 112</p> <p>5/13/14. An IPC (Individual Program Coordinator) monthly notes, dated 4/7/14, indicated a day program objective for Client 143 was to, "take clothing protector to dining table 3x/w (three times a week) for 6 cm (six consecutive months).</p> <p>The facility failed to ensure these self management objectives were provided to Client 138 and 143 in their day program.</p> <p>2. During observation on [REDACTED] 14 at 9:40 a.m. in [REDACTED] of the Lux Day Program, three male clients and two female clients from Poppe unit were observed with one psychiatric trainer (Psychiatric Trainer B). The clients were observed not engaged in any activities from 9:40 a.m. thru 10:16 a.m., until Psychiatric Trainer B grabbed an object that made a rattling sound. Psychiatric Trainer B started saying "Kabaza" while going around and rattling the object in front of each client's face. The clients were not observed engaging or interacting with the activity. One client was observed to push the object away from him.</p> <p>At 10:34 a.m., Psychiatric Trainer B was observed to grab another object, rattling shells and bells. He went around again and started rattling the objects in front of each client's face while stating, "Shell, bells; which sound do you like?" The clients in the room were observed without interest and not engaged in the activity. Psychiatric Trainer B was not observed to encourage or provide opportunities for choice to the clients as it related to activities.</p> <p>On 5/14/14 at 4:40 p.m., an interview with the Individual Program Coordinator A (IPC A) for the Poppe unit was conducted. She stated that when</p>	W 247			

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

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OMB NO. 0938-0391

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W 247	Continued From page 113 clients were in the day program, they had objectives to meet. He also stated that clients should have been provided choices. When she was told of the observation in [REDACTED] of the day program on [REDACTED] 14, she stated, "Clients weren't provided choices."	W 247			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a continuous active treatment program was provided in the Turners B classroom, Powers, LUX Day Programs and Residences for 7 of 17 sampled clients (Client's 64, 68, 78, 100, 102, 119, 138) and 7 clients outside the core sample (Client's 6, 7, 20, 24, 54, 57, 77).  These failures prevented potential growth, progression, and achievement of the individuals' program plans.  Findings:  1. On [REDACTED] 14 between [REDACTED] the offsite day program [REDACTED] was observed. The radio was on, but the radio station	W 249			

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W 249	<p>Continued From page 114</p> <p>could not be heard clearly because there was a lot of static coming through the radio. There were 10 clients and 4 staff in the classroom.</p> <p>In an interview with Staff 1, on 5/7/14, at 11 a.m., staff stated they had extra staff working today (5/7/14). Staff stated they normally had two staff for 10 clients.</p> <p>There were no structured activities observed.</p> <p>On 5/7/14 at 11:15 a.m., Staff 2 referred to the clients and stated, "A lot of them just like to hang out."</p> <p>a. On 5/7/14 from 9:40 to 10:10 a.m., Client 54 was observed sitting in a chair with ■ shirt over ■ head.</p> <p>An interview was conducted with Client 54's psychologist on 5/7/14 at 10:10 a.m. The psychologist stated he had worked with Client 54 for over two years. The psychologist was asked if it was usual behavior for Client 54 to pull ■ shirt over ■ head and not interact in class. The psychologist stated Client 54 was probably tired and could be the reason why ■ had ■ shirt over ■ head, and was not interacting in class.</p> <p>On 5/7/14 at 10:30 a.m., the psychologist stated he reviewed Client 54's medical records and the documentation showed that Client 54 had been sleeping well (eight hours a night). The psychologist stated Client 54 ■ and had a harmless habit of staying to ■ self. The psychologist stated that when Client 54 pulled ■ shirt over ■ head, ■ was not sleeping, but listening to everything that was going on ■. The psychologist stated there really was not</p>	W 249			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 249	<p>Continued From page 115 anything that could be done about Client 54 [REDACTED]</p> <p>On 5/7/14 at 11:30 a.m., the classroom teacher stated regarding Client 54, "I need to give [REDACTED] some type of activity to keep [REDACTED] awake."</p> <p>Between 10:10 a.m. and 12 p.m., Client 54 was observed sitting in a chair with [REDACTED] shirt over [REDACTED] head. Staff was not observed trying to actively engage Client 54 in any type of activity. From time to time, staff would call out Client 54's name, but then leave [REDACTED] alone when Client 54 did not respond. No structured activity was observed being implemented with Client 54 during this observation period.</p> <p>On [REDACTED]/14 between 9a.m. and 10:15 a.m. Client 54 was observed in the day program. During this observation, Client 54 was observed sitting on the chair with [REDACTED] shirt pulled over his head. Staff was not observed attempting to actively engage Client 54 in any type of structured activity.</p> <p>There were two times noted during this period that staff was observed paying attention to Client 54. At one point the teacher yelled out to Client 54, "[name of client] are you awake? Do you want to come over here?" The teacher was in the snack/lunch area about 25 feet away from Client 54. Client 54 did not respond and no further attempts by the teacher were observed to get [REDACTED] involved in an activity.</p> <p>At approximately 10 a.m., the psychologist was observed walking over to Client 54. He touched [REDACTED] arm and gently shook it. It looked like the psychologist was talking to the client and then the psychologist walked away. Client 54 remained in</p>	W 249			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 249	<p>Continued From page 116</p> <p>█ chair with this shirt over █ head. The psychologist stated, "█ awake."</p> <p>An interview was conducted with the Individual Program Coordinator (IPC) on 5/13/14 at 9 a.m. The IPC stated █ but that did not mean that █ did not have to do anything in the classroom. The IPC stated she did not know if the facility had someone who specialized in █ to help assess Client 54. The IPC stated she did not consult with anyone who specialized in █ when writing Client 54's objectives. The IPC stated that she was not aware if the psychologist had any special training in dealing with autistic clients.</p> <p>█</p> <p>█</p> <p>█</p> <p>1b. On █ 14 between 9:40 a.m. and 12 p.m. no</p>	W 249			

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W 249	<p>Continued From page 117</p> <p>structured activity was observed for Client 57. When Client 57 first arrived to the classroom ■ walked around moving chairs for a few minutes. For the remainder of the morning Client 57 was not noted to be engaged in any structured activities. Client 57 walked around the classroom and at times pushed the chair against the table.</p> <p>Client 57 was seen pushing clients off their chairs. At 9:55 a.m., Client 78 was sitting on a chair. Client 57 was observed pushing Client 78 to get off the chair that ■ was sitting on. Staff did not redirect Client 57 from pushing ■ peer. Staff was heard telling Client 78, "That is [Name of Client 57]'s chair," and staff had Client 78 get up from the chair. Client 57 then sat in the chair for a few minutes and then got up and started pacing around the classroom.</p> <p>At approximately 10:50 a.m., Client 57 walked behind Client 58 and pushed ■ off ■ chair. Staff did not intervene, or redirect Client 57.</p> <p>In an interview with the teacher, on 5/7/14, at 11:15 a.m., the teacher stated they did not have assigned seating in the classroom. The teacher stated the clients could sit wherever they wanted to. The teacher further stated that if they did not let Client 57 do what ■ wanted, Client 57 would get upset in class, and they did not want that to happen. The teacher stated, "The more you intervene, the more ■ will escalate."</p> <p>From 11 a.m. to 12 p.m., on ■/14, Client 57 was not observed to be engaged in any structured activities. Client 57 walked around the classroom, picking things off the floor, and at times pushed in the chair against the table.</p>	W 249			

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W 249	<p>Continued From page 118</p> <p>On 5/8/14, during the day program observation Client 57 was observed walking around the classroom and not engaged in any type of structured activity.</p> <p>On 5/8/14, at 10:15 a.m., an interview was conducted with Client 57's psychologist. [REDACTED]</p> <p>[REDACTED] The psychologist stated it was important that Client 57 be allowed to do his rituals. As Client 57 paced around the classroom, the psychologist stated, "That is part of his active treatment."</p> <p>On [REDACTED] 14 at 1 p.m., the Turner B offsite day program was observed. All the clients were sitting in chairs. In a concurrent interview with the offsite staff, they stated that the clients were in transition back to the unit.</p> <p>On [REDACTED]/14 at 1:15 p.m., staff was observed wiping down the table where the clients ate lunch. Client 78 was sitting with a toy at hand and staff turned on a yoga video and stated that the clients were supposed to be doing exercises. The clients, including Client 78, did not appear interested in the yoga video. Client 57 stood up and started fixing the chairs. Client 57 started pacing around the classroom.</p> <p>On [REDACTED]/13 and [REDACTED]/13 staff were not observed using sign language with Client 57. During lunch observation, Client 57 was not observed wiping the table after the clients ate. Staff was observed wiping the table after the clients were done eating. Client 78 was not observed carrying [REDACTED] lunch tray to the table.</p>	W 249			

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W 249	<p>Continued From page 119</p> <p>During all observations of the day program on 5/7/14, 5/8/14, 5/12/14, and 5/13/14, Client 78 was observed doing the same thing. [REDACTED] was observed sitting in a chair with a toy at hand.</p> <p>Record review revealed the offsite objectives for Client 57's were to wipe down table after lunch and wash hands after using restroom. [REDACTED]</p> <p>1c. Record review revealed the offsite objectives for Client 78 were, "Will choose to do at least one activity a day from class activities of daily living," and "Will carry lunch tray to table when asked." The offsite window also indicated, "Will choose between 2 preferred leisure items.</p> <p>The offsite objectives also indicated that it was important to be invited to activities and reminded of choices.</p> <p>2. On [REDACTED]/14 from 1 p.m. to 2:20 p.m. the Powers Day Program was observed. The classroom was divided into four different classroom areas.</p> <p>On [REDACTED]/14 at 1 p.m., Client 64 was asleep, Client 68 was walking around ([REDACTED] shirt was pulled up and [REDACTED] stomach was exposed), without staff intervention. An unsampled client was observed drooling with no staff intervention. Client 77 was by [REDACTED]self in the last classroom. Client 77 was not involved in any activity.</p> <p>On [REDACTED]/14 at 1:14 p.m. staff went over to Client 77 for a few minutes and then stated, "I'll leave [REDACTED] alone for a while." From 1:14 to 2:20 p.m., Client 77 was left by [REDACTED]self in the last classroom until it was time to go back to the unit. During this time</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 249	<p>Continued From page 120</p> <p>period Client 77 was not observed engaged in any structured type of activity.</p> <p>On █/14 from 10:20 a.m. to 11:15 a.m., the Powers day program was observed.</p> <p>On █/14 at 10:20 a.m. Client 77 was observed in the last classroom, sitting on a chair by █self. Client 77 was not involved in an activity. Client 64 was sitting in a corner table by █self. There were tabletop games at the round table, but Client 64 was not involved in any type of activity.</p> <p>On █/14 at 10:45 a.m., Client 77 remained by █self in the last classroom. Staff was not seem interacting with Client 77 or offering █ activities to be involved in. Client 64 remained sitting in a corner table by himself. Staff did not interact with Client 64. Staff was seen with their back to Client 64.</p> <p>On █/14 at 11:05 a.m., Client 77 remained by █self in the last classroom. Staff was not engaging █ in any activity, talking to █, and/or offering Client 77 a choice of activity. Client 77 was not involved in any type of structured activity. Client 64 remained sitting at the round table by █self. Staff told Client 64 to play with the wooden block tabletop game. Client 64 was not given a choice between two different types of activities.</p> <p>On 5/8/14 at 11:15 a.m., an interview was conducted with the day program unit supervisor (US). The US stated staff should be continuously interacting with all the clients. The US stated every five to ten minutes staff should be inviting the client to participate in an activity.</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 249	<p>Continued From page 121</p> <p>On [REDACTED]/14 from 10:20 a.m. to 11:55 a.m., the Powers offsite day program was observed. There were two staff members in the classroom. A white board with all the names of the clients and staff members scheduled for the day revealed that there were four staff members assigned to the classroom on [REDACTED]/14.</p> <p>2a. Client 77 was observed in the last classroom, sitting on a chair by [REDACTED] self. There were no other clients in the area and no staff was working with her. Client 77 was left alone and no one addressed [REDACTED] until 10:59 a.m. when the classroom teacher entered the classroom and went over to Client 77 for a brief moment and then left the classroom. From 11:05 to 11:35 a.m., Client 77 again was observed by [REDACTED] self in the last classroom. Staff was not observed interacting with Client 77.</p> <p>2b. On [REDACTED]/14 at 10:30, Client 64 was observed in the middle classroom sitting at a round table by [REDACTED] self. Staff was not observed working with him. Another client was observed sitting in a chair at another table drooling. Staff was near that client but did not redirect the client to wipe [REDACTED] face.</p> <p>On [REDACTED]/14 at 11 a.m., the kitchen staff arrived to the classroom and Client 64 got up from [REDACTED] chair and went over to the kitchen staff. Client 64 was curious as to what the kitchen staff were doing.</p> <p>On [REDACTED]/14 at 11:05 a.m., an unsampled client was observed walking around the kitchen/eating area with [REDACTED]. Staff was in the eating area. Several minutes passed before staff noticed and wiped the client's face for [REDACTED]. Staff was not observed to verbally prompt or attempt to get the client to wipe</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 249	<p>Continued From page 122</p> <p>█ self.</p> <p>On █/14 at 11:20 a.m. Client 64 was observed sitting back at the round table alone in the corner of the second classroom. Client 64 was not involved in an activity. Staff was at a long table with five other clients. An unsampled client was sitting at the long table and was drooling onto █ shirt. Staff did not address the drooling.</p> <p>On █/14 at approximately 11:35 a.m., a staff member placed a wooden puzzle game in front of Client 64, and told Client 64 to play with it, and then walked away.</p> <p>On █/14 at 11:45 a.m. the day program supervisor entered the classroom. The day program supervisor stated there should always be three staff members in the classroom to provide activities and sufficient supervision.</p> <p>2c. Client 77's offsite objectives were, "Will walk and deliver to various classrooms and will remain seated during snack/lunch while █ drinks all █ fluids."</p> <p>█</p> <p>2d. Client 64's offsite objectives were, Will deliver design items in different parts of Powers and will choose between 2 leisure activities.</p> <p>The Goal and Purpose Statement for the offsite Day Program was, "Maintain &amp; increase abilities</p>	W 249			

