

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for the investigation of complaint #IN00156187.</p> <p>Complaint #IN00156187 - Substantiated, Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W154, W155, W156, and W186.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the PCR, completed on 8/26/14, to the PCR, completed on 6/27/14, to the full annual recertification and state licensure survey completed on 4/17/14.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00154686 completed on 8/26/14.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: September 23, 24, 25, 26, 29, 30, and October 1, 2014</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state</p>	W000000		

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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W000102	<p>findings in accordance with 460 IAC 9. Quality Review completed 10/8/14 by Ruth Shackelford, QIDP.</p> <p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 3 of 3 clients living at the group home (A, B and C), the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise operating direction over the facility by failing to ensure staff did not discard their cigarette butts under the group home's attached wooden deck. The Governing Body failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported</p>	W000102	<p>Investigations have been completed for all incidents To correct the deficient practice and ensure it does not continue, all staff,including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident reporting, including reporting allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. Investigations have been completed for all incidents. All ND/Qs were retrained on</p>	10/31/2014

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	<p>an allegation of abuse to the administrator. The Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days. The Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended. The Governing Body failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B and C. The Governing Body failed to identify an allegation of abuse, neglect, and/or mistreatment. The Governing Body failed to ensure the Network Director was able to identify the need for investigations to address potential abuse, neglect and/or mistreatment in regard to injuries of unknown origin. The Governing Body failed to provide sufficient staff to meet the needs of the clients.</p> <p>Findings include:</p>		<p>LifeDesigns investigation policies and procedures on 10/15/14. Additionally, the ND/Q was retrained individually by the Director of Support Services and the interim Director of Residential Services on what constitutes an allegation of abuse, neglect, mistreatment and exploitation is and how to proceed if such an allegation is made. The ND/Q will submit all unusual incident reports and BDDS reports to the interim DORS and DOSS for review. To ensure the training has been effective, the Quality Assurance Director, DOSS, interim DORS and CEO will do a weekly review of documentation in the home for at least 2 months to verify that any allegation, report of injury of unknown origin, peer to peer incident, etc., has been acted upon appropriately. Any concerns noted will result in corrective action for the ND/Q. On an ongoing basis, the ND/Q will submit a weekly report for the home that includes all incidents for the home and related follow up. The Residential Services Monthly Report is completed for each individual living in the home, which also includes incident information. Both weekly and monthly reports are submitted to the DORS and CEO for review. The DORS will be in the home no less than monthly to review documentation and observe the overall environment, and the CEO will do</p>		

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	<p>1) Please refer to W104. For 3 of 3 clients living at the group home (A, B and C), the Governing Body failed to exercise operating direction over the facility by failing to ensure staff did not discard their cigarette butts under the group home's attached wooden deck. The Governing Body failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days. The Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended. The Governing Body failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B and C. The</p>		<p>an on-site visit to each group home no less than quarterly. All staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to ensure safety measures to prevent further abuse are implemented when an allegation of abuse is reported, and those safety measures will be documented on the investigation summary. The will also be reminded of the requirement to report the results of all investigations to an administrator within 5 working days. A new Team Manager has been hired for the home (in addition to the ND/Q who is currently only responsible for the Park Lane home), as well as additional DSP staff. The ND/Q will submit the staff schedule weekly to the interim DORS and CEO for review to ensure that 2 staff are scheduled for waking hours when all 3 customers are in the home. Staff needs will be addressed weekly at the ND/Q meeting, so any open shifts can be identified and filled. Additional monitoring will be accomplished through weekly observations by the QAD, DOSS, interim DORS and CEO for the next 6 weeks. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all</p>	

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	<p>Governing Body failed to identify an allegation of abuse, neglect, and/or mistreatment. The Governing Body failed to ensure the Network Director was able to identify the need for investigations to address potential abuse, neglect and/or mistreatment in regard to injuries of unknown origin. The Governing Body failed to provide sufficient staff to meet the needs of the clients.</p> <p>2) Please refer to W122. For 3 of 3 clients living in the group home (A, B and C), the facility failed to meet the Condition of Participation: Client Protections. The Governing Body failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days. The Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the</p>		<p>outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The weekly report is submitted to the ND/Q and CEO for review.</p>	

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W000104	<p>Network Director. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended. The Governing Body failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 clients living at the group home (A, B and C), the Governing Body failed to exercise operating direction over the facility by failing to ensure staff did not discard their cigarette butts under the group home's attached wooden deck. The Governing Body failed to implement its policies and procedures to ensure direct care staff</p>	W000104	Investigations have been completed for all incidents To correct the deficient practice and ensure it does not continue, all staff,including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident	10/31/2014			

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	<p>immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days. The Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended. The Governing Body failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B and C. The Governing Body failed to identify an allegation of abuse, neglect, and/or mistreatment. The Governing Body failed to ensure the Network Director was able to identify the need for investigations to address potential abuse, neglect and/or mistreatment in regard to injuries of unknown origin. The Governing Body failed to provide</p>		<p>reporting, including reporting allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. Investigations have been completed for all incidents. All ND/Qs were retrained on LifeDesigns investigation policies and procedures on 10/15/14. Additionally, the ND/Q was retrained individually by the Director of Support Services and the interim Director of Residential Services on what constitutes an allegation of abuse, neglect, mistreatment and exploitation is and how to proceed if such an allegation is made. The ND/Q will submit all unusual incident reports and BDDS reports to the interim DORS and DOSS for review. To ensure the training has been effective, the Quality Assurance Director, DOSS, interim DORS and CEO will do a weekly review of documentation in the home for at least 2 months to verify that any allegation, report of injury of unknown origin, peer to peer incident, etc., has been acted upon appropriately. Any concerns noted will result in corrective action for the ND/Q. On an ongoing basis, the ND/Q will submit a weekly report for the home that includes all incidents for the home and related follow up. The Residential Services Monthly Report is completed for each individual</p>				

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	<p>sufficient staff to meet the needs of the clients.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 5 of 5 incident/investigative reports reviewed affecting clients A, B and C, the Governing Body failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days. The Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended.</p> <p>2) Please refer to W153. For 1 of 6 incident/investigative reports reviewed</p>		<p>living in the home, which also includes incident information. Both weekly and monthly reports are submitted to the DORS and CEO for review. The DORS will be in the home no less than monthly to review documentation and observe the overall environment, and the CEO will do an on-site visit to each group home no less than quarterly. Due to client B's increase in aggression towards peers, her Behavior Support Plan has been revised, and all staff, including school staff, will be trained on the revised plan. The ND/Q will do observations twice weekly for at least 4 weeks to ensure school is implementing the plan as written, and will do monthly observations on an ongoing basis. There is a communication log that travels between home and school and is reviewed by staff each day- staff have been instructed to report all incidents, including incidents of peer to peer aggression reported by school staff, immediately to the ND/Q, who will immediately report to an administrator. The ND/Q has also increased communication with school staff to ensure they are letting LifeDesigns know right away when incidents occur at school. All staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to ensure safety</p>		

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	<p>affecting client C, the Governing Body failed to ensure staff immediately reported an allegation of abuse to the administrator. The Governing Body failed to ensure the Network Director immediately reported an allegation of abuse to the administrator.</p> <p>3) Please refer to W154. For 4 of 5 incident/investigative reports reviewed affecting clients A, B and C, the Governing Body failed to conduct a thorough investigation into an allegation of abuse. The Governing Body failed to investigate injuries of unknown origin on clients A and B. The Governing Body failed to investigate client to client abuse at the school clients B and C attended.</p> <p>4) Please refer to W155. For 1 of 5 incident/investigative reports reviewed affecting clients A, B and C, the Governing Body failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director.</p> <p>5) Please refer to W156. For 1 of 5 incident/investigative reports reviewed affecting clients A, B and C, the Governing Body failed to ensure the investigation results were reported to the administrator within 5 working days.</p>		<p>measures to prevent further abuse are implemented when an allegation of abuse is reported, and those safety measures will be documented on the investigation summary. The will also be reminded of the requirement to report the results of all investigations to an administrator within 5 working days. All staff have been retrained on the policy that all Life Designs' facilities are non-smoking, and that smoking is not allowed on Life Designs property. Signage to that affect has also been posted in the group home, and an agency-wide reminder was sent to all staff. Staff found to be smoking on agency property will be provided written corrective action. A new Team Manager has been hired for the home (in addition to the ND/Q who is currently only responsible for the Park Lane home), as well as additional DSP staff. The ND/Q will submit the staff schedule weekly to the interim DORS and CEO for review to ensure that 2 staff are scheduled for waking hours when all 3 customers are in the home. Staff needs will be addressed weekly at the ND/Q meeting, so any open shifts can be identified and filled. Additional monitoring will be accomplished through weekly observations by the QAD, DOSS, interim DORS and CEO for the next 6 weeks. The Services Leadership Team, which includes all Directors of Services,</p>				

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	<p>6) Please refer to W186. For 3 of 3 clients living at the group home (A, B and C), the Governing Body failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>7) An observation was conducted at the group home on 9/23/14 from 2:59 PM to 5:00 PM. At 4:55 PM, as the surveyor exited the back sliding door onto the wooden deck attached to the group home, there was a crack with black marks surrounding it. Upon inspection, there was a pile of cigarette butts under the deck. This affected clients A, B and C.</p> <p>On 9/23/14 at 4:55 PM, the interim Director of Residential Services (DRS) indicated there was to be no smoking on the facility's property. The DRS stated the placement of the cigarette butts under the wooden deck was a "fire hazard."</p> <p>On 9/23/14 at 4:55 PM, staff #3 indicated there were three staff she was aware of who smoked. Staff #3 indicated she smoked in the front of the house near the street.</p> <p>On 9/25/14 from 1:20 PM to 3:55 PM, an observation was conducted at the group home. There were signs posted near both</p>		<p>the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The weekly report is submitted to the ND/Q and CEO for review.</p>				

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	<p>the front and rear doors of the home indicated, "There will be No smoking on the premises!" There was also a sign posted in the living room near other memorandums.</p> <p>On 9/25/14 at 1:11 PM, the Maintenance Director (MD) stated, "Have you seen this?" as the surveyor walked from the parking lot to the back door of the group home. The MD had a plastic garbage bag full of cigarette butts. The MD indicated he removed the cigarette butts from under two holes in the deck. The MD indicated he had told the staff previously, on several occasions, not to throw cigarette butts under the deck. The MD stated it was a "fire hazard." The MD indicated he cut out the holes in the deck and replaced the board where the holes were. The MD indicated he observed ashes on the deck which led him to look under the deck where he found two piles of cigarette butts.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she told the staff to not throw cigarette butts into the crack on the deck.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 3 of 3 clients living in the group home (A, B and C), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The facility failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The facility failed to conduct a thorough investigation into an allegation of abuse. The facility failed to ensure the investigation results were reported to the administrator within 5 working days. The facility failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The facility failed to investigate injuries of unknown origin on clients A and B. The facility failed to investigate client to client abuse at the school clients B and C attended. The facility failed to provide sufficient direct care staff to manage and supervise the</p>	W000122	<p>Investigations have been completed for all incidents To correct the deficient practice and ensure it does not continue, all staff, including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident reporting, including reporting allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. Investigations have been completed for all incidents. All ND/Qs were retrained on LifeDesigns investigation policies and procedures on 10/15/14. Additionally, the ND/Q was retrained individually by the Director of Support Services and the interim Director of Residential Services on what constitutes an allegation of abuse, neglect, mistreatment and exploitation is and how to proceed if such an allegation is made. The ND/Q will submit all unusual incident reports and BDDS reports to the</p>	10/31/2014

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	<p>clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 5 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The facility failed to ensure the Network Director immediately reported an allegation of abuse to the administrator. The facility failed to conduct a thorough investigation into an allegation of abuse. The facility failed to ensure the investigation results were reported to the administrator within 5 working days. The facility failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The facility failed to investigate injuries of unknown origin on clients A and B. The facility failed to investigate client to client abuse at the school clients B and C attended.</p> <p>2) Please refer to W153. For 1 of 6 incident/investigative reports reviewed affecting client C, the facility failed to ensure staff immediately reported an</p>		<p>interim DORS and DOSS for review. To ensure the training has been effective, the Quality Assurance Director, DOSS, interim DORS and CEO will do a weekly review of documentation in the home for at least 2 months to verify that any allegation, report of injury of unknown origin, peer to peer incident, etc., has been acted upon appropriately. Any concerns noted will result in corrective action for the ND/Q. On an ongoing basis, the ND/Q will submit a weekly report for the home that includes all incidents for the home and related follow up. The Residential Services Monthly Report is completed for each individual living in the home, which also includes incident information. Both weekly and monthly reports are submitted to the DORS and CEO for review. The DORS will be in the home no less than monthly to review documentation and observe the overall environment, and the CEO will do an on-site visit to each group home no less than quarterly. Due to client B's increase in aggression towards peers, her Behavior Support Plan has been revised, and all staff, including school staff, will be trained on the revised plan. The ND/Q will do observations twice weekly for at least 4 weeks to ensure school is implementing the plan as written, and will do monthly observations on an ongoing basis. There is a</p>	

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	<p>allegation of abuse to the administrator. The facility failed to ensure the Network Director immediately reported an allegation of abuse to the administrator.</p> <p>3) Please refer to W154. For 4 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to conduct a thorough investigation into an allegation of abuse. The facility failed to investigate injuries of unknown origin on clients A and B. The facility failed to investigate client to client abuse involving clients B and C at school.</p> <p>4) Please refer to W155. For 1 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director.</p> <p>5) Please refer to W156. For 1 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure the investigation results were reported to the administrator within 5 working days.</p> <p>6) Please refer to W186. For 3 of 3 clients living at the group home (A, B and C), the facility failed to provide sufficient direct care staff to manage and</p>		<p>communication log that travels between home and school and is reviewed by staff each day- staff have been instructed to report all incidents, including incidents of peer to peer aggression reported by school staff, immediately to the ND/Q, who will immediately report to an administrator. The ND/Q has also increased communication with school staff to ensure they are letting LifeDesigns know right away when incidents occur at school. All staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to ensure safety measures to prevent further abuse are implemented when an allegation of abuse is reported, and those safety measures will be documented on the investigation summary. The will also be reminded of the requirement to report the results of all investigations to an administrator within 5 working days. A new Team Manager has been hired for the home (in addition to the ND/Q who is currently only responsible for the Park Lane home), as well as additional DSP staff. The ND/Q will submit the staff schedule weekly to the interim DORS and CEO for review to ensure that 2 staff are scheduled for waking hours when all 3 customers are in the home. Staff needs will be addressed</p>	

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W000125	<p>supervise the clients in accordance with their individual program plans.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-2(a)</p> <p>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, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 3 of 3 clients living at the group home (A, B and C), the facility failed to ensure the clients had the right to due process in regard to the use of door alarms.</p>	W000125	<p>weekly at the ND/Q meeting, so any open shifts can be identified and filled. Additional monitoring will be accomplished through weekly observations by the QAD, DOSS, interim DORS and CEO for the next 6 weeks. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The weekly report is submitted to the ND/Q and CEO for review.</p> <p>To correct the deficient practice, the door alarms are no longer in use. To ensure the deficient practice does not continue, the keys to activate the door alarms are not readily available to staff. All staff will be retrained on each customer's targeted interfering</p>	10/31/2014	

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	<p>Findings include:</p> <p>An observation was conducted at the group home on 9/23/14 from 2:59 PM to 5:00 PM. During the observation, the front door alarm was on. This affected clients A, B and C.</p> <p>On 9/23/14 at 4:30 PM, staff #3 indicated the door alarms were in place for clients A, B and C due to elopement risks. Staff #3 indicated both the front and back door alarms should be on.</p> <p>On 9/24/14 at 4:28 PM, client A's Replacement Skills Plan (RSP), dated June 2014, was reviewed. The RSP indicated he had the following targeted behaviors: self-injurious behavior (defined as head banging, hair pulling, biting, pinching, or scratching self, putting things in his ears), aggression (defined as hitting or pinching others), inappropriate touch (defined as slapping or grabbing other people's buttocks, trying to lift others' shirts, grabbing others between the legs), sexual hyperactivity (defined as requesting 'private time' (masturbation) more than three times daily), and medication refusal (defined as refusing to participate in medication administration or refusing to finish drink containing medication). There was no documentation in his RSP</p>		behaviors, which do not include issues of elopement, nor the need for door alarms. Ongoing monitoring will be accomplished by the ND/Q, who is in the home at least 3 times per week and will ensure that door alarms are not being used.				

