

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 05/15/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Survey dates: April 29 and 30, May 1, 2, 3, 14 and 15, 2013.</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/20/13 by Ruth Shackelford, QIDP.</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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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 5 of 5 clients living at the group home who attended high school (#1, #2, #3, #4 and #5), the facility failed to ensure the school met the needs of the clients.</p> <p>Findings include:</p> <p>An interview with client #1, #2, #3, #4 and #5's teacher was conducted on 5/1/13 at 10:06 AM. The teacher indicated the school used to meet with several staff from the group home on a monthly basis. The teacher indicated the meetings now consist of her and the Network Director (ND). The teacher indicated she was aware of one observation, last week, for the school year. The teacher indicated client #2 had two choking incidents during the school year requiring the Heimlich. The teacher indicated the school implemented a soft food diet to ensure client #2 did not choke at school. After the school reported to the group home that they implemented the soft food diet, the school received a plan from the group home. The teacher indicated the school took an additional step to puree client #2's food at school. The teacher indicated the group home told her a</p>	W000120	All QDDPs, ND-Rs, and TM-Rs were trained on completing observations of day programs at least monthly following a survey of another of the agency's facilities. Following this training at least one observation was conducted at the day program listed in this survey. These observations will continue to be monitored through routine monthly ND audits and through submission to the Director of Residential Services. These observations will be on file at the group home.	06/14/2013			

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	<p>swallow study was conducted however the school had not received a copy of the report. The teacher indicated the school was not receiving information when the clients' medications were changed. The teacher indicated the school received one updated Nursing Care Plan for the clients this school year approximately 1-1.5 months ago. The teacher indicated the school nurse was not being informed, in writing, when the clients' medications were changed. The teacher indicated the group home nurse was called several times this year however the nurse did not answer and did not have a voicemail set up in order to leave a message. The teacher indicated the nurse did not return the missed calls. The teacher indicated the school did not have communication with the group home nurse. The teacher indicated it was set up at the beginning of the school year the group home was to send in \$12.00 per month per student. The teacher indicated the school received some of the money but not routinely. The previous home manager told the ND she forgot to send the money and then never did send the money.</p> <p>A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM. The group home, unless otherwise noted, indicated the facility was not informed of the incidents:</p>						

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	<p>1) On 4/10/13 at 1:20 PM, client #4 was picked up at school due to maladaptive behavior. On the way to the van, client #4 punched a car in the parking lot with her fist denting the right rear quarter panel of the car. Client #4's hand had redness and swelling but no bruising or loss of range of motion. The facility was notified of the incident.</p> <p>2) On 3/14/13 when dropped off at home after school by the bus, an undated and untitled document received from the high school client #5 attended indicated, in part, "PM bus [client #5] got off and placed inside fenced area. Ran around side of house; staff going into house unaware [client #5] was not with them. Bus had to stop and tell them!" The facility indicated they were not notified of the incident.</p> <p>3) On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab</p>						

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	<p>her up out of her set (sic), [client #2] fill (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. The QIDP indicated she was verbally informed client #2 was eating mashed potatoes and coughed. The QIDP indicated a BDDS report was not submitted. The QIDP indicated she requested additional information but none was received. The QIDP indicated an</p>			

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	<p>investigation was not conducted. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used. The facility indicated they were notified of the incident but did not receive an incident report.</p> <p>4) On 3/1/13 at 1:36 PM while at school, an undated and untitled document received from the high school client #4 attended indicated, in part, "Sent home for hitting another student in class." The facility indicated they were not notified of the incident.</p> <p>5) On 2/18/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting sub para; stabbing with plastic tweezers during activity; hit student 2x." The facility indicated they were not notified of the incident.</p> <p>6) On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. The facility was notified of the incident.</p> <p>7) On 1/25/13 (no time indicated) while at school, an undated and untitled</p>			

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	<p>document received from the high school client #3 attended indicated, in part, "Hit another student in classroom." The facility indicated they were not notified of the incident.</p> <p>8) On 1/15/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, pinching, shoved scissors at staff as if to stab; hit student 2x (two times) hard on back; hit monitors on a.m. bus." The facility indicated they were not notified of the incident.</p> <p>9) On 1/11/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff all day. Hit another student on bus home." The facility indicated they were not notified of the incident.</p> <p>10) On 1/10/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff on morning bus, continued to hit staff all day, smacked [client #1] in face on bus home." The facility indicated they were not notified of the incident.</p> <p>11) On 12/6/12 (no time indicated) while</p>				

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	<p>at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Refused to cooperate all day; crying and hitting staff/students." The facility indicated they were not notified of the incident.</p> <p>12) On 11/28/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, slapped staff in fac (sic)/eye, hit another student." The facility indicated they were not notified of the incident.</p> <p>13) On 9/26/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff and student...pain?" The facility indicated they were not notified of the incident.</p> <p>A review, conducted on 5/2/13 at 10:33 AM, of the facility's observations conducted at the high school for the school year, August 2012 to April 2013, indicated the facility conducted two observations at the school (3/5/13 and 4/25/13).</p> <p>An interview with the Licensed Practical Nurse (LPN) for the group home was</p>				

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	<p>conducted on 5/1/13 at 2:33 PM. The LPN indicated she was not providing the updated Nursing Care Plans to the school. The LPN indicated the ND should be taking them during his monthly meetings with the school. The LPN indicated she did not attend the school meetings monthly but tried to go quarterly. The LPN stated she "usually" called missed calls back since she did not have a voicemail set up.</p> <p>On 5/3/13 at 10:07 AM, the Director of Residential Services (DRS) indicated the group home should conduct monthly observations at the school. The DRS indicated she was not aware of the incidents occurring at school.</p> <p>A follow-up interview with the teacher was conducted on 5/3/13 at 1:56 PM. The teacher indicated the DRS was given the same document for clients #1, #2, #3, #4 and #5 during a meeting indicating the incidents and concerns during the school year. The teacher was not certain of the date of the meeting but indicated it was a meeting with just the DRS. The teacher indicated the information was also documented in the clients' group home communication books.</p> <p>9-3-1(a)</p>						

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W000125	<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, record review and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients' right to due process in regard to covering and locking one of two thermostats in the home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/30/13 from 2:53 PM to 6:09 PM and 5/1/13 from 5:49 AM to 8:45 AM. During the observations, the thermostat located in the front room by the front door had a locked, plastic cover over the thermostat. Clients #1, #2, #3, #4 and #5 were not able to access the thermostat without a key. The key was located in the office hanging on the wall.</p> <p>A review of client #1's Individual Program Plan, dated June 2012, and Replacement Skills Plan, dated June 2012, was conducted on 5/3/13 at 2:30 PM. There was no documentation in his program plans indicating the thermostat</p>	W000125	The thermostat in question has been unlocked. Director of Residential Services will train the LifeDesigns, Inc. maintenance staff regarding not locking thermostats without ensuring that proper procedures have been followed including behavior plans and HRC and guardian approval. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	06/14/2013			

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	<p>needed to be locked.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client #4's record was conducted on 5/2/13 at 10:30 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client #5's Individual Program Plan, dated May 2012, and Replacement Skills Plan, dated May 2012, was conducted on 5/3/13 at 2:34 PM. There was no documentation in her program plans indicating the thermostat needed to be locked.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated she was not aware the thermostat was locked. The DRS indicates she was not aware of a program</p>			

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	<p>plan requiring the thermostat to be locked. The DRS indicated she could not think of a reason for the thermostat to be locked.</p> <p>An interview with the maintenance supervisor was conducted on 5/2/13 at 9:13 AM. He indicated it was his decision to put the locked cover over one of the thermostats to see if the furnace was operating appropriately. He indicated he was trying to figure out if there was an issue with the furnace or the staff changing the thermostat. He indicated the clients did not bother the thermostat. He indicated the furnace was working appropriately and the staff were adjusting it too much. He indicated he needed to remove the cover and did not mean to restrict the clients' access to the thermostat.</p> <p>9-3-2(a)</p>			

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients accessed their personal funds on a regular basis.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 4/30/13 at 7:54 AM.</p> <p>1) Client #1 did not access his personal funds from 5/29/12 to 8/13/12, 11/17/12 to 1/30/13, and 1/30/13 to 4/5/13.</p> <p>2) Client #2 did not access her personal funds from 5/29/12 to 8/4/12 and 8/23/12 to 4/5/13. The form indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>3) Client #3 did not access her personal funds from 5/29/12 to 8/13/12 and 8/4/12 to 4/5/13. The form indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>4) Client #4 did not access her personal funds from 5/29/12 to 8/4/12, 8/4/12 to 1/29/13, and 1/30/13 to 4/5/13. The form</p>	W000126	The TM in place at the time of the inaccess of the money is no longer employed with the agency. The new TM has been trained on the requirement that every individual must access their personal funds at least monthly if not more frequently. A copy of this training sheet is on file at the LifeDesigns, Inc office. All ND-Rs and TM-Rs will be trained on the process of issuing corrective action to employees that are not following requirements of any kind, including those regarding money. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing compliance will be monitored through increasing the TM audit from monthly to weekly. These audits will be submitted to the ND-Rs and on file in the group homes.	06/14/2013			

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	<p>indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>5) Client #5 did not access her personal funds from 5/16/12 to 8/4/12, 8/4/12 to 1/29/13, and 1/29/13 to 4/5/13. The form indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>An interview with the Network Director (ND) was conducted on 4/30/13 at 7:54 AM. The ND indicated there were issues with the clients accessing their money. The ND indicated the clients should access their personal funds at least monthly.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:17 PM. The QIDP indicated the clients should access their personal funds on a monthly basis. The QIDP indicated the clients were supposed to have a weekly outing. The clients have goals to go on outings to spend money. The QIDP indicated the clients should be practicing their money skills.</p> <p>9-3-2(a)</p>				