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W 249	<p>Continued From page 123</p> <p>&amp; skills towards independence in Adult Living Skills &amp; ADLs with development of hobbies through engaging in activities...Purpose of classroom activities...communication/listening skills...cooperation with others/sharing...motor development...increase attention span...sensory input...improve daily skills..." The day program purpose statement further indicated, "BEHAVIOR! If a client is engaged in a positive activity, it is impossible for them to be engaged in a negative behavior."</p> <p>An interview was conducted with the Individual Program Coordinator (IPC) on 5/13/14 at 9 a.m. The IPC stated she tried to visit the day programs at least every other week, and spent about 30 minutes at each day program. The observations during survey were shared with the IPC. The IPC stated that she was not aware that continuous active treatment was not happening at the day program. The IPC stated active treatment should be given continuously. The IPC further stated that if a client did not want to participate, they should still be encouraged about every five minutes by staff to participate in different types of activity. The IPC stated that it was important that the clients be provided different choices and activities that interested the clients.</p> <p>3. On [REDACTED] 14, observation was done of the clients at their home. Most of the clients were observed to be in separate group rooms with staff. Client 64 was sitting in front of the nursing station. Client 78 was observed sitting in a chair (holding a toy) in the group room with several other clients. Staff were observed looking for an activity to do. Staff were overheard asking the SPT, "Do we have magazines? The SPT stated, "no" and that he would get some tomorrow ([REDACTED]/14). Another staff</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 249	<p>Continued From page 124</p> <p>member brought in the Yellow Pages to the group room and started talking to the clients about the yellow pages. When asked about the activity, staff stated that the clients liked to look at the pictures, but since they did not have any magazines, they used the Yellow Pages.</p> <p>On [REDACTED] 14, at 3:45 p.m., Client 78 was observed in the group room sitting at a table with other clients. There were tabletop games and construction paper on the table. When asked what the purpose of the activity, staff responded by saying the purpose of the activity was to keep Client 78 busy.</p> <p>On several days of the survey [REDACTED], during multiple observations of the unit routine and group rooms, Client 78 was observed either standing or sitting and holding a toy. Client 78 was not observed engaged in a meaningful or structured activity.</p> <p>On [REDACTED] 14, at 8:30 a.m., observations were made of the men's group. A client was observed putting color pegs onto a game board. In a concurrent interview with the psychiatric technician (PT), the PT stated that the client loved to play with the "Bright Light (A game that lights up after the pegs are put in the holes of the board. Used to make pictures)" The PT stated that the client liked to see the board light up. The game was observed not to be working. The PT checked the game and the batteries were missing. The PT stated they had two more Bright Light games in the cabinet. The PT checked the other Bright Light games and none were working. The batteries to the games were missing.</p> <p>The supply cabinet was noted not to have many</p>	W 249			

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

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FORM APPROVED  
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W 249	<p>Continued From page 125</p> <p>items for the clients to use. The supply cabinet had two bright light games and two puzzles. In a concurrent interview with the PT, the PT stated a lot of their active treatment supplies/games had been stolen since they were not allowed to lock the supply cabinet.</p> <p>4. A dinner observation was conducted for Client 138 on [REDACTED] 14 starting at 5:45 p.m., a breakfast observation on [REDACTED]/14 at 8:50 a.m. The client was not observed to have a snuggly vest (pressure vest) in place during the meals observed.</p> <p>On [REDACTED]/14, another breakfast observation was conducted starting at 8:35 a.m. for Client 138. At the beginning of the meal, the client was observed restless, and refusing to eat his food. The client was not observed to have a snuggly vest in place during the meal.</p> <p>The record for Client 138 was reviewed on 5/13/14. A physician's order dated 4/1/14, indicated, "Application of snuggly vest per HCOP P5-1 (Health Care Objective Plan)" [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
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W 249	<p>Continued From page 126</p> <p>[REDACTED]</p> <p>An interview was conducted with the PT Shift Lead (Psychiatric Technician) on 5/13/14 at 2:40 p.m. When asked why the client had not been using the vest during meals, he stated the snuggly vest was supposed to be in place during every meal. He stated if the vest was not put on, there should have been an IDN (Interdisciplinary Notes) written, indicating the reason for not applying the vest. He stated Client 138 got anxious when he went to the dining room. He stated the vest was used to decrease the client's anxiety during the meals. He stated there was only one staff who knew how to put on the vest.</p> <p>A concurrent review of the IDN was conducted with the PT. There was no documentation in the IDN to indicate the reason for not applying the vest.</p> <p>5. On [REDACTED]/14 at 9:50 a.m., Client 102 was observed sitting by [REDACTED] self in room 150 without being engaged in activities for 10 minutes. On 5/7/14 at 8:15 a.m. [REDACTED] was observed in [REDACTED] room for almost an hour without any activities.</p> <p>On [REDACTED] 14 at 10 a.m., an observation in [REDACTED] of Lux Day Program was conducted. Five clients were observed inside the room with one staff. Clients were observed sitting in a chair for over an hour without being engaged in any activities. At 11:55 a.m., Client 102 arrived in the room. Staff was observed entering and exiting the room. [REDACTED] was observed for over an hour sitting on a couch and not engaged in any activities. There was no staff observed in [REDACTED] from 12:05</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 249	<p>Continued From page 127 p.m. through 2:15 p.m.</p> <p>On 5/7/14 at 11:33 a.m., an interview with Teacher B of the [REDACTED] unit was conducted. She stated that each of the clients in the day program had two vocational objectives (A specific, job-related, time-oriented statement which is set forth at the beginning of, and may be modified during, the client's rehabilitation program) that they had to meet.</p> <p>On 5/7/14 at 1:10 p.m., an interview with the Registered Nurse A (RN A) assigned to Client 102 in [REDACTED] was conducted. RN A stated that she knew the objective for Client 102, but was unable to describe the documented objective for the client. She further stated that Client 102 liked to play with [REDACTED] favorite toy.</p> <p>On [REDACTED] 14 at 9 a.m., Client 102 was observed sitting on a chair in room 138 of Poppe unit for half an hour without any activities. [REDACTED] was also observed in [REDACTED] of Lux Day Program sitting on a couch. Client 102 remained seated in the room without any activities observed for an hour.</p> <p>On 5/14/14 at 10:40 a.m., a review of Client 102's "Individual Plan Skill/Behavior Development Objectives and Plan," dated 4/17/13 was conducted. The review indicated that Client 102 should be involved in an adult living task by helping the staff in folding towels and bringing the laundry in and out.</p> <p>5.b On [REDACTED]/14 at 9:30 a.m., Client 100 was observed in the group room of Poppe unit. [REDACTED] was observed sitting for half an hour without any activities. On [REDACTED]/14 during morning observation, [REDACTED] was observed in [REDACTED] of Lux Day</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 249	<p>Continued From page 128</p> <p>Program sitting on a chair without being engaged in any activities.</p> <p>On █/14, Client 100 was observed with two other █ clients in █ of Poppe unit for a half an hour, in which there were no activities observed for the clients. █ was observed in █ of the Lux Day Program on the same day with three █ clients, five █ clients, and one staff. Client 100 was again observed without activities for an hour. The staff started engaging the clients at 10:17 a.m., one at a time.</p> <p>█</p> <p>6. On █/14 at 3:15 p.m., Client 119 was observed in █ of Stoneman Unit. █ was observed curled in a fetal position in a chair, with █ head resting on █ arms. █ was observed for over two hours in █ room without any activities.</p> <p>On █ 14 at 9:54 a.m., an observation in █ and █ of Lux Day Program was conducted. Client 119 was observed with three █ clients, a █ peer, and one staff in room █. Client 119 was observed slouched in a chair with █ head resting on █ arms for over an hour. A wooden square board with items on it was the only table activity observed. The staff was observed to involve the client once, in an activity at 10:42 a.m. by having █ touch a green</p>	W 249			

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W 249	<p>Continued From page 129</p> <p>vibrating pillow, but Client 119 refused to engage. [REDACTED] remained slouched in a chair with [REDACTED] head resting on her arms.</p> <p>Three [REDACTED] clients were observed sitting in a chair without any involvement in any activities. One [REDACTED] client was observed rocking back and forth in a chair, without any activities. At 11:09 a.m., the same staff engaged another client in touching the green vibrating pillow. There were none to very minimal activities and coaching observed in [REDACTED] of Lux Day Program.</p> <p>During a concurrent observation in [REDACTED], four [REDACTED] clients and two [REDACTED] clients were observed. One [REDACTED] client was observed rocking back and forth in a chair, without any activities. A staff started reading a book to the clients in the room. There were no interactions or attention paid to the activity provided by the staff. There was very minimal teaching and coaching observed in the room. Only one client was observed engaged in an activity where [REDACTED] was seen in front of a monitor and tapping [REDACTED] foot to the sound of the music. The rest of the clients in the room were just observed sitting in their chairs and not engaged in any activities.</p> <p>On 5/13/14 at 10 a.m., a review of the client's objective in [REDACTED] was conducted. The objectives identified and documented was inconsistent with what was observed in the rooms. The objectives that were documented, were not implemented during the observation.</p> <p>On 5/14/14 at 5:15 p.m., a review of the facility's Policy and Procedure titled, "Section 400 Client Services - Continuous Active Treatment," dated 4/14, was conducted. The review indicated,</p>	W 249			

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

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W 249	<p>Continued From page 130</p> <p>"Policy - individuals living in the Intermediate Care Facility (ICF) receive a Continuous Active Treatment Program, which includes consistent implementation of a program of specialized and generic training, treatment, health services, and related services ...3.0 Implementation ...3.1 Each individual will 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 IPP.</p> <p>7. On [REDACTED]/14, at 6:35 a.m., an observation was conducted on the Cohen unit. A direct care staff (DCS 1) was observed working with Client 7. The client was dressed sitting in a chair in [REDACTED] bedroom. The DCS staff was in the restroom cleaning the client's dentures and applying denture cream on the upper denture. DCS 1 handed the dentures to the client and the client put on [REDACTED] upper denture. Next, the staff put lotion on the client's hands. As Client 7 started to rub [REDACTED] hands the staff rubbed the lotion on the client's hands and arms for [REDACTED]. Following that, the staff got a wet wash cloth and dampened and brushed Client 7's hair while [REDACTED] sat in the chair. The staff finished by placing braids in the client's hair. The client sat in [REDACTED] chair the entire time smiling with the interaction [REDACTED] was having with the staff.</p> <p>A review of the Client 7's Approaches and Strategies, (tool - developed by the IDT [interdisciplinary team] based on the client's needs and learning abilities, which directed staff in the implementation of the active treatment program), contained a section "Activities of Daily Livings Involving Care: The section titled "Dental." The care directives were, "Requires some</p>	W 249			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 249	<p>Continued From page 131</p> <p>assistance with oral hygiene. Is able to brush teeth and apply adhesive with reminders from staff." Documented under "Hygiene &amp; Grooming: ..., Can independently brush hair, apply deodorant and clean glasses." The plan listed the "Training Steps, Methods and Instructions." The instructions were written as "Will try almost any task presented to . Has excellent fine motor skills. Learns best through verbal instruction. Occasionally requires some hand over hand instruction. Is able to understand multiple step instructions. "</p> <p>8. During observation of morning care on /14 at 6:48 a.m., DCS 1 began with Client 6. After waking up, Client 6 walked to the restroom. While the client was in the restroom DCS 1 washed dentures and put on denture cream and handed the dentures to Client 6 and put them in self. After the client put in own dentures DCS 1 took electric razor and shaved , then took a wash cloth and washed face, wiped the sleep from eyes, and combed hair while remained seated in chair near bed. After completion, Client 6 gathered dirty linen with some minor assistance from the DCS 1 and took the dirty linen down the hall and put dirty linen away.</p> <p>A review of Client 6's Approaches and Strategies: was conducted on 5/14/14. Documented in the plan was "Dental requires some assistance with oral hygiene. Requires assistance to put denture paste on dentures. Documented in the plan for "Hygiene &amp; Grooming: Requires some assistance with hygiene and grooming ..., May require assistance for hair to be combed neatly " Documented under the section Training Steps, Methods and Instructions. "Learns best with hand</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 249	<p>Continued From page 132</p> <p>over hand instruction"... The plan did not address shaving or washing █ face.</p> <p>On █/14 at 7 a.m., DCS 1 continued with care and began to help Client 24 who shared a room with Client 6. Client 6 woke up and went to the restroom. As the client was in the restroom, DCS 1 changed the client's linen on █ bed and then Client 6 sat on █ bed. DCS 1 went to the client's closet and picked out clothes and asked █ if that was what █ wanted. Client 24 agreed and DCS 1 then approached the client and started dressing █ by placing █ head through the opening and rested the shirt on █ shoulder and walked back to the closet allowing the client to complete the procedure by placing █ arms through █ sleeves and pulling █ own shirt down. DCS 1 encouraged the client to go the restroom and wash █ own glasses and do oral care. Client 24 was able to follow the direction and brushed █ own teeth and washed █ glasses. Then both Client 24 and DCS 1 took █ linen and walked to the dirty linen room located at the end of the hall.</p> <p>A review of the Client 6's "Approaches and Strategies" was conducted on 5/14/14. Documented for "Dressing" was "Is able to dress █self."</p> <p>On 5/13/14, at 7:20 a.m., an interview was conducted with DCS 1. She explained that she was a teacher assistant and would come over and help Client's 6 and 7. She added, that she would help other clients if needed. The DCS 1 was asked about training objectives for the clients. She stated she knew that Client 24 had a new objective to wash █ glasses. She was not able to state any training objective for Client's 6</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 249	Continued From page 133 and 7.  9. On [REDACTED]/14 at 8:30 a.m., an observation of Client 20 was conducted while [REDACTED] received an antibiotic injection for a [REDACTED]. The nurse administering the medication explained that Client 20 was prone to [REDACTED].  An interview was conducted with the Unit Supervisor (US) on 5/14/14 at 5 p.m., and she explained that Client 20 was prone to [REDACTED] and [REDACTED] required a specific way to be cleaned after using the restroom. The US added Client 20 was checked every two hours to ensure [REDACTED] was clean. The client was able to use the restroom by [REDACTED] self so [REDACTED] needed to be checked every two hours. The US stated, Client 20 had never been trained on how to clean [REDACTED] self and stated that is something we could do.  [REDACTED]	W 249			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan	W 252			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 252	<p>Continued From page 134</p> <p>objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure data was accurately collected, documented, and analyzed in the method and frequency required by the plan for one of three sampled clients (Client 29) from the Human Rights Review and five of ten focused clients (Client's 13, 27, 51, 85 and 86) from 131 clients identified by the facility to be at high risk for constipation and one death review (Client 174). This failure had the potential to not accurately reflect the Clients' actual individual performance.</p> <p>Findings:</p> <p>1. Review of Client 29's behavior data collection for targeted behavior of [REDACTED] revealed no target behavior had occurred during the months of November, December, January, February, March or April 2014.</p> <p>Review of the Individual Planning Coordinator (IPC) note dated 4/10/14 for the month of March 2014 confirmed the data for [REDACTED] had been zero (Jan, Feb, March). However, during a review of the facility system to prevent abuse, neglect and mistreatment incidents were noted related to Client 29's [REDACTED] target behavior resulting in bruises [REDACTED].</p> <p>During review of the Human Rights Committee (HRC) meeting minutes dated 4/24/14, Client 29 was identified to be reviewed and approved for a new restrictive intervention involving the use of a</p>	W 252			