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	<p>indicating the need for door alarms.</p> <p>On 9/24/14 at 4:28 PM, client B's Replacement Skills Plan (RSP) was reviewed. The RSP, dated 3/23/14, indicated she had the following targeted behaviors: tantrum (defined as screaming), aggression (defined as hitting with open hand or object such as baby doll or shoe), and emptying closet and/or dresser drawers (defined as taking clothes out of closet and/or dresser drawers and throwing them in the floor). There was no documentation in her RSP indicating the need for door alarms.</p> <p>A review of client C's Replacement Skills Plan (RSP), dated May 2014, was conducted on 9/24/14 at 4:28 PM. A revised RSP, not dated, indicated, she had the following targeted behaviors: "Obsessing: Defined as obsessing over clothing items, bras, tank tops, socks, Dafoe (leg braces) and shoes. She obsesses over items such as, lanyards, large necklaces, bracelets, key chains, keys, hair elastics, hair ties, or anything shiny, or catches her attention. Her obsessive behavior is not typical OCD type behavior, but more like that of a small child who has had a comfort item taken away, and she is looking for it. Self-Injurious Behavior (SIB): Defined as hitting/slapping self in the head or mouth.</p>				

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W000149	<p>Aggression: Defined as hitting, pinching, biting or scratching staff or housemates. Tantrums: Defined as screaming, crying and dropping to the floor. PICA: Defined as eating non-food items such as paper, foam, trash from floor, and trash can. Refusal: Defined as refusing to get on or off the bus for school." There was no documentation in her RSP indicating the need for door alarms.</p> <p>On 9/25/14 at 10:58 AM, the interim Director of Residential Services (DRS) indicated it was a violation of the clients' rights to have the door alarms on. The DRS indicated there was nothing in client A, B and C's plans indicating the use of the door alarms. The DRS indicated the door alarms should not be used.</p> <p>On 9/25/14 at 1:50 PM, the Network Director (ND) indicated the door alarms should not be on. The ND stated the "girls" (meaning staff) use them due to being afraid of strangers. The ND indicated there was nothing in client A, B and C's plans for the use of door alarms.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement</p>						

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	<p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility neglected to implement its policies and procedures to ensure direct care staff immediately reported an injury of unknown origin and an allegation of abuse to the administrator. The facility neglected to ensure the Network Director immediately reported an allegation of abuse to the administrator. The facility neglected to conduct a thorough investigation into an allegation of abuse. The facility neglected to ensure the investigation results were reported to the administrator within 5 working days. The facility neglected to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director. The facility neglected to investigate injuries of unknown origin on clients A and B. The facility neglected to investigate client to client abuse at the school clients B and C attended.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated the following:</p>	W000149	<p>To correct the deficient practice and ensure it does not continue, all staff, including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. Additionally, the ND/Q was retrained individually by the Director of Support Services and the interim Director of Residential Services on what constitutes an allegation of abuse, neglect, mistreatment and exploitation is and how to proceed if such an allegation is made. The ND/Q will submit all unusual incident reports and BDDS reports to the interim DORS and DOSS for review. To ensure the training has been effective, the Quality Assurance Director, DOSS, interim DORS and CEO will do a weekly review of documentation in the home for at least 2 months to verify that any allegation, report of injury of unknown origin, peer to peer incident, etc., has been acted upon appropriately. Any concerns noted will result in corrective action for the ND/Q. On an ongoing basis, the ND/Q will submit a weekly report for the home that includes all incidents for the home and related follow up. The Residential Services Monthly Report is completed for each individual living in the home, which also includes incident information. Both weekly and</p>	10/31/2014

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	<p>1) A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #5, indicated on 9/14/14 at 11:20 PM, in part, "I arrived to work about 9:45 PM. [Client C] woke up and walked into kitchen about 10:15 PM when I noticed bruising to her right eye, I then asked offgoing (sic) staff if she had any SIB's (self-injurious behaviors) after looking at [client C] more I noticed cut on her neck. Offgoing (sic) staff had informed me that she noticed and marked in body scan, offgoing (sic) staff called [Network Director] to let her know of possible suspicion of abuse." The UIR indicated, by being circled, the type of incident was an injury to customer or staff and suspected abuse/neglect/exploitation. The UIR indicated on-call staff was notified at 11:20 PM (no date documented). The UIR was not given to the surveyor when the facility was requested to provide all incident and investigative reports. The UIR was given to the surveyor from a mailbox located in the office at the group home.</p> <p>A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #3, indicated on 9/14/14 at 4:00 PM, in part, "Sunday morning when [client C] got up staff had noticed her eye was a</p>		<p>monthly reports are submitted to the DORS and CEO for review. The DORS will be in the home no less than monthly to review documentation and observe the overall environment, and the CEO will do an on-site visit to each group home no less than quarterly. All staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to ensure safety measures to prevent further abuse are implemented when an allegation of abuse is reported, and those safety measures will be documented on the investigation summary. The will also be reminded of the requirement to report the results of all investigations to an administrator within 5 working days. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The weekly report is submitted to the ND/Q and CEO for review.</p>				

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	<p>little swollen, thought she had slept on that side. At 4pm meds staff noticed the bruise under her eye &amp; marked in the body scan. When staff did paperwork around 8pm staff noticed there was (sic) no SIB's yesterday. After staff ended shift, the overnight (staff) was also noticing her eye &amp; noticed on her neck there were scratches on her neck. Staff called [Network Director] to inform her, that there were (sic) reasonable suspicion of someone possible (sic) grabbing her." The UIR indicated on-call staff was notified at 11:20 PM (no date documented). The UIR was not given to the surveyor when the facility was requested to provide all incident and investigative reports. The UIR was given to the surveyor from a mailbox located in the office at the group home.</p> <p>A 9/15/14 Bureau of Developmental Disabilities Services (BDDS) incident report indicated on 9/14/14 at 10:00 AM, staff #3 found a bruise on client C's right eye. The BDDS report indicated, "[Staff #3], DSP (Direct Support Professional), sent me a text at 11:23 PM 9/14/2014 telling me that [client C] has a bruise on her right eye. [Staff #3] stated that she had noticed it when she came in, in the morning at 10:00 AM but forgot to tell me. She also failed to mention it to me when I was at [name of group home] to</p>						

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	<p>do training with new staff at 7:30 PM. I did not notice the bruise at that time. I discussed the injury with [staff #3] at 11:30 (PM) by phone. I called [name of group home] this morning, asking overnight, [staff #5] and the morning staff, [staff #4] what it looked like. They described it as a bruise in the corner of her right eye. I asked staff to hold [client C] at home until I arrived this morning, so I could see the injury. I came to [name of group home], arriving at 7:50. [Client #3] has a small bruise in the corner of her right eye. It is smaller than a nickel. There may be some swelling, but it is minimal. [Staff #3] indicated she thought [client C] might have had an (sic) SIB (self-injurious behavior), but there are no incidents indicated in [client C's] daily book. I will discuss with overnight staff, [staff #6], and with new staff, [staff #2], and see what they observed. There will be 2 staff to 3 customers until the weekend to provide a layer of safety for customers. Saturday, 9/20 I will at least check in the house several times, and Sunday has 2 day staff. I will retrain staff on reporting procedures on 9/18/2014."</p> <p>The BDDS follow-up report, dated 9/19/14, indicated, "My investigation: The night that [staff #3] reported the injury to me, on 9/15/14 (incorrect date - should read 9/14/14) she reported that</p>			

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	<p>[client C] had an injury to her right eye. She also reported that there was a mark on her neck, that staff has determined came from her seat belt rubbing on her neck. I called the house on 9/16/14 (incorrect date - should read 9/15/14) at 7:30 AM and discussed the mark with [staff #5], who noted the injury at shift change on 9/15/14 (incorrect date - should read 9/14/14) (10:00p to 10:00a). She said it was a bruise in the corner of her right eye. She could not determine when and how it happened. I asked staff to not send [client C] to school until I arrived. I arrived at 8:30am on 9/16/14 (incorrect date - should read 9/15/14). I determined that indeed, there was bruising in the corner of [client C's] right eye. When discussed with staff present, we could not determine how or when the bruising occurred. I have reviewed the written statements of the staff that discovered the injury. [Staff #3] reported that [client C] got up after 10:00 AM staff noticed her right eye was a little swollen. At 4:00 PM [staff #3] noticed there was a bruise under the same eye. [Staff #3] marked the body scan. She checked the behavior logs, there were no SIB's (possible cause of the mark), when discussing the mark with overnight staff, they noticed a mark on her neck. (Determined to be from her seat belt). At 11:28 PM they reported the marks to me.</p>			

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	I have reviewed the written statement of [staff #5], (10p to 10a), she noticed and discussed the mark with [staff #3], and [staff #3] called me. On 9/16/14 I asked the second staff on the floor on Sunday, [staff #2], what she saw, and she reported that she didn't notice it until [staff #3] mentioned it in the morning, after 10:00 AM, 9/15/14, (after [client C] got out of bed). I worked in the house on 9/15/14 (incorrect date - should read 9/14/14) from 7:30p to 9p to provide coverage for training [staff #2] on passing medications. I did not notice the mark, nor did [staff #3] show it to me. She called me at 11:28p and I noted her concerns. On 9/16/14 I discussed the mark with [staff #4], who worked the day shift, 10:00a to 10:00p on 9/14 (incorrect date - should read 9/13/14). She had not seen the mark on her eye, and did not know how it happened. We discussed what might have caused the mark on her neck, and she told me she had seen it, (the mark on her neck), and it had been caused by her seat belt rubbing on her neck. On 9/18/14 I discussed the mark on [client C's] eye, with [staff #6], who was the overnight staff on 9/14/14 from 10p to 10a. She had not noticed the mark on [client C's] eye. There were no behaviors that could be associated with [client C] getting the mark. I have not determined the cause of the mark on her						

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	<p>eye. Staff did not see her have SIB's, when she could have smacked herself; she has also been known to rub her eyes very forcefully. If she was galloping through the house she could have bumped her eye. I have two staff on the floor for most daytime shifts at this time. I have no reason to believe that staff would injure her. I am certain that other customers did not cause this injury.</p> <p>What I will do: Continue increasing staff so there are 2 on the floor during waking hours. Retrain staff on reporting injuries. When there are not 2 staff on the floor during waking hours, perform spot checks, noted on Acell (facility's electronic records), in the reporting section. Continue tracking injuries to determine if there is a pattern associated with them. Do spot checks and observations to provide support and training as needed."</p> <p>The investigation, dated 9/22/14, contained the same information as the BDDS follow-up report dated 9/19/14. The investigation was not submitted for review to the administrator within 5 working days. The investigation did not include interviews with clients A, B and C. The investigation did not indicate how the facility determined the scratches on client C's neck were caused by a seatbelt. The investigation did not</p>						

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	<p>address staff #3 and #5's allegation of staff abuse. The investigation did not address staff #3 indicating she discovered the bruises on 9/14/14 at 10:00 AM when her timesheet indicated she started working at 2:00 PM. There was no documentation of the ND's interviews with the staff.</p> <p>On 9/23/14 at 12:32 PM, the Quality Assurance Director (QAD) indicated the Network Director (ND) completed the investigation of client C's injury of unknown origin. The QAD indicated staff did not immediately report the injury, per policy. The QAD indicated the staff noted the injury in the morning and reported the injury later in the day. The QAD stated, "Seems like an odd place to get a bruise." The QAD indicated the bruise could have been caused by self injurious behavior or the way she sleeps (balls up and sleeps). The QAD stated he could not imagine staff "beat up" [client C]. The QAD indicated he and the Director of Support Services conduct investigations of abuse and neglect. The QAD indicated the ND conducts investigations of client to client aggression and injuries of unknown origin. The QAD indicated the ND conducted the investigation of client C's injury of unknown origin. The QAD indicated this was not an allegation of</p>			

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	<p>abuse/neglect/exploitation.</p> <p>On 9/23/14 at 2:59 PM, staff #3 indicated she had concerns regarding client C's black eye. Staff #3 indicated she found the bruising on 9/14/14 during the morning shift. Staff #3 stated she "suspect [staff #4] is abusing the kids." Staff #3 stated the clients were "jittery around her" and flinch when staff #4 was near them. Staff #3 indicated she had observed staff #4 to use a raised voice but it was not verbally abusive. Staff #3 indicated she had never witnessed staff #4 abuse the clients. Staff #3 indicated client B would cry, at times, when staff #4 was near her. Staff #3 indicated she reported her concerns to the Network Director. Staff #3 stated she did not notice anything until the past few months when the clients started "acting funny" when staff #4 was around them. Staff #3 indicated a former staff reported concerns to staff #3 about staff #4 but did not think the former staff reported her concerns to management. Staff #3 indicated prior to injuries being found on client C on 9/14/14, staff #4 had worked 9/13/14 by herself with the clients. On 9/23/14 at 3:29 PM, staff #3 indicated she completed an Unusual Incident Report indicating she had suspicions someone grabbed client C. Staff #3 indicated the UIRs were given to the ND on 9/15/14</p>			

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	<p>after they were completed.</p> <p>On 9/25/14 at 3:15 PM, staff #3 indicated she did not believe the seat belt caused the mark on client C's neck. Staff #3 indicated client C puts the seatbelt behind her. Staff #3 indicated client C did not like the seatbelt to be in front of her. Staff #3 indicated there were no issues with the seatbelt in the group home van.</p> <p>On 9/23/14 at 3:07 PM, staff #3 allowed the surveyor to review her personal cellphone's text messages to verify she notified the Network Director (ND) of her concerns:</p> <p>-On 9/14/14 at 11:23 PM, staff #3 indicated in a text message, "I almost forgot to tell you. [Client C] has a bruise on her right eye. I put it in the body scan. I have no idea how she got it. I don't know of (sic) you noticed when you did the med pass at 8pm."</p> <p>-On 9/14/14 at 11:24 PM, the ND responded, "Yep."</p> <p>-On 9/14/14 at 11:27 PM, staff #3 indicated, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts on her neck (sic) it looks like someone grabbed her."</p> <p>-On 9/14/14 at 11:27 PM, the ND responded, "What."</p> <p>-On 9/14/14 at 11:28 PM, staff #3 replied</p>			