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#3 and #4), the facility failed to ensure the guardians were notified of medical appointments and the outcomes of medical appointments.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. There was no documentation in her record indicating the facility communicated with the guardian, either verbally or in writing.</p> <p>A review of client #4's record was conducted on 5/2/13 at 10:30 AM. There was no documentation in her record indicating the facility communicated with the guardian, either verbally or in writing.</p> <p>On 4/30/13 at 3:25 PM, an interview with client #3's guardian was conducted. The guardian indicated she received calls regarding incidents at the home but the staff did not give specific information. The guardian indicated she wanted to</p>	W000148	All QDDPs, ND-Rs, and TM-Rs were trained on the expectations of parental/guardian contacts including appointments, meetings, etc during the time the survey was conducted by the DORS. This training included emphasis on where to file documentation of contacts, as well as how to ensure cross communication of contacts when following the on-call schedule. Since that time communication has been more frequent and these contacts have been documented in the customers books. Continued compliance will be monitored through more specific documentation on the monthly tally sheets completed by the QDDPs and submitted to DORS to include dates and time of contacts not just that contact had been made. For the Parklane home specifically, the group home nurse trained the MC on communication regarding appointments. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	06/14/2013			

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	<p>know when medical appointments were scheduled and the outcomes of the appointments. The guardian indicated she did not learn about an appointment until after the appointment was held.</p> <p>On 5/2/13 at 8:50 AM, client #4's guardian was interviewed. The guardian stated communication with the group home was "hit and miss." The guardian indicated she wanted to know when medical appointments were scheduled and the outcomes of the appointments.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:21 PM. The QIDP indicated she was not conducting quarterly meetings with the guardians. The QIDP indicated the monthly notes were sent out to the guardians for review. The QIDP indicated the Medical Coordinator was responsible for notifying guardians of appointments.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated the group home should communicate to the guardians the information the guardians wanted to know. The DRS indicated this included appointments, meetings, incidents, and</p>				

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	major changes. 9-3-2(a)			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 18 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policy and procedure to prevent client to client abuse, staff to client abuse, conduct thorough investigations, ensure staff reported abuse and neglect immediately and reported incidents to the Bureau of Developmental Disabilities Services in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/29/13 at 11:33 AM. A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM.</p> <p>1. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2</p>	W000149	<p>DORS will train QDDPs on completing investigation summaries for choking incidents. DORS will train QDDPs on completing investigation summaries for incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns office. Group home staff will be trained on reporting information recieved from the school communication book to the appropriate person to ensure proper follow up and/or thorough investigation as needed. A copy of this training sheet will be on file at the LifeDesigns, Inc office. The communication with the school will be as follows; 1. At the start of the next school year, ND will provide Teacher of Record (TOR) with a list of the phone numbers including, QDDP, ND-R, DORS, the group home, the group home nurse, and a LifeDesigns, Inc office. 2. A daily book with a sheet specific to each individual is sent to school and back to the group home daily. 3. QDDP and ND meet monthly with TOR and other school personnel, as determined by the school. 4. DORS meets monthly with TOR and other school personnel, as determined by the school. This meeting is seperate from the monthly meeting by QDDP and</p>	06/14/2013			

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	<p>for signs of aspiration, none were noted and her breathing was normal. There was no documentation the facility investigated the choking incident.</p> <p>2. On 4/18/13 at 2:45 PM, client #4 would not get on the bus at the end of the day to go back to the group home. The school staff called the group home and asked the group home to transport client #4 home. When the group home staff arrived to pick up client #4, client #2 was also at school and needed to be transported home. The school did not indicate client #2 needed to be transported. During the transport to the group home, client #4 hit client #2 in the back of the head. Client #2 was assessed by the nurse and no injuries were found.</p> <p>3. On 4/10/13 at 1:20 PM, client #4 was picked up at school due to maladaptive behavior. On the way to the van, client #4 punched a car in the parking lot with her fist denting the right rear quarter panel of the car. Client #4's hand had redness and swelling but no bruising or loss of range of motion. The incident was reported to BDDS on 4/12/13.</p> <p>4. On 3/14/13 when dropped off at home after school by the bus, an undated and untitled document received from the high school client #5 attended indicated, in</p>		<p>ND. 5. A monthly schedule of appointments is provided to the TOR at the beginning of the month by the MC. 6. As needed communication regarding medications, changes in behavior, LOAs, etc is completed by the QDDP, ND-R, TM-R, and MC as information arises. Group home completed a mandatory training on reporting and the two staff present that failed to report immediately received progressive disciplinary actions. ND completed retraining on reporting immediately. ON stated she did not want to wake anyone up, investigator reviewed with ON the importance of reporting immediately.</p>				

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	<p>part, "PM bus [client #5] got off and placed inside fenced area. Ran around side of house; staff going into house unaware [client #5] was not with them. Bus had to stop and tell them!" There was no documentation of a BDDS report or an investigation of the incident.</p> <p>5. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that</p>				

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	<p>[client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. The QIDP indicated she was verbally informed client #2 was eating mashed potatoes and coughed. The QIDP indicated a BDDS report was not submitted. The QIDP indicated she requested additional information but none was received. The QIDP indicated an investigation was not conducted. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used. The facility did not submit a BDDS report or conduct an investigation.</p> <p>6. On 3/1/13 at 1:36 PM while at school, an undated and untitled document received from the high school client #4 attended indicated, in part, "Sent home for hitting another student in class." The</p>			

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	<p>facility did not have a BDDS report or an investigation of the incident.</p> <p>7. On 2/18/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting sub para; stabbing with plastic tweezers during activity; hit student 2x." The facility did not have a BDDS report or an investigation for review.</p> <p>8. On 2/5/13 "after 8:00 PM," staff #5 asked former staff #7 why client #3 was crying when staff #7 left client #3's room after assisting her with personal hygiene. Staff #7 indicated, "[Client #3] was being a little b----." Staff #5 indicated, "[Client #3's] cry sounded like an abuse cry, not her whimper or fake whine." Staff #3 heard staff #7 say the word "b----" but due to vacuuming, did not hear what else staff #7 stated. Staff #3 indicated staff #7 "came stomping from the back hallway and slammed the door." Staff #3 indicated staff #7 had been on the phone fighting with his girlfriend and she thought it was regarding the girlfriend. Staff #3 indicated client #3 was crying "hysterically." The BDDS report was submitted on 2/7/13. The investigative report was signed by the administrator on 2/15/13. Staff #3 and #5 received disciplinary action for failing to report</p>			

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	<p>abuse timely. Staff #7 was terminated on 2/15/13 for "poor job fit." The facility substantiated abuse.</p> <p>9. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. There was no documentation the facility conducted an investigation to rule out neglect.</p> <p>10. On 1/25/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit another student in classroom." The facility did not have a BDDS report or an investigation for review.</p> <p>11. On 1/15/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, pinching, shoved scissors at staff as if to stab; hit student 2x (two times) hard on back; hit monitors on a.m. bus." The facility did not have a BDDS report or an investigation for review.</p> <p>12. On 1/12/13 at 6:45 AM when staff #3 arrived for work, former staff #8 was asleep on the couch. Staff #8's cousin (not an employee) was also at the group home. The clients were wet through their</p>				

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	<p>clothes and the house was not cleaned. Staff #3 reported her concerns on 1/12/13 at 9:15 PM. Staff #3 indicated both staff #8 and her cousin were asleep. Former staff #7 indicated he had previously observed staff #8's cousin at the group home. Staff #7 indicated on 1/12/13 the clients were not dry and appeared to not have been changed for awhile. The laundry hampers were full and the kitchen had not been swept or mopped. Former staff #8 denied being asleep but indicated her cousin was at the home and the home manager told her it was okay. The home manager indicated she did not tell staff #8 she could bring a guest into the group home. The facility substantiated neglect. The report indicated, "The incident of [staff #8] failing to assist individuals and completing cleaning tasks is substantiated. In addition, [staff #8] brought in a visitor which is against company policy." Staff #8 was terminated on 1/18/13.</p> <p>13. On 1/11/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff all day. Hit another student on bus home." The facility did not have a BDDS report or an investigation for review.</p> <p>14. On 1/10/13 (no time indicated) while</p>						

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	<p>on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff on morning bus, continued to hit staff all day, smacked [client #1] in face on bus home." The facility did not have a BDDS report or an investigation for review.</p> <p>15. On 12/6/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Refused to cooperate all day; crying and hitting staff/students." The facility did not have a BDDS report or an investigation for review.</p> <p>16. On 11/28/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, slapped staff in fac (sic)/eye, hit another student." The facility did not have a BDDS report or an investigation for review.</p> <p>17. On 10/16/12 at 10:00 PM, staff #2 indicated when she arrived for her overnight shift the house smelled of feces. The evening shift staff did not offer to assist in checking the clients prior to leaving her shift. Staff #2 indicated three of the clients (#1, #3 and #5) were soiled.</p>						

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	<p>Staff #2 reported her concerns on 10/17/12 at 7:30 AM. The investigative report, dated 10/24/12, indicated, in part, "It cannot be substantiated that [staff #8] neglected to check on the individuals prior to the overnight arriving on shift. The individuals with bowel movements, discovered by the overnight, were assigned to the nine o' clock person (staff #3) who indicates she would have checked them at nine or an hour before. Based on this information, checks occurred per the hygiene protocols which state everyone should be checked at minimum every two hours. [Staff #3] did indicate that she has changes (sic) all the individuals in the home because other staff will not. She indicated the major one being [staff #8]. As two staff have reported concerns of [staff #8] changing individuals, it will be addressed with corrective action. There was no documentation of when the checks and changes were completed by the staff. Staff have been trained to complete the documentation and should receive corrective action for the documentation error." The facility indicated the incident was partially substantiated (the findings support part of how the alleged event was described, but not entirely). Staff #3 and #8 were given verbal counseling for failing to complete required documentation at the end of their shift.</p>						

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	<p>Staff #8 was given a written warning for not completing tasks relating to caring for assigned individuals' hygiene and toileting needs. The hygiene protocols were revised to include hourly checks.</p> <p>18. On 9/26/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff and student...pain?" The facility did not have a BDDS report or an investigation for review.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 4/29/13 at 11:37 AM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to</p>						