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W 252	<p>Continued From page 135</p> <p>non FDA (Food and Drug Administration) approved herbal supplement related to [REDACTED] increased target behavior of [REDACTED]</p> <p>Further review of the general event reporting by the facility, and review of the clinical record revealed the following incidents related to the target behavior which were not transferred to the collection of data required by the behavior plan. Those examples were:</p> <p>A. On [REDACTED]/14 and [REDACTED] 3/14, bruises were discovered [REDACTED]</p> <p>B. On [REDACTED] 1/14 Client 29 was observed rubbing a cup [REDACTED]. The rubbing was vigorous enough to result in a bruise [REDACTED]</p> <p>[REDACTED]</p> <p>In addition, the IPC note for March 2014 showed no data had been collected or documented for the months of February or March 2014 to evaluate if Client 29's active treatment goals were implemented and/or completion of activities of daily living training in the areas of Leisure / Use of a Pressure Brush, Communication and Dental improvement. The data collection was also not completed for March 2014 in the area of Self Administration of Medications. There was no indication the IPC in the review of Client 29's individual program plan assured data was collected, documented or analyzed in the method and frequency required by the plan.</p> <p>An IPC interview on 5/13/14 at 1:30 p.m. revealed it was the psychologist's area to chart and</p>	W 252			

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W 252	Continued From page 136 analyze data for behavior. She verified she had been at a special conference on 4/17/14 to discuss Client 29's bruising, but they did not think to review or revise the data collection. The IPC did not verify data based on Client 29's actual behaviors.  2. During a focus review of Client's 13, 27, 51, 85, 86 and 174 receiving, "Bowel Care Management," the documentation of clients hydration/fluid intake was not thoroughly understood by staff and was not documented, and was not analyzed for discrepancies and concerns so it could be acted upon timely.  The facility policy titled, "Bowel Care Management," dated March 2014 indicated staff were to document and track fluid intake totals for each shift on activity of daily living (ADL) flow sheets # DS5504 by the end of each shift. The fluid hydration totals were to be documented by cc (fluid measurement) on a separate row from the percentage of meal consumed.  The shift lead was to ensure completion and an RN was to provides a synthesis of subjective and objective information which included nursing actions, interventions, follow-up and notifications. For clients at risk for constipation a monthly/ weekly review by licensed staff was required.  Fluid hydration data was not documented per policy, totaled accurately, and discrepancies in the collection was not identified by the RN / HSS during monitoring and quarterly review per policy. (SEE W192, W331)	W 252			
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE	W 255			

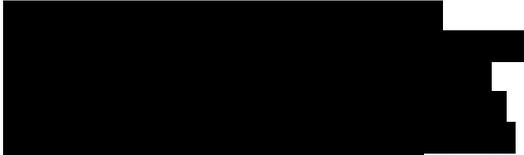
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 255	<p>Continued From page 137</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure the individual program plan was reviewed and revised for one of three focused clients (Client 86) during the human rights review when the client had successfully completed an objective to reduce episodes of hitting [REDACTED] self in the face and/or loud vocalization for which highly restrictive interventions (antipsychotic drugs) were employed. This failure had the potential to result in the client not acquiring or attaining new objectives after successfully accomplishing previously identified objectives.</p> <p>Findings:</p> <p>Review of the behavior objectives and plan for Client 86 revealed an objective set on 2/6/13 to reduce the frequency of hitting [REDACTED] self in the face and/or loud vocalizing to 15 or fewer times per month for 6 months by 2/28/15. [REDACTED] [REDACTED] were part of the highly restrictive interventions to reduce Client 86's episodes of hitting [REDACTED] self or loud vocalizing.</p> <p>Review of the data collection revealed the target behavior had been lower than 15 for the previous eight months (9 episodes in 8/13, 4 in 9/13, 1 in 10/13, 0 in 11/13, 0 in 12/13, 0 in 1/14, 0 in 2/14,</p>	W 255			

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

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W 255	Continued From page 138 0 in 3/14.)   The IPP inaccurately indicated Client 86 had not met objective to reduce episodes of hitting self in the face and loud vocalizing to 15 times per month. The IPP indicated the team would "try to taper and discontinue any medications not essential."    Interview with the Human Rights Committee (HRC) Chairperson on 5/12/14 at 3 p.m. revealed Client 86's pain medications were being tapered before a reduction in the use of the antipsychotic. Physician orders, dated 5/6/14, showed Client 86 had been not prescribed medications for pain since 2/14.  When asked why there was no evidence of a specific sequential plan and objective for the reduction of highly restrictive drugs, the HRC chair person indicated the IDT (Interdisciplinary Team) should not be held to a specific plan to reduce medications because it was "discretionary," (done or used as necessary) by the team.	W 255			

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

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W 255	Continued From page 139 Review of the policy titled, "Human Rights Committee," dated September 2013 and the attached HRC requirements for "Individual Program Plans (IPP) Discussion of Restrictives" dated 2013, revealed the behavioral restrictives interventions should cover objectives for decreasing use of behavioral restrictives and a description of the long term plan for all psychotropic medications.	W 255			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on interview and record review, for the time parameter 2/1/14 through 5/15/14, the facility failed to ensure the Human Rights Committee (HRC) reviewed and monitored individual programs designed to manage behavior which involved risks to client protections and rights for one of three focused sampled clients (Client 86). Client 86 had monthly PRN (as needed) usage of an antipsychotic drug used for anxiety related to medical procedures without an active treatment plan or Human Rights approval. Client 86 also received drugs for the management of inappropriate behavior for which there were no long term plan and objectives to decrease these behavioral restrictive interventions, i.e. drugs to modify behavior.  Findings:	W 262			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 262	<p>Continued From page 140</p> <p>Review of the policy titled, "Human Rights Committee" (HRC) dated September 2013 and the HRC and Whole Person Review (WPR) Process 2013 revealed the HRC requirements for IPP discussion of restrictives included:</p> <ul style="list-style-type: none"> <li>* Description of the long term plan.</li> <li>* Objectives for decreasing use of the behavioral restrictives.</li> </ul> <p>The policy indicated the HRC reviews medical restrictives and restraints and/or sedation to assure the restraints were appropriate and the least restrictive intervention and contains the required fading plan; less restrictive alternatives tried in the past or rationale for not pursuing less restrictive techniques and assures a desensitization (the diminished emotional responsiveness to a negative stimulus after repeated exposure to it) plan to minimize/reduce the use of sedation and or restraint during medical treatment/procedures.</p> <p>1. Client 86 had monthly as needed usage (PRN) of an antipsychotic (a class of medicines used to treat psychosis and other mental and emotional conditions) drug used for anxiety related to medical procedures without an active treatment plan or Human Rights approval.</p> <div style="background-color: black; width: 300px; height: 60px; margin: 10px 0;"></div> <p>A consent, dated [REDACTED]/13, indicated sedation was used for [REDACTED]</p>	W 262			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 262	<p>Continued From page 141</p> <p>catheter (a hollow flexible tube that is used to drain urine from the bladder), routine laboratory blood draws and oral sedation, but did not specify the drugs to be used.</p> <p>Psychotropic Drug Reviews dated 2/24/14 and 4/21/14, did not reflect the usage of the antipsychotic drug used for anxiety during [REDACTED] changes of the [REDACTED] catheter, blood draws or dental procedures for Client 86.</p> <p>Interview with the HRC chairperson on 5/12/14 at 11 a.m. revealed the HRC was unaware of the use of the antipsychotic drug [REDACTED] being used to treat anxiety for medical procedures and no approval had been sought for its use.</p> <p>[REDACTED]</p> <p>The Individual Program plan, dated 2/9/14, indicated the team was to "try to taper and discontinue any medications that may not be essential."</p> <p>In an interview with the Human Rights Committee Chairperson on 5/12/14 at 3 p.m., he indicated that Client 86's pain medications were being tapered before a reduction in the use of the antipsychotic. Physician orders, dated 5/6/14, showed Client 86 had not been prescribed medications for pain since 2/14.</p> <p>When asked why there was no evidence of a specific sequential plan and objective for the reduction of highly restrictive drugs, the HRC chair person indicated the IDT should not be held to a specific plan to reduce medications because</p>	W 262			

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

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W 262	<p>Continued From page 142 it was "discretionary."</p> <p>In an interview with two pharmacists on 5/12/14 at noon, they indicated anxiety was not a just indication for use with an antipsychotic like [REDACTED] and they were unaware it was used for that purpose as it was a PRN or as needed drug.</p> <p>During an interview with the Unit Supervisor and residence nurse on 5/15/14 at 10 a.m., they said the combination of [REDACTED] with [REDACTED] restraints really calmed the individual. They verified there was no active treatment program designed to teach Client 86 how to tolerate and decrease his anxiety related the [REDACTED] catheter changes, routine blood draws or any other medical procedure the drugs were being used for.</p> <p>Review of the policy titled, "Physical Medical Restraints and Supports," dated April 2014, revealed the Individual Program Plan would address situations where sedation and restraints were necessary. Justification for the need of sedation/restraints, less restrictive alternatives attempted, and desensitization plan to reduce the use of sedation and or restraints was to be implemented.</p> <p>Review of the policy titled, "Psychotropic Medication 454," dated January 2014 indicated there would be no PRN (as needed) orders for psychotropic medications. Orders not part of the WPR (Whole Person Review) approved monthly medication plan would be on a one time administration (STAT) basis only, with one repeat dose if the client's condition had not sufficiently improved. Frequent multiple uses of STAT</p>	W 262			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 262	Continued From page 143 medication must be incorporated into a Behavior Management Plan and have WPR review and approval.	W 262			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written consents were obtained by all co-conservators (a guardian and protector appointed by a judge to protect and manage the financial affairs and/or the person's daily life due to physical or mental limitations or old age) for programs to manage inappropriate behaviors, or containing the administration of behavior altering medications prior to implementation for one of 17 sampled clients (Client 68) and two focused clients (Client's 44 and 131).  Findings:  1. An interview was conducted with Client 68's sister on 5/11/14 at 6:30 p.m. The sister stated [REDACTED] had been living at the facility for [REDACTED] years. Client 68's sister stated she and her brother became Client 68's conservators in 2005 when her mother passed away. The sister stated they were co-conservators for Client 68, but she was the one that signed all the consents.  [REDACTED]	W 263			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 263	Continued From page 144    The Social Service Assessment, dated April 2013, indicated that Client 68's brother and sister had been granted powers of co-conservatorship of Client 68. "[Name of sister] signs consents that may be needed if in agreement." There was no documentation that the brother had agreed to having the sister sign consents. There were three consents in the medical records that had only been signed by Client 68's sister. Two consents titled, "Consents For Medical Restraints/Restrictives," were signed by the sister on 12/1/13 and 4/22/14 respectively. A third consent titled, "Consent For Restrictive Behavior/Access Management Program," was signed by the sister, on 4/22/14. None of the consents were signed by the brother.  An interview was conducted with the Social Worker on 5/15/14 at 1:45 p.m. The social worker stated the procedure for when there were more than one conservator was to establish a primary conservator who would sign all consents. The social worker further stated that the procedure had changed, and currently the facility was requiring that all the conservators be contacted to sign consents.	W 263			

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

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W 263	<p>Continued From page 145</p> <p>The facility's policy and procedure titled, "Informed Consents: Capacity and Consenters," with date of May 2014 was reviewed. The policy indicated, "If an adult is conserved by more than one conservator, both conservators are required to sign consent..."</p> <p>The facility failed to ensure that both of Client 68's conservators were contacted, provided with pertinent information and were fully informed of all proposed treatments, restrictives, and/or procedures prior to implementation.</p> <p>2. During review of facility incident reports on 5/12/14 commencing at 1:20 p.m. it was revealed the facility completed a General Event Report (GER) on Client 136 for person to person abuse on 3/21/14 when Client 136 hit Client 131 lightly on the head.</p> <p>Record review for Client 136 on 5/13/14 commencing at 1:40 p.m. revealed Client 131 was prescribed [REDACTED] as behavior altering medications to ameliorate (to make [something bad or unsatisfactory] better) the target behaviors of self-injurious behavior and physical aggression.</p> <p>Additional record review revealed Client 131 originally had three co-conservators (Client 131's, mother, sister and brother) appointed in 1981. Under the Probate Code - Section 2355, the co-consenters were given the "power to give consent to medical treatment for conservatee." Since the 1981 appointment, Client 131's mother had expired leaving the conservator duties to Client 131's surviving siblings (brother and sister).</p> <p>Per record review Client 131's sister had given</p>	W 263			

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W 263	<p>Continued From page 146</p> <p>consent for the current behavioral plan updated on 4/21/14. There was no written consent from Client 131's co-conservator (brother).</p> <p>Per interview with Client 131's Social Worker (SW) on 5/13/14 at 2:20 p.m. the SW explained Client 131's sister was the primary consenter of records. The establishment of a consenter of records was enacted subsequent to a previous plan of correction.</p> <p>During a follow-up interview with the facility's Chief Psychologist (CP) on 5/14/14 at 3:45 p.m. the psychologist explained he had reviewed the issue of needing written consent for restrictive interventions from co-conservators and the facility was reconsidering its position on the subject.</p> <p>Review of the Human Rights Committee (HRC) meeting minutes on 5/15/14 commencing at 9:20 a.m. revealed there were no HRC meetings held during February, March or April 2014 reflecting any review of Client 131's updated Behavior Support Plan, dated 4/22/14. An archival notation was presented by the HRC on 5/15/14 at 9:20 a.m., indicating Client 131's last HRC review was conducted on 6/13/13 and the next "whole person review" would not be scheduled until June of 2014. Under the "Comments" section of the meeting minutes was the statement, "IDT is seeking initial approval for [REDACTED] due to increased SIB, vocalization and aggression. SIB and aggression remains frequent. Consent current. Medication approved."</p> <p>The CP (Chief Psychologist) provided further information regarding co-conservators, explaining a departmental "legal" opinion had been given identifying that all co-conservators must give</p>	W 263			