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	<p>with the same text, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts o." Staff #3 indicated while she was typing the information again the ND called her cellphone. Staff #3 indicated she reported an allegation of possible abuse to the ND during the phone call.</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Body Scan Monthly Tracking for September 2014 was conducted. The documentation dated 9/14/14 indicated, "Right eye. 1/2 in (inch) purple roundish. From SIB?"</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Nursing Narrative Note, dated 9/15/14, indicated, "[Client C] assessed due to bruise under right eye 5 cm (centimeters) in length also scratch 0.5 cm in length under (right) ear on her neck. Her eye is 'bloodshot,' she was rubbing it with palm of her hand during exam. Vitals are as follows P (pulse) 103 R (respirations) 20 B.P. (blood pressure) 108/72 T (temperature) 99.6. No other marks or bruises found at this time."</p> <p>A review of the facility's staffing hours worked documentation was conducted on 9/25/14 at 11:55 AM. -On 9/13/14, staff #6 worked from 12:00</p>			

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	<p>AM to 10:00 AM. -On 9/13/14, staff #4 worked from 6:00 AM to 10:00 PM. -On 9/14/14, staff #3 worked from 2:00 PM to 10:15 PM. -On 9/14/14, staff #2 worked from 10:00 AM to 10:00 PM. -On 9/14/14, staff #6 worked from 12:00 AM to 10:00 AM. -On 9/14/14, the ND worked from 7:30 PM to 9:00 PM. -On 9/14/14, staff #5 worked from 9:45 PM to 12:00 AM.</p> <p>An observation was conducted at the group home on 9/23/14 from 2:59 PM to 5:00 PM. On 9/23/14 at 3:24 PM, staff #3 informed the interim Director of Residential Services (DRS) of her concerns regarding staff #4. Staff #3 indicated she found the bruising on 9/14/14 and documented the injury on client C's body scan. Staff #3 indicated she checked the previous body scans and found no documentation of SIBs. Staff #3 indicated when staff #5 arrived on 9/14/14, staff #5 noticed the cuts on client C's neck. Staff #3 indicated she had not noticed the cuts on client C's neck. Staff #3 indicated she informed the ND by text of the injury and her concerns. Staff #3 indicated the ND responded to the text indicating she was aware of the bruise. Staff #3 indicated</p>			

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	<p>the ND did not interview her during the investigation of client C's injuries.</p> <p>On 9/23/14 at 3:35 PM, the interim DRS indicated staff #4 needed to be suspended. The DRS indicated the ND did not treat the incident as an allegation of abuse. The DRS indicated the injury was investigated as an injury of unknown origin. On 9/23/14 at 3:44 PM, the DRS indicated staff #4 should have been suspended on 9/14/14. The DRS indicated he was not certain the ND was made aware of the allegation.</p> <p>On 9/25/14 at 11:06 AM, the interim DRS indicated for the investigation to be thorough, the clients should have been interviewed (or attempted to be interviewed). The DRS indicated the investigation should have included a review of the UIRs. The DRS indicated when he received the BDDS follow up report, he directed the ND to conduct an investigation. The DRS indicated the investigation should have indicated how the marks on client C's neck were determined to be from the seatbelt. The DRS indicated the investigation was not thorough. The DRS indicated the ND did not address the allegation of abuse. The DRS indicated an allegation of abuse should be investigated. The DRS indicated the timeframe for reporting the</p>			

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	<p>results of investigations to the administrator was 5 working days. The DRS indicated the results of the ND's investigation were reported to the administrator on 9/22/14 at 4:57 AM. The DRS stated, "It was late." The DRS indicated the ND thought by reporting the follow-up to BDDS, she was in compliance with completing an investigation. The DRS indicated the ND was not aware she needed to complete an investigation form. The DRS indicated staff failed to immediately report the allegation. The DRS indicated the staff was not suspended when the allegation was made.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the injury of unknown origin was reported to her on 9/14/14. The ND indicated on 9/15/14, she asked that client C be kept home from school until the ND could assess her. The ND indicated staff #5 should have stayed with client C and staff #4 if staff #5 was concerned about staff #4. The ND indicated she had to get a flashlight in order to see the bruise on client C's eye. The ND indicated staff #4 told her the marks on client C's neck were from the seatbelt. The ND indicated she was not sure if the bus client C rode had seatbelts or not. The ND indicated she did not assess the seatbelts in the group</p>			

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	<p>home van. The ND indicated she was at the group home on 9/14/14 in the evening to train staff #2 to do medication administration. The ND indicated she did not see the bruise on client C's eye or cut on her neck at that time. The ND indicated staff #3 did not report her concerns to her while she was in the group home. The ND indicated staff #3 should have reported the injury to her as soon as staff #3 observed the injury. The ND indicated she did not find out the origin of the injury. The ND indicated she did not attempt to interview the clients. The ND indicated staff #3 and #5 told her they thought someone did it. The ND stated, "I have a fail there... at this minute, one big long fail." The ND indicated the UIRs staff #3 and #5 completed did not mention a suspected perpetrator. The ND indicated she reviewed the UIRs. The ND indicated she completed the investigation on 9/22/14. The ND indicated the investigation would have been done earlier but she was not satisfied with her initial investigation documentation. The ND indicated she got the investigation done within a week. The ND indicated she did not address the allegation of abuse. The ND stated she "thought she had a little bit of an ability to make decisions. I don't." The ND indicated she could not pinpoint anyone who</p>			

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	<p>caused the injuries. The ND indicated staff #3 and #5 did not name another staff who they suspected of abusing client C. The ND indicated she did not immediately report the allegation to administrative staff due to the time of the allegation. The ND indicated she knew staff #4 was not at the home at the time. The ND indicated she did not perceive the report as an allegation of abuse. The ND indicated she reviewed the UIRs the staff completed on 9/16/14.</p> <p>On 9/25/14 at 2:20 PM, the Network Director (ND) and surveyor assessed the seatbelts in the group home van. The ND indicated she had not assessed the seatbelts in the van prior to this date and time. There were no issues noted with the seatbelts in the van. There were no frayed areas or cuts on the seatbelts. The seatbelts were in good condition with no rips or tears that would cause an injury.</p> <p>On 9/29/14 at 12:36 PM, the follow-up investigation, dated 9/26/14, indicated in the Findings section, "Not substantiated, the findings do not support suspected abuse." The report indicated, "There is nothing to indicate staff abuse or neglect. [Client C's] injury can be explained by either the rubbing of the eye and scratch across the neck as noted by the nurse on 9/15 (she observed that occur) or an</p>			

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	<p>action by a peer. It was noted that [client B] had grabbed and scratch (sic) [client C] by the school on two occasions in the past month. This would have had to happen while staff did not have both in their site (sic), as no one observed it. It should be noted that there is to be 2 staff on shift during waking hours to ensure customers are safe and to encourage activities. There were not 2 people on until 10 am that day. This is not compliant with our plan of correction for earlier citations or consistent with staffing schedule. The incident should have been investigated as potential abuse and neglect according to agency policies. While there were protections put in place, and all staff were interviewed, the investigation could have been more thorough by reviewing school communication, talking with the school, and interviewing the nursing staff. This revealed the incidents of peer to peer (aggression) that happened at the school which should have been documented and investigated." The report indicated, in part, in the Summary of interview with staff #5, "What is the proper procedure for notifying administrators of potential ANE (Abuse/Neglect/Exploitation)? notify the pager or [Network Director] immediately; [staff #3] called after they determined it should be reported; [staff #5] wondered if [staff #3] was reluctant</p>			

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	<p>before because she could hear [Network Director] yelling when [staff #3] called her...". The report indicated, in part, in the Summary of interview with staff #3, "What is the proper procedure for notifying administrators of potential ANE: called at 11:30, an hour and a half after the ON (overnight) came in. Texted [Network Director]...told her that it looked like someone had grabbed her; [Network Director] was there at 7:30 to 9 and did not mention to [Network Director]; know now it has to be immediate." The Summary of interview with the Network Director indicated, in part, "Why was [staff #4] not suspended pending outcome of investigation? Did not indicate who was suspected on the form so did not know who to suspend or other measures to put in place. Did not know exactly when it happened besides that morning."</p> <p>The Recommendations section of the follow-up investigation indicated, in part, "The NDQ (Network Director) needs to meet with the QAD (Quality Assurance Director) to go over ANE (Abuse/Neglect/Exploitation) policies and procedures and shadow with the QAD on at least two investigations. The QAD will assess her ability to complete investigations independently. The NDQ is not consistently following up on school</p>			

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	<p>communication. There should always be a note back to the school for all noted issues to ensure closure and follow through. Also, there were peer to peer incidents that were not investigated. The NDQ will shadow with an experienced NDQ to learn proper procedure. She will be counseled on communication with the school and will be expected to follow up on the following by 10/2/14: 8/14/14: object expelled during BM (bowel movement), 8/22/14: peer to peer with [client B], 9/4/14: peer to peer with [client B]. Additionally, there need (sic) to be some review of [client B's] body scans and whether several of the noted items had sufficient evidence of how the injury occurred. There are several noted that have some rationale attached but no clear evidence referenced. The NDQ and CEO will review all incidents to note whether there needs to be follow up investigations. The NDQ will provide evidence to support any rationale for injuries in the Body Scan book going forward. The CEO will review Body Scans during weekly onsite observations for the next 4 weeks. The NDQ will conduct random drop in visits on the overnight shift a minimum of 2 times per week to monitor staff through the end of October. The NDQ will follow up with [staff #3] regarding time reporting for the day of 9/14 to correct the entry. The</p>			

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	<p>Services Leadership team will review policies and report formats for injuries of unknown origin to be sure there is no confusion about how to treat these incidents. An update to the policies and forms will be noted on Services Leadership minutes. Any change will be communicated to Network Directors and Team Managers and trained on at the next available opportunity."</p> <p>2) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her (client B) left ear - were very noticeable yesterday! Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The note was initialed by the Network Director.</p> <p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2</p>			

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	<p>inch round bruise on her left arm. The documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks (sic) fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures."</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the bruises noted to client B's right leg and knee were not investigated. The ND indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff</p>			

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	<p>#4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medication for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p> <p>On 9/25/14 at 11:37 AM, the interim Director of Residential Services (DRS) indicated the bruises should have been investigated and documented in her record. The DRS indicated until an investigation was conducted, the injuries were of unknown origin.</p> <p>3) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM for client B. On 9/4/14 the school documented, in part, "Crying when placed on bus in a.m. Jumping up &amp; down crying - slapping staff &amp; other students. Grabbed &amp; squeezed [client C's] hand tightly then yelled at her. Grabbed [client C's] left eye during lunch &amp; attempted to pull it. Hit other classmates sev (several) times - hit/slapped/smacked staff more than a</p>						

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	<p>dozen times today. Lots of crying &amp; screaming." The note was initialed by the Network Director. There was no documentation an investigation of client to client abuse was conducted. There was no documentation of follow-up by the ND.</p> <p>On 9/25/14 at 11:37 AM, the interim Director of Residential Services (DRS) indicated client to client aggression was considered abuse, should be investigated and prevented. The DRS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>4) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM for client A. On 9/16/14, the school documented, "Bruise noted on upper right thigh!" The note was initialed by the Network Director.</p> <p>An email, dated 9/16/14 at 5:23 PM, from the Network Director to the teacher indicated, in part, "Regarding the bruise on the upper right thigh of [client A], noted today, 9/16/2014. I am checking with his physician about an exam done on 9/15/2014, and will inform you of my findings...".</p> <p>The facility did not have documentation</p>			

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	<p>of an investigation. There was no documentation regarding the ND checking with client A's physician.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she did not conduct an investigation. The ND indicated she did not realize she needed to do an investigation. The ND indicated staff #4 was going to take him to the doctor to get the bruise checked. The ND indicated staff #4 informed her the injury may have happened during an exam. The doctor's appointment did not occur.</p> <p>On 9/25/14 at 11:34 AM, the interim Director of Residential Services (DRS) indicated an investigation should have been conducted.</p> <p>5) On 9/26/14 at 9:10 AM, client A's teacher emailed the Network Director. The email was forwarded to the surveyor on 9/26/14 at 9:22 AM and reviewed at that time. The email indicated, "[Network Director]: per our phone conversation this morning (Sept. 26, 2014), I just wanted to (as I stated I would) follow up with an email.</p> <p>I apologize for not getting info re (regarding) [client A] in (sic) book yesterday. I had two case conferences for new students back to back and was not in</p>			
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	<p>the classroom at the end of the day.</p> <p>[Client A] did come to school with dried feces on him (stuck in pubic hair) and in the diaper. When it was noticed during toileting, he was placed on the changing table to have him cleaned up. It was then that it was obvious it was stuck in his hair and that he had open sores on his upper interior thigh area, as if the control garment had chaffed (sic) him, either due to urine/feces, or ill fitting garment. School staff did apply baby powder to the area to make sure that the control garment did not adhere to the open wounds.</p> <p>Additionally, as I told you on the phone, we (per your calendar) showed that [client B] was supposed to be picked up for an appointment yesterday with her PCP (primary care physician). We did not receive a call or note stating it was cancelled, nor did anyone pick her up.</p> <p>Again, per our phone conversation, yes, I did have phone contact with [Chief Executive Officer] yesterday, but I did not call her. She called me to follow up on some things, per your company protocol.</p> <p>If you have any further questions or concerns, please do not hesitate to</p>				

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	<p>contact me."</p> <p>On 9/29/14 at 12:36 PM, a BDDS report, dated 9/25/14 at 8:00 AM, indicated, in part, "While talking with [name of high school] staff [name of teacher] regarding a separate matter, CEO [Chief Executive Officer] (name) was informed that on the morning of 9/25/14, when [client A] arrived to school, he had what appeared to be dried feces on his bottom, as well as a rash. [Client A] wears adult briefs and is reliant on staff to assist in cleaning himself. [Teacher] indicated concern that [client A] and his housemates are not coming to school with (sic) well groomed. The incident will be investigated to determine whether or not [client A's] personal hygiene needs are being met. The nurse will check [client A's] rash. Network Director [name] will do morning spot checks to ensure staff are attending to hygiene needs of all individuals prior to sending them to school."</p> <p>On 9/29/14 at 1:14 PM, the facility submitted a nursing assessment of client A. The assessment, dated 9/26/14 at 3:00 PM, indicated, "Writer (Licensed Practical Nurse) assessed [client A's] rectal area this date as school reported a rash on his rectal area. Area clean, no rashes or redness noted. [Client A]</p>						

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	<p>denies discomfort. [Client A] is going LOA (leave of absence) at this time with his mother, she was notified of findings."</p> <p>On 9/29/14 at 2:17 PM, the interim Director of Residential Services (DRS) indicated a nurse assessed client A and did not find a rash or open areas. The DRS indicated the CEO also assessed client A and she did not see a rash or open areas. The DRS indicated the ND was directed to do spot checks of the clients in the mornings.</p> <p>On 9/29/14 at 2:12 PM, the Licensed Practical Nurse (LPN) indicated she conducted an assessment of client A. The LPN indicated she did not observe a rash or open areas. The LPN indicated the facility was conducting spot checks prior to the clients leaving for school in the morning to ensure the clients were clean. The LPN indicated this was to be done daily prior to the clients leaving for school. The LPN indicated client B missed a Physical Therapy appointment last week due to the facility not having enough staff for someone to take her to the appointment.</p> <p>On 9/24/14 at 3:12 PM, the facility's policy titled, "Investigating suspected cases of violations of rights," dated May 2014, was reviewed. The policy</p>						