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	<p>the Christole Administrator within 24 hours of the verbal report. Upon receiving the verbal allegation the Christole Administrator will: Complete a thorough review of all incident investigations, make necessary recommendations, sign off and close out all investigations." The policy indicated, "Ensure safety of person receiving services during the investigation. The Director of Human Resources (or designee) will also provide information to the Lead Investigator regarding pertinent information on any employee named within an incident or investigation. The Lead Investigator under the direction of the Quality Improvement Director will: a. Prepare relevant questions regarding the incident, b. Select a support investigator (There should always be 2 investigators), c. Gather statements from all parties involved, i. Three attempts to interview staff present during the incident will be made by investigation team. The investigation team will contact each staff during scheduled shifts or by personal contact information. If a staff person fails to comply with the interview process prior to the investigation being completed (five working days from the incident date) the staff will be placed on administrative leave until the interview is completed. ii. All interview attempts will be documented by the investigation team.</p>						

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	<p>The Director of Human Resources will be notified following the third attempt to interview a staff for the staff to be placed on administrative leave. d. Thoroughly review all documents pertaining to the incident/employee. e. Document all interviews. f. Digitally photograph bruises/injuries and/or document on Injury Map. g. Complete a comprehensive report utilizing the approved format within 72 hours (3 days), of the incident, h. Submit the Report to the Administrators for review, i. If recommendations are approved by Administrators. j. Ensure all recommendations are carried out and documentation is in file. k. Complete all investigations/incident reviews within five (5) working days." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm." The policy indicated, in part, "Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more then (sic) 24 hours of alleged incident."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:23</p>				

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	<p>PM. The QIDP indicated the timeframe for reporting incidents to BDDS was 24 hours. The QIDP indicated the timeframe for staff reporting suspected abuse was immediately. The QIDP indicated client to client aggression was abuse. The QIDP indicated the facility should report client to client abuse to BDDS and conduct investigations of client to client abuse. The QIDP indicated the facility should investigate choking incidents. The QIDP indicated there was no form to complete to document the investigation. The QIDP indicated there was a policy prohibiting abuse of the clients. The QIDP indicated the staff should prevent client to client abuse and staff to client abuse. The QIDP indicated staff sleeping during the shift was considered neglect. The QIDP indicated staff failing to assist the clients with changing their Attends or Depends was neglect. The QIDP indicated calling clients names was abuse.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated incidents should be reported to BDDS within 24 hours. The DRS indicated the timeframe for staff to report abuse and neglect was to do so as soon as it was safe to report it. The DRS indicated investigations should be concluded within 5 business days. The</p>						

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	<p>DRS indicated the incidents at school were not reported since the group home was not aware of the incidents. The DRS indicated the school was not informing the group home of the incidents. The DRS indicated client to client abuse could be considered abuse. The DRS indicated the facility looked at the intent and what the situation was. The DRS indicated the facility should look into client to client abuse. The DRS indicated the facility did not conduct investigations of a client choking. The DRS indicated the abuse and neglect form was not filled out. The DRS indicated there was no investigative report indicating choking incidents were investigated. The DRS indicated there was a policy prohibiting abuse and neglect of the clients. The DRS indicated the staff should prevent client to client abuse and staff to client neglect. The DRS indicated staff sleeping during the overnight was neglect since one staff was on duty. The DRS indicated staff failing to change a client's Attends was neglect. Staff referring to a client as a "b----" was verbal abuse.</p> <p>9-3-2(a)</p>				

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W000153	<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 15 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to ensure staff immediately reported abuse and neglect to the administrator and submitted incident reports to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/29/13 at 11:33 AM. A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM.</p> <p>1. On 4/10/13 at 1:20 PM, client #4 was picked up at school due to maladaptive behavior. On the way to the van, client #4 punched a car in the parking lot with her fist denting the right rear quarter panel of the car. Client #4's hand had redness and swelling but no bruising or loss of range of motion. The incident was</p>	W000153	At the start of the next school year, TOR will be provided with a new list of BDDS reportable incidents and the required timeframe of reporting to ensure that such incidents are reported to LifeDesigns, Inc in a timely manner. A copy of a signed receipt of this information will be on file at the LifeDesigns, Inc office. This list and information should clarify any misunderstandings that the school staff may have had regarding incidents. This will be monitored through routine communication with the school as outlined below. The communication with the school will be as follows; 1. At the start of the next school year, ND will provide Teacher of Record (TOR) with a list of the phone numbers including, QDDP, ND-R, DORS, the group home, the group home nurse, and a LifeDesigns, Inc office. 2. A daily book with a sheet specific to each individual is sent to school and back to the group home daily. 3. QDDP and ND meet monthly with TOR and other school personnel, as determined by the school. 4. DORS meets monthly with TOR	06/14/2013			

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	<p>reported to BDDS on 4/12/13.</p> <p>2. On 3/14/13 when dropped off at home after school by the bus, an undated and untitled document received from the high school client #5 attended indicated, in part, "PM bus [client #5] got off and placed inside fenced area. Ran around side of house; staff going into house unaware [client #5] was not with them. Bus had to stop and tell them!" There was no documentation of a BDDS report.</p> <p>3. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli</p>		and other school personnel, as determined by the school. This meeting is separate from the monthly meeting by QDDP and ND. 5. A monthly schedule of appointments is provided to the TOR at the beginning of the month by the MC. 6. As needed communication regarding medications, changes in behavior, LOAs, etc is completed by the QDDP, ND-R, TM-R, and MC as information arises.				

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	<p>was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. The QIDP indicated she was verbally informed client #2 was eating mashed potatoes and coughed. The QIDP indicated a BDDS report was not submitted. The QIDP indicated she requested additional information but none was received. The QIDP indicated an investigation was not conducted. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used. The facility did not submit a BDDS report.</p> <p>4. On 3/1/13 at 1:36 PM while at school,</p>						

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	<p>an undated and untitled document received from the high school client #4 attended indicated, in part, "Sent home for hitting another student in class." The facility did not submit a BDDS report.</p> <p>5. On 2/18/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting sub para; stabbing with plastic tweezers during activity; hit student 2x." The facility did not submit a BDDS report.</p> <p>6. On 2/5/13 "after 8:00 PM," staff #5 asked former staff #7 why client #3 was crying when staff #7 left client #3's room after assisting her with personal hygiene. This was reported to an administrator on 2/7/13. Staff #7 reported indicated, "[client #3] was being a little b----." Staff #5 indicated, "[Client #3's] cry sounded like an abuse cry, not her whimper or fake whine." Staff #3 heard staff #7 say the word "b----" but due to vacuuming, did not hear what else staff #7 stated. Staff #3 indicated staff #7 "came stomping from the back hallway and slammed the door." Staff #3 indicated staff #7 had been on the phone fighting with his girlfriend and she thought it was regarding the girlfriend. Staff #3 indicated client #3 was crying</p>				

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	<p>"hysterically." The BDDS report was submitted on 2/7/13. The investigative report was signed by the administrator on 2/15/13. Staff #3 and #5 received disciplinary action for failing to report abuse timely. Staff #7 was terminated on 2/15/13 for "poor job fit." The facility substantiated abuse.</p> <p>7. On 1/25/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit another student in classroom." The facility did not submit a BDDS report.</p> <p>8. On 1/15/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, pinching, shoved scissors at staff as if to stab; hit student 2x (two times) hard on back; hit monitors on a.m. bus." The facility did not submit a BDDS report.</p> <p>9. On 1/12/13 at 6:45 AM when staff #3 arrived for work, former staff #8 was asleep on the couch. Staff #8's cousin (not an employee) was also at the group home. The clients were wet through their clothes and the house was not cleaned. Staff #3 reported her concerns on 1/12/13 at 9:15 PM. Staff #3 indicated both staff #8 and her cousin were asleep. Former</p>						

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	<p>staff #7 indicated he had previously observed staff #8's cousin at the group home. Staff #7 indicated on 1/12/13 the clients were not dry and appeared to not have been changed for awhile. The laundry hampers were full and the kitchen had not been swept or mopped. Former staff #8 denied being asleep but indicated her cousin was at the home and the home manager told her it was okay. The home manager indicated she did not tell staff #8 she could bring a guest into the group home. The facility substantiated neglect. The report indicated, "The incident of [staff #8] failing to assist individuals and completing cleaning tasks is substantiated. In addition, [staff #8] brought in a visitor which is against company policy." Staff #8 was terminated on 1/18/13.</p> <p>10. On 1/11/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff all day. Hit another student on bus home." The facility did not submit a BDDS report.</p> <p>11. On 1/10/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff on morning bus, continued</p>				

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	<p>to hit staff all day, smacked [client #1] in face on bus home." The facility did not submit a BDDS report.</p> <p>12. On 12/6/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Refused to cooperate all day; crying and hitting staff/students." The facility did not have a BDDS report.</p> <p>13. On 11/28/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, slapped staff in fac (sic)/eye, hit another student." The facility did not have a BDDS report.</p> <p>14. On 10/16/12 at 10:00 PM, staff #2 indicated when she arrived for her overnight shift the house smelled of feces. The evening shift staff did not offer to assist in checking the clients prior to leaving her shift. Staff #2 indicated three of the clients (#1, #3 and #5) were soiled. Staff #2 reported her concerns on 10/17/12 at 7:30 AM. The investigative report, dated 10/24/12, indicated, in part, "It cannot be substantiated that [staff #8] neglected to check on the individuals prior to the overnight arriving on shift. The individuals with bowel movements,</p>						

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	<p>discovered by the overnight, were assigned to the nine o' clock person (staff #3) who indicates she would have checked them at nine or an hour before. Based on this information, checks occurred per the hygiene protocols which state everyone should be checked at minimum every two hours. [Staff #3] did indicate that she has changes (sic) all the individuals in the home because other staff will not. She indicated the major one being [staff #8]. As two staff have reported concerns of [staff #8] changing individuals, it will be addressed with corrective action. There was no documentation of when the checks and changes were completed by the staff. Staff have been trained to complete the documentation and should receive corrective action for the documentation error." The facility indicated the incident was partially substantiated (the findings support part of how the alleged event was described, but not entirely). Staff #3 and #8 were given verbal counseling for failing to complete required documentation at the end of their shift. Staff #8 was given a written warning for not completing tasks relating to caring for assigned individuals (sic) hygiene and toileting needs. The hygiene protocols were revised to include hourly checks.</p> <p>15. On 9/26/12 (no time indicated) while</p>				