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W 263	<p>Continued From page 147</p> <p>consent for treatment and a majority must agree when there are three or more co-conservators in place. The CP also gave an example in the case where two co-conservators disagree on treatment. The CP stated the matter would have to go to court.</p> <p>3. A review of the GER (General Events Report) dated 4/7/14 indicated that Client 44's sister is conservator but father had been signing current consents. Client 44 had the general Consent for Care and Treatment and Consent for Restrictive Behavior/ Access Management Program signed by father, who was listed as Consenter of Record, on 1/7/14 and 3/20/14 respectively. A review of Client 44's Person Centered IPP (Individual Program Plan) Narrative, dated 1/7/14, indicated that received the medications</p> <p>The IPP also indicated that Client 44's sister was conservator and father was consenter of record. A review of the Letters of Conservatorship, filed in Sonoma County Superior Court on 9/4/09 indicated that the client's sister and mother were conservators and had "exclusive authority to give consent for and to require the conservatee to receive medical treatment ..."</p> <p>A review of the facility's policy 440, "Informed Consent: Capacity and Consenters," dated March 2014, indicated that under the section of the hierarchy of consenters, conservator was listed above the closest available relative. The policy</p>	W 263		

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

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W 263	<p>Continued From page 148</p> <p>also indicated that " Adults, conserved, not competent to give consent, consent forms will be given to the conservator for signature."</p> <p>In an interview on 5/13/14 at 2:20 p.m. with the Licensed Clinical Social Worker (LCSW) of the unit where Client 44 resides, she stated that the client's mother and sister were originally co-conservators but then the mother passed away around three years ago. The LCSW stated that the client's father came to visit [REDACTED] regularly and the sister only occasionally and that she was sometimes difficult to contact regarding consents. She stated that she drafted a letter to the sister requesting that the father be designated the consenter of record and that Client 44's sister did agree to that change, allowing the father to sign consents in her absence. The LCSW stated that the father has been signing all consents for Client 44 since May, 2013. She stated that the consent issue was brought up at the IPP meeting on 1/17/14 and it was noted that the sister was the conservator and the father the consenter of record but no one noted the discrepancy on the consent at that time.</p> <p>In an interview on 5/13/14 at 3:10 p.m. with the Chief Psychologist, he stated that the issue of consents did come up at the Human Rights Committee meeting on 3/6/14. He stated that the consent was reviewed at that time and noted to be signed by Client 44's father, as the consenter of record. He acknowledged that the Committee did miss that Client 44 was conserved by [REDACTED] sister and that she was the one who should have signed the consent. He acknowledged that the Committee should have caught the error at that time, but it did not do so.</p>	W 263			

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W 312 W 312	Continued From page 149 483.450(e)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure drugs used for control of inappropriate behavior were an integral part of the Whole Person Review / Individual Program Plan directed specifically toward the reduction and eventual elimination of the behavior for which the drug was prescribed. This affected two of three focused clients from the Human Rights Review (Clients 29 & 86.)  Findings:  1. Client 29 was prescribed a non FDA approved drug "Chasteberry" as a restrictive intervention to target behaviors ( self injurious/ agitation ) related to [REDACTED] to show how use of the Chasteberry may change in relation to the active treatment program and progression or regression of the behavior for which it was prescribed.  2. Client 86 had monthly as needed usage (PRN) of an antipsychotic drug used for anxiety related to medical procedures without an active treatment plan or Human Rights approval.  Findings:	W 312 W 312			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 312	<p>Continued From page 150</p> <p>1. During review of incident reports on 5/8/14 commencing at 8:50 a.m., for the time parameter 2/1/14 through 5/15/14, it was revealed the facility reported an injury of unknown source for Client 29 wherein Client 29 was discovered with [REDACTED] described as being "dark purple in color" on 4/21/14. A recommendation was made in the General Event Report (GER) to consider use of the herbal supplement "chaste berry" [REDACTED].</p> <p>Review of the Whole Person Review through Human Rights Committee (HRC) and related Behavior Intervention Restrictive Team (BIRT) meeting minutes dated 4/24/14, showed that Client 29's team was seeking initial approval for the use of Chasteberry [REDACTED] and decrease injuries to sensitive areas. The HRC indicated a [REDACTED] I consult had began, informed written consent was current, plans appropriate and the medication was approved.</p> <p>According to the U.S. Department of Health and Human Services, National Institutes of Health, National Center for Complementary and Alternative Medicine; Chasteberry is from the fruit of the chaste tree, native to Central Asia and the Mediterranean region. [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]. Chasteberry can cause gastrointestinal problems, acne like rashes and dizziness. Chasteberry may affect dopamine systems in the brain and individuals taking</p>	W 312			

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W 312	<p>Continued From page 151</p> <p>dopamine related medications, antipsychotics and Parkinson's disease medications should not take it. Chasteberry is a non FDA approved herbal supplement.</p> <p>Review of the written consent revealed a restrictive behavior management program, dated 4/29/14, for the Chasteberry ( no dosage) to treat Client 29's [REDACTED] behaviors and agitation.</p> <p>The consent indicated the anticipated benefits from the restrictive procedure were to reduce maladaptive behaviors and reduce injury with potential risks defined as a decreased independence. Less restrictive procedures attempted were listed as medication changes and changes to behavior support plans as indicated although not specified on the consent.</p> <p>The physician order, dated 4/30/14, indicated Chasteberry Plus two tablets twice daily to be given for Client 29's [REDACTED]</p> <p>There was no identification of potential side effects related to the use of the Chasteberry or its potential for interactions with Client 29's current drug regimen or clinical conditions. Client 29 had [REDACTED] ( non FDA approved herbal supplement ) and an antiviral drug [REDACTED]. Other conditions include [REDACTED]</p> <p>A request to review the [REDACTED]</p>	W 312			

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W 312	<p>Continued From page 152</p> <p>consult revealed it was dated 5/13/14; and indicated Client 29 [REDACTED] ( IQ 33), was recently initiated in a trial of Chasteberry 4 tabs daily to [REDACTED]. The consult indicated Client 29 had a history [REDACTED]. There was no indication in the consult if these behaviors had been learned or how the items were obtained.</p> <p>There was no identified criteria to show how the use of the Chasteberry may change in relation to the active treatment program and progression or regression of Client 29's [REDACTED] disorder and target behaviors of self injurious behavior / agitation for which it was prescribed.</p> <p>Interview with the Supervising Senior Psychologist / chair person for HRC on 5/12/14 at 11 am, revealed he was unaware of the potential side effects to observe for during the use of Chasteberry and was unaware of Client 29's diagnosis of [REDACTED] and if the Chasteberry was contraindicated.</p> <p>Interview with two facility pharmacists on 5/12/14 at 2 pm revealed they were aware of the use of Chasteberry, indicating several other clients in the facility were being tried on it. Both were unaware of Client 29's physical diagnoses or the potential for interactions related to his medical concerns. The pharmacists indicated no training had been provided to staff on the potential side effects of Chasteberry nor had any been requested.</p> <p>2. Client 86 had monthly as needed usage (PRN)</p>	W 312			

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W 312	<p>Continued From page 153 of an antipsychotic drug used for anxiety related to medical procedures without an active treatment plan or Human Rights approval.</p> <p>[REDACTED]</p> <p>A consent, dated 12/12/13, indicated sedation was used for [REDACTED] changing the [REDACTED] catheter, routine laboratory blood draws and oral sedation, but did not specify the drugs to be used.</p> <p>Psychotropic Drug Reviews dated 2/24/14 and 4/21/14 did not reflect the usage of the antipsychotic drug used for anxiety during [REDACTED] changes of the [REDACTED] catheter, blood draws or dental procedures.</p> <p>Interview with the HRC chairperson on 5/12/14 at 11 a.m. revealed the HRC was unaware of the use of the [REDACTED] being used to treat for anxiety for medical procedures and no approval had been sought for it.</p> <p>In an interview with two pharmacists on 5/12/14 at noon, they indicated anxiety was not a just indication for use with a [REDACTED] like [REDACTED] and they were unaware it was used for that purpose as it was a PRN or as needed drug.</p> <p>In interviews with the Unit Supervisor and residence nurse on 5/15/14 at 10 a.m., they said the combination of [REDACTED] and [REDACTED] with [REDACTED] restraints really calmed the individual. They verified there was no assessment or training completed and designed to teach Client 86 how</p>	W 312			

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W 312	Continued From page 154 to tolerate and decrease [REDACTED] anxiety related the [REDACTED] catheter changes, routine blood draws or any other medical procedure the drugs were being used for.  Review of the policy titled, "Physical Medical Restraints and Supports," dated April 2014, revealed the "Individual Program Plan" would address situations where sedation and restraints were necessary. Justification for the need of sedation/restraints, less restrictive alternatives attempted, and desensitization plan to reduce the use of sedation and or restraints would be implemented.  Review of the policy titled, "Psychotropic Medication 454," dated January 2014, indicated there would be no PRN (as needed) orders for psychotropic medications. Orders not part of the WPR approved monthly medication plan would be on a one time administration ( STAT) basis only, with one repeat dose if the client's condition had not sufficiently improved. Frequent multiple uses of STAT medication were to be incorporated into a Behavior Management Plan and have WPR review and approval.	W 312			
W 315	483.450(e)(4)(i) DRUG USAGE  Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff.  This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure drugs used for the control of inappropriate behavior were monitored closely for	W 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 315	<p>Continued From page 155</p> <p>adverse side effects affecting two of three focus sampled clients of the Human Rights Review (Client's 25 &amp; 29).</p> <p>Findings:</p> <p>Client 25's assessments titled, "Monitoring of Side Effects Scale" (MOSES) showed an increase in signs and symptoms of [REDACTED] due to long term use of antipsychotics drugs not accurately identified or assessed during the Psychotropic Drug Reviews (PDR).</p> <p>Client 29 was prescribed a non FDA approved drug "Chasteberry" as a restrictive intervention without identification of the potential adverse side effects, potential interactions related to his clinical condition or training / education from the pharmacy to the staff to enable them to monitor for the desired or adverse effects.</p> <p>Findings:</p> <p>1. Review of Client 25's Human Rights Committee (HRC) minutes dated 3/27/14 revealed long term usage of the atypical antipsychotic drug, [REDACTED] daily which had remained unchanged for the past five years. The HRC notes identified an increase in a MOSES score from 1 (June 2012) to 4 (2014) suggesting an increase in EPS (extrapyramidal symptoms) and recommended the IDT (Interdisciplinary Team) review the trend.</p> <p>The use of [REDACTED] came with an alert or Federal Drug Administration BLACK BOX safety warning due to potentially life-threatening irregular heartbeat and sudden death. In addition, adverse</p>	W 315			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 315	<p>Continued From page 156</p> <p>side effects of [REDACTED] could include twitching or uncontrollable movements of eyes, lips, tongue, face, arms, or legs; tremor (uncontrolled shaking), drooling, trouble swallowing, problems with balance or walking; feeling restless, jittery, or agitated; very stiff (rigid) muscles, and high fever.</p> <p>Review of Client 25's PDR minutes indicated inaccuracies of identified adverse drug reactions and showed a failure to ensure careful monitoring and planning was completed for Client 25.</p> <p>[REDACTED]</p> <p>The most recent MOSES, dated 2/6/14, indicated the assessment of Client 25 revealed a score of 4 (four) or severe adverse side effects which were almost continuous, and presented a hazard to Client 25's health and well being.</p> <p>The PDR, dated 2/15/14, inaccurately indicated Client 25's last MOSES gave a score of 1 with no action necessary. The referenced MOSES, dated 6/8/13, was scored at 2 (two) or mild adverse side effects that could progress to future severity or problems if ignored.</p> <p>Interview with the clinical nurse on the residence beginning on 5/7/14 at 2 p.m. revealed the Health Services Specialist usually completed the MOSES evaluation, but the residence nurse</p>	W 315			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 315	<p>Continued From page 157</p> <p>attended the PDR. When asked if the MOSES were part of the PDR review she indicated they were.</p> <p>Review of the Nursing Protocol for MOSES dated December 2013 indicated the MOSES is an integral part of the Psychotropic Drug Review process, the RN representation of the MOSES for review and discussion was required by the PDR process.</p> <p>Review of the policy and procedures titled, "Psychotropic Medication 454," dated January 2014, indicated a psychotropic drug review team consisting of the client's physician, psychiatrist, psychologist, unit supervisor, social worker and IPC were to conduct a least bimonthly review of the use and effects of the medication. The PDR process included assessing the risk of the medications and identifying adverse effects of the medications.</p> <p>2. During review of incident reports on 5/8/14 commencing at 8:50 a.m. for the time parameter 2/1/14 through 5/15/14 it was revealed the facility reported an injury of unknown source for Client 29 wherein Client 29 was discovered with [REDACTED] described as being "dark purple in color" on 4/21/14. A recommendation was made in the General Event Report (GER) to consider use of the herbal supplement "chaste berry" [REDACTED]</p> <p>Review of the Whole Person Review through Human Rights Committee (HRC) and related Behavior Intervention Restrictive Team (BIRT) meeting minutes dated 4/24/14, Client 29's team was seeking initial approval for the use of Chasteberry to treat [REDACTED]</p>	W 315			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 315	<p>Continued From page 158</p> <p>decrease injuries to sensitive areas. The HRC indicated a [REDACTED] consult had begun, informed written consent was current, plans were appropriate, and the medication was approved.</p> <p>According to the U.S. Department of Health and Human Services, National Institutes of Health, National Center for Complementary and Alternative Medicine; Chasteberry is from the fruit of the chaste tree, native to Central Asia and the Mediterranean region. [REDACTED]</p> <p>[REDACTED]</p> <p>Chasteberry, according to the references cited is used by woman to ease menstrual problems and to stimulate breast milk. Chasteberry can cause gastrointestinal problems, acne like rashes and dizziness. Chasteberry may affect dopamine systems in the brain and individuals taking dopamine related medications, antipsychotics and Parkinson's disease medications should not take it. Chasteberry is a non FDA approved herbal supplement.</p> <p>Review of the written consent revealed a restrictive behavior management program dated 4/29/14 for the Chasteberry ( no dosage) to treat Client 29's [REDACTED]</p> <p>[REDACTED] targeting behaviors of self injurious behaviors and agitation.</p> <p>The consent indicated the anticipated benefits from the restrictive procedure were to reduce maladaptive behaviors and reduce injury with potential risks defined as a decreased independence. Less restrictives procedures</p>	W 315			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 315	<p>Continued From page 159</p> <p>attempted were listed as medication changes and changes to behavior support plans as indicated although not specified on the consent.</p> <p>The physician order, dated 4/30/14, indicated Chasteberry Plus two tablets twice daily to be given for Client 29's [REDACTED]</p> <p>There was no identification of potential side effects related to the use of the Chasteberry or its potential for interactions with Client 29's current drug regimen or clinical conditions. Client 29 had [REDACTED] ( non FDA approved herbal supplement ) and an [REDACTED]. Other conditions included [REDACTED]</p> <p>There was no identified criteria to show how the use of the Chasteberry may change in relation to the active treatment program and progression or regression of Client 29's [REDACTED] and target behaviors of self injurious behavior / agitation for which it was prescribed.</p> <p>Interview with the Supervising Senior Psychologist / chair person for HRC on 5/12/14 at 11 am, revealed he was unaware of the potential side effects to observe for during the use of Chasteberry and was unaware of Client 29's diagnosis of [REDACTED] and if the Chasteberry was contraindicated.</p> <p>Interview with two facility pharmacists on 5/12/14 at noon revealed they were aware of the use of Chasteberry, indicating several other clients in the facility were being tried on it. Both were unaware</p>	W 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 315	Continued From page 160 of Client 29's physical diagnoses or the potential for interactions related to [REDACTED] medical concerns. The pharmacists indicated no training had been provided to staff on the potential side effects of Chasteberry nor had any been requested.	W 315			
W 316	483.450(e)(4)(ii) DRUG USAGE  Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a gradual drug reduction of sampled Client 119's antipsychotic medication was implemented when [REDACTED] achieved success and [REDACTED] behavioral issues decreased. The facility failed to ensure a dose reduction was attempted for [REDACTED] since September 2009 for sampled Client 68's [REDACTED]. This affected 2 of 17 sampled clients (Client's 68 and 119).  Findings:  1. On [REDACTED]/14, sampled Client 119 was observed in [REDACTED] room from 3:15 p.m. thru 4:06 p.m. [REDACTED] was observed sitting in a chair, on a fetal position, with [REDACTED] head on [REDACTED] arms. There was no behavioral issue observed.  On [REDACTED] 14, [REDACTED] was observed in [REDACTED] of Lux Day Program from 9:54 a.m. thru 11:21 a.m. Sampled Client 119 was observed sitting in a chair, on a fetal position, with [REDACTED] head on [REDACTED] arms. There was no behavioral issue observed.  On [REDACTED]/14, [REDACTED] was again observed in [REDACTED]	W 316			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 316	<p>Continued From page 161 of Lux Day Program from 10:40 a.m. thru 11:05 a.m. Client 119 was again observed sitting in a chair, on a fetal position, with [REDACTED] head on [REDACTED] arms. There was no behavioral issue observed.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>The "Psychotropic Drug Review" (PDR), dated 2/25/14, indicated that when Client 119's behavior nears zero, weaning [REDACTED] off [REDACTED] should</p>	W 316		