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	indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator. a. Death of customer receiving services at the time of death will be treated as a suspected violation of rights. In this case the Director not in charge of the service area will conduct the investigation. b. Injuries of unknown origin will be treated as a suspected violation of rights, and will be investigated by the Network Director or						

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	<p>QDDP... 7. The investigator will inform the Chief Operating Officer of the status of the investigation... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report. 14. The investigation shall include the following: a. Review of incident reports, b. Interview and or observation with customer and/or guardian and/or advocate. c. Interview with other customers, as needed. d. Interview of all parties involved, including, whenever possible: i. Person suspected of violation, ii. Persons who witnessed violation, iii. Other staff who provide service to the individual. 20. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the Administrator (Chief Operating Officer or Director of Services) within five working dates of the incident... 22. The Director of Support Services is responsible for monitoring the timeliness of the investigation process. He/she will inform the Chief Operating Officer of the status of the investigation on the 5th working day of the initiation of the investigation. 23. If the situation requires further investigation at the end of 5 working days, the investigator must</p>						

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W000153	<p>review with the Chief Operating Officer all information gathered thus far, and request additional time to complete the investigation. At this time a date for completion will be established. This does NOT apply to group homes per #19 above."</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-2(a)</p> <p>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. Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator. The facility failed to ensure the Network Director immediately reported an allegation of abuse to the administrator in accordance with state law.</p>	W000153	To correct the deficient practice and ensure it does not continue, all staff, including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident reporting, including reporting	10/31/2014

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	<p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated the following: A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #5, indicated on 9/14/14 at 11:20 PM, in part, "I arrived to work about 9:45 PM. [Client C] woke up and walked into kitchen about 10:15 PM when I noticed bruising to her right eye, I then asked offgoing (sic) staff if she had any SIB's (self-injurious behaviors) after looking at [client C] more I noticed cut on her neck. Offgoing (sic) staff had informed me that she noticed and marked in body scan, offgoing (sic) staff called [Network Director] to let her know of possible suspicion of abuse." The UIR indicated, by being circled, the type of incident was an injury to customer or staff and suspected abuse/neglect/exploitation. The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #3, indicated on 9/14/14 at 4:00 PM, in part, "Sunday morning when [client C] got up staff had noticed her eye was a little swollen, thought she had slept on</p>		<p>allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup.</p>				

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	<p>that side. At 4pm meds staff noticed the bruise under her eye &amp; marked in the body scan. When staff did paperwork around 8pm staff noticed there was (sic) no SIB's yesterday. After staff ended shift, the overnight was also noticing her eye &amp; noticed on her neck there were scratches on her neck. Staff called [Network Director] to inform her, that there were (sic) reasonable suspicion of someone possible (sic) grabbing her." The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A 9/15/14 Bureau of Developmental Disabilities Services (BDDS) incident report indicated on 9/14/14 at 10:00 AM, staff #3 found a bruise on client C's right eye. The BDDS report indicated, "[Staff #3], DSP (Direct Support Professional), sent me a text at 11:23 PM 9/14/2014 telling me that [client C] has a bruise on her right eye. [Staff #3] stated that she had noticed it when she came in, in the morning at 10:00 AM but forgot to tell me. She also failed to mention it to me when I was at [name of group home] to do training with new staff at 7:30 PM. I did not notice the bruise at that time. I discussed the injury with [staff #3] at 11:30 (PM) by phone. I called [name of group home] this morning, asking overnight, [staff #5] and the morning</p>			

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	<p>staff, [staff #4] what it looked like. They described it as a bruise in the corner of her right eye. I asked staff to hold [client C] at home until I arrived this morning, so I could see the injury. I came to [name of group home], arriving at 7:50. [Client #3] has a small bruise in the corner of her right eye. It is smaller than a nickel. There may be some swelling, but it is minimal. [Staff #3] indicated she thought [client C] might have had an (sic) SIB (self-injurious behavior), but there are no incidents indicated in [client C's] daily book. I will discuss with overnight staff, [staff #6], and with new staff, [staff #2], and see what they observed. There will be 2 staff to 3 customers until the weekend to provide a layer of safety for customers. Saturday, 9/20 I will at least check in the house several times, and Sunday has 2 day staff. I will retrain staff on reporting procedures on 9/18/2014."</p> <p>The BDDS follow-up report, dated 9/19/14, indicated, "My investigation: The night that [staff #3] reported the injury to me, on 9/15/14 (incorrect date - should read 9/14/14) she reported that [client C] had an injury to her right eye. She also reported that there was a mark on her neck, that staff has determined came from her seat belt rubbing on her neck. I called the house on 9/16/14 (incorrect date - should read 9/15/14) at</p>			

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	<p>7:30 AM and discussed the mark with [staff #5], who noted the injury at shift change on 9/15/14 (incorrect date - should read 9/14/14) (10:00p to 10:00a). She said it was a bruise in the corner of her right eye. She could not determine when and how it happened. I asked staff to not send [client C] to school until I arrived. I arrived at 8:30am on 9/16/14 (incorrect date - should read 9/15/14). I determined that indeed, there was bruising in the corner of [client C's] right eye. When discussed with staff present, we could not determine how or when the bruising occurred. I have reviewed the written statements of the staff that discovered the injury. [Staff #3] reported that [client C] got up after 10:00 AM staff noticed her right eye was a little swollen. At 4:00 PM [staff #3] noticed there was a bruise under the same eye. [Staff #3] marked the body scan. She checked the behavior logs, there were no SIB's (possible cause of the mark), when discussing the mark with overnight staff, they noticed a mark on her neck. (Determined to be from her seat belt). At 11:28 PM they reported the marks to me. I have reviewed the written statement of [staff #5], (10p to 10a), she noticed and discussed the mark with [staff #3], and [staff #3] called me. On 9/16/14 I asked the second staff on the floor on Sunday, [staff #2], what she saw, and she reported</p>						

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	<p>that she didn't notice it until [staff #3] mentioned it in the morning, after 10:00 AM, 9/15/14, (after [client C] got out of bed). I worked in the house on 9/15/14 (incorrect date - should read 9/14/14) from 7:30p to 9p to provide coverage for training [staff #2] on passing medications. I did not notice the mark, nor did [staff #3] show it to me. She called me at 11:28p and I noted her concerns... What I will do: Continue increasing staff so there are 2 on the floor during waking hours. Retrain staff on reporting injuries. When there are not 2 staff on the floor during waking hours, perform spot checks, noted on Acell (facility's electronic record), in the reporting section. Continue tracking injuries to determine if there is a pattern associated with them. Do spot checks and observations to provide support and training as needed."</p> <p>On 9/29/14 at 12:36 PM, the follow-up investigation, dated 9/26/14, indicated, in part, in the Summary of interview with staff #5, "What is the proper procedure for notifying administrators of potential ANE (Abuse/Neglect/Exploitation)? notify the pager or [Network Director] immediately; [staff #3] called after they determined it should be reported; [staff #5] wondered if [staff #3] was reluctant before because she could hear [Network</p>			

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	<p>Director] yelling when [staff #3] called her...". The report indicated, in part, in the Summary of interview with staff #3, "What is the proper procedure for notifying administrators of potential ANE: called at 11:30, an hour and a half after the ON (overnight) came in. Texted [Network Director]...told her that it looked like someone had grabbed her; [Network Director] was there at 7:30 to 9 and did not mention to [Network Director]; know now it has to be immediate."</p> <p>On 9/23/14 at 12:32 PM, the Quality Assurance Director (QAD) indicated the Network Director (ND) completed the investigation of client C's injury of unknown origin. The QAD indicated staff did not immediately report the injury, per policy. The QAD indicated the staff noted the injury in the morning and reported the injury later in the day.</p> <p>On 9/23/14 at 2:59 PM, staff #3 indicated she had concerns regarding client C's black eye. Staff #3 indicated she found the bruising on 9/14/14 during the morning shift. Staff #3 indicated she reported her concerns to the Network Director after her shift was over.</p> <p>On 9/23/14 at 3:07 PM, staff #3 allowed the surveyor to review her personal</p>			

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	<p>cellphone's text messages to verify she notified the Network Director (ND) of her concerns:</p> <p>-On 9/14/14 at 11:23 PM, staff #3 indicated in a text message, "I almost forgot to tell you. [Client C] has a bruise on her right eye. I put it in the body scan. I have no idea how she got it. I don't know of (sic) you noticed when you did the med pass at 8pm."</p> <p>-On 9/14/14 at 11:24 PM, the ND responded, "Yep."</p> <p>-On 9/14/14 at 11:27 PM, staff #3 indicated, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts on her neck (sic) it looks like someone grabbed her."</p> <p>-On 9/14/14 at 11:27 PM, the ND responded, "What."</p> <p>-On 9/14/14 at 11:28 PM, staff #3 replied with the same text, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts o." Staff #3 indicated while she was typing the information again the ND called her cellphone. Staff #3 indicated she reported an allegation of possible abuse to the ND during the phone call.</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Body Scan Monthly Tracking for September 2014 was conducted. The</p>			

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	<p>documentation dated 9/14/14 indicated, "Right eye. 1/2 in (inch) purple roundish. From SIB?"</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Nursing Narrative Note, dated 9/15/14, indicated, "[Client C] assessed due to bruise under right eye 5 cm (centimeters) in length also scratch 0.5 cm in length under (right) ear on her neck. Her eye is 'bloodshot,' she was rubbing it with palm of her hand during exam. Vitals are as follows P (pulse) 103 R (respirations) 20 B.P. (blood pressure) 108/72 T (temperature) 99.6. No other marks or bruises found at this time."</p> <p>On 9/23/14 at 3:24 PM, staff #3 informed the interim Director of Residential services (DRS) of her concerns regarding staff #4. Staff #3 indicated she found the bruising on 9/14/14 and documented the injury on client C's body scan. Staff #3 indicated she checked the previous body scans and found no documentation of SIBs. Staff #3 indicated when staff #5 arrived on 9/14/14, staff #5 noticed the cuts on client C's neck. Staff #3 indicated she had not noticed the cuts on client C's neck. Staff #3 indicated she informed the ND by text of the injury and her concerns.</p> <p>On 9/25/14 at 11:06 AM, the interim</p>			

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W000154	<p>DRS indicated staff failed to immediately report the allegation.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the injury of unknown origin was reported to her on 9/14/14. The ND indicated she was at the group home on 9/14/14 in the evening to train staff #2 to do medication administration. The ND indicated she did not see the bruise on client C's eye or cuts on her neck at that time. The ND indicated staff #3 did not report her concerns to her while she was in the group home. The ND indicated staff #3 should have reported the injury to her as soon as staff #3 observed the injury. The ND indicated she did not immediately report the allegation to administrative staff due to the time of the allegation. The ND indicated she knew staff #4 was not at the home at the time. The ND indicated she did not perceive the report as an allegation of abuse.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>						

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to conduct a thorough investigation into an allegation of abuse. The facility failed to investigate injuries of unknown origin on clients A and B. The facility failed to investigate client to client abuse involving clients B and C at school.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated the following:</p> <p>1) A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #5, indicated on 9/14/14 at 11:20 PM, in part, "I arrived to work about 9:45 PM. [Client C] woke up and walked into kitchen about 10:15 PM when I noticed bruising to her right eye, I then asked offgoing (sic) staff if she had any SIB's (self-injurious behaviors) after looking at [client C] more I noticed cut on her neck. Offgoing (sic) staff had informed me that she noticed and marked in body scan, offgoing (sic) staff called</p>	W000154	To correct the deficient practice, investigations have been completed for all incidents. To ensure the deficient practice does not continue, all ND/Qs were retrained on LifeDesigns investigation policies and procedures on 10/15/14. Due to client B's increase in aggression towards peers, her Behavior Support Plan has been revised, and all staff, including school staff, will be trained on the revised plan. The ND/Q will do observations twice weekly for at least 4 weeks to ensure school is implementing the plan as written, and will do monthly observations on an ongoing basis. There is a communication log that travels between home and school and is reviewed by staff each day- staff have been instructed to report all incidents, including incidents of peer to peer aggression reported by school staff, immediately to the ND/Q, who will immediately report to an administrator. The ND/Q has also increased communication with school staff to ensure they are letting LifeDesigns know right away when incidents occur at school. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well	10/31/2014

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	<p>[Network Director] to let her know of possible suspicion of abuse." The UIR indicated, by being circled, the type of incident was an injury to customer or staff and suspected abuse/neglect/exploitation. The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #3, indicated on 9/14/14 at 4:00 PM, in part, "Sunday morning when [client C] got up staff had noticed her eye was a little swollen, thought she had slept on that side. At 4pm meds staff noticed the bruise under her eye &amp; marked in the body scan. When staff did paperwork around 8pm staff noticed there was (sic) no SIB's yesterday. After staff ended shift, the overnight (staff) was also noticing her eye &amp; noticed on her neck there were scratches on her neck. Staff called [Network Director] to inform her, that there were (sic) reasonable suspicion of someone possible (sic) grabbing her." The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A 9/15/14 Bureau of Developmental Disabilities Services (BDDS) incident report indicated on 9/14/14 at 10:00 AM, staff #3 found a bruise on client C's right</p>		as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The weekly report is submitted to the ND/Q and CEO for review.				