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	<p>at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff and student...pain?" The facility did not have a BDDS report.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:23 PM. The QIDP indicated incidents reportable to BDDS were to be submitted within 24 hours. The QIDP indicated the staff should immediately report (or report when safe to do so) abuse and neglect to the administrator.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated BDDS reports should be submitted within 24 hours, when the facility was notified of incidents. The DRS indicated she was not aware, unless the facility submitted a BDDS report, of the incidents occurring at the school. The DRS indicated she looked at the list of incidents from the school submitted to the Quality Improvement Director to find out if there were investigations conducted. The DRS indicated she was not aware of the incidents at school. The DRS indicated the staff were to report to the administrator, as soon as it was safe to do so, allegations of abuse and neglect.</p>				

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	<p>An interview with clients #1, #2, #3, #4 and #5's teacher was conducted on 5/3/13 at 1:56 PM. The teacher indicated the DRS was given the same document for clients #1, #2, #3, #4 and #5 during a meeting indicating the incidents and concerns during the school year. The teacher was not certain of the date of the meeting but indicated it was a meeting with just the DRS. The teacher indicated the information was also documented in the clients' group home communication books.</p> <p>9-3-2(a)</p>			
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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 13 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to conduct thorough investigations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/29/13 at 11:33 AM. A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM.</p> <p>1. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2 for signs of aspiration, none were noted and her breathing was normal. There was no documentation the facility investigated the choking incident.</p>	W000154	DORS will train QDDPs on completing investigation summaries for choking incidents. DORS will train QDDPs on completing investigation summaries for incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns office.	06/14/2013			

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	<p>2. On 3/14/13 when dropped off at home after school by the bus, an undated and untitled document received from the high school client #5 attended indicated, in part, "PM bus [client #5] got off and placed inside fenced area. Ran around side of house; staff going into house unaware [client #5] was not with them. Bus had to stop and tell them!" There was no documentation of an investigation of the incident.</p> <p>3. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] chocking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fill (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An</p>						

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	<p>email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. The QIDP indicated she was verbally informed client #2 was eating mashed potatoes and coughed. The QIDP indicated a BDDS report was not submitted. The QIDP indicated she requested additional information but none was received. The QIDP indicated an investigation was not conducted. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used. The facility did not conduct an investigation.</p> <p>4. On 3/1/13 at 1:36 PM while at school, an undated and untitled document</p>						

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	<p>received from the high school client #4 attended indicated, in part, "Sent home for hitting another student in class." The facility did not conduct an investigation of the incident.</p> <p>5. On 2/18/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting sub para; stabbing with plastic tweezers during activity; hit student 2x." The facility did not conduct an investigation.</p> <p>6. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. There was no documentation the facility conducted an investigation to rule out neglect.</p> <p>7. On 1/25/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit another student in classroom." The facility did not conduct an investigation.</p> <p>8. On 1/15/13 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, pinching, shoved scissors at staff as</p>						

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	<p>if to stab; hit student 2x (two times) hard on back; hit monitors on a.m. bus." The facility did not conduct an investigation.</p> <p>9. On 1/11/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff all day. Hit another student on bus home." The facility did not conduct an investigation.</p> <p>10. On 1/10/13 (no time indicated) while on the bus, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff on morning bus, continued to hit staff all day, smacked [client #1] in face on bus home." The facility did not conduct an investigation.</p> <p>11. On 12/6/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Refused to cooperate all day; crying and hitting staff/students." The facility did not conduct an investigation.</p> <p>12. On 11/28/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hit staff, slapped staff in fac (sic)/eye, hit</p>				

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	<p>another student. The facility did not conduct an investigation.</p> <p>13. On 9/26/12 (no time indicated) while at school, an undated and untitled document received from the high school client #3 attended indicated, in part, "Hitting staff and student...pain?" The facility did not conduct an investigation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:23 PM. The QIDP indicated the facility should conduct investigations of client to client abuse. The QIDP indicated the facility should investigate choking incidents. The QIDP indicated there was no form to complete to document the investigation.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS stated the facility "should look into it" in regard to client to client abuse. The DRS indicated choking incidents were not documented on the same form as abuse and neglect investigations. The DRS indicated the choking incidents were discussed on how to prevent future occurrences and there were nursing notes and interventions. The DRS indicated the facility did not have investigations for the</p>						

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	choking incidents. 9-3-2(a)			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to 1) provide communication training to the staff in order to communicate with the clients and 2) provide training to the Medical Coordinator.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM and 4/30/13 from 5:49 AM to 8:45 AM. During the observations, staff were not observed to use sign language with clients #2, #3, #4 and #5. Staff were not observed to prompt the clients to use sign language, picture exchange communication (PEC), choice boards or picture schedules. During the observations, there was no sign language reference book in the home. Client #3's choice board was ripped and missing the top third of the page. There were no picture schedules observed in the home.</p> <p>A review of client #2's record was</p>	W000189	<p>Group home nurse will provide Medical Coordinator Training to the group home MC. A copy of this training sheet will be on file at the LifeDesigns, Inc office. TM will purchase an ASL reference book and flashcards for staff to use as needed. Documentation of these purchases will be on file at the LifeDesigns, Inc office.</p> <p>Group home staff who are able will attend an already scheduled training with a fluent ASL translator on 6/17. A copy of this training sheet will be on file at the LifeDesigns, Inc office. An additional training with a fluent ASL translator will be scheduled for staff unable to attend on 6/17. Documentation of this being scheduled will be on file at the LifeDesigns, Inc office. Ongoing monitoring of communication with clients will be through observations completed by supervisory staff and submitted to DORS.</p>	06/17/2013			

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	<p>conducted on 5/1/13 at 1:43 PM. Client #2's Individual Program Plan (IPP), dated 2/14/12, indicated, in part, "[Client #2] will utilize more ways of communication to be able to effectively communicate with more people and more easily express her wants and needs. CURRENT LEVEL: [Client #2] is non-verbal and communicates by leading people to what she wants or simply going to the item and taking it. NEXT STEP: [Client #2] will utilize PEC cards and Choice Boards in her daily communication. PROCEDURE: During the appropriate time each day staff will ensure that PEC Cards or Choice Boards are available and offer the appropriate level of prompts to encourage [client #2] to utilize them. The goal will be marked as met regardless of which is used, or what was indicated."</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's IPP, dated 3/23/12, indicated, in part, "[Client #3] will utilize more than one form of communication and be able to more accurately express her wants, needs, and emotions. CURRENT LEVEL: [Client #3] is familiar with choice boards and will use them to make choices for things, such as a daily chore or outing. NEXT STEP: [Client #3] will learn to apply the use of choice boards to more individual wants and needs.</p>						

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	<p>PROCEDURE: Throughout the day, staff should cue [client #3] to utilize her choice boards to indicate her wants, needs, or feelings. When [client #3] attempts to physically lead staff from place to place to communicate, staff should remind [client #3] to use her choice boards. [Client #3] prefers to remain in physical contact with others at all time. Staff should prompt [client #3] to use her hands to show what she wants on her choice board and then prompt her that they will follow her or help her or do what she wants or needs if she utilizes one of her choice boards."</p> <p>A review of client #4's record was conducted on 5/2/13 at 10:30 AM. Client #4's IPP, dated June 2012, indicated, in part, "[Client #4] will communicate wants and needs other than food items. CURRENT LEVEL: [Client #4] is very clear about communicating in regards to food. NEXT STEP: [Client #4] will begin to communicate more wants and needs for items other than food. PROCEDURE: Throughout the day staff will encourage communication with [client #4] regarding things other than food choices. Staff will offer choice boards, picture cards, or use sign language. Goal will be met if [client #4] communicates any want, need, desire that is not associated with food."</p>			

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	<p>A review of client #5's record was conducted on 4/30/13 at 12:45 PM. Client #5's IPP, dated May 2012, indicated, in part, "[Client #5] will utilize more ways of communication to be able to effectively communicate with more people and more easily express her wants and needs. CURRENT LEVEL: [Client #5] is non-verbal and communicates by leading people to what she wants or simply going to the item and taking it. NEXT STEP: [Client #5] will utilize PEC cards and Choice Boards in her daily communication. PROCEDURE: During the appropriate time each day staff will ensure that PEC Cards or Choice Boards are available and offer the appropriate level of prompts to encourage [client #5] to utilize them. The goal will be marked as met regardless of which is used, or what was indicated."</p> <p>An interview with direct care staff #3 was conducted on 5/2/13 at 11:50 AM. Staff #3 indicated she received no training on communication with clients #2, #3, #4 and #5.</p> <p>An interview with direct care staff #5 was conducted on 5/2/13 at 11:50 AM. Staff #5 indicated she received no training on communication with clients #2, #3, #4 and #5.</p>						

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 10:33 AM. The QIDP indicated staff received training when they started working at the home. The QIDP indicated there was no documentation of the training. The QIDP indicated the staff knew simple, basic sign language. The QIDP indicated there was no formal class training the staff on sign language. The QIDP indicated the staff would benefit from communication training. The QIDP indicated there was no reference book in the home for staff.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated the direct care staff did not receive training from a certified instructor. The DRS indicated the staff were trained on the clients' familiar signs. The DRS indicated there used to be a reference sign language book in the home. The DRS indicated the facility was working on a class for teaching sign language to the staff. The DRS indicated the staff should receive training on the clients' communication to increase their communication skills. The DRS indicated she was made aware yesterday (5/2/13) some of the boards and PEC systems were not in the home.</p>			

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	2) A review of the facility's Medical Coordinator (MC) position was conducted on 5/14/13 at 12:57 PM. The job description indicated, in part, "The MC schedules and attends all health-related appointments (unless otherwise specified by QDDP); is responsible for receipt of all physician order medication within 24 hours of receipt and notification of nursing personnel; monitors first aid kit usage and orders replacement supplies; verifies personnel protective equipment/supplies are readily available per OSHA regulations; assists with maintaining a clean, healthy, and safe environment for the individuals in the assigned setting. The MC completes informative written responses to Nursing Audits, Nursing Care Plans, and Nursing Recommendations; maintains proper maintenance of medication storage and preparation area; orders and receives medication exchange following established policies and protocols; maintains medication administration records (MAR) in an organized, accurate and informative manner, verifying accuracy prior to the first of each month; maintains individual client records						