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 316	<p>Continued From page 162</p> <p>be considered. The PDR, dated 4/14/14, also indicated that when [REDACTED] behavior nears zero in June 2014, decreasing the medication [REDACTED] to 7.5 mg should be considered.</p> <p>There were no gradual drug reduction documented found in the clinical record, based on the recommendation. The current order still reflected the same order from 10/15/13 for [REDACTED] 15 mg, although Client 119 showed success in meeting [REDACTED] objectives.</p> <p>On 5/13/14 at 4:12 p.m., an interview with the Senior Psychologist was conducted. He stated that the reduction in medication depends on what was being treated. According to him, Client 119 was being treated for [REDACTED] and agitation. The Senior Psychologist reviewed the data collected for Client 119 and agreed that [REDACTED] achieved success on [REDACTED] objectives. He reviewed Client 119's record and was unable to find documentation and explanation why the recommendation to taper the medication was not implemented.</p> <p>On 5/15/14 at 9 a.m., a review of the PDR Minutes dated, 2/24/14, and 4/14/14 was conducted. The review indicated that there were no attempts made to reduce Client 119's psychotropic medication. The justification documented on 2/24/14 was identical to 4/14/14, which indicated, "Behaviors were worst in the fall of 2010, and [REDACTED] was increased ...Client seems to be better overall on a consistent basis since changes were implemented."</p> <p>On 5/15/14 at 9:30 a.m., a review of the facility's Policy and Procedure (P&amp;P) titled Policy 454 "Psychotropic Medication," updated on 4/2/14</p>	W 316			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 316	<p>Continued From page 163</p> <p>was conducted. The review indicated, "3.0 Bi-monthly psychotropic drug review meetings ...g. Indicate that either an attempt was made to reduce the dose of one or more psychotropic medications during the past 12 months, or provide explanation of why such an attempt was not made."</p> <p>2. The facility policy and procedure titled, "Psychotropic Medication," dated January 2014, was reviewed on May 15, 2014. The policy indicated, "Psychotropic medications are drugs used to modify behavior, mood, cognition, or state of arousal. They should only be used when absolutely necessary to protect the person from harming self or others or as pharmacotherapy for a diagnosed mental disorder, and will be a component of an overall program plan utilizing positive behavior supports. Psychotropic medication will be used only after other intervention strategies have failed to eliminate the undesirable impact of the problem behavior(s)...The results of the Psychotropic Drug Review (PDR) are based on relevant data and are recorded on appropriate PDR forms and a PPN (Physician's Progress Note)...Fading Plan for Psychotropic Medication...The purpose of the fading plan should be to find the minimum effect dosage or to discontinue the medication...The chosen fading plan will be documented in the IPP based on relevant data and input from the service providers...If a client's psychotropic medications has not been decreased within 12 months, the reason must be documented in the PDR minutes and IPP."</p>	W 316			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 316	Continued From page 164 Record review for Client 68 was conducted on 5/13/14. [REDACTED]  [REDACTED]  The record further revealed that Client 68 had three behaviors with Behavior Support Plans for self-abusive behaviors, [REDACTED]  Client 68's Psychotropic Drug Review dated April 28, 2014 and signed by the psychologist was reviewed. The Psychotropic Drug Review indicated the medication, [REDACTED], was being monitored along [REDACTED] and [REDACTED]. The data collected and documented on the form revealed Client 68 had	W 316			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 316	<p>Continued From page 165</p> <p>not exhibited any behaviors for the past four months (January, February, March and April 2014).</p> <p>In addition, there were no psychiatric symptoms documented on the data sheets. The Psychotropic Drug Review Minutes indicated, [REDACTED] behaviors) rates have been zeros for the past five months, lower than the previous year and a half." The document indicated that Client 68 had been on the same dose since 2009 and an annual dose reduction of the medication had not been attempted. The Rational for not attempting a dose reduction was, [REDACTED] has demonstrated its effectiveness; it is commonly prescribed for General Anxiety Disorder as a long-term psychotropic support and has minimal potential side effects...Based on the above assessment, team's decision today with the target outcome (behavior or psychiatric symptoms) - No change of psychotropic medication..." The Psychotropic Drug Review, dated February 3, 2014, documented the same rationale for not attempting a gradual dose reduction as in the 4/28/14 Psychotropic Drug Review.</p> <p>The Individual Program Plan (IPP), dated April 22, 2014 indicated under Restrictive Interventions, "Psychotropic Medication; [name of Client 68] never took psychotropic drugs until 5/09 when [REDACTED] was started to reduce [REDACTED] hitting and biting [REDACTED] self related to [REDACTED] anxiety and [REDACTED]..." There was no fading or gradual dose reduction plan documented on the IPP. There was no rationale as to why a fading plan or dose reduction attempt was not implemented in the past 12 months.</p>	W 316			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
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W 316	Continued From page 166 An interview was conducted with Client 68's Psychologist on 5/14/14, at 3:40 p.m. The Psychologist stated Client 68 had been on the same dose (10 mg) of [REDACTED] since 2009. The psychologist stated they have Psychotropic Drug Review every two months, and the interdisciplinary team determined if the psychotropic medications are appropriate for the individuals. The Psychologist went over the behavior data and stated Client 68 was doing well on the medication as [REDACTED] had not exhibited any negative behaviors in the past several months. The psychologist stated no gradual dose had ever been attempted because Client 68 did not appear to be having any adverse or side effects on the medication and the Psychiatrist felt [REDACTED] [REDACTED] was an appropriate dose to keep Client 68 on for long-term treatment. The psychologist stated the Psychotropic Drug Review team consisted of the psychiatrist, psychologist, Individual Program Coordinator, social worker, Clinical Registered Nurse, Unit supervisor, and sometimes the physician and/or a pharmacist. The psychologist stated a lower dose attempt of [REDACTED] had not been discussed with the team because the psychiatrist intended to keep Client 68 on 10 mg for long term treatment. The psychologist stated it was possible that Client 68, "Would do just as well with a lower dose of [REDACTED] or with no dose at all. We would not know until we tried it."	W 316			
W 318	483.460 HEALTH CARE SERVICES  The facility must ensure that specific health care services requirements are met.	W 318			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 318	<p>Continued From page 167</p> <p>This CONDITION is not met as evidenced by: Based on observations, interviews, record reviews, and document reviews, for the time parameter 2/1/14 through 5/15/14, the Condition of Participation in Health Care Services was not met. Individuals did not receive adequate health care monitoring and services, including appropriate and timely notifications, follow up and assessment based upon their individual needs. The facility failed to ensure that clients were provided nursing services in accordance with their needs. This affected 1 of 17 sampled clients (Client 13) and 12 focused clients (Client's 21, 27, 43, 51, 55, 85, 86, 107, 112, 155, 173 and 174) as evidenced by the following:</p> <ol style="list-style-type: none"> <li>1. The nursing protocol for Falls Prevention, Assessment and Care/Cervical Spine Precautions was not implemented. A client, at risk for frequent falls and fractures, sustained a fall onto [REDACTED] right hip. There was no notification to the HSS (Health Services Specialist)/ACNS (Assistant Coordinator of Nursing Services)/ or CNS (Coordinator of Nursing Services). Thus, there was no initial assessment of the client after the fall. These failures had the potential for a delay in treatment, injuries, and fractures. This affected 1 focused client (Client 21). (See W331)</li> <li>2. The facility failed to ensure that a nursing care plan for "Constipation (slow transit)" was implemented when total fluid intake was not consistently documented on the daily care flow sheet for a client at high risk for constipation and [REDACTED]</li> </ol> <p>[REDACTED] This affected one focused</p>	W 318			

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W 318	<p>Continued From page 168 client (Client 174). (See W331)</p> <p>3. The facility failed to ensure that a mobility care plan was implemented for one focused client (Client 55). (See W331)</p> <p>4. The nursing procedure for, "Transfer an Individual to a Community Hospital or Community Appointment" was not implemented. A client was transferred to an outside acute care hospital for surgery. There were no Interdisciplinary Notes (IDN) written that indicated appropriate information relating to the clients' transfers. This affected two clients during a focused review. (Client's 107, 155). (See W331)</p> <p>5. The facility failed to ensure an identified concern by the facility in staff competency, documentation, and implementation of clients' hydration and fiber needs related to their risk of constipation was thoroughly understood by staff, documented, analyzed for discrepancies, and acted upon timely. (See W331)</p> <p>6. The facility failed to ensure that staff were able to demonstrate or verbalize how to access information regarding fluid requirements for one focused client (Client 51), with [REDACTED] failed to ensure documentation of bowel monitoring was being done for one focused client (Client 27). (See W331)</p> <p>7. The facility failed to implement their policy titled, "Bowel Care Management" dated March 2014 placing five of ten focused clients of 131 identified to be at high risk of constipation for complications [REDACTED],</p>	W 318			

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W 318	<p>Continued From page 169</p> <p>[REDACTED]</p> <p>8. The facility failed to ensure timely notification to the physician when a client, at risk for bowel obstruction and constipation [REDACTED] exhibited two episodes of emesis (vomiting) within 5 hours for one focused client (Client 174). (See W331)</p> <p>9. The facility failed to implement the policy titled , "Gastrostomy Tube" (G-tube: a medical device used to provide nutrition to patients who cannot obtain nutrition by mouth or are unable to swallow), dated 3/14, which indicated if the fluid withdrawn from the G-tube had an alteration from baseline, staff were to hold the feeding and report to the clinical registered nurse (CRN), HSS, or ACNS and follow up with the physician. Client 173's G-tube residual was discovered to be bronze in color on 1/10/14 and the feeding was not held and the abnormal color was not reported to the nurse or physician. Four days later fecal content was found in the G-tube. (See W331)</p> <p>10. The facility failed to implement the policy titled, "Notification of Unit Physician and/or Health Services Specialist," dated December 2013, which indicated to call the physician directly when any and all significant changes from baseline were discovered. Client 173 was re-admitted to</p>	W 318			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 318	Continued From page 170 the residence on [REDACTED] /14 following surgery [REDACTED] and had a change noted in his lungs at 8:30 p.m. and further decompensated physically (functional deterioration of a previously working structure or system), as evidenced by his vital signs, without the benefit of a physician evaluation, requiring an emergency transfer to the acute care community hospital where [REDACTED] expired. This affected one client outside the core sample, Client 173. (See W331)	W 318			
	11. The facility failed to ensure prompt medical care and treatment was provided for one focused client (Client 43). Client 43 fell [REDACTED] Saturday [REDACTED] /14 and was not assessed by a physician for three days despite complaints of pain, edema and bruising, when on 4/8/14 an x-ray was ordered and revealed a fracture at the base of the 5th metatarsal (bone in the foot). (See W338)				
	12. The facility failed to ensure infection control practices were implemented when Client 112 was observed inserting [REDACTED] left hand inside [REDACTED] pants and staff did not redirect and encourage the client to wash [REDACTED] hands. (See W341)				
W 331	The cumulative effect of these systemic practices, resulted in the facility's inability to meet the requirements for the Condition of Participation: Health Care Services. 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:	W 331			



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W 331	<p>Continued From page 172 (Client 55).</p> <p>4. The nursing procedure for, "Transfer an Individual to a Community Hospital or Community Appointment" was not implemented for 2 focused clients (Clients 107,155). A client was transferred to an outside acute care hospital for surgery. There were no Interdisciplinary Notes written that indicated appropriate information relating to the clients' transfers. This affected two clients during a focused review of hospital transfers for the time parameter 2/1/14 through 5/15/14.</p> <p>5. The facility failed to ensure that staff competency, documentation and implementation of clients' hydration and fiber needs related to their risk of constipation was thoroughly understood by staff, documented, analyzed for discrepancies and acted upon timely.</p> <p>6. The facility failed to implement their policy titled "Bowel Care Management" dated 3/14 placing five of ten focused clients of 131 identified to be at high risk of constipation for [REDACTED] and acute hospital transfers this affected 1 of 17 sampled clients (Client 13) and two focused clients (Clients 85 and 86).</p> <p>7. The facility failed to ensure that staff were able to demonstrate or verbalize how to access information regarding fluid requirements for one focused client (Client 51), [REDACTED]</p>	W 331		