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	<p>eye. The BDDS report indicated, "[Staff #3], DSP (Direct Support Professional), sent me a text at 11:23 PM 9/14/2014 telling me that [client C] has a bruise on her right eye. [Staff #3] stated that she had noticed it when she came in, in the morning at 10:00 AM but forgot to tell me. She also failed to mention it to me when I was at [name of group home] to do training with new staff at 7:30 PM. I did not notice the bruise at that time. I discussed the injury with [staff #3] at 11:30 (PM) by phone. I called [name of group home] this morning, asking overnight, [staff #5] and the morning staff, [staff #4] what it looked like. They described it as a bruise in the corner of her right eye. I asked staff to hold [client C] at home until I arrived this morning, so I could see the injury. I came to [name of group home], arriving at 7:50. [Client #3] has a small bruise in the corner of her right eye. It is smaller than a nickel. There may be some swelling, but it is minimal. [Staff #3] indicated she thought [client C] might have had an (sic) SIB (self-injurious behavior), but there are no incidents indicated in [client C's] daily book. I will discuss with overnight staff, [staff #6], and with new staff, [staff #2], and see what they observed. There will be 2 staff to 3 customers until the weekend to provide a layer of safety for customers. Saturday, 9/20 I will at least</p>			

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	<p>check in the house several times, and Sunday has 2 day staff. I will retrain staff on reporting procedures on 9/18/2014."</p> <p>The BDDS follow-up report, dated 9/19/14, indicated, "My investigation: The night that [staff #3] reported the injury to me, on 9/15/14 (incorrect date - should read 9/14/14) she reported that [client C] had an injury to her right eye. She also reported that there was a mark on her neck, that staff has determined came from her seat belt rubbing on her neck. I called the house on 9/16/14 (incorrect date - should read 9/15/14) at 7:30 AM and discussed the mark with [staff #5], who noted the injury at shift change on 9/15/14 (incorrect date - should read 9/14/14) (10:00p to 10:00a). She said it was a bruise in the corner of her right eye. She could not determine when and how it happened. I asked staff to not send [client C] to school until I arrived. I arrived at 8:30am on 9/16/14 (incorrect date - should read 9/15/14). I determined that indeed, there was bruising in the corner of [client C's] right eye. When discussed with staff present, we could not determine how or when the bruising occurred. I have reviewed the written statements of the staff that discovered the injury. [Staff #3] reported that [client C] got up after 10:00 AM staff noticed her right eye was a little</p>			

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	swollen. At 4:00 PM [staff #3] noticed there was a bruise under the same eye. [Staff #3] marked the body scan. She checked the behavior logs, there were no SIB's (possible cause of the mark), when discussing the mark with overnight staff, they noticed a mark on her neck. (Determined to be from her seat belt). At 11:28 PM they reported the marks to me. I have reviewed the written statement of [staff #5], (10p to 10a), she noticed and discussed the mark with [staff #3], and [staff #3] called me. On 9/16/14 I asked the second staff on the floor on Sunday, [staff #2], what she saw, and she reported that she didn't notice it until [staff #3] mentioned it in the morning, after 10:00 AM, 9/15/14, (after [client C] got out of bed). I worked in the house on 9/15/14 (incorrect date - should read 9/14/14) from 7:30p to 9p to provide coverage for training [staff #2] on passing medications. I did not notice the mark, nor did [staff #3] show it to me. She called me at 11:28p and I noted her concerns. On 9/16/14 I discussed the mark with [staff #4], who worked the day shift, 10:00a to 10:00p on 9/14 (incorrect date - should read 9/13/14). She had not seen the mark on her eye, and did not know how it happened. We discussed what might have caused the mark on her neck, and she told me she had seen it, (the mark on her neck), and it had been			

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	<p>caused by her seat belt rubbing on her neck. On 9/18/14 I discussed the mark on [client C's] eye, with [staff #6], who was the overnight staff on 9/14/14 from 10p to 10a. She had not noticed the mark on [client C's] eye. There were no behaviors that could be associated with [client C] getting the mark. I have not determined the cause of the mark on her eye. Staff did not see her have SIB's, when she could have smacked herself; she has also been known to rub her eyes very forcefully. If she was galloping through the house she could have bumped her eye. I have two staff on the floor for most daytime shifts at this time. I have no reason to believe that staff would injure her. I am certain that other customers did not cause this injury.</p> <p>What I will do: Continue increasing staff so there are 2 on the floor during waking hours. Retrain staff on reporting injuries. When there are not 2 staff on the floor during waking hours, perform spot checks, noted on Acell (facility's electronic record), in the reporting section. Continue tracking injuries to determine if there is a pattern associated with them. Do spot checks and observations to provide support and training as needed."</p> <p>The investigation, dated 9/22/14, contained the same information as the</p>						

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	<p>BDDS follow-up report dated 9/19/14. The investigation did not include interviews with clients A, B and C. The investigation did not indicate how the facility determined the scratches on client C's neck were caused by a seatbelt. The investigation did not address staff #3 and #5's allegation of staff abuse. The investigation did not address staff #3 indicating she discovered the bruises on 9/14/14 at 10:00 AM when her timesheet indicated she started working at 2:00 PM. There was no documentation of the ND's interviews with the staff.</p> <p>On 9/23/14 at 12:32 PM, the Quality Assurance Director (QAD) indicated he and the Director of Support Services conduct investigations of abuse and neglect. The QAD indicated the ND conducts investigations of client to client aggression and injuries of unknown origin. The QAD indicated the ND conducted the investigation of client C's injury of unknown origin. The QAD indicated this was not an allegation of abuse/neglect/exploitation.</p> <p>On 9/23/14 at 2:59 PM, staff #3 indicated she had concerns regarding client C's black eye. Staff #3 indicated she found the bruising on 9/14/14 during the morning shift. Staff #3 stated she "suspect [staff #4] is abusing the kids."</p>			

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	<p>Staff #3 stated the clients were "jittery around her" and flinch when staff #4 was near them. Staff #3 indicated she had observed staff #4 to use a raised voice but it was not verbally abusive. Staff #3 indicated she had never witnessed staff #4 abuse the clients. Staff #3 indicated client B would cry, at times, when staff #4 was near her. Staff #3 indicated she reported her concerns to the Network Director. Staff #3 stated she did not notice anything until the past few months when the clients started "acting funny" when staff #4 was around them. Staff #3 indicated a former staff reported concerns to staff #3 about staff #4 but did not think the former staff reported her concerns to management. Staff #3 indicated prior to injuries being found on client C on 9/14/14, staff #4 had worked 9/13/14 by herself with the clients. On 9/23/14 at 3:29 PM, staff #3 indicated she completed an Unusual Incident Report indicating she had suspicions someone grabbed client C. Staff #3 indicated the UIRs were given to the ND on 9/15/14 after they were completed.</p> <p>On 9/25/14 at 3:15 PM, staff #3 indicated she did not believe the seat belt caused the mark on client C's neck. Staff #3 indicated client C puts the seatbelt behind her. Staff #3 indicated client C did not like the seatbelt to be in front of her.</p>			

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	<p>Staff #3 indicated there were no issues with the seatbelt in the group home van.</p> <p>On 9/23/14 at 3:07 PM, staff #3 allowed the surveyor to review her personal cellphone's text messages to verify she notified the Network Director (ND) of her concerns:</p> <p>-On 9/14/14 at 11:23 PM, staff #3 indicated in a text message, "I almost forgot to tell you. [Client C] has a bruise on her right eye. I put it in the body scan. I have no idea how she got it. I don't know of (sic) you noticed when you did the med pass at 8pm."</p> <p>-On 9/14/14 at 11:24 PM, the ND responded, "Yep."</p> <p>-On 9/14/14 at 11:27 PM, staff #3 indicated, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts on her neck (sic) it looks like someone grabbed her."</p> <p>-On 9/14/14 at 11:27 PM, the ND responded, "What."</p> <p>-On 9/14/14 at 11:28 PM, staff #3 replied with the same text, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts o." Staff #3 indicated while she was typing the information again the ND called her cellphone. Staff #3 indicated she reported an allegation of possible</p>			

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	<p>abuse to the ND during the phone call.</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Body Scan Monthly Tracking for September 2014 was conducted. The documentation dated 9/14/14 indicated, "Right eye. 1/2 in (inch) purple roundish. From SIB?"</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Nursing Narrative Note, dated 9/15/14, indicated, "[Client C] assessed due to bruise under right eye 5 cm (centimeters) in length also scratch 0.5 cm in length under (right) ear on her neck. Her eye is 'bloodshot,' she was rubbing it with palm of her hand during exam. Vitals are as follows P (pulse) 103 R (respirations) 20 B.P. (blood pressure) 108/72 T (temperature) 99.6. No other marks or bruises found at this time."</p> <p>A review of the facility's staffing hours worked documentation was conducted on 9/25/14 at 11:55 AM.</p> <p>-On 9/13/14, staff #6 worked from 12:00 AM to 10:00 AM.</p> <p>-On 9/13/14, staff #4 worked from 6:00 AM to 10:00 PM.</p> <p>-On 9/14/14, staff #3 worked from 2:00 PM to 10:15 PM.</p> <p>-On 9/14/14, staff #2 worked from 10:00 AM to 10:00 PM.</p> <p>-On 9/14/14, staff #6 worked from 12:00</p>			

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	<p>AM to 10:00 AM.</p> <p>-On 9/14/14, the ND worked from 7:30 PM to 9:00 PM.</p> <p>-On 9/14/14, staff #5 worked from 9:45 PM to 12:00 AM.</p> <p>On 9/23/14 at 3:24 PM, staff #3 indicated the ND did not interview her during the investigation of client C's injuries.</p> <p>On 9/23/14 at 3:35 PM, the interim Director of Residential Services (DRS) indicated the ND did not treat the incident as an allegation of abuse. The DRS indicated the injury was investigated as an injury of unknown origin.</p> <p>On 9/25/14 at 11:06 AM, the interim DRS indicated for the investigation to be thorough, the clients should have been interviewed (or attempted to be interviewed). The DRS indicated the investigation should have included a review of the UIRs. The DRS indicated when he received the BDDS follow up report, he directed the ND to conduct an investigation. The DRS indicated the investigation should have indicated how the marks on client C's neck were determined to be from the seatbelt. The DRS indicated the investigation was not thorough. The DRS indicated the ND did not address the allegation of abuse. The</p>			

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	<p>DRS indicated an allegation of abuse should be investigated. The DRS indicated the ND thought by reporting the follow-up to BDDS, she was in compliance with completing an investigation. The DRS indicated the ND was not aware she needed to complete an investigation form.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the injury of unknown origin was reported to her on 9/14/14. The ND indicated she had to get a flashlight in order to see the bruise on client C's eye. The ND indicated staff #4 told her the marks on client C's neck were from the seatbelt. The ND indicated she was not sure if the school bus client C rode had seatbelts or not. The ND indicated she did not assess the seatbelts in the group home van. The ND indicated she was at the group home on 9/14/14 in the evening to train staff #2 to do medication administration. The ND indicated she did not see the bruise on client C's eye or cuts on her neck at that time. The ND indicated she did not find out the origin of the injury. The ND indicated she did not attempt to interview the clients. The ND indicated staff #3 and #5 told her they thought someone did it. The ND stated, "I have a fail there... at this minute, one big long fail." The ND indicated the UIRs staff #3 and #5</p>			

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	<p>completed did not mention a suspected perpetrator. The ND indicated she reviewed the UIRs. The ND indicated she did not address the allegation of abuse. The ND stated she "thought she had a little bit of an ability to make decisions. I don't." The ND indicated she could not pinpoint anyone who caused the injuries. The ND indicated staff #3 and #5 did not name another staff who they suspected of abusing client C. The ND indicated she did not perceive the report as an allegation of abuse.</p> <p>On 9/25/14 at 2:20 PM, the Network Director (ND) and surveyor assessed the seatbelts in the group home van. The ND indicated she had not assessed the seatbelts in the van prior to this date and time. There were no issues noted with the seatbelts in the van. There were no frayed areas or cuts on the seatbelts. The seatbelts were in good condition with no rips or tears that would cause an injury.</p> <p>On 9/29/14 at 12:36 PM, the follow-up investigation, dated 9/26/14, indicated in the Findings section, "Not substantiated, the findings do not support suspected abuse." The report indicated, "There is nothing to indicate staff abuse or neglect. [Client C's] injury can be explained by either the rubbing of the eye and scratch across the neck as noted by the nurse on</p>			

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	<p>9/15 (she observed that occur) or an action by a peer. It was noted that [client B] had grabbed and scratch (sic) [client C] by the school on two occasions in the past month. This would have had to happen while staff did not have both it their site (sic), as no one observed it. It should be noted that there is to be 2 staff on shift during waking hours to ensure customers are safe and to encourage activities. There were not 2 people on until 10 am that day. This is not compliant with our plan of correction for earlier citations or consistent with staffing schedule. The incident should have been investigated as potential abuse and neglect according to agency policies. While there were protections put in place, and all staff were interviewed, the investigation could have been more thorough by reviewing school communication, talking with the school, and interviewing the nursing staff. This revealed the incidents of peer to peer that happened at the school which should have been documented and investigated."</p> <p>The Recommendations section of the follow-up investigation indicated, in part, "The NDQ (Network Director) needs to meet with the QAD (Quality Assurance Director) to go over ANE (Abuse/Neglect/Exploitation) policies and procedures and shadow with the</p>			

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	<p>QAD on at least two investigations. The QAD will assess her ability to complete investigations independently. The NDQ is not consistently following up on school communication. There should always be a note back to the school for all noted issues to ensure closure and follow through. Also, there were peer to peer incidents that were not investigated. The NDQ will shadow with an experienced NDQ to learn proper procedure. She will be counseled on communication with the school and will be expected to follow up on the following by 10/2/14: 8/14/14: object expelled during BM (bowel movement), 8/22/14: peer to peer with [client B], 9/4/14: peer to peer (aggression) with [client B]. Additionally, there need (sic) to be some review of [client B's] body scans and whether several of the noted items had sufficient evidence of how the injury occurred. There are several noted that have some rationale attached but no clear evidence referenced. The NDQ and CEO will review all incidents to note whether there needs to be follow up investigations. The NDQ will provide evidence to support any rationale for injuries in the Body Scan book going forward. The CEO will review Body Scans during weekly onsite observations for the next 4 weeks. The NDQ will conduct random drop in visits on the</p>						

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	<p>overnight shift a minimum of 2 times per week to monitor staff through the end of October. The NDQ will follow up with [staff #3] regarding time reporting for the day of 9/14 to correct the entry. The Services Leadership team will review policies and report formats for injuries of unknown origin to be sure there is no confusion about how to treat these incidents. An update to the policies and forms will be noted on Services Leadership minutes. Any change will be communicated to Network Directors and Team Managers and trained on at the next available opportunity."</p> <p>2) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her left (client B) ear - were very noticeable yesterday! Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The note was initialed by the Network Director.</p> <p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented</p>			

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	<p>by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2 inch round bruise on her left arm. The documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks (sic) fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures."</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the bruises noted to client B's right leg and knee were not investigated. The ND indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid</p>			

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	<p>across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff #4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medication for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p> <p>On 9/25/14 at 11:37 AM, the interim Director of Residential Services (DRS) indicated the bruises should have been investigated and documented in her record. The DRS indicated until an investigation was conducted, the injuries were of unknown origin.</p> <p>3) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM for client B. On 9/4/14 the school documented, in part, "Crying when placed on bus in a.m. Jumping up &amp; down crying - slapping staff &amp; other students. Grabbed &amp; squeezed [client</p>						

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	<p>C's] hand tightly then yelled at her. Grabbed [client C's left eye during lunch &amp; attempted to pull it. Hit other classmates sev (several( times - hit/slapped/smacked staff more than a dozen times today. Lots of crying &amp; screaming." The note was initialed by the Network Director. There was no documentation an investigation of client to client abuse was conducted. There was no documentation of follow-up by the ND.</p> <p>On 9/25/14 at 11:37 AM, the interim Director of Residential Services (DRS) indicated client to client aggression was considered abuse and should be investigated.</p> <p>4) A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM for client A. On 9/16/14, the school documented, "Bruise noted on upper right thigh!" The note was initialed by the Network Director.</p> <p>An email, dated 9/16/14 at 5:23 PM, from the Network Director to the teacher indicated, in part, "Regarding the bruise on the upper right thigh of [client A], noted today, 9/16/2014. I am checking with his physician about an exam done on 9/15/2014, and will inform you of my</p>			

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W000155	<p>findings...".</p> <p>The facility did not have documentation of an investigation. There was no documentation regarding the ND checking with client A's physician.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she did not conduct an investigation. The ND indicated she did not realize she needed to do an investigation. The ND indicated staff #4 was going to take him to the doctor to get the bruise checked. The ND indicated staff #4 informed her the injury may have happened during an exam. The doctor's appointment did not occur.</p> <p>On 9/25/14 at 11:34 AM, the interim Director of Residential Services (DRS) indicated an investigation should have conducted.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-3(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>						