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	<p>(charts) related to health and safety in an organized manner to allow continuity of service delivery and easily retrievable data; documents all information related to health; ensures compliance for all state and federal regulations, including, but not limited to, agency conditions, and health and safety issues. The MC is responsible for knowing and respecting each customer's rights and choices when performing or observing tasks and for following State and Federal compliance regulations. The MC will be held accountable for knowing and understanding abuse/neglect policies and complying with all policies and procedures of the Abuse/Neglect Policy; keeping current on all updates to policies and procedures of the position, attending staff meetings, and providing input to the management team on issues related to the position. All responsibilities are to be carried out following all policies and procedures of LifeDesigns, Inc., and all regulations related to the care of customers who are receiving services. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with the Medical</p>				

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	<p>Coordinator (MC) was conducted on 5/1/13 at 12:10 PM. The MC indicated she was not properly trained. The MC indicated she received no training to be the Medical Coordinator. She indicated she took the position on 3/10/13. The MC indicated she requested training from the nurse, QIDP, Network Director and another MC at a different group home. The MC indicated she went to receive training from another MC however the other MC did not provide training. The other MC just talked about other employees. The MC indicated she informed the nurse she did not receive training from the other MC.</p> <p>An interview with the QIDP was conducted on 5/1/13 at 1:39 PM. The QIDP indicated the MC was in training.</p> <p>An interview with the nurse was conducted on 5/1/13 at 2:33 PM. The nurse indicated the MC had not received formal training for the position. The nurse indicated there was no formal training program in place to train the Medical Coordinators. On 5/14/13 at 2:12 PM, the nurse indicated she was not sure if the MC who conducted training with the new MC documented the training. The nurse indicated the training should have been documented.</p>			

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	The facility did not provide documentation the MC received training to perform the duties of the Medical Coordinator position. 9-3-3(a)			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 3 of 3 clients in the sample (#2, #3 and #4), the facility failed to ensure staff implemented the clients' program plans.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM. At 5:46 PM, dinner was started. During the meal, client #2 was not prompted to chew her food for 30 seconds. Staff #3 and #5 prompted client #2 to sit up and bring her fork to her mouth however there was no prompting from staff #3 and #5 for client #2 to chew her food for a period of time.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Individual Program Plan (IPP), dated 2/14/12, indicated a goal was added in February 2013 for client #2 to chew her food for 30 seconds prior to swallowing. The IPP indicated, in part, "[Client #2]</p>	W000249	<p>Group Home ND-R will give staff # 3, and 5 and HM counseling memorandums for implementing plans as written. Copies of these memorandums will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through routine observations by QDDP and ND-R. Group home staff will be trained on all dining plans, as well as client #2's money goal. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Continued monitoring for the money goal will be on the TM audit which has been increased from monthly to weekly. Compliance with the dining plans will be monitored through twice weekly meal time observations for 30 days and monthly thereafter by QDDP, ND-R, and/or other supervisory staff. Any issues noted during the observation will be addressed verbally and immediately, follow up will include written documentation of corrective action taken. These observations will be submitted to DORS. Observations of meals during the 30 day period will also</p>	06/14/2013			

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	<p>will chew her food more thoroughly before swallowing to decrease her risk of choking. [Client #2] needs constant reminders to chew her food. [Client #2's] food must be cuit (sic) into small 1/2 in (inch) bite sizes prior to serving." The plan indicated, in part, "Staff will then monitor [client #2] during the meal and prompt her at the appropriate level to chew her food prior to swallowing."</p> <p>2) A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's IPP, dated 2/14/12, indicated she had a goal to become familiar with transactions and the steps involved in making a purchase. The plan indicated, "[Client #2] currently shows not (sic) understanding of money, how to purchase things, or the steps involved in purchases." The goal indicated, "One (sic) a weekly outing, [client #2] will hand money to the cashier to make a purchase." The procedure indicated, "Each week on an outing staff will allow [client #2] to select a need or want that she would like to purchase. At the check out staff will talk [client #2] through what is going on (First we give the item to the cashier, the cashier scans it, then the cashier tells us how much to pay, etc). Staff will give [client #2] the amount of money needed and prompt [client #2] at the appropriate level to give the money to</p>		be submitted to QAD for the POC file.				

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	<p>the cashier." A review of the Monthly Reports for January, February and March 2013 indicated there were no trials for the training objective. The Monthly reports did not address the lack of trials or indicate what was implemented to address the lack of trials.</p> <p>A review of the clients' finances was conducted on 4/30/13 at 7:54 AM. Client #2 did not access her personal funds from 5/29/12 to 8/4/12 and 8/23/12 to 4/5/13. The form indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>3) An observation was conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM. At 5:46 PM, dinner was started. During the meal, client #3 was not prompted to chew her food for 30 seconds.</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's IPP, dated 3/23/12, indicated, in part, "[Client #3] needs constant reminders to remember to chew her food. [Client #3's] meat must be cut into small pieces prior to serving. [Client #3] will chew her food more thoroughly before swallowing to decrease her risk of choking. [Client #3] with chew her food for 30 seconds prior</p>						

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	<p>to swallowing. Staff will then monitor [client #3] during the meal and prompt her at the appropriate level to chew her food prior to swallowing. As this is a safety issue, and [client #3] has had a choking incident within the last year, this goal will continue until [client #3] routinely meets the goal with 100% accuracy."</p> <p>4) A review of client #4's record was conducted on 5/2/13 at 10:30 AM. Her IPP, dated June 2012, indicated, in part, "[Client #4] understands that when you want something from a store someone has to give the cashier something for it. She does not do this, she will have the person that is with her do it. It is unclear if [client #4] knows that it is money or if she just knows that you must give the cashier something, most often the green papers and small metal items." The training objective indicated, "[Client #4] will hand money to the cashier and wait for her change one time weekly. At the time of purchase, staff will hand [client #4] the money needed to pay for her item and visually cue her to give the money to the cashier. [Client #4] will then be visually cued to retrieve the change and receipt from the cashier and then hand it to the staff member."</p> <p>Client #4 did not access her personal</p>						

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	<p>funds from 5/29/12 to 8/4/12, 8/4/12 to 1/29/13, and 1/30/13 to 4/5/13. The form indicated in the margins, documented by the Network Director on 11/26/12, in part, "Advised to spend money."</p> <p>5) An observation was conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM. Dinner started at 5:41 PM. At 5:54 PM, client #4 hit (self-injurious behavior) her hand on her chair. Client #4 tried to grab more chicken. Client #4 was redirected verbally. Client #4 hit her hand against the chair. Staff #3 verbally prompted client #4 to leave the table. Client #4 left the table. Staff #3 took client #4's plate off the table and put it in the microwave.</p> <p>An observation was conducted at the group home on 4/30/13 from 5:49 AM to 8:45 AM. At 8:37 AM, client #4 opened the refrigerator door to get a drink. Client #4 took a pudding cup from the refrigerator. The Home Manager (HM) took the pudding cup from client #4's hands and returned it to the refrigerator. The HM did not prompt client #4 to get a snack from her snack box or offer a free food item.</p> <p>The HM indicated on 4/30/13 at 8:37 AM client #4 was testing her due to the HM being new. The HM indicated client #4</p>				

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	<p>was on a restricted diet.</p> <p>A review of client #4's record was conducted on 5/2/13 at 10:30 AM. Client #4's June 2012 Replacement Skills Plan (RSP) defined food seeking as getting into cabinets and refrigerators looking for food that is not part of her diet plan and between regular meal and snack times. The plan indicated, in bold, "At no time should food be removed from [client #4's] hands." The plan indicated, "1. Staff will prompt [client #4] to get a snack from her snack box. 2. If [client #4] refuses to utilize her snack box, and acquires another snack, one snack will be removed from her snack box. 3. If [client #4's] snack box is empty, staff will prompt [client #4] with a 'free choice' foods choice board to select a 'free food' to have for a snack."</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated the staff should implement the clients' plans as written.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/13 at 1:17 PM. The QIDP indicated the clients' program plans should be implemented as written. On 5/2/13 at 10:33 AM, the</p>						

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	<p>QIDP indicated food should not be removed from client #4's hands. The QIDP indicated the staff should not have taken her food away during dinner. The QIDP indicated the Network Director told the staff they could not take her food away. The QIDP indicated the plan should be implemented as written.</p> <p>9-3-4(a)</p>			

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure the client's comprehensive functional assessment (CFA) was reviewed/revised annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's CFA was dated 2/23/12. There was no documentation in client #2's record indicating the CFA was reviewed/revised annually.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated the client's CFA should be reviewed annually or more frequently as needed.</p> <p>9-3-4(a)</p>	W000259	<p>DORS will give QDDP corrective action for failure to review/revise annual plans, including IPPs, RSPs, and functional assessments annually. A copy of this corrective action will be on file at the LifeDesigns office. Ongoing compliance will be monitored through routine ND-R audits submitted to DORS. ND-R audit includes a review of plan and assement dates to ensure they are current and to note if any are approaching renewal times. DORS reviews plan revisions and all new plans prior to implementation. QDDP will revise client #3's IPP and #2's functional assessment. Documentation of this completion will be on file at the group home.</p>	06/14/2013	

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure the clients' Individual Program Plans (IPP) were reviewed/revised annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's IPP was dated 2/23/12. There was no documentation in client #2's record indicating the IPP was reviewed/revised annually.</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's IPP was dated 3/23/12. There was no documentation in client #3's record indicating the IPP was reviewed/revised annually.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 9:23 AM. The QIDP indicated the clients' IPPs should be reviewed on an annual basis.</p>	W000260	<p>DORS will give QDDP corrective action for failure to review/revise annual plans, including IPPs, RSPs, and functional assessments annually. A copy of this corrective action will be on file at the LifeDesigns office. Ongoing compliance will be monitored through routine ND-R audits submitted to DORS. ND-R audit includes a review of plan and assement dates to ensure they are current and to note if any are approaching renewal times. DORS reviews plan revisions and all new plans prior to implementation. QDDP will revise client #3's IPP and #2's functional assessment. Documentation of this completion will be on file at the group home.</p>	06/14/2013			

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	An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated the clients' IPPs should be reviewed on an annual basis or more frequently, as needed. 9-3-4(a)				