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W 331	<p>Continued From page 173</p> <p>██████████ and failed to ensure documentation of bowel monitoring was being done for one focused client (Client 27).</p> <p>8. The facility failed to ensure timely notification of the physician when a client, at risk for bowel obstruction and constipation ██████████</p> <p>██████████ exhibited two episodes of emesis (vomiting) within five (5) hours time for one focused client (Client 174).</p> <p>9. The facility failed to implement the facility policy titled, "Gastrostomy Tube" (G-tube: a medical device used to provide nutrition to patients who cannot obtain nutrition by mouth or are unable to swallow), dated 3/14, which indicated if the fluid withdrawn from the G-tube had an alteration from baseline, staff were to hold the feeding and report to the clinical registered nurse, HSS, or ACNS and follow up with the physician. Client 173's G-tube residual was discovered to be bronze in color on ██████/14 and the feeding was not held and the abnormal color of the residual (bronze) was not reported to the nurse or physician. Four days later fecal content (stool) was found in the G-tube.</p> <p>The facility failed to implement the policy titled, "Notification of Unit Physician and /or Health Services Specialist," dated 12/13, which indicated to call the physician directly when any and all significant changes from baseline were discovered. Client 173 was re-admitted to the residence on ██████/14 following surgery for a</p>	W 331			

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

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FORM APPROVED  
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W 331	<p>Continued From page 174</p> <p>[REDACTED] and had a change noted in his lungs at 8:30 p.m. and further decompensated physically (the functional deterioration of a previously working structure or system), as evidenced by his vital signs, without benefit of a physician evaluation, requiring an emergency transfer to the acute care community hospital where he expired. This affected one focused client (Client 173).</p> <p>Findings:</p> <p>1. On 5/7/14, review of the IPP (Individual Program Plan), dated 11/6/13, indicated that Client 21 was [REDACTED] years of age and at risk for fractures [REDACTED].</p> <p>[REDACTED] A subsequent IPP, dated 2/11/14, indicated that Client 21 had limited hazard awareness and was at risk for falls.</p> <p>[REDACTED]</p> <p>On 5/7/14, review of a TC (Temporary Condition) Interdisciplinary Note (IDN), dated [REDACTED]/14 at 4:20 p.m., indicated that Client 21 sustained a fall to [REDACTED] right hip. [REDACTED]</p>	W 331		

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W 331	<p>Continued From page 175</p> <p>The TC "Plan" contained the following:</p> <ol style="list-style-type: none"> <li>1. HSS/ACNS notified.</li> <li>2. Observe for bruising /change in ambulation.</li> </ol> <p>The Nursing Protocol for "Falls Prevention, Assessment and Care/Cervical Spine Precautions," P 901, reviewed in 10/2013, indicated the following: If a client falls and no obvious injury is noted:</p> <ol style="list-style-type: none"> <li>1. Assist the client</li> <li>2. Notify CRN/HSS/ACNS for assessment</li> <li>3. Initiate TC in the ID note and put in MD communication book.</li> <li>4. Document on 24 hour log.</li> </ol> <p>Review of subsequent IDNs failed to indicate any assessment by the CRN/HSS/ or ACNS, as indicated in the Nursing Protocol for Fall Prevention, Assessment and Care/Cervical Spine Precautions," .</p> <p>The fall incident was not recorded in the 24 hour log, as indicated in the Nursing Protocol for Fall Prevention.</p> <p>The first IDN written by a unit RN was on [REDACTED]/14 at 6 a.m., approximately 13.5 hours after the fall.</p> <p>During an interview with the Unit Supervisor on 5/7/14 at 10:30 a.m., staff stated that if a client fell, the HSS or ACNS should come and evaluate the client. The Unit Supervisor acknowledged that she could not locate an IDN from either staff.</p> <p>During an interview with the CNS (Coordinator of Nursing Services) on 5/12/14 at 3:40 p.m., the CNS stated that the clinical nurse was on vacation and the ACNS (Asst Coordinator of Nursing Services) would have been the only</p>	W 331			

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W 331	<p>Continued From page 176</p> <p>nurse that the unit staff would have paged. The CNS stated that the ACNS was never notified nor was her department, Central Nursing Services, notified. The CNS further stated that the fall was not entered onto the HSS log or the 24 hour log. The CNS stated that the unit staff should have informed CNS so a full physical assessment could be done.</p> <p>2. Review of the IPP (Individual Program Plan) on 5/14/14 indicated that Client 174 was at risk for bowel obstruction and constipation [REDACTED]</p> <p>The Nursing Care Plan for "Constipation (slow transit)" contained the following: Encourage fluids to achieve recommended standards of 1440-2000 cc (cubic centimeter: a unit of volume)/day or specific hydration orders per MD. Notify HSS/ACNS/MD if client refuses fluids.</p> <p>Document total fluid intake every shift on daily care flow sheet #5504. Notify HSS/ACNS if daily intake is less that 50% of baseline.</p> <p>Review of the daily care flow sheet for 2/14 contained a section for documenting fluids which instructed staff to record CCs (cubic centimeters/unit of measure) of fluids taken in the AM and PM.</p> <p>On 2/1/14, 2/2/14 and 2/3/14 there were six (6) entries that documented fluid intake for the AM and PM shifts. The majority of entries were illegible (not clear enough to be read).</p> <p>On [REDACTED] 14 Client 174 was admitted to the facility</p>	W 331			

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W 331	<p>Continued From page 177</p> <p>GACH (general acute care hospital) [REDACTED] and returned to his home unit on 2/6/14.</p> <p>Aside from one IDN shift entry that documented 1,680 cc's of fluid intake on 2/7/14 at 2 p.m., there was no further documentation of fluid intake for the next 7 days, upon which time Client 174 was hospitalized for a volvulus in the sigmoid colon (the part of the large intestine that is closest to the rectum).</p> <p>The daily care flow sheet also contained a section entitled, "Eating," and included documentation of nourishments for 8 ounces of prune juice at breakfast and Carnation Instant Breakfast at breakfast, lunch and dinner. The majority of fluid entries were noted to be illegible, resulting in staff being unable to determine the actual amount of nourishments that were actually consumed by the client.</p> <p>During an interview with the CNS (Coordinator of Nursing Services) on 5/15/14 at 12 p.m., the CNS stated that any high risk client required fluid tracking every day. The CNS further stated that the flow sheet should be filled in.</p> <p>3. Record review on 5/14/14 indicated that Client 55 had a health care plan / mobility care plan for difficulty walking.</p> <p>A health care plan that addressed the client's risk for falls, indicated that staff must use a gait belt (a device used to transfer people from one position to another) for safety during ambulation.</p>	W 331			

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W 331	<p>Continued From page 178</p> <p>During an observation on the Roadruck Unit on [REDACTED]/14 at 2:45 p.m., Client 55 was observed sitting in a chair in the group room. The client had a belt around [REDACTED] waist, over [REDACTED] clothes. In a concurrent interview with staff, staff stated it was a gait belt used to help Client 55 ambulate.</p> <p>During a subsequent observation on [REDACTED]/14 at 9:55 a.m., Client 55 was observed sitting in [REDACTED] wheelchair with [REDACTED] gait belt in place.</p> <p>The PT (Psychiatric Technician) present stated that Client 55 should not have the gait belt on and should only be using the seat belt when in the wheelchair. Staff immediately removed the gait belt when questioned by the surveyor.</p> <p>4a. The Nursing Procedure for "Transfer an Individual to a Community Hospital or Community Appointment," Procedure D 104, reviewed in 11/12, contained the following: For Non-Emergency transfers for admission: Record appropriate information in the IDNs. Include reason for transfer, when and where transferred, note copies of documents sent, vital signs, medications given and client consent.</p> <p>On 5/7/14, Client 155's record was reviewed. The medical record lacked documented evidence of an IDN upon transfer to the acute care hospital [REDACTED] on 4/7/14.</p> <p>During an interview with the Unit Supervisor on 5/7/14 at 1:35 p.m., the Unit Supervisor stated that there should be a sign out note indicating the</p>	W 331			

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

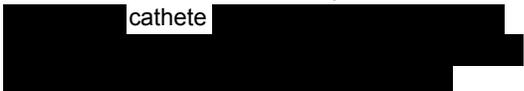
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W 331	<p>Continued From page 179 transfer.</p> <p>4b. Record review beginning on 5/7/14 revealed Client 107 was transferred to an outside acute care hospital for surgery on [REDACTED]/14 for a [REDACTED]).</p> <p>There was no interdisciplinary note or physician note written at the time of transfer or even within 24 of transfer showing Client 107's physical or emotional condition, supports or services required to meet [REDACTED] needs during hospitalization, how [REDACTED] was transferred/transported or who accompanied [REDACTED]</p> <p>Interview with the Unit Supervisor on 5/7/14 at 10 a.m. indicated Client 107's surgery was planned, a transfer packet completed and a special conference was held. Further interview determined the transfer information was not in Client 107's clinical record. A request for the transfer information was unmet as of 5/15/14.</p> <p>Review of a special meeting note, dated 4/9/14, revealed the team obtained consent for the [REDACTED]. The team indicated Client 107 would "most likely require one to one supervision." However, the note did not mention discussion of nursing concerns pertinent to the planned hospitalization.</p> <p>The Individual Program Plan dated, 2/14/14, indicated Client 107, a [REDACTED]</p>	W 331			

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W 331	<p>Continued From page 180</p> <p>██████. The special meeting to discuss Client 107's planned surgery failed to discuss the nursing concerns identified in the home residence and documented in the IPP.</p> <p>5. Interview with the ACNS on 5/12/14 at noon revealed the facility had identified a systems concern, with staff competency, documentation, and implementation of clients' hydration and fiber needs related to their risk of constipation. The facility revised their policy titled "Bowel Care Management" dated March 2014 and provided training with on-going audits.</p> <p>In a interview with the CNS on 5/15/14 at 12 p.m., the CNS confirmed the policy revision and staff training, and stated that any high risk client required fluid tracking every day. The CNS further stated that the flow sheet should be filled in.</p> <p>Review of the policy titled, "Bowel Care Management," dated 3/14, revealed staff were to: Encourage fluids and ensure adequate fluid intake. Provide diet as ordered with encouragement of foods high in fiber when not contra-indicated. Monitor bowel movements and document results on ADL flow sheet. Additionally, for clients who were identified as at HIGH RISK for CONSTIPATION: Hydration totals by cc (fluid measurement) would be tracked and documented on the activities of daily living (ADL) flow sheet each shift on a separate row than percentage of meal consumed. Licensed staff were to review daily total fluid intake to ensure standard hydration goal of 6-8 glasses, or 1440 -2000 cc/day was met. When daily hydration goal was not met additional fluids</p>	W 331			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 331	<p>Continued From page 181</p> <p>should be offered and encouraged. Staff were to notify the CRN/HSS/ACNS if daily intake was less than 50% of baseline.</p> <p>Staff were to document: ADL flow sheet form #DS5504 by the end of each shift, shift lead will ensure completion. The PT / LVN documents observations of signs and symptoms, deviations from usual condition. RN provides a synthesis of subjective and objective information which included nursing actions, interventions, follow-up and notifications. For clients at risk for constipation a monthly/ weekly review by licensed staff is required.</p> <p>On 5/14/14 a request was made to Quality Assurance for a list of clients identified to be at high risk for constipation. A list of 131 clients was received. Ten focus clients were chosen with descriptions of "constipation other... constipation unspecified... constipation slow transit..." for focus review of implementation of the revised policy.</p> <p>6a. Client 86's Medical History dated 1/17/14 indicated he had chronic constipation and a cathete    The facility protocol for individuals with a suprapubic catheter was to monitor and document daily fluid input and urinary output (I &amp; O).</p> <p>Client 86's I &amp; O and flow sheets showed inconsistencies. For example: On 3/18/14 the a.m. fluid documented on the flow sheet was 720 cc's at breakfast and lunch and 240 cc prune juice at breakfast and lunch. The I &amp; O sheet</p>	W 331			

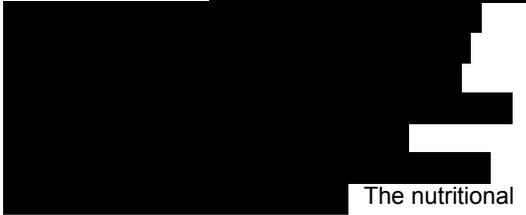
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W 331	<p>Continued From page 182</p> <p>showed for breakfast and lunch; 720 cc, 720 cc and 240 cc to equal 1680 however the total documented was 1440 cc. When asked if the total fluid consumed on the flow sheet included the prune juice served with meals, the nurse wasn't sure.</p> <p>Other inconsistencies for Client 86's fluid intake documentation were: On 3/29/14 the daily fluid total was not calculated.</p> <p>On 4/4/14 the I &amp; O for the a.m. shift was 240, plus 150, plus 480 to equal 870 cc and the PM shift was 720 plus 400 cc equaling 1120ccs; But, the daily total was not 1990 (the sum of 870 cc and 1120 ccs) it was documented to be 2310 ccs consumed.</p> <p>There was no identification of what Client 86's daily estimated fluid needs were on the I &amp; O or ADL flow sheets. There was no signature of the person totaling the fluid on the I &amp; O sheets.</p> <p>The quarterly nursing evaluation dated 4/3/14 indicated Client 86's bowel pattern was normal but 5 PRN's for bowel care had been given. Client 86's "urine looked dark, the urinalysis showed some bacteria, an antibiotic was prescribed" and "extra fluids encouraged." The ADLs were recorded are usual. There was no synthesis of Client 86's intake of fluids and urinary output by the nurse. The Psychotropic Drug Review dated 4/21/14 indicated more frequent PRN's for bowel care - March showed 6 prns and April showed 3prns.</p> <p>A monthly summary dated 5/9/14 indicated Client 86 was at "High Risk for Constipation" but there was no reference of [redacted] fluid intake or fiber, how staff encouraged fluids or fiber or if [redacted] daily goals</p>	W 331			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 331	<p>Continued From page 183 of fluid were met.</p> <p>The annual nutritional assessment dated 1/9/14 estimated Client 86's daily fluid requirements to be 2651 cc with a recommendation to increase clear fluids.</p> <p>In an interview with the residence nurse and Health Services Specialist on 5/15/14 starting at 8 a.m., they were unable verbalize how to access the information regarding daily fluid requirements for Client 86. Both thought that the fluid requirements would be found in the physician orders, but when orders were accessed on the computer, the nurses were unable to find any specific information. The nurse said the plan of care for Client 86's constipation concern did not include daily fluid requirements. When asked how the nurse communicated to the staff the need for increased fluids or fiber in the diet, she indicated the ordered diet met all Client 86's needs. When asked if a lack of fluid or fiber in the diet could be related to Client 86's need for PRN's to stimulate bowel, she replied, there was no correlation. The nurse indicated she had been trained in the new Bowel Care Management protocol.</p> <p>6b. Client 85 had a   The nutritional evaluation dated 2/3/14 estimated his fluid needs to be 2245 cc daily with recommendations to drink only 2 ounces at a time. The ADL sheet for May 2014 showed staff documented Client 85</p>	W 331			