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	<p>The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client A, B and C, the facility failed to implement measures to prevent further potential abuse when an allegation of abuse was reported to the Network Director.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated the following: A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #5, indicated on 9/14/14 at 11:20 PM, in part, "I arrived to work about 9:45 PM. [Client C] woke up and walked into kitchen about 10:15 PM when I noticed bruising to her right eye, I then asked offgoing (sic) staff if she had any SIB's (self-injurious behaviors) after looking at [client C] more I noticed cut on her neck. Offgoing (sic) staff had informed me that she noticed and marked in body scan, offgoing (sic) staff called [Network Director] to let her know of possible suspicion of abuse." The UIR indicated, by being circled, the type of incident was an injury to customer or staff and suspected abuse/neglect/exploitation. The UIR</p>	W000155	To correct the deficient practice and ensure it does not continue, all staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to ensure safety measures to prevent further abuse are implemented when an allegation of abuse is reported, and those safety measures will be documented on the investigation summary. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup.	10/31/2014			

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	<p>indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #3, indicated on 9/14/14 at 4:00 PM, in part, "Sunday morning when [client C] got up staff had noticed her eye was a little swollen, thought she had slept on that side. At 4pm meds staff noticed the bruise under her eye &amp; marked in the body scan. When staff did paperwork around 8pm staff noticed there was no SIB's yesterday. After staff ended shift, the overnight was also noticing her eye &amp; noticed on her neck there were scratches on her neck. Staff called [Network Director] to inform her, that there were (sic) reasonable suspicion of someone possible (sic) grabbing her." The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A 9/15/14 Bureau of Developmental Disabilities Services (BDDS) incident report indicated on 9/14/14 at 10:00 AM, staff #3 found a bruise on client C's right eye. The BDDS report indicated, "[Staff #3], DSP (Direct Support Professional), sent me a text at 11:23 PM 9/14/2014 telling me that [client C] has a bruise on her right eye. [Staff #3] stated that she had noticed it when she came in, in the morning at 10:00 AM but forgot to tell</p>			

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	<p>me. She also failed to mention it to me when I was at [name of group home] to do training with new staff at 7:30 PM. I did not notice the bruise at that time. I discussed the injury with [staff #3] at 11:30 (PM) by phone. I called [name of group home] this morning, asking overnight, [staff #5] and the morning staff, [staff #4] what it looked like. They described it as a bruise in the corner of her right eye. I asked staff to hold [client C] at home until I arrived this morning, so I could see the injury. I came to [name of group home], arriving at 7:50. [Client #3] has a small bruise in the corner of her right eye. It is smaller than a nickel. There may be some swelling, but it is minimal. [Staff #3] indicated she thought [client C] might have had an (sic) SIB (self-injurious behavior), but there are no incidents indicated in [client C's] daily book. I will discuss with overnight staff, [staff #6], and with new staff, [staff #2], and see what they observed. There will be 2 staff to 3 customers until the weekend to provide a layer of safety for customers. Saturday, 9/20 I will at least check in the house several times, and Sunday has 2 day staff. I will retrain staff on reporting procedures on 9/18/2014."</p> <p>The BDDS follow-up report, dated 9/19/14, indicated, "My investigation: The night that [staff #3] reported the</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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	<p>injury to me, on 9/15/14 (incorrect date - should read 9/14/14) she reported that [client C] had an injury to her right eye. She also reported that there was a mark on her neck, that staff has determined came from her seat belt rubbing on her neck. I called the house on 9/16/14 (incorrect date - should read 9/15/14) at 7:30 AM and discussed the mark with [staff #5], who noted the injury at shift change on 9/15/14 (incorrect date - should read 9/14/14) (10:00p to 10:00a). She said it was a bruise in the corner of her right eye. She could not determine when and how it happened. I asked staff to not send [client C] to school until I arrived. I arrived at 8:30am on 9/16/14 (incorrect date - should read 9/15/14). I determined that indeed, there was bruising in the corner of [client C's] right eye. When discussed with staff present, we could not determine how or when the bruising occurred. I have reviewed the written statements of the staff that discovered the injury. [Staff #3] reported that [client C] got up after 10:00 AM staff noticed her right eye was a little swollen. At 4:00 PM [staff #3] noticed there was a bruise under the same eye. [Staff #3] marked the body scan. She checked the behavior logs, there were no SIB's (possible cause of the mark), when discussing the mark with overnight staff, they noticed a mark on her neck.</p>			

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	(Determined to be from her seat belt). At 11:28 PM they reported the marks to me. I have reviewed the written statement of [staff #5], (10p to 10a), she noticed and discussed the mark with [staff #3], and [staff #3] called me. On 9/16/14 I asked the second staff on the floor on Sunday, [staff #2], what she saw, and she reported that she didn't notice it until [staff #3] mentioned it in the morning, after 10:00 AM, 9/15/14, (after [client C] got out of bed). I worked in the house on 9/15/14 (incorrect date - should read 9/14/14) from 7:30p to 9p to provide coverage for training [staff #2] on passing medications. I did not notice the mark, nor did [staff #3] show it to me. She called me at 11:28p and I noted her concerns. On 9/16/14 I discussed the mark with [staff #4], who worked the day shift, 10:00a to 10:00p on 9/14 (incorrect date - should read 9/13/14). She had not seen the mark on her eye, and did not know how it happened. We discussed what might have caused the mark on her neck, and she told me she had seen it, (the mark on her neck), and it had been caused by her seat belt rubbing on her neck. On 9/18/14 I discussed the mark on [client C's] eye, with [staff #6], who was the overnight staff on 9/14/14 from 10p to 10a. She had not noticed the mark on [client C's] eye. There were no behaviors that could be associated with			

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	<p>[client C] getting the mark. I have not determined the cause of the mark on her eye. Staff did not see her have SIB's, when she could have smacked herself; she has also been known to rub her eyes very forcefully. If she was galloping through the house she could have bumped her eye. I have two staff on the floor for most daytime shifts at this time. I have no reason to believe that staff would injure her. I am certain that other customers did not cause this injury. What I will do: Continue increasing staff so there are 2 on the floor during waking hours. Retrain staff on reporting injuries. When there are not 2 staff on the floor during waking hours, perform spot checks, noted on Acell (facility's electronic record), in the reporting section. Continue tracking injuries to determine if there is a pattern associated with them. Do spot checks and observations to provide support and training as needed."</p> <p>The investigation, dated 9/22/14, contained the same information as the BDDS follow-up report dated 9/19/14. The investigation did not indicate how the facility determined the scratches on client C's neck were caused by a seatbelt. The investigation did not address staff #3 and #5's allegation of staff abuse. The investigation did not address staff #3</p>			

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	<p>indicating she discovered the bruises on 9/14/14 at 10:00 AM when her timesheet indicated she started working at 2:00 PM. The investigation did not indicate the actions the facility implemented to ensure further abuse did not occur during the investigation process.</p> <p>On 9/23/14 at 12:32 PM, the Quality Assurance Director (QAD) indicated the Network Director (ND) completed the investigation of client C's injury of unknown origin. The QAD indicated staff did not immediately report the injury, per policy. The QAD indicated the staff noted the injury in the morning and reported the injury later in the day. The QAD stated, "Seems like an odd place to get a bruise." The QAD indicated the bruise could have been caused by self injurious behavior or the way she sleeps (balls up and sleeps). The QAD stated he could not imagine staff "beat up"[client C]. The QAD indicated he and the Director of Support Services conduct investigations of abuse and neglect. The QAD indicated the ND conducts investigations of client to client aggression and injuries of unknown origin. The QAD indicated the ND conducted the investigation of client C's injury of unknown origin. The QAD indicated this was not an allegation of abuse/neglect/exploitation.</p>						

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	<p>On 9/23/14 at 2:59 PM, staff #3 indicated she had concerns regarding client C's black eye. Staff #3 indicated she found the bruising on 9/14/14 during the morning shift. Staff #3 stated she "suspect [staff #4] is abusing the kids." Staff #3 stated the clients were "jittery around her" and flinch when staff #4 was near them. Staff #3 indicated she had observed staff #4 to use a raised voice but it was not verbally abusive. Staff #3 indicated she had never witnessed staff #4 abuse the clients. Staff #3 indicated client B would cry, at times, when staff #4 was near her. Staff #3 indicated she reported her concerns to the Network Director. Staff #3 stated she did not notice anything until the past few months when the clients started "acting funny" when staff #4 was around them. Staff #3 indicated a former staff reported concerns to staff #3 about staff #4 but did not think the former staff reported her concerns to management. Staff #3 indicated prior to injuries being found on client C on 9/14/14, staff #4 had worked 9/13/14 by herself with the clients. On 9/23/14 at 3:29 PM, staff #3 indicated she completed an Unusual Incident Report indicating she had suspicions someone grabbed client C. Staff #3 indicated the UIRs were given to the ND on 9/15/14 after they were completed.</p>			

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	<p>On 9/25/14 at 3:15 PM, staff #3 indicated she did not believe the seat belt caused the mark on client C's neck. Staff #3 indicated client C puts the seatbelt behind her. Staff #3 indicated client C did not like the seatbelt to be in front of her. Staff #3 indicated there were no issues with the seatbelt in the group home van.</p> <p>On 9/23/14 at 3:07 PM, staff #3 allowed the surveyor to review her personal cellphone's text messages to verify she notified the Network Director (ND) of her concerns: -On 9/14/14 at 11:23 PM, staff #3 indicated in a text message, "I almost forgot to tell you. [Client C] has a bruise on her right eye. I put it in the body scan. I have no idea how she got it. I don't know of (sic) you noticed when you did the med pass at 8pm." -On 9/14/14 at 11:24 PM, the ND responded, "Yep." -On 9/14/14 at 11:27 PM, staff #3 indicated, "Okay she got up when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts on her neck (sic) it looks like someone grabbed her." -On 9/14/14 at 11:27 PM, the ND responded, "What." -On 9/14/14 at 11:28 PM, staff #3 replied with the same text, "Okay she got up</p>						

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	<p>when I got there &amp; noticed it. When [staff #5] got here we were looking at (sic) cause she got up. And there are cuts o." Staff #3 indicated while she was typing the information again the ND called her cellphone. Staff #3 indicated she reported an allegation of possible abuse to the ND during the phone call.</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Body Scan Monthly Tracking for September 2014 was conducted. The documentation dated 9/14/14 indicated, "Right eye. 1/2 in (inch) purple roundish. From SIB?"</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Nursing Narrative Note, dated 9/15/14, indicated, "[Client C] assessed due to bruise under right eye 5 cm (centimeters) in length also scratch 0.5 cm in length under (right) ear on her neck. Her eye is 'bloodshot,' she was rubbing it with palm of her hand during exam. Vitals are as follows P (pulse) 103 R (respirations) 20 B.P. (blood pressure) 108/72 T (temperature) 99.6. No other marks or bruises found at this time."</p> <p>A review of the facility's staffing hours worked documentation was conducted on 9/25/14 at 11:55 AM. -On 9/13/14, staff #6 worked from 12:00 AM to 10:00 AM.</p>			

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	<p>-On 9/13/14, staff #4 worked from 6:00 AM to 10:00 PM.</p> <p>-On 9/14/14, staff #3 worked from 2:00 PM to 10:15 PM.</p> <p>-On 9/14/14, staff #2 worked from 10:00 AM to 10:00 PM.</p> <p>-On 9/14/14, staff #6 worked from 12:00 AM to 10:00 AM.</p> <p>-On 9/14/14, the ND worked from 7:30 PM to 9:00 PM.</p> <p>-On 9/14/14, staff #5 worked from 9:45 PM to 12:00 AM.</p> <p>On 9/23/14 at 3:24 PM, staff #3 informed the interim Director of Residential Services (DRS) of her concerns regarding staff #4. Staff #3 indicated she found the bruising on 9/14/14 and documented the injury on client C's body scan. Staff #3 indicated she checked the previous body scans and found no documentation of SIBs. Staff #3 indicated when staff #5 arrived on 9/14/14, staff #5 noticed the cuts on client C's neck. Staff #3 indicated she had not noticed the cuts on client C's neck. Staff #3 indicated she informed the ND by text of the injury and her concerns. Staff #3 indicated the ND responded to the text indicating she was aware of the bruise. Staff #3 indicated the ND did not interview her during the investigation of client C's injuries.</p> <p>On 9/23/14 at 3:35 PM, the interim DRS</p>						

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	<p>indicated staff #4 needed to be suspended. The DRS indicated the ND did not treat the incident as an allegation of abuse. The DRS indicated the injury was investigated as an injury of unknown origin. On 9/23/14 at 3:44 PM, the DRS indicated staff #4 should have been suspended on 9/14/14.</p> <p>During the observation at the group home on 9/23/14 from 2:59 PM to 5:00 PM, staff #4 was suspended by the interim DRS at 4:08 PM. Staff #4 left the group home at 4:16 PM.</p> <p>On 9/25/14 at 11:06 AM, the interim DRS indicated the staff was not suspended when the allegation was made. The DRS indicated staff #4 should have been suspended immediately.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated the UIRs staff #3 and #5 completed did not mention a suspected perpetrator. The ND indicated she reviewed the UIRs. The ND stated she "thought she had a little bit of an ability to make decisions. I don't." The ND indicated she could not pinpoint anyone who caused the injuries. The ND indicated staff #3 and #5 did not name another staff who they suspected of abusing client B.</p>			

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	<p>On 9/29/14 at 12:36 PM, the follow-up investigation, dated 9/26/14, indicated in the Findings section, "Not substantiated, the findings do not support suspected abuse." The report indicated, in part, in the Summary of interview with staff #5, "What is the proper procedure for notifying administrators of potential ANE (Abuse/Neglect/Exploitation)? notify the pager or [Network Director] immediately; [staff #3] called after they determined it should be reported; [staff #5] wondered if [staff #3] was reluctant before because she could hear [Network Director] yelling when [staff #3] called her...". The report indicated, in part, in the Summary of interview with staff #3, "What is the proper procedure for notifying administrators of potential ANE: called at 11:30, an hour and a half after the ON (overnight) came in. Texted [Network Director]...told her that it looked like someone had grabbed her; [Network Director] was there at 7:30 to 9 and did not mention to [Network Director]; know now it has to be immediate." The Summary of interview with the Network Director indicated, in part, "Why was [staff #4] not suspended pending outcome of investigation? Did not indicate who was suspected on the form so did not know who to suspend or other measures to put in place. Did not know exactly when it happened besides</p>			

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W000156	<p>that morning."</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-2(a)</p> <p>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. Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure the investigation results were reported to the administrator within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated the following: A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #5, indicated on 9/14/14 at 11:20 PM, in part, "I arrived to work about 9:45 PM. [Client C] woke up and walked into kitchen about 10:15 PM</p>	W000156	To correct the deficient practice and ensure it does not continue, all staff who complete investigations (including ND/Qs, Quality Assurance Director and Directors of Services) will be re-trained on the requirement to report the results of all investigations to the administrator within 5 working days. The Director of Support Services tracks and monitors all investigations to ensure they are completed within the required timeframes. The DOSS will monitor each investigation from the time it begins, and will send a reminder to the investigator on day 4 that the investigation is due the following day. The Services Leadership Team, which includes all Directors of Services, the	10/31/2014	

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	<p>when I noticed bruising to her right eye, I then asked offgoing (sic) staff if she had any SIB's (self-injurious behaviors) after looking at [client C] more I noticed cut on her neck. Offgoing (sic) staff had informed me that she noticed and marked in body scan, offgoing (sic) staff called [Network Director] to let her know of possible suspicion of abuse." The UIR indicated, by being circled, the type of incident was an injury to customer or staff and suspected abuse/neglect/exploitation. The UIR indicated on-call staff was notified at 11:20 PM (no date documented).</p> <p>A LifeDesigns Unusual Incident Report (UIR), dated 9/15/14 and completed by staff #3, indicated on 9/14/14 at 4:00 PM, in part, "Sunday morning when [client C] got up staff had noticed her eye was a little swollen, thought she had slept on that side. At 4pm meds staff noticed the bruise under her eye &amp; marked in the body scan. When staff did paperwork around 8pm staff noticed there was no SIB's yesterday. After staff ended shift, the overnight was also noticing her eye &amp; noticed on her neck there were scratches on her neck. Staff called [Network Director] to inform her, that there were (sic) reasonable suspicion of someone possible (sic) grabbing her." The UIR indicated on-call staff was notified at</p>		Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as the status of all investigations.				