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility's specially constituted committee (Human Rights Committee - HRC) failed to periodically review or monitor the clients' restrictive program plans.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Replacement Skills Plan (RSP), dated 3/14/12, indicated she took Clonidine, Intuniv and Risperdal as psychotropic medications to address aggression and self-injurious behavior. There was no documentation the HRC reviewed or monitored client #2's RSP since 3/30/12.</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's RSP, dated 3/23/12, indicated she had restrictive interventions including door alarms and locks for elopement. There was no documentation the HRC</p>	W000262	<p>Following the survey dates, Director of Residential Services trained QDDPs, ND-Rs, and TMs on receiving HRC approval for plans at least annually and more often as needed as well as the need for guardian approval of plans and restrictions. Continued monitoring of the recommendation will be through routine ND-R audits submitted to Director of Residential Services. ND-R audit includes a review of plan and assessment dates to ensure they are current and to note if any are approaching renewal times. DORS reviews plan revisions and all new plans prior to implementation. QAD will provide QDDPs with quarterly statements of needed HRC approvals and meeting dates.</p>	06/14/2013			

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	<p>reviewed or monitored client #3's RSP since 3/23/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 9:23 AM. The QIDP indicated there was no current consent for clients #2 and #3's RSPs. The QIDP indicated the HRC should review, approve and monitor the clients' restrictive plans annually.</p> <p>An interview was conducted on 5/3/13 at 10:07 AM with the Director of Residential Services (DRS). The DRS indicated the HRC should review or monitor the clients' restrictive plans annually or more frequently if the plan was changed.</p> <p>9-3-4(a)</p>				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to ensure the facility's nursing services met the nursing needs of client #2 by failing to refer client #2 to the Speech Language Pathologist (SLP), as recommended, following incidents of choking. The facility's nursing services failed to ensure client #3 had an annual physical and hearing assessment. The facility's nursing services failed to ensure client #2's diet texture was consistent at school and the group home. The facility's nursing services failed to ensure there was documentation the nurse's instructions to address client #3's vaginal discharge were implemented. The facility's nursing services failed to ensure there was a Registered Nurse (RN) available to the Licensed Practical Nurse (LPN) for consultation. The facility's nursing services failed to ensure staff prompted client #5 to sniff following the administration of nasal spray.</p> <p>Findings include:</p>	W000318	<p>W189 Group home nurse will provide Medical Coordinator Training to the group home MC. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W322 Documentation of client #3's annual exam will be on file at the LifeDesigns, Inc office and in client #3's chart. Continued compliance will be monitored by the group home nurse and through ND-R audits. W323 Documentation of client #3's annual exam will be on file at the LifeDesigns, Inc office and in client #3's chart. Continued compliance will be monitored by the group home nurse and through ND-R audits. W331 1.) Group home nurse has contacted client #2's primary care physician to request a referral to a Speech Language Pathologist. Documentation of this contact will be on file at the LifeDesigns, Inc office and in client #2's chart. Group home nurse will ensure follow up after receiving the referral. 2.) QDDP will provide the Teacher of Record a copy of current nursing care plan that includes client #2's doctor ordered diet texture. A copy of the signed receipt acknowledgement will be on file at the LifeDesigns, Inc office and in client #2's chart. Routine observations will assist in ensuring diet textures are</p>	06/14/2013			

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	<p>1) Please refer to W189. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to provide training to the Medical Coordinator.</p> <p>2) Please refer to W322. For 1 of 3 clients in the sample (#3), the facility failed to ensure she had an annual physical examination.</p> <p>3) Please refer to W323. For 1 of 3 clients in the sample (#3), the facility failed to ensure her hearing was evaluated annually.</p> <p>4) Please refer to W331. For 3 of 5 clients living in the group home (#2, #3 and #5), the facility's nursing services failed to ensure: 1) client #2's swallow study recommendations were implemented and incidents of choking were documented and addressed in the nurse's monthly nursing notes, 2) client #2's diet textures at school and at the group home were consistent, 3) client #3's nursing instructions were implemented by the group home staff to address vaginal discharge, and 4) staff prompted client #5 to sniff following the staff spraying her nose spray.</p> <p>5) Please refer to W338. For 1 of 3 clients in the sample (#2), the facility's</p>		<p>consistent. Any inconsistencies with diet texture noted during the observation will be addressed verbally and immediately with the staff involved in the meal. Written documentation of this communication will be included in the observation report submitted to DORS and on file a the group home. All diet plans will be reviewed at each monmthly meeting of the QDDP and ND-R with the TOR and other school personnel as determined by the school. 3.) ND-R will train group home staff on ensuring that nurses orders are documented in the TAR (Treatment Administration Record - this includes non medication health maintenance such as OT/PT items, nail clipping, weights and vitals, etc.) when they are received. A refresher training will be provided to remind staff to check the TAR and MAR of all clients for any newly received orders prior to starting their shift. This training will include clarification that doctors orders over the phone must be transcribed by the nurse and staff should only be transcribing non medication orders given by the nurse. Examples of this will include but may not be limited to: baking soda/cornstarch bath for freshness, clear liquid diet following vomitus, not wearing an Attends at night, etc. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4.)</p>		

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	nursing services failed to refer client #2 to a Speech Language Pathologist following incidents of choking. 6) Please refer to W346. For 5 of 5 clients living in the group home (#1, #2, #3, #4, and #5), the facility failed to ensure there was a Registered Nurse (RN) available to the group home Licensed Practical Nurse (LPN) for consultation. 9-3-6(a)		TM for the group home will train staff on appropriate cuing for medications. This will include examples such as sniffing nose spray, inhaling inhalants, keeping head tilted for ear drops, etc. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through medication pass audits twice weekly for 30 days and then monthly thereafter completed monthly by QDDP, Nurse, TM, ND-R, and/or other supervisory staff. Nursing staff completed med pass observations monthly. These audits will be submitted to the nurse assigned to the home and the DORS. W338 Group home nurse has contacted client #2's primary care physician to request a referral to a Speech Language Pathologist. Documentation of this contact will be on file at the LifeDesigns, Inc office and in clinet #2's chart. Group home nurse will ensure follow up after receiving the referral. W346 The contract RN's contract with LifeDesigns, Inc has been revised to include consultation for group home LPNs as needed. A copy of this contract is on file at the LifeDesigns, Inc office. Ongoing compliance with this will be done by the Director of Support Services.		

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure she had an annual physical examination.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's record did not contain documentation she had an annual physical exam since 4/23/12.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated client #3 should have an annual physical.</p> <p>9-3-6(a)</p>	W000322	Documentation of client #3's annual exam will be on file at the LifeDesigns, Inc office and in client #3's chart. Continued compliance will be monitored by the group home nurse and through ND-R audits.	06/14/2013	

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure her hearing was evaluated annually.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's record did not contain documentation she had an audiological exam. There was no documentation in client #3's annual physical exam documentation, dated 4/23/12, indicating her hearing was screened during the exam.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 10:04 AM. The QIDP indicated client #3's hearing should be assessed annually or every two years. The QIDP stated, "I can't remember."</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated client #3's hearing should be assessed every 2-3 years or as ordered.</p>	W000323	Client #3 has been scheduled for a hearing evaluation. Documentation of this appointment will be on file at the LifeDesigns, Inc office as well as in client #3's chart. Follow up regarding any possible recommendations will be be nurse assigned to group home.	06/14/2013	

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 5 clients living in the group home (#2, #3 and #5), the facility's nursing services failed to ensure: 1) client #2's swallow study recommendations were implemented and incidents of choking were documented and addressed in the nurse's monthly nursing notes, 2) client #2's diet textures at school and at the group home were consistent, 3) client #3's nursing instructions were implemented by the group home staff to address vaginal discharge, and 4) staff prompted client #5 to sniff following the staff spraying her nose spray.</p> <p>Findings include:</p> <p>1) A review of client #2's record was conducted on 5/1/13 at 1:43 PM. On 3/16/12 at 11:45 AM, client #2 choked at school requiring abdominal thrusts. The school called 911. On 4/3/12, client #2 had a swallow study. The report indicated, in part, "[Client #2] was brought in for an evaluation secondary to a choking incident at school approximately 2-3 weeks ago. The type of food she choked on is unknown. [Client #2] received the Heimlich Maneuver and was taken to the ER</p>	W000331	<p>1.) Group home nurse has contacted client #2's primary care physician to request a referral to a Speech Language Pathologist. Documentation of this contact will be on file at the LifeDesigns, Inc office and in clinet #2's chart. Group home nurse will ensure follow up after receiving the referral. 2.) QDDP will provide the Teacher of Record a copy of current nursing care plan that includes client #2's doctor ordered diet texture. A copy of the signed receipt acknowledgement will be on file at the LifeDesigns, Inc office and in client #2's chart. Routine observations will assist in ensuring diet textures are consistent. Any inconsistencies with diet texture noted during the observation will be addressed verbally and immediately with the staff involved in the meal. Written documenation of this communication will be included in the observation report submitted to DORS and on file a the group home. All diet plans will be reviewed at each monmthly meeting of the QDDP and ND-R with the TOR and other school personnel as determined by the school. 3.) ND-R will train group home staff on ensuring that nurses orders are documented in the TAR (Treatment Administration Record - this</p>	06/14/2013			

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	<p>(emergency room). Per caregiver reports, no concerns were noted from her visit to the ER." The report indicated for her current intake, "[Client #2] eats all foods cut into bite sized pieces." The report indicated in the Feeding History section, "[Client #2] is missing her front teeth, she uses her molars to chew. [Client #2] loves to eat meat. [Client #2] had always eaten table food that is chopped into small pieces. Caregiver reports, 2 instances when [client #2] coughed while trying to eat the fatty part of meat; since her recent choking event, caregivers have removed the fatty part of her meat and no choking instances have been noted since the change. No changes in diet have been made since the choking event at school 2-3 weeks ago, and caregiver reported no concerns about her eating." The recommendations indicated, "Continue to chop food into bite-sized pieces. Continue to cut the fat off of her meat. Contact the clinic if additional choking/coughing instances occur as a result of eating." The Medical/Dental/Visit Consult form, dated 4/3/12, indicated, in part, "No changes in diet. Please contact the clinic (phone number) with (sic) and concerns or additional coughing/choking incident during meal time."</p> <p>A review of the facility's</p>		<p>includes non medication health maintenance such as OT/PT items, nail clipping, weights and vitals, etc.) when they are received. A refresher training will be provided to remind staff to check the TAR and MAR of all clients for any newly received orders prior to starting their shift. This training will include clarification that doctors orders over the phone must be transcribed by the nurse and staff should only be transcribing non medication orders given by the nurse. Examples of this will include but may not be limited to: baking soda/cornstarch bath for freshness, clear liquid diet following vomitus, not wearing an Attends at night, etc. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4.) TM for the group home will train staff on appropriate cuing for medications. This will include examples such as sniffing nose spray, inhaling inhalants, keeping head tilted for ear drops, etc. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through medication pass audits twice weekly for 30 days and then monthly thereafter completed monthly by QDDP, Nurse, TM, ND-R, and/or other supervisory staff. Nursing staff completed med pass observations monthly. These audits will be submitted to the nurse assigned to the home and</p>				