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W 331	<p>Continued From page 184 drank a low of 1,354 cc to 2,199 cc daily.</p> <p>In an interview with the residence nurse and Health Services Specialist on 5/15/14 starting at 8 a.m., they were unable to verbalize how to access the information regarding daily fluid or fiber requirements for Client 85, see interview above.</p> <p>6c. A review of Client 13's "Objectives - Expected Outcomes" was conducted on 5/14/14. Listed as "Objective 1. [Clients Name] [REDACTED] The objective contained steps to implement the plan. Step 3 - "Encourage fluids. Document total fluid intake every shift on a daily care flow sheet #5504 per NP A405. Notify HSS/CRN/MD if daily intake is less than 50% of baseline."</p> <p>On 5/14/14 at 5:30 p.m., a review of Client 13's Individualized Daily Care Flow Sheet (DCFS) DS 5504 was conducted. An inadequate amount of fluid intake was recorded from 5/1/14 through 5/14/14. On 6 out of 14 days for the month of 5/14 the documentation recorded 300 cc's per day (equivalent to about 10 ounces of fluid per day). Documented was 100 for breakfast 100 for lunch and 100 for dinner, for May 1, 2, 3, 4, 10 and 11, 2014.</p> <p>The month of March and April listed inconsistencies in the documentation of fluid consumed. In the month of March 2014, fluid intake was listed on 3/1/14, as breakfast 80, lunch "S". The intake for 3/2/14 was written the same as Breakfast 100 and lunch "S". On April 2014, the Breakfast was 100, Lunch "S" and diner 100. On April 15 the documentation was recorded as Breakfast 100, Lunch "S".</p>	W 331			

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W 331	<p>Continued From page 185</p> <p>The DCFS (daily care flow sheet) contained a legend that listed abbreviations for "Care completed as planned." The letter S was an abbreviation for the word self. It was not an indication of cc's consumed.</p> <p>The policy titled, "Assisted Feeding Estimating Intake Procedure," A405 revised 10/13 section III, was reviewed on 5/15/14. Documented in Section III, "Estimating Fluid Consumed By Clients - standard recommendation is 6-8 glasses or 1440-2000 ml (cc) per day for the average sized person"...</p> <p>Further review of the clinical record revealed there was no documentation that addressed the inadequate fluid intake, for the days recorded as 300ccs' per day.</p> <p>On 5/15/14 at 2 p.m., during an interview with the Unit Supervisor she stated that the staff who were documenting 100 must mean 100% of fluids per meal consumed. The unit supervisor confirmed that the DCFS form should contain the amount of cc's of fluid consumed per shift, and not the percent of meals. The nurse failed to identify this concern.</p> <p>6d. The Clinical Nurse stated that as per the new policy, all clients on the unit had been assessed and were monitored for bowel problems and bowel care needed. When Client 27's record was randomly pulled and the Activities of Daily Living (ADL) sheet was reviewed it was noted that there was no documentation of any bowel monitoring being done. The ADL sheet in Client 27's record did not even have any space for bowel monitoring and was completely different from the ADL sheets</p>	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 331	<p>Continued From page 186 in other clients' records. The Clinical Nurse could not explain why Client 27 did not have the correct sheet in his medical record.</p> <p>7. A review of Client 51's [REDACTED] [REDACTED] A review of the dietary assessment indicated that her fluid requirements were calculated to be 2476 cc/day.</p> <p>During an interview with a Clinical Nurse on 5/15/14 at 11:50 a.m., he was unable to demonstrate or verbalize how to access the information regarding fluid requirements for Client 51. He thought that the fluid requirements would be found in the dietary orders, but when [REDACTED] accessed those orders on the computer, he was unable to find any specific fluid requirement information so he stated that she would be on standard requirements which would be about 2000 cc/day. Even when he was told by the surveyor that the fluid requirements would be found on the dietary assessment he still did not find the section listing Client 51's specific fluid requirements. The surveyor had to point it out to him.</p> <p>When asked what he would do if Client 51 did not meet [REDACTED] fluid requirements for the day, he stated that [REDACTED] could be offered other fluids but could only name a few sources of supplemental fluids, such as juice, soda, coffee or tea. He was unable to verbalize other common, and more nutritious, sources of fluids available such as Jell-O, pudding, soups, ice cream, popsicles, etc., even with prompting by the surveyor.</p>	W 331			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 331	<p>Continued From page 187</p> <p>8. Client 174, at risk for bowel obstruction and constipation [REDACTED]</p> <p>The physician was not promptly notified of the two episodes of emesis. The failure to notify the physician of two episodes of emesis (prior to the client having 2 additional emesis) potentially resulted in a delay in treatment. Subsequently, Client 174, at high risk for bowel complications, required an emergent hospital transfer and surgery. Client 174 passed away on [REDACTED]/14.</p> <p>[REDACTED]</p> <p>Review of the IPP (Individual Program Plan) on 5/14/14 indicated that Client 174 was at risk for bowel obstruction and constipation.</p> <p>[REDACTED]</p>	W 331		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 331	<p>Continued From page 188</p> <p>On 5/21/14 record review indicated that on 2/13/14 at 5:10 p.m. a TC (Temporary Condition) was initiated after Client 174 had an emesis of semi-undigested food with coughing. Documentation indicated that Client 174 was in no distress and vital signs were as follows: Temperature-97degrees F., pulse-81, respirations-20 and blood pressure - 117/83. His oxygen saturation was 97%. Documentation indicated that the HSS (Health Services Specialist) was made aware and the MD was notified via the log ( a written notification to the physician). Staff were to monitor for complications.</p> <p>In response to the Temporary Condition noted above, the HSS (Health Services Specialist) note, dated 2/13/14 at 6:30 p.m., indicated that Client 174 had a small (50cc) emesis associated with a coughing episode. ■ had no signs of illness, had a stool in the morning, and ate a light dinner. Documentation indicated that ■ abdomen was "quite distended" and tympanic (drum like sound indicating that intestines were distended with gas). Further documentation indicated that, "Staff state that this is not a new finding."</p> <p>Further documentation indicated that Client 174 had a standing order for a ■ (as needed) for distention which staff were instructed to use. Bowel sounds were present in (unable to read) quadrants, but sluggish. ■ seemed happy and in no acute distress.</p> <p>On 2/13/14 at 10:15 p.m., a unit RN IDN noted that Client 174 had a moderate amount of emesis (second episode), approximately 100cc of semi undigested food particles, with coughing noted. Documentation indicated that ■ was in no acute</p>	W 331			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 331	<p>Continued From page 189</p> <p>distress, ■ abdomen was soft, non tender, and slightly round. There was no indication of pain and vital signs were stable. Temperature- 97.8 degrees F., pulse- 85, respirations-20, and blood pressure-115/65. Oxygen saturation was 96%. Documentation indicated, "HSS made aware. MD notified via log."</p> <p>Although documentation indicated that the HSS was "made aware" of the second episode of vomiting at 10:15 p.m., there was no documented evidence of an HSS assessment that addressed this second episode of vomiting nor was there evidence of a verbal notification to the physician for this high risk client.</p> <p>The HSS was not available for interview.</p> <p>The HSS log was reviewed on 5/27/14 and included documentation of both episodes of emesis that occurred at approximately 5 p.m. and 10:15 p.m. Documentation indicated, "Unit MD to eval (evaluate) in a.m."</p> <p>A subsequent assessment note was completed over two hours later when the ACNS (Assistant Coordinator of Nursing Services) was on the unit at which time the client had a third emesis as noted below.</p> <p>An ACNS IDN, dated 2/14/14 at 12:30 a.m., indicated that Client 174 had another emesis described as a large amount of brown colored emesis (which may be indicative of blood in the gastrointestinal tract). The note indicated that the client had eaten chocolate earlier. Client 174 was alert and cooperative. ■ color was fair, and ■ skin was warm and dry. ■ abdomen was distended but not tender and was tympanic</p>	W 331			

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

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FORM APPROVED  
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W 331	<p>Continued From page 190</p> <p>throughout. The emesis had a "rancid" odor and was checked for blood using a guiac test. The test was positive. At this time, [REDACTED] temperature was 99.1, pulse-86, respirations-20, blood pressure- 138/72, oxygen saturation was 94% and [REDACTED] airway was clear per auscultation. The MOD (medical officer on duty) was notified and an order for Maalox was received along with additional telephone orders for clear liquid diet, vital signs every 4 hours for 48 hours, CBC and Chemistry panel (blood work) in the morning, and stool for occult blood x1. The client was not evaluated by the MOD at this time.</p> <p>A subsequent ACNS note, dated 2/14/14 at 2:45 a.m., indicated that Client 174 had a large emesis (fourth episode), coffee ground color, and a moderate emesis. [REDACTED] color was fair to pale and he was alert and cooperative. Gaseous bowel sounds were present and [REDACTED] abdomen was distended and soft. [REDACTED] blood pressure was 90/61. The MOD was notified and Client 174 was transferred to the emergency department at the acute care hospital.</p> <p>During a telephone interview with the ACNS (Assistant Coordinator of Nursing Services) on 5/22/14 at 6:30 a.m., the ACNS stated that he had no knowledge that the client had previously vomited at 5:10 p.m. on 2/13/14. The ACNS stated that the HSS covered the units until 11 p.m. on 2/13/14. At 10:30 p.m. on 2/13/14, when he received report from the HSS, the ACNS was informed that Client 174 had an emesis.</p> <p>After receiving the report of the emesis, the ACNS stated he had thought to himself, "I better keep my radar open." The ACNS stated that he went to check on the client to see how [REDACTED] was</p>	W 331			

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

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W 331	<p>Continued From page 191</p> <p>doing and when he walked into ■■■ room Client 174 had another emesis at 12:30 a.m. on 2/14/14, (brown colored). The ACNS stated that he was not too concerned as Client 174 was calm and ■■■ did not seem to be in distress. The ACNS stated that there was no fresh blood observed. The ACNS stated that the emesis smelled like iron and he checked the emesis for blood (guaiac), which was positive. The MOD was notified and the client received Maalox. The ACNS stated that he visited the unit several times to keep a close eye on the client.</p> <p>On 2/14/14 on or about 2:45 a.m., the ACNS stated that he received a call from the unit regarding another episode of emesis. The ACNS notified the MOD and went to the unit. The ACNS stated that although Client 174 was alert and cooperative, ■■■ blood pressure had decreased and ■■■ was a "little more pale." Client 174 was transferred to the acute care hospital.</p> <p>On 5/22/14 at 2 p.m., during an interview with the MOD (Medical Officer on Duty), the MOD stated that his first notification that the client had vomited was at 12:30 a.m. on 2/14/14 and that he was unaware of the first two episodes of emesis that occurred the previous evening at 5:10 p.m. and 10:15 p.m. The MOD stated that the incident was presented to him at 12:30 a.m. by the ACNS and it did not come across as acute at that time. The MOD stated that the oxygen saturations were OK, there were no signs of aspiration, and vital signs were stable. The MOD further stated that he felt the nursing assessment was reliable.</p> <p>The medical summary after death indicated that the final diagnoses were sepsis due to necrotic bowel, adynamic colon (loss of strength or</p>	W 331			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 331	<p>Continued From page 192</p> <p>function of the colon), toxic megacolon (abnormal dilation of the colon), renal (kidney) mass, and hypertension. The cause of death was sepsis due to necrotic bowel.</p> <p>9. Record review conducted on 5/5/14 revealed Client 173, a [REDACTED], expired on [REDACTED]/14 from respiratory failure related to sepsis (a severe blood infection that can lead to organ failure and death) due to a perforated (torn) sigmoid diverticulum (intestine) with peritonitis (an inflammation of the membrane which lines the inside of the abdomen and all of the internal organs) and acute (sudden) kidney failure. Client 173's torn intestines leaked intestinal fluids into his abdominal cavity thru a fistula (torn hole) causing a fatal infection.</p> <p>Client 173's history was significant for a surgical placement of a G- tube due to dysphagia and severe esophageal atony (inability to swallow fluids and foods) in 11/12.</p> <p>[REDACTED]</p> <p>On [REDACTED]/14 at 6 a.m. during a routine residual check, bronze colored liquid that smelled like</p>	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 331	<p>Continued From page 193</p> <p>vitamins was noted in the G-tube by the psychiatric technician (PT). The PT failed to hold Client 173's feeding, save the residual from the stomach for examination by an RN or physician, or notify the RN and physician. The PT administered Client 173's feeding solution, wrote an interdisciplinary note and did not document notification to a nurse or physician of the client's bronze colored residual.</p> <p>Feeding tube residuals are monitored regularly to ensure the liquids/feeding in the stomach are being absorbed. Too much fluid in the stomach can cause aspiration into the lungs causing infection. Residuals that do not look like the formula being administered are to be reported immediately for evaluation by a nurse and or physician. The formula was a light tan color.</p> <p>The policy titled, "Gastrostomy Tube" dated 3/14 indicated if the fluid withdrawn from the tube had an alteration from baseline ( e.g. blood, black stomach contents, coffee ground, etc.) staff are to hold the feeding and report immediately to the clinical registered nurse, health services specialist nurse (HSS), ACNS and follow up with the physician.</p> <p>The ACNS said in an interview, on 5/12/14 at 3:30 p.m., that the psych tech should have held the feeding and notified the RN/HSS/ACNS and physician immediately.</p> <p>Four days later, on [REDACTED]/14 during a residual check, fecal content was observed during a residual check indicating a possible migration of the tube into the colon or other complication.</p> <p>Client 173 was transferred to the acute care</p>	W 331			

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W 331	<p>Continued From page 194</p> <p>community hospital and underwent a [REDACTED] change of the G-tube. A gastrointestinal fistula is an abnormal opening that allows the contents of the stomach or intestines to leak and can lead to potentially fatal infection in the abdominal cavity and organ system failure. The bronze colored residual might have been the first indication of concern.</p> <p>On [REDACTED]/14, Client 173 was re-admitted to the residence and at 11 a.m. and received an admission assessment with no abnormal findings. Client 173's vital signs were recorded to be temperature 98.2, pulse 84, respiration 20 , blood pressure 108/81.</p> <p>On [REDACTED]/14 at 8:30 p.m. (9.5 hours later) an assessment showed Client 173 had decreased left lung sounds, and scattered rhonchi in the right lung. Rhonchi are continuous low pitched, rattling lung sounds and may be caused by airway secretions and airway narrowing. Decreased lung sounds can be attributed to poor inspiratory effort or it may be a sign of impending respiratory concern. Client 173's abdomen was tympanic (drum-like sounds heard over air filled structures during the abdominal examination) with decreased bowel sounds. The vital signs were 98.5, pulse 74-78, respirations 18, blood pressure 127 /72 and oxygen level 96% on room air. There is no indication the nurse referred the change noted in Client 173's lungs to a physician.</p> <p>The policy titled, "Notification of Unit Physician and /or Health Services Specialist" dated 12/13 indicated to call the physician directly when any and all significant changes from baseline are discovered.</p>	W 331			