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	<p>11:20 PM (no date documented).</p> <p>The BDDS follow-up report, dated 9/19/14, indicated, "My investigation: The night that [staff #3] reported the injury to me, on 9/15/14 (incorrect date - should read 9/14/14) she reported that [client C] had an injury to her right eye. She also reported that there was a mark on her neck, that staff has determined came from her seat belt rubbing on her neck. I called the house on 9/16/14 (incorrect date - should read 9/15/14) at 7:30 AM and discussed the mark with [staff #5], who noted the injury at shift change on 9/15/14 (incorrect date - should read 9/14/14) (10:00p to 10:00a). She said it was a bruise in the corner of her right eye. She could not determine when and how it happened. I asked staff to not send [client C] to school until I arrived. I arrived at 8:30am on 9/16/14 (incorrect date - should read 9/15/14). I determined that indeed, there was bruising in the corner of [client C's] right eye. When discussed with staff present, we could not determine how or when the bruising occurred. I have reviewed the written statements of the staff that discovered the injury. [Staff #3] reported that [client C] got up after 10:00 AM staff noticed her right eye was a little swollen. At 4:00 PM [staff #3] noticed there was a bruise under the same eye.</p>						

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	<p>[Staff #3] marked the body scan. She checked the behavior logs, there were no SIB's (possible cause of the mark), when discussing the mark with overnight staff, they noticed a mark on her neck. (Determined to be from her seat belt). At 11:28 PM they reported the marks to me. I have reviewed the written statement of [staff #5], (10p to 10a), she noticed and discussed the mark with [staff #3], and [staff #3] called me. On 9/16/14 I asked the second staff on the floor on Sunday, [staff #2], what she saw, and she reported that she didn't notice it until [staff #3] mentioned it in the morning, after 10:00 AM, 9/15/14, (after [client C] got out of bed). I worked in the house on 9/15/14 (incorrect date - should read 9/14/14) from 7:30p to 9p to provide coverage for training [staff #2] on passing medications. I did not notice the mark, nor did [staff #3] show it to me. She called me at 11:28p and I noted her concerns. On 9/16/14 I discussed the mark with [staff #4], who worked the day shift, 10:00a to 10:00p on 9/14 (incorrect date - should read 9/13/14). She had not seen the mark on her eye, and did not know how it happened. We discussed what might have caused the mark on her neck, and she told me she had seen it, (the mark on her neck), and it had been caused by her seat belt rubbing on her neck. On 9/18/14 I discussed the mark</p>				

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	<p>on [client C's] eye, with [staff #6], who was the overnight staff on 9/14/14 from 10p to 10a. She had not noticed the mark on [client C's] eye. There were no behaviors that could be associated with [client C] getting the mark. I have not determined the cause of the mark on her eye. Staff did not see her have SIB's, when she could have smacked herself; she has also been known to rub her eyes very forcefully. If she was galloping through the house she could have bumped her eye. I have two staff on the floor for most daytime shifts at this time. I have no reason to believe that staff would injure her. I am certain that other customers did not cause this injury. What I will do: Continue increasing staff so there are 2 on the floor during waking hours. Retrain staff on reporting injuries. When there are not 2 staff on the floor during waking hours, perform spot checks, noted on Acell (facility's electronic record), in the reporting section. Continue tracking injuries to determine if there is a pattern associated with them. Do spot checks and observations to provide support and training as needed."</p> <p>The investigation, dated 9/22/14, contained the same information as the BDDS follow-up report dated 9/19/14. The investigation was not submitted for</p>			

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	<p>review to the administrator within 5 working days.</p> <p>On 9/23/14 at 2:59 PM, staff #3 indicated she had concerns regarding client C's black eye. Staff #3 indicated she found the bruising on 9/14/14 during the morning shift. Staff #3 indicated she "suspect [staff #4] was abusing the kids." Staff #3 stated the clients were "jittery around her" and flinch when staff #4 was near them. Staff #3 indicated she had observed staff #4 to use a raised voice but it was not verbally abusive. Staff #3 indicated she had never witnessed staff #4 abuse the clients. Staff #3 indicated client B would cry, at times, when staff #4 was near her. Staff #3 indicated she reported her concerns to the Network Director. Staff #3 stated she did not notice anything until the past few months when the clients started "acting funny" when staff #4 was around them. Staff #3 indicated a former staff reported concerns to staff #3 about staff #4 but did not think the former staff reported her concerns to management. Staff #3 indicated prior to injuries being found on client C on 9/14/14, staff #4 had worked 9/13/14 by herself with the clients. On 9/23/14 at 3:29 PM, staff #3 indicated she completed an Unusual Incident Report indicating she had suspicions someone grabbed client C. Staff #3 indicated the</p>						

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	<p>UIRs were given to the ND on 9/15/14 after they were completed.</p> <p>On 9/25/14 at 3:15 PM, staff #3 indicated she did not believe the seat belt caused the mark on client C's neck. Staff #3 indicated client C puts the seatbelt behind her. Staff #3 indicated client C did not like the seatbelt to be in front of her. Staff #3 indicated there were no issues with the seatbelt in the group home van.</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Body Scan Monthly Tracking for September 2014 was conducted. The documentation dated 9/14/14 indicated, "Right eye. 1/2 in (inch) purple roundish. From SIB?"</p> <p>On 9/23/14 at 3:20 PM, a review of client C's Nursing Narrative Note, dated 9/15/14, indicated, "[Client C] assessed due to bruise under right eye 5 cm (centimeters) in length also scratch 0.5 cm in length under (right) ear on her neck. Her eye is 'bloodshot,' she was rubbing it with palm of her hand during exam. Vitals are as follows P (pulse) 103 R (respirations) 20 B.P. (blood pressure) 108/72 T (temperature) 99.6. No other marks or bruises found at this time."</p> <p>On 9/29/14 at 12:36 PM, the follow-up investigation, dated 9/26/14, indicated in</p>			

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	<p>the Findings section, "Not substantiated, the findings do not support suspected abuse." The report indicated, "There is nothing to indicate staff abuse or neglect. [Client C's] injury can be explained by either the rubbing of the eye and scratch across the neck as noted by the nurse on 9/15 (she observed that occur) or an action by a peer. It was noted that [client B] had grabbed and scratch (sic) [client C] by the school on two occasions in the past month. This would have had to happen while staff did not have both it their site (sic), as no one observed it. It should be noted that there is to be 2 staff on shift during waking hours to ensure customers are safe and to encourage activities. There were not 2 people on until 10 am that day. This is not compliant with our plan of correction for earlier citations or consistent with staffing schedule. The incident should have been investigated as potential abuse and neglect according to agency policies. While there were protections put in place, and all staff were interviewed, the investigation could have been more thorough by reviewing school communication, talking with the school, and interviewing the nursing staff. This revealed the incidents of peer to peer that happened at the school which should have been documented and investigated." The report indicated, in part, in the</p>			

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	<p>Summary of interview with staff #5, "What is the proper procedure for notifying administrators of potential ANE (Abuse/Neglect/Exploitation)? notify the pager or [Network Director] immediately; [staff #3] called after they determined it should be reported; [staff #5] wondered if [staff #3] was reluctant before because she could hear [Network Director] yelling when [staff #3] called her...". The report indicated, in part, in the Summary of interview with staff #3, "What is the proper procedure for notifying administrators of potential ANE: called at 11:30, an hour and a half after the ON (overnight) came in. Texted [Network Director]...told her that it looked like someone had grabbed her; [Network Director] was there at 7:30 to 9 and did not mention to [Network Director]; know now it has to be immediate." The Summary of interview with the Network Director indicated, in part, "Why was [staff #4] not suspended pending outcome of investigation? Did not indicate who was suspected on the form so did not know who to suspend or other measures to put in place. Did not know exactly when it happened besides that morning."</p> <p>On 9/25/14 at 11:06 AM, the interim Director of Residential Services (DRS) indicated the timeframe for reporting the</p>			

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W000159	<p>results of investigations to the administrator was 5 working days. The DRS indicated the results of the ND's investigation were reported to the administrator on 9/22/14 at 4:57 AM. The DRS stated, "It was late." The DRS indicated the ND thought by reporting the follow-up to BDDS, she was in compliance with completing an investigation. The DRS indicated the ND was not aware she needed to complete an investigation form.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she completed the investigation on 9/22/14. The ND indicated the investigation would have been done earlier but she was not satisfied with her initial investigation documentation. The ND indicated she got the investigation done within a week.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-2(a)</p> <p>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.</p>						

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	<p>Based on record review and interview for 1 of 2 clients in the sample (B), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure staff administered client B's medication as directed before a medical procedure leading to an unnecessary restraint resulting in injuries of unknown origin attributed to a dental appointment.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated there were no incident reports or investigations addressing client B's injuries of unknown origin.</p> <p>A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her left ear - were very noticeable yesterday! Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The response was not dated. The note was initialed by the Network Director (ND).</p>	W000159	The PRN medication that had been prescribed for client B was felt to be ineffective by the agency nurse, and she had requested the physician change the PRN, but had not received a response from the physician. To correct the deficient practice, client B has an appointment scheduled with her physician on 10/30/14, at which time the agency nurse will request a different PRN medication from the physician. To prevent the deficient practice from recurring, all staff will be re-trained on the necessity to follow all individualized appointment procedures, including checking for PRN medication. The LifeDesigns Medical Appointment Form will be revised to include a place to document the administration of pre-appointment PRN medications. The Health Services Director will provide the LPN and Medical Coordinator with additional instruction related to what to do if a medication has an adverse side effect, or is ineffective. Ongoing monitoring will be accomplished through a monthly meeting between the LPN, ND/Q and Medical Coordinator to discuss and resolve any issues related to recent and upcoming appointments, as well as effectiveness of medications.	10/31/2014	

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	<p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2 inch round bruise on her left arm. The documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks (sic) fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam (Valium) 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures." Client B's 6/12/14 Nursing Care Plan did not include the use of diazepam prior to medical procedures.</p>			

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	<p>A review of client B's Individual Support Plan and Replacement Skills Plan, dated 3/23/14, was conducted on 9/24/14 at 4:28 PM. There was no documentation in client B's plan regarding the use of a pre-medication for medication procedures.</p> <p>On 9/26/14 at 11:57 AM, the Licensed Practical Nurse (LPN) indicated client B had an order for Valium for procedures. The LPN indicated the medication did not work well for client B since it seems to make her anxious. The LPN indicated client B had a Physician's Order for Valium prior to procedures. The LPN indicated the use of Valium was not part of client B's Nursing Care Plan but should be. The LPN indicated the Valium was rarely used due to not being effective. The LPN indicated client B's physician was notified the Valium was not effective but he did not change the order. The LPN indicated the facility had not tried anything else for client B to assist her during appointments. The LPN indicated the use of the Valium would be better than restraints.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid</p>			

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W000186	<p>across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff #4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medications for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for</p>	W000186	To correct the deficient practice	10/31/2014	

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	<p>3 of 3 clients living at the group home (A, B and C), the facility failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 9/23/14 at 1:33 PM, client A, B and C's teacher indicated the group home staff reported there was one staff working with the clients at the group home. The teacher indicated there had been no changes in the staffing level since the survey completed on 8/26/14, based on the group home staff's reports of the staffing level.</p> <p>A review of the direct care staffs' timesheets was conducted on 9/25/14 at 11:55 AM. As indicated by the timesheets, the group home had one staff working with clients A, B and C on the following dates and times:</p> <p>-8/26/14 from 4:30 PM to 10:00 PM -8/27/14 from 3:30 PM to 10:00 PM -8/28/14 from 5:30 PM to 10:00 PM -8/29/14 from 4:00 PM to 9:15 PM -8/30/14 from 6:00 AM to 10:00 PM -8/31/14 from 8:00 AM to 10:15 PM -9/1/14 from 7:00 AM to 2:45 PM and 4:00 PM to 10:00 PM</p>		<p>and ensure it does not continue, a new Team Manager has been hired for the home (in addition to the ND/Q who is currently only responsible for the Park Lane home), as well as additional DSP staff. The ND/Q will submit the staff schedule weekly to the interim DORS and CEO for review to ensure that 2 staff are scheduled for waking hours when all 3 customers are in the home. Staff needs will be addressed weekly at the ND/Q meeting, so any open shifts can be identified and filled. Additional monitoring will be accomplished through weekly observations by the QAD, DOSS, interim DORS and CEO for the next 6 weeks.</p>		

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	<p>-9/2/14 from 3:00 PM to 10:00 PM                      -9/3/14 from 3:00 PM to 10:00 PM                      -9/4/14 from 4:15 PM to 10:00 PM                      -9/5/14 from 2:00 PM to 8:15 PM                      -9/6/14 from 8:00 AM to 3:30 PM and 8:00 PM to 10:00 PM                      -9/7/14 from 10:00 AM to 10:00 PM                      -9/8/14 from 6:00 PM to 10:00 PM                      -9/9/14 from 2:00 PM to 10:00 PM                      -9/10/14 from 2:00 PM to 10:00 PM                      -9/11/14 from 4:30 PM to 8:00 PM                      -9/12/14 from 6:00 PM to 10:00 PM                      -9/13/14 from 10:00 AM to 10:00 PM                      -9/14/14 from 6:00 AM to 2:00 PM                      -9/17/14 from 4:30 PM to 10:00 PM                      -9/18/14 from 5:00 PM to 8:00 PM                      -9/19/14 from 2:00 PM to 8:00 PM                      -9/20/14 from 10:00 AM to 8:00 PM                      -9/21/14 from 6:00 AM to 10:00 AM                      -9/22/14 from 4:00 PM to 10:00 PM</p> <p>On 9/26/14 at 9:10 AM, client A's teacher emailed the Network Director. The email was forwarded to the surveyor on 9/26/14 at 9:22 AM. The email indicated, "[Network Director]: per our phone conversation this morning (Sept. 26, 2014), I just wanted to (as I stated I would) follow up with an email... Additionally, as I told you on the phone, we (per your calendar) showed that [client B] was supposed to be picked up for an appointment yesterday with her PCP (primary care physician). We did</p>			