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	<p>incident/investigative reports was conducted on 4/29/13 at 11:33 AM. A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM.</p> <p>A. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. The letter from the school, signed by the paraprofessional, indicated, "At around 9:55 AM the kids were having a snack (hard crackers sent for snack by group home staff). [Client #2] started to cough a little bit and some of the crackers came out of her nose. Then she started choking. I noticed she could not get it coughed up and I started doing the Heimlich on [client #2]. She did get the snack spit out and we called the school nurse who contacted staff at the group home."</p> <p>The Nursing Narrative Note, dated 1/29/13, was reviewed on 5/1/13 at 1:43 PM. The note indicated, in part, "Writer assessed [client #2] this date due to choking incident at school when she choked on a cracker and was taken to [name of hospital] ER. No issues found at ER (1/28). [Client #2] was alert and active this date. Chest is clear with no SOB (shortness of breath) or coughing noted. She is afebrile (no temperature).</p>		the DORS.		

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	<p>AP (apical pulse) is 82, R (respirations) 16, Refused to allow BP (blood pressure) to be taken." There was no documentation client #2's physician was notified. There was no documentation the speech language pathologist was notified.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 2/1/13 was reviewed. The note indicated, following the 1/28/13 incident of choking, "No further choking incidents."</p> <p>B. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor</p>						

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	<p>that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 3/6/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." Client</p>				

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	<p>#2's Monthly Health Care Coordination/Nursing Note dated 4/4/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." There was no documentation in client #2's record indicating the physician and Speech Language Pathologist were notified of the incident.</p> <p>C. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2 for signs of aspiration, none were noted and her breathing was normal.</p> <p>The School Communication Sheets, dated 4/26/13, indicated the following, "Also [client #2] choked on a hot dog that was cut into quarter pieces while at [name of restaurant]. Her caregiver yelled & told me she needed help. I pulled the heimlich maneuver on her several times & couldn't get her to cough it up & did it one last time really hard & I got her to cough it out. Hot dog was seriously cut up & she still choked. Keep an eye on her eating. SCARY! Nurse, QDDP & doctor were</p>				

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	<p>all informed."</p> <p>The Nursing Narrative Note, dated 4/25/13, was reviewed on 5/1/13 at 1:43 PM. The note indicated, in part, "Writer was called by [staff #3]. She reports while at [name of restaurant] eating dinner [client #2] choked on a piece of hot dog and required the hemlich (sic) maneuver (two thrusts) to remove the piece of hot dog. [Client #2] did not loose (sic) consciousness, no color changes noted, no signs of respiratory distress following the incident. Wanted to go back to eating her dinner. Writer assessed [client #2] following the incident. Chest was clear, no SOB (shortness of breath) noted. No cough noted. Skin warm and pink without any signs or cyanosis. Respirations even at 16. Alert and active... Note indicated [client #2's] physician to report incident and to see if he had any further orders. No further orders received other than to monitor for above symptoms." There was no documentation the Speech Language Pathologist was notified of the incident.</p> <p>On 5/3/13 at 10:07 AM, the Director of Residential Services (DRS) indicated there should be documentation in client #2's record indicating the steps taken to address her choking incidents. The DRS indicated the Speech Language</p>						

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	<p>Pathologist should have been notified following incidents of choking due to the recommendations in the swallow study.</p> <p>An interview with the nurse was conducted on 5/14/13 at 2:12 PM. The nurse indicated the SLP was not notified of the choking incidents. The nurse indicated she was not aware the SLP recommendation to contact the clinic if there were further issues with choking. The nurse indicated the SLP should have been contacted following the choking incidents. The nurse indicated she should have included the information regarding the choking incidents in her monthly notes. The nurse indicated she documented the incidents and the information should be in the record.</p> <p>2) On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] chocking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fill (sic) to the floor. With [name of aide] on</p>			

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	<p>one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used.</p> <p>An email sent by the school's Speech Language Pathologist (SLP), dated 3/7/13</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>at 9:19 AM, indicated, in part, "Well so much for getting to spend lunch with [client #2] yesterday as we had discussed! Anyway, I have come up with some changes to implement in the interim prior to meeting with the group home or our own team etc. The next safest diet consistency is pureed. So, lucky for us that is what the meal choice is today for [client #2]. List of Mealtime Suggestions 1) puree consistency diet, 2) moisten all food w/ (with) milk or other appropriate liquid such as water or juice or gravy, 3) offer water or juice in am (morning) instead of milk to thin mucous secretions, 4) offer milk later in day at lunch and snack if secretions are not a concern/also offer water and or juice, 5) encourage [client #2] to drink from a lipped cup - do not use a straw - the liquid flows too fast and is hard to control through a straw."</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's diet, as recommended by the dietician's review on 3/27/13, was regular with meat/large pieces cut up. There was no documentation in client #2's record indicating the group home and the school met to discuss the changes recommended by the school SLP. There was no documentation the nurse contacted client #2's physician or SLP to report the changes in her diet orders at school.</p>			

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	<p>There was no documentation in the nurse's monthly or quarterly documentation discussing the changes to her diet at school.</p> <p>An interview with client #2's teacher was conducted on 5/1/13 at 10:06 AM. The teacher indicated there were 2 choking incidents at school this year involving client #2 requiring the Heimlich. The teacher indicated the school implemented a soft food diet. The teacher indicated the Qualified Intellectual Disabilities Professional (QIDP) was aware of the change at school and was concerned about the school violating client #2's rights instead of being concerned about choking. The teacher indicated the school took additional steps beyond the plan provided by the group home to address choking. The teacher indicated client #2's food was pureed at school to prevent choking. On 5/3/13 at 1:56 PM, the teacher indicated the school implemented a soft food diet. The teacher indicated she went to the director of food services to request a soft food diet. The teacher indicated client #2 still received some food the teachers in the room needed to chop up or use the food processor to puree. The teacher indicated the QIDP and the Network Director were informed of the change to client #2's food consistency at school.</p>			

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	<p>An interview with the nurse was conducted on 5/14/13 at 2:12 PM. The nurse indicated she was not aware of client #2's diet inconsistency until the interview conducted with the nurse on 5/1/13 at 2:33 PM. The nurse indicated she did not know where the order came from and was not contacted by the school regarding the diet change. The nurse indicated a diet change should be ordered by the physician. The nurse indicated there was no physician order for the change to a puree diet. The nurse indicated client #2's diet should be the same at school and at the group home.</p> <p>3) A review of client #3's record was conducted on 5/2/13 at 9:38 AM. On 4/11/13, client #3 was seen by her primary care physician. The assessment indicated, in part, "Vaginal erythema (redness or rash), edema, foul smelling discharge, will send to ER for sedation & pelvic exam. There may be a foreign body?" The diagnosis was "Vaginal discharge."</p> <p>The Clinical Summary, dated 4/11/13, indicated, in part, "The patient is a [age] year old female who presents with vaginal itching. The patient has been having vaginal itch and discharge. They are not certain if there could be a foreign body. They noted that she does not use tampons</p>				

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	<p>at all."</p> <p>A review of a Nursing Narrative Note, authored by the Licensed Practical Nurse, dated 4/11/13, indicated, in part, "Writer had [client #3] seen by PCP (primary care physician) this date due to vaginal irritation. PCP attempted to examine [client #3] and complete swab for yeast infection, but exam was inconclusive due to lack of cooperation. PCP suggested having her seen at ER under sedation. Writer called and spoke with [client #3's] mother who did not wish for [client #3] to be seen in ER for this issue. Write instructed staff to have [client #3] bathe/soak in bathtub in warm water with 1/2 cup of cornstarch powder daily over the weekend. Also instructed staff to have [client #3] sleep in underwear or loose PJ (pajama) bottoms/shorts without depends over the weekend using a bed pad to protect linens/bed. [Client #3's] mother also thought it might be easier/better for [client #3] to have a female physician. Writer will seek new provider." There was no documentation in client #3's record indicating the facility followed up on the possible foreign body. There was no documentation in client #3's record indicating the facility implemented the nurse's instructions. The nurse did not provide documentation indicating her recommendations of a soak in cornstarch</p>						

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	<p>and wearing loose clothing with no depends was implemented by the staff.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 9:41 AM. Initially, the QIDP indicated she did not know anything about the possible foreign body. The QIDP indicated the nurse spoke to client #3's mother and the mother did not want her sedated. The QIDP indicated the nurse instructed staff to do treatments. On 5/2/13 at 9:47 AM, the QIDP indicated she was not sure if there was documentation of the implementation of the treatments.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/2/13 at 10:07 AM. The DRS indicated she was not aware of the possibility of a foreign object. The DRS indicated she should have been notified. The DRS was not aware of anyone looking into the issue further.</p> <p>An interview with the nurse was conducted on 5/14/13 at 2:12 PM. The nurse indicated client #3's vagina was red so she went to see her primary care physician (PCP). The nurse indicated the PCP kept insisting client #3 could have a tampon in her vagina. Client #3 did not use tampons. The PCP did not want to</p>						

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	<p>examine her because she was yelling. The PCP wanted client #3 to have a sedated exam in the ER. Client #3's mother did not want her to have a sedated exam. The nurse indicated she had the staff do cornstarch soaks and instructed the staff to not have her wear depends over the weekend. The nurse indicated client #3 had redness again last week and she was taken for a full exam. There were no foreign bodies found.</p> <p>4) An observation was conducted at the group home on 4/30/13 from 5:49 AM to 8:45 AM. At 6:34 AM, client #5 received her medications from staff #3. Client #5 received two nasal sprays, Saline Mist and Fluticasone Prop. Staff #3 did not prompt, model or encourage client #5 to breathe or sniff the medications after receiving the nasal sprays.</p> <p>An interview with the nurse was conducted on 5/14/13 at 2:12 PM. The nurse indicated she had never thought about having the staff encourage, prompt or model sniffing the medication into her nose. The nurse indicated the medications would not be as effective if they were not sniffed. The nurse indicated it should be part of the administration of nasal medications to client #5.</p>						