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

PRINTED: 07/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 331	<p>Continued From page 195</p> <p>An hour and a half later at 10 p.m., on [REDACTED]/14, Client 173's temperature was noted to be 100 degrees, pulse was increased to 118, respirations 22, blood pressure 105/60 and oxygen saturation level was 88.6 - 89 % on room air.</p> <p>At 10:45 p.m. an IDN recorded Client 173's pulse elevated to 100, and included, "no pain medications had been ordered," the nurse spoke with the medical officer on duty (MOD) and received an order for an analgesic drug, known as APAP to be given thru the G-tube. There is no indication the residual was checked, client's history was provided to the physician, or a request made for the physician to come to the residence and evaluate Client 173's change in vital signs and condition.</p> <p>At 5:30 a.m. the IDN recorded that staff noted Client 173 was very pale, diaphoretic (sweaty), oxygen saturation level was 88 % and oxygen was applied via a mask to increase level to normal of 90 -92 %. Client 173's blood pressure had fallen to 70/50, pulse 109 and respirations 20. [REDACTED] abdomen distended and no bowel sounds were heard, a medical emergency was finally activated and the client transferred via ambulance to community hospital.</p> <p>Client 173 underwent emergency surgery due to perforation of the bowel with peritonitis [REDACTED]</p>	W 331			

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

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OMB NO. 0938-0391

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W 331	<p>Continued From page 196</p> <p>Client 173's family placed [REDACTED] on comfort care and [REDACTED] expired on [REDACTED] 14 from respiratory failure related to sepsis due to a perforated ( torn) sigmoid diverticulum (intestine) with peritonitis and acute (sudden) kidney failure.</p> <p>The first physician note at 5 a.m. revealed, "called to unit for client emergency when found client to be pale, diaphoretic and hypoxic, awake but listless ... Hypotension/ Hypoxia, Possible Pneumonia, with early septic shock. "</p> <p>The Death Review Committee summary, no date, indicated Client 173 "received excellent care" and his treatment met all current medical standards. The Mortality Review Committee Minutes dated 4/14/14 indicated Client 173's "death was expected," and there were no findings from the Quality Assurance Review. The Nursing Mortality review recommendation was a closer review of Health Care Plans to ensure plans are current and not closed out by the physician.</p> <p>Interview with the CNS on 5/15/14 at 12p.m. revealed on 1/23/14 the nurse who documented Client 173's decreased lung sounds and rhonchi believed it to be normal for the Client 173 and so did not refer the change to the physician. The CNS further indicated the nurse on 1/24/14 at 10:30 p.m. told the MOD about the change in the client's condition although it was not documented whether the physician was requested to come and evaluate the client.</p> <p>When the CNS was asked why the Medical Officer of the Day (MOD) did not come to the residence to evaluate Client 173, she replied the MOD covers the entire facility on nights, weekends and holidays including, all clients in</p>	W 331			

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W 331	Continued From page 197 certified beds, uncertified units, the skilled nursing facility and general acute care hospital and relies on the nurses to assess and provide the client history and current change status information to determine if a visit is needed. Staff are directed to put information regarding client changes in the physician log book, so the next physician on the residence can review it and evaluate the client. There is no standard format/document to show what information is provided to the physician when called after hours regarding a client change in condition.	W 331			
W 338	483.460(c)(3)(v) NURSING SERVICES  Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure prompt medical care and treatment was provided for one focused client (Client 43). Client 43 fell in a pothole on Saturday 4/5/14 and was not assessed by a physician for three days despite complaints of pain, edema and bruising when on 4/8/14 an x-ray was ordered and revealed a fracture at the base of the 5th metatarsal (bone in the foot).  Findings:  On [redacted]/14 Client 43 was observed with a cast on [redacted] right foot.	W 338			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 338	<p>Continued From page 198</p> <p>On 5/14/14, at 4:45 p.m., a telephone interview was conducted with the Health Services Specialist (HSS) who indicated she had looked at Client 43 on Saturday, 4/5/14, because [REDACTED] had [REDACTED], fell to the ground, injured her knee and received an abrasion. The HSS said, "When I looked at her, I saw redness on the top of her foot. I knew it happened this morning, so the morning HSS also looked at it. When I saw her the next time it was redder. She had no pain or fever so it did not need further attention, it was in the MD log book, and he (the physician) checks it when he comes in on Monday. I did consider her age and she had osteoarthritis (a disease of the entire joint involving the cartilage, joint lining, ligaments, and underlying bone)." The HSS indicated she was not aware if Client 43 received pain medication but thought she received pain medication after the x ray.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] The change in Client 43's condition, i.e. complaints of pain, edema and large bruise was not relayed to the Medical Officer of the Day (MOD) / physician for further evaluation.</p>	W 338			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 338	<p>Continued From page 199</p> <p>At 4/5/14 at 8:30 p.m., an IDN showed a Temporary Condition (TC) was opened and noted; "Condition: Bruise top of right foot " . Subjective: "It hurts don't touch it. " Objective: Large bruise noted forming on top of right foot below ankle ...wearing her shoes, ambulation without difficulty. Assessment: Client fell this morning resulting in a light red abrasion on her left knee. The bruise on top of right foot was not noted earlier today and may be from another fall or from bumping her right foot later in the day. Unwitnessed injury. Plan: Client has scheduled pain meds [REDACTED] both twice a day [REDACTED] receives [REDACTED] at 8 p.m. Staff will encourage her to keep her right foot elevated. Offer ice to reduce swelling. Staff to observe for any difficulty ambulating and to notify the HSS/ACNS (Assistant Coordinator Nursing Services)/MD if there is a change in condition.</p> <p>The next day on 4/6/14 an IDN showed "HSS note 8:55 top of right foot is red &amp; swollen, complaints of pain." There was no indication of notification to MOD / physician for further evaluation.</p> <p>Further review of the Client 43's record confirmed Client 43 did not have a physician evaluation until Tuesday 4/8/14 at 9:40 a.m. and was documented in the "Physicians Progress Notes" ...Right foot mild swelling and diffuse bruising over foot patient refuses to allow palpitation or further exam.. bruising injury is consistent with ankle sprain patient is not limping or displaying sign of pain in light of patient history of osteoporosis will obtain X ray today. Further documentation on the Physicians Progress notes at 3:15 p.m., X ray reveals fracture at base of 5th metatarsal non-displaced. Fracture is consistent</p>	W 338			

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W 338	Continued From page 200 with mechanism of injury on Saturday. Likely patients pain meds [REDACTED] allowed [REDACTED] to ambulate with a limp along with [REDACTED] higher than normal pain threshold."	W 338			
W 341	483.460(c)(5)(ii) NURSING SERVICES  Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.  This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, the facility failed to ensure:  1. Infection control practices were implemented. Client 112 was observed inserting [REDACTED] left hand inside [REDACTED] pants and staff did not redirect and encourage the client to wash [REDACTED] hands.  2. Handwashing was performed by staff during client care.  These failures to implement proper hand hygiene had the potential for the spread of infection among the clients, direct and non-direct care staff.  re were multiple observations where staff did not perform handwashing during client care. The facility failed to ensure the practice to prevent the potential spread of infection was implemented by direct and non-direct care staff.	W 341			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
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W 341	<p>Continued From page 201</p> <p>Findings:</p> <p>1. During observation on 5/8/14 at 10:50 a.m. in [REDACTED] of Lux Day Program, Client 112 was observed sitting in a chair when [REDACTED] placed [REDACTED] left hand inside [REDACTED] pants. Psychiatric Trainer A was observed to approach the client and started applying lotion to both arms while [REDACTED] left hand was still inside [REDACTED] pants. Psychiatric Trainer A was not observed to redirect the client to remove [REDACTED] hand out of [REDACTED] pants and encourage the client to wash [REDACTED] hands. She (Psychiatric Trainer A) then left Client 112 with [REDACTED] left hand still inside [REDACTED] pants to attend to another client in the room.</p> <p>During a concurrent observation, the day program teacher (Teacher A) approached Client 112 and encouraged [REDACTED] to remove [REDACTED] hands out of [REDACTED] pants. Client 112 was resistive and did not comply. Teacher A grabbed a story book, took the client's left hand out of [REDACTED] pants, and placed it on top of the story book. Client 112 pulled [REDACTED] left hand and placed it back inside [REDACTED] pants. Teacher A then stated, "I guess [Client 112's name] didn't want to take it out." Teacher A then left without encouraging the client to wash [REDACTED] hands. The teacher was not observed to wash her hands after touching the client's left hand.</p> <p>On 5/8/14 at 11:10 a.m., an interview with Teacher A was conducted. She stated that she tried to encourage Client 112 to remove [REDACTED] left hand out of [REDACTED] pants, but the client didn't comply. She stated that Psychiatric Trainer A could be encouraging the client to remove [REDACTED] left hand out of [REDACTED] pants when she used the lotion. She (Teacher A) stated that she (Psychiatric Trainer A) should have encouraged the client to wash [REDACTED]</p>	W 341			

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

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W 341	<p>Continued From page 202 hand.</p> <p>On [REDACTED]/14 at 3:38 p.m., Client 112 was observed in the group room of the Stoneman Unit, sitting in a chair with [REDACTED] left hand inside [REDACTED] pants. A Senior Psychiatric Technician A (SPT A) was observed inside the room, encouraging the client and [REDACTED] peers to engage in an activity. SPT A observed the client with [REDACTED] left hand inside [REDACTED] pants. SPT A grabbed a small black board with a carpet like texture and had the client touch it with [REDACTED] left hand. Afterwards, Client 112 was observed with [REDACTED] left hand inside [REDACTED] mouth. SPT A was not observed to redirect the client to remove [REDACTED] hand out of [REDACTED] pants and encourage the client to wash [REDACTED] hands. SPT A was not observed to wash [REDACTED] hands as well.</p> <p>On 5/8/14 at 3:52 p.m., an interview with SPT A was conducted. He stated that he tried to encourage Client 112 to remove [REDACTED] left hand out of [REDACTED] pants by having [REDACTED] touch a small black board with a carpet like texture, but the client didn't comply. SPT A also stated, I should have encouraged the client to wash [REDACTED] hand, it was my fault."</p> <p>On 5/13/14 at 10:45 a.m., Client 112's Individual Program Plan (IPP) Narrative dated 1/13/14 was conducted. The review indicated that Client 112 [REDACTED] required extensive</p>	W 341			

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

PRINTED: 07/25/2014  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55G374</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SONOMA DEVELOPMENTAL CENTER ICF/IID</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1493 ELDRIDGE, CA 95431</b>		
(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 341	<p>Continued From page 203</p> <p>assistance with personal hygiene tasks and living skills training screening tool made reference to the importance of oral motor activities related to having hands in mouth.</p> <p>On 5/13/14 at 4:05 p.m., a review of the Nursing Procedure Manual titled "IC (Infection Control) 303" dated 5/13 was conducted. The review indicated, "Utilize Standard Precautions: Concept:..After handling soiled items or being in contact with a "Dirty" area perform hand hygiene before touching clean items or environments ...Note: ...Proper technique is imperative for all who have direct or indirect contact with clients ..."</p> <p>2. On /14 at 8:08 a.m., an observation of a gastric tube (G.T.) (soft tube inserted through the abdominal wall into the stomach used to feed people with difficulty swallowing) feeding was observed. The Psychiatric Technician (PT 1) and PT student were observed bringing Client 2 into the medication room. A brief explanation was given to Client 2 by PT 1 and (Client 2) acknowledged in agreement. The P.T. student was observed reaching into pocket and putting on gloves and began to clean around the G.T. site. Both the student and PT 1 participated in the process of cleaning the G.T. site, and then giving 750 cc's of water through the tube. After completion of giving the 750 cc's of water and cleaning the site the student removed gloves and documented the procedure. Then the PT student left the room and started to proceed down a client hallway. The PT student did not wash hands before or after the procedure. The PT 1 confirmed that the student did not wash hands.</p> <p>On 14 at 7:45 a.m., a PT assistant (PTA)</p>	W 341			

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W 341	Continued From page 204 was observed leaving a client room walking in the hall and into the dirty linen room. The PTA was observed while in the dirty linen room. The PTA removed [REDACTED] used gloves and put them in [REDACTED] shirt pocket. The PTA did not wash [REDACTED] hands and walked to the dining area where clients were in line getting their breakfast. The PTA then went to the tray line (The lineup of trays on which the food for patients is placed) and began to interact and assist the Clients.  A concurrent interview was conducted with the PTA and she explained the reason she had the gloves on because she was cleaning a client's restroom she confirmed she did not wash her hands prior to assisting with breakfast.  On 5/14/14, a review of policy titled, "Standard Precautions," revised 7/13 was conducted. Documented in section D. Process Standards: 1. "Hand washing with soap is indicated before and after each new client contact, whenever hands are soiled, after touching blood, body fluids, secretions, excretions, contaminated items and/or after gloves use." 3., ...Employees are expected to wash hands immediately after glove removal to avoid transfer of microorganisms to other clients or environments.	W 341			
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.	W 436			

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W 436	<p>Continued From page 205</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that one focused client (Client 25) was furnished and taught to use [REDACTED] hearing aide. Client 25 had hearing loss, staff held the hearing aide and there was no evidence of training or modification to ensure the hearing aide was available to the client and maintained in good working repair.</p> <p>Findings:</p> <p>On 5/11/14 a review of Client 25's Human Rights notes revealed a Person Centered Individualized Plan, dated 1/28/14, which indicated a hearing loss. According to the documentation, during the planning meeting Client 25 was asked if [REDACTED] would like to "hear better " to which [REDACTED] replied,"yes."</p> <p>The level of care staff indicated Client 25 used to have a hearing aide and that a year and a half later staff "still had it." Client 25's teacher indicated a trial of the hearing aide was troublesome, as it had ringing problems and did not fit Client 25 well [REDACTED]. The Interdisciplinary team agreed the physician would set up a conference with the audiologist.</p> <p>A review of the Individual Planning Coordinator (IPC) notes dated 2/3/14, 3/26/14 and 4/30/14 there was no discussion of the follow- up for Client 25's hearing aide.</p> <p>In an interview on 5/14/14 at 1 p.m., Client 25's IPC indicated she did not know where the hearing aide was or if the audiologist was made aware of</p>	W 436			

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W 436	Continued From page 206 the teams recommendation and re-evaluated Client 25.	W 436			