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	<p>not receive a call or note stating it was cancelled, nor did anyone pick her up."</p> <p>On 9/29/14 at 2:12 PM, the Licensed Practical Nurse (LPN) indicated client B missed a Physical Therapy appointment last week due to the facility not having enough staff for someone to take her to the appointment.</p> <p>On 9/29/14 at 12:36 PM, a follow-up investigation, dated 9/26/14, was reviewed addressing an allegation of abuse involving client C. The Network Director's interview in the investigation indicated, in part, "Why were there not 2 people on the floor as recommended by the investigation and POC (Plan of Correction)? We have not had sufficient staff to fill and have not had support from the other homes. Have been told that [name of company providing temporary staff] does not cover [name of county]."</p> <p>On 9/24/14 at 4:28 PM, client A's Replacement Skills Plan (RSP), dated June 2014, was reviewed. The RSP indicated, in part, "[Client A] needs staff assistance in most areas of independent living and self-care, but can participate in all things if given directions one step at a time. [Client A] communicates verbally with one or two words or simple sentences. [Client A] functions best in a</p>						

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	<p>fun, playful, consistent environment with activities that interest him. [Client A] responds better to being asked to 'help' someone with something, rather than being prompted with something HE has to do. He enjoys being outside and swinging on the swing set. [Client A] needs encouragement to participate in activities outside of his bedroom, although this has improved over time. [Client A] enjoys going for rides in vehicles and will often ask to go somewhere. [Client A] has a strong personality and knows what he wants to do or not do as well as when he wants to do it." The RSP indicated he had the following targeted behaviors: self-injurious behavior (defined as head banging, hair pulling, biting, pinching, or scratching self, putting things in his ears), aggression (defined as hitting or pinching others), inappropriate touch (defined as slapping or grabbing other people's buttocks, trying to lift others' shirts, grabbing others between the legs), sexual hyperactivity (defined as requesting 'private time' (masturbation) more than three times daily), and medication refusal (defined as refusing to participate in medication administration or refusing to finish drink containing medication).</p> <p>On 9/24/14 at 4:28 PM, client B's Replacement Skills Plan (RSP) was</p>			

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	<p>reviewed. The RSP, dated 3/23/14, indicated she had the following targeted behaviors: tantrum (defined as screaming), aggression (defined as hitting with open hand or object such as baby doll or shoe), and emptying closet and/or dresser drawers (defined as taking clothes out of closet and/or dresser drawers and throwing them in the floor). Client B's plan indicated, in part, "[Client B] needs staff assistance in all areas of personal care, but can participate in most things if given simple one step instructions. [Client B] enjoys attention from and interacting with staff members, as well as with her roommates. When [client B's] requests cannot be immediately met, she often does not respond to verbal cues. If request cannot be met she can be given a favorite item at that time and she is able to wait and amuse herself. [Client B] prefers interaction with others, particularly staff members. Preferred activities with staff include dancing, singing, and bouncing on an exercise ball. [Client B] is non-verbal, but does understand most verbal communication. [Client B] makes an effort to mimic one syllable words if given playful prompting as part of a game. [Client B] can use a few simple signs to communicate, but most often will lead to things that she wants. [Client B] does well when offered 3-5 minutes of processing time after each</p>			

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	<p>cue and between activities. [Client B] works well in a fun, light toned atmosphere and is sensitive to the moods and behaviors of others. She will often try to comfort others if she senses that they are upset. [Client B] needs staff prompts and/or guidance to leave the area when a peer is having a behavior to avoid aggressive behavior as she will often want to comfort the peer that is upset."</p> <p>A review of client C's Replacement Skills Plan (RSP), dated May 2014, was conducted on 9/24/14 at 4:28 PM. Client C had a targeted behavior of PICA (defined as eating non-food items, including diaper padding, laundry/dishwasher detergent pods (this type of detergent should be avoided for use in the home), flowers/plants/leaves, paper products (napkins, tissue, etc.) and other random items). In the proactive measures section, the plan indicated, in part, "Staff should be monitoring her every hour to ensure she has not wet and has not consumed parts of her Attend." The plan indicated, in part, "During sleep hours, [client C] should be encouraged to wear pajama bottoms with ties and will ensure the pants are tied when bed checks are made. Ensure her attends do not come out around her waist area." A revised RSP, not dated, indicated, in part, "PICA: defined as eating non-food items</p>			

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	<p>such as paper, foam, trash from floor, and trash can." The revised plan did not address the ingestion of diaper padding. The revised plan section addressing PICA indicated in the Reactive Measures section, "1. When preparing for bed, staff should dress [client C] in her choice of once piece sleep outfits, or be sure her shirt is tucked into her bottoms. 2. Before putting her to bed staff needs to scan her room for items she might put in her mouth, (stickers, fluff on the floor, bits of trash, etc.) and remove them. 3. If [client C] enters a housemates ' room, staff to make certain that while in the room she has not picked up any items that she might put in her mouth. 4. Once [client C] is in bed, staff should check her every hour while she is in her room. They should make sure she is asleep, and if not, they should make sure she cannot reach her disposable brief. (One piece sleep outfit, shirt tucked into her bottoms.) 5. During the day, staff will check her frequently, making sure that items she might put in her mouth are not easily available. (Crayons, paper, etc.)"</p> <p>On 9/25/14 at 2:47 PM, staff #3 indicated the staffing level had not changed since the survey exited on 8/26/14. Staff #3 indicated one staff was not sufficient to supervise the clients. Staff #3 indicated the most difficult periods of the shift to</p>			

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W000227	<p>monitor and supervise the clients were during meal preparation, medication administration, and when she gave client B a shower (clients A and C received showers in the morning).</p> <p>On 9/25/14 at 1:41 PM, the Network Director indicated the Chief Executive Officer wanted the group home to have two staff during the time the clients were awake. On 9/25/14 at 3:39 PM, the Network Director indicated one staff was not sufficient to provide supervision of clients A, B and C.</p> <p>This federal tag relates to complaint #IN00156187.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure client B's as needed medication before a medical procedure was part of her program plan.</p>	W000227	The PRN medication that had been prescribed for client B was felt to be ineffective by the agency nurse, and she had requested the physician change the PRN, but had not received a response from the physician. To correct the	10/31/2014	

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	<p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated there were no incident reports or investigations addressing client B's injuries of unknown origin.</p> <p>A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her left ear - were very noticeable yesterday! Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The response was not dated. The note was initiated by the Network Director (ND).</p> <p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2 inch round bruise on her left arm. The</p>		<p>deficient practice, client B has an appointment scheduled with her physician on 10/30/14, at which time the agency nurse will request a different PRN medication from the physician. The LPN will add the prescribed PRN medication to client B's Nursing Care Plan. To ensure no others were affected by the deficient practice, the LPN will review all Nursing Care Plans and confirm any pre-appointment PRNs are included. To prevent the deficient practice from recurring, all staff will be re-trained on the necessity to follow all individualized appointment procedures, including checking for PRN medication. The LifeDesigns Medical Appointment Form will be revised to include a place to document the administration of pre-appointment PRN medications. The Health Services Director will provide the LPN and Medical Coordinator with additional instruction related to including PRN medications as part of the Nursing Care Plan, and what to do if a medication has an adverse side effect, or is ineffective. Ongoing monitoring will be accomplished through a monthly meeting between the LPN, ND/Q and Medical Coordinator to discuss and resolve any issues related to recent and upcoming appointments, as well as effectiveness of medications.</p>		

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	<p>documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks (sic) fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam (Valium) 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures." Client B's 6/12/14 Nursing Care Plan did not include the use of diazepam prior to medical procedures.</p> <p>A review of client B's Individual Support Plan and Replacement Skills Plan, dated 3/23/14, was conducted on 9/24/14 at 4:28 PM. There was no documentation in client B's plan regarding the use of a pre-medication for medication procedures.</p> <p>On 9/26/14 at 11:57 AM, the Licensed Practical Nurse (LPN) indicated client B</p>						

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	<p>had an order for Valium for procedures. The LPN indicated the medication did not work well for client B since it seems to make her anxious. The LPN indicated client B had a Physician's Order for Valium prior to procedures. The LPN indicated the use of Valium was not part of client B's Nursing Care Plan but should be. The LPN indicated the Valium was rarely used due to not being effective. The LPN indicated client B's physician was notified the Valium was not effective but he did not change the order. The LPN indicated the facility had not tried anything else for client B to assist her during appointments. The LPN indicated the use of the Valium would be better than restraints.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff #4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication</p>						

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W000285	<p>prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medication for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p> <p>9-3-4(a)</p> <p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure interventions to manage inappropriate client behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights of client B were adequately protected.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated there were no incident reports or investigations addressing client B's injuries of unknown</p>	W000285	The PRN medication that had been prescribed for client B was felt to be ineffective by the agency nurse, and she had requested the physician change the PRN, but had not received a response from the physician. To correct the deficient practice, client B has an appointment scheduled with her physician on 10/30/14, at which time the agency nurse will request a different PRN medication from the physician. The LPN will add the prescribed PRN medication to client B's Nursing Care Plan. To ensure no others were affected by the deficient practice, the LPN will review all Nursing Care Plans and confirm any pre-appointment	10/31/2014

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	<p>origin.</p> <p>A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her left ear - were very noticeable yesterday! Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The response was not dated. The note was initialed by the Network Director (ND).</p> <p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2 inch round bruise on her left arm. The documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was</p>		<p>PRNs are included. To prevent the deficient practice from recurring, all staff will be re-trained on the necessity to follow all individualized appointment procedures, including checking for PRN medication. The LifeDesigns Medical Appointment Form will be revised to include a place to document the administration of pre-appointment PRN medications. The Health Services Director will provide the LPN and Medical Coordinator with additional instruction related to including PRN medications as part of the Nursing Care Plan, and what to do if a medication has an adverse side effect, or is ineffective. Ongoing monitoring will be accomplished through a monthly meeting between the LPN, ND/Q and Medical Coordinator to discuss and resolve any issues related to recent and upcoming appointments, as well as effectiveness of medications.</p>				

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	<p>conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam (Valium) 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures." Client B's 6/12/14 Nursing Care Plan did not include the use of diazepam prior to medical procedures.</p> <p>A review of client B's Individual Support Plan and Replacement Skills Plan, dated 3/23/14, was conducted on 9/24/14 at 4:28 PM. There was no documentation in client B's plan regarding the use of a pre-medication for medication procedures.</p> <p>On 9/26/14 at 11:57 AM, the Licensed Practical Nurse (LPN) indicated client B had an order for Valium for procedures. The LPN indicated the medication did not work well for client B since it seems to make her anxious. The LPN indicated client B had a Physician's Order for Valium prior to procedures. The LPN indicated the use of Valium was not part</p>			

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	<p>of client B's Nursing Care Plan but should be. The LPN indicated the Valium was rarely used due to not being effective. The LPN indicated client B's physician was notified the Valium was not effective but he did not change the order. The LPN indicated the facility had not tried anything else for client B to assist her during appointments. The LPN indicated the use of the Valium would be better than restraints.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff #4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medications for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2014
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W000368	<p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure staff administered client B's medication as directed before a medical procedure leading to an unnecessary restraint resulting in injuries of unknown origin attributed to a dental appointment.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 9/23/14 at 12:28 PM and indicated there were no incident reports or investigations addressing client B's injuries of unknown origin.</p> <p>A review of the communication between the school and the group home was conducted on 9/23/14 at 1:33 PM. On 9/4/14 the school documented, in part, "What has caused the bruises to her left ear - were very noticeable yesterday!</p>	W000368	The PRN medication that had been prescribed for client B was felt to be ineffective by the agency nurse, and she had requested the physician change the PRN, but had not received a response from the physician. To correct the deficient practice, client B has an appointment scheduled with her physician on 10/30/14, at which time the agency nurse will request a different PRN medication from the physician. The LPN will add the prescribed PRN medication to client B's Nursing Care Plan. To ensure no others were affected by the deficient practice, the LPN will review all Nursing Care Plans and confirm any pre-appointment PRNs are included. To prevent the deficient practice from recurring, all staff will be re-trained on the necessity to follow all individualized appointment procedures, including checking for PRN medication. The LifeDesigns Medical Appointment Form will be revised to include a place to	10/31/2014

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	<p>Also has new bruises on R (right) inner thigh &amp; smaller one on same knee." Staff #4 documented, in response, "Bruise on leg and ear from dentist. They had to hold her down so they could clean and check her teeth." The response was not dated. The note was initialed by the Network Director (ND).</p> <p>A review of client B's body scans for September 2014 was conducted on 9/23/14 at 3:55 PM. On 9/5/14, the documentation indicated, as documented by staff #4, "On right leg &amp; knee, 1/2 inch round bruise." The documentation indicated in the section, How Did Client Obtain Mark?, "At dentist." On 9/11/14, the ND documented client B had a 1/2 inch round bruise on her left arm. The documentation indicated in the section, How Did Client Obtain Mark?, "probably dentist."</p> <p>A review of client B's medical record was conducted on 9/23/14 at 3:55 PM. Client B's most recent dental visit was conducted on 9/3/14 at 10:00 AM. The Medical Appointment Record, dated 9/3/14, indicated, "Gums &amp; tissue looks (sic) fair today. Brush as well as able to. No cavities - continue daily oral hyg (hygiene)." There was no documentation client B was restrained at the dentist. There was no documentation client B was</p>		document the administration of pre-appointment PRN medications. The Health Services Director will provide the LPN and Medical Coordinator with additional instruction related to including PRN medications as part of the Nursing Care Plan, and what to do if a medication has an adverse side effect, or is ineffective. Ongoing monitoring will be accomplished through a monthly meeting between the LPN, ND/Q and Medical Coordinator to discuss and resolve any issues related to recent and upcoming appointments, as well as effectiveness of medications.				

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	<p>given an as needed medication. Client B's most recent Physician's Orders, dated 7/23/14, indicated, "Diazepam (Valium) 5 mg (milligrams) tablet. Give 1 tablet orally as directed before procedures." Client B's 6/12/14 Nursing Care Plan did not include the use of diazepam prior to medical procedures.</p> <p>A review of client B's Individual Support Plan and Replacement Skills Plan, dated 3/23/14, was conducted on 9/24/14 at 4:28 PM. There was no documentation in client B's plan regarding the use of a pre-medication for medication procedures.</p> <p>On 9/26/14 at 11:57 AM, the Licensed Practical Nurse (LPN) indicated client B had an order for Valium for procedures. The LPN indicated the medication did not work well for client B since it seems to make her anxious. The LPN indicated client B had a Physician's Order for Valium prior to procedures. The LPN indicated the use of Valium was not part of client B's Nursing Care Plan but should be. The LPN indicated the Valium was rarely used due to not being effective. The LPN indicated client B's physician was notified the Valium was not effective but he did not change the order. The LPN indicated the facility had not tried anything else for client B to</p>			

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	<p>assist her during appointments. The LPN indicated the use of the Valium would be better than restraints.</p> <p>On 9/25/14 at 1:41 PM, the Network Director (ND) indicated she was present during the dental exam. The ND indicated the dental staff restrained client B. The ND indicated the dental staff laid across client B's leg, held her arms and the hygienist held her face while client B was struggling. The ND indicated she knew the restraint was going to leave a mark. She indicated she informed staff #4 to complete a body scan following the appointment however staff #4 did not follow through as directed. The ND indicated client B was supposed to receive a PRN (as needed) medication prior to the appointment. The ND indicated the medication was not administered. The ND indicated client B had a PRN medications for appointments. The ND indicated the appointment form should have included documentation client B was restrained.</p> <p>9-3-6(a)</p>				