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W000338	<p>483.460(c)(3)(v) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility's nursing services failed to refer client #2 to a Speech Language Pathologist following incidents of choking.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. On 3/16/12 at 11:45 AM, client #2 choked at school requiring abdominal thrusts. The school called 911. On 4/3/12, client #2 had a swallow study. The report indicated, in part, "[Client #2] was brought in for an evaluation secondary to a choking incident at school approximately 2-3 weeks ago. The type of food she choked on is unknown. [Client #2] received the Heimlich Maneuver and was taken to the ER (emergency room). Per caregiver reports, no concerns were noted from her visit to the ER." The report indicated for her current intake, "[Client #2] eats all foods cut into bite sized pieces." The report</p>	W000338	<p>Group home nurse has contacted client #2's primary care physician to request a referral to a Speech Language Pathologist. Documentation of this contact will be on file at the LifeDesigns, Inc office and in client #2's chart. Group home nurse will ensure follow up after receiving the referral.</p>	06/14/2013	

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	<p>indicated in the Feeding History section, "[Client #2] is missing her front teeth, she uses her molars to chew. [Client #2] loves to eat meat. [Client #2] had always eaten table food that is chopped into small pieces. Caregiver reports, 2 instances when [client #2] coughed while trying to eat the fatty part of meat; since her recent choking event, caregivers have removed the fatty part of her meat and no choking instances have been noted since the change. No changes in diet have been made since the choking event at school 2-3 weeks ago, and caregiver reported no concerns about her eating." The recommendations indicated, "Continue to chop food into bite-sized pieces. Continue to cut the fat off of her meat. Contact the clinic if additional choking/coughing instances occur as a result of eating." The Medical/Dental/Visit Consult form, dated 4/3/12, indicated, in part, "No changes in diet. Please contact the clinic (phone number) with (sic) and concerns or additional coughing/choking incident during meal time."</p> <p>A review of the facility's incident/investigative reports was conducted on 4/29/13 at 11:33 AM. A review of the school's documentation of incidents was reviewed on 5/1/13 at 10:33 AM.</p>						

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	<p>1. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. The letter from the school, signed by the paraprofessional, indicated, "At around 9:55 AM the kids were having a snack (hard crackers sent for snack by group home staff). [Client #2] started to cough a little bit and some of the crackers came out of her nose. Then she started choking. I noticed she could not get it coughed up and I started doing the Heimlich on [client #2]. She did get the snack spit out and we called the school nurse who contacted staff at the group home."</p> <p>The Nursing Narrative Note, dated 1/29/13, was reviewed on 5/1/13 at 1:43 PM. The note indicated, in part, "Writer assessed [client #2] this date due to choking incident at school when she choked on a cracker and was taken to [name of hospital] ER. No issues found at ER (1/28). [Client #2] was alert and active this date. Chest is clear with no SOB (shortness of breath) or coughing noted. She is afebrile (no temperature). AP (apical pulse) is 82, R (respirations) 16, Refused to allow BP (blood pressure) to be taken." There was no documentation client #2's physician was notified. There was no documentation the</p>			

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	<p>speech language pathologist was notified.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 2/1/13 was reviewed. The note indicated, following the 1/28/13 incident of choking, "No further choking incidents."</p> <p>2. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on</p>						

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	<p>3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used.</p> <p>A review of client #2's record was conducted on 5/1/13 at 1:43 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 3/6/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." Client #2's Monthly Health Care Coordination/Nursing Note dated 4/4/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." There</p>						

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	<p>was no documentation in client #2's record indicating the physician and Speech Language Pathologist were notified of the incident.</p> <p>3. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2 for signs of aspiration, none were noted and her breathing was normal.</p> <p>The School Communication Sheets, dated 4/26/13, indicated the following, "Also [client #2] choked on a hot dog that was cut into quarter pieces while at [name of restaurant]. Her caregiver yelled & told me she needed help. I pulled the heimlich maneuver on her several times & couldn't get her to cough it up & did it one last time really hard & I got her to cough it out. Hot dog was seriously cut up & she still choked. Keep an eye on her eating. SCARY! Nurse, QDDP & doctor were all informed."</p> <p>The Nursing Narrative Note, dated 4/25/13, was reviewed on 5/1/13 at 1:43 PM. The note indicated, in part, "Writer</p>						

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	<p>was called by [staff #3]. She reports while at [name of restaurant] eating dinner [client #2] choked on a piece of hot dog and required the hemlich (sic) maneuver (two thrusts) to remove the piece of hot dog. [Client #2] did not loose (sic) consciousness, no color changes noted, no signs of respiratory distress following the incident. Wanted to go back to eating her dinner. Writer assessed [client #2] following the incident. Chest was clear, no SOB (shortness of breath) noted. No cough noted. Skin warm and pink without any signs or cyanosis. Respirations even at 16. Alert and active... Note indicated [client #2's] physician to report incident and to see if he had any further orders. No further orders received other than to monitor for above symptoms." There was no documentation the Speech Language Pathologist was notified of the incident.</p> <p>On 5/3/13 at 10:07 AM, the Director of Residential Services (DRS) indicated there should be documentation in client #2's record indicating the steps taken to address her choking incidents. The DRS indicated the Speech Language Pathologist should have been notified following incidents of choking due to the recommendations in the swallow study.</p> <p>9-3-6(a)</p>						

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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 05/15/2013	
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W000346	<p>483.460(d)(4) NURSING STAFF</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4, and #5), the facility failed to ensure there was a Registered Nurse (RN) available to the group home Licensed Practical Nurse (LPN) for consultation.</p> <p>Findings include:</p> <p>On 5/14/13 at 9:58 AM, the contract with the facility RN was reviewed. The contact indicated, in part, "Review and advise LifeDesigns in matters of documentation and care of Supported Living customers, as assigned by the Director of Support Services, to include, but not be limited to: Medication Administration Plans, High Risk Plans, Medication Administration Records and Inventory, Side Effects Tracking and Physician Consults." The contract did not include clients living in group homes. This affected clients #1, #2, #3, #4, and #5.</p> <p>On 5/1/13 at 2:33 PM, the LPN indicated</p>	W000346	The contract RN's contract with LifeDesigns, Inc has been revised to include consultation for group home LPNs as needed. A copy of this contract is on file at the LifeDesigns, Inc office. Ongoing compliance with this will be done by the Director of Support Services.	06/14/2013			

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	<p>there was no RN for her to consult. The LPN indicated a RN was hired but was not starting until later in the month (May 2013).</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated there was no Registered Nurse for the Licensed Practical Nurse to consult. The DRS indicated a RN was hired and will be in training in May 2013.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 4 of 4 clients living in the group home needing communication aids (#2, #3, #4 and #5), the facility failed to provide/maintain the communication adaptive equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM and 4/30/13 from 5:49 AM to 8:45 AM. During the observations, staff were not observed to use sign language with clients #2, #3, #4 and #5. Staff were not observed to prompt the clients to use sign language, picture exchange communication (PEC), choice boards or picture schedules. During the observations, there was no sign language reference book in the home. Client #3's choice board was ripped and missing the top third of the page. There were no picture schedules observed in the home. The PEC system was in a plastic bag.</p> <p>A review of client #2's record was</p>	W000436	<p>Group Home TM will purchase a new ASL sign language reference book for the home. Proof of this purchase will be file at the LifeDesigns, Inc office. QDDP will ensure that replacements for the needed PEC cards, choice boards, etc are replaced and a master set of these items will be in group home office. Staff will be trained on the location and use of the master set to allow for copies to be made when needed. Staff will also be trained on reporting to the QDDP when a needed supply is low or missing to allow for the QDDP to replace it both in the home and in the master set. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through ND-R monthly audit documenting the presences of needed programming supplies in the home submitted to the DORS and routine observations completed by ND-R and QDDP and submitted to DORS.</p>	06/14/2013			

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	<p>conducted on 5/1/13 at 1:43 PM. Client #2's Individual Program Plan (IPP), dated 2/14/12, indicated, in part, "[Client #2] will utilize more ways of communication to be able to effectively communicate with more people and more easily express her wants and needs. CURRENT LEVEL: [Client #2] is non-verbal and communicates by leading people to what she wants or simply going to the item and taking it. NEXT STEP: [Client #2] will utilize PEC cards and Choice Boards in her daily communication. PROCEDURE: During the appropriate time each day staff will ensure that PEC Cards or Choice Boards are available and offer the appropriate level of prompts to encourage [client #2] to utilize them. The goal will be marked as met regardless of which is used, or what was indicated."</p> <p>A review of client #3's record was conducted on 5/2/13 at 9:38 AM. Client #3's IPP, dated 3/23/12, indicated, in part, "[Client #3] will utilize more than one form of communication and be able to more accurately express her wants, needs, and emotions. CURRENT LEVEL: [Client #3] is familiar with choice boards and will use them to make choices for things, such as a daily chore or outing. NEXT STEP: [Client #3] will learn to apply the use of choice boards to more individual wants and needs.</p>			

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	<p>PROCEDURE: Throughout the day, staff should cue [client #3] to utilize her choice boards to indicate her wants, needs, or feelings. When [client #3] attempts to physically lead staff from place to place to communicate, staff should remind [client #3] to use her choice boards. [Client #3] prefers to remain in physical contact with others at all time. Staff should prompt [client #3] to use her hands to show what she wants on her choice board and then prompt her that they will follow her or help her or do what she wants or needs if she utilizes one of her choice boards."</p> <p>A review of client #4's record was conducted on 5/2/13 at 10:30 AM. Client #4's IPP, dated June 2012, indicated, in part, "[Client #4] will communicate wants and needs other than food items. CURRENT LEVEL: [Client #4] is very clear about communicating in regards to food. NEXT STEP: [Client #4] will begin to communicate more wants and needs for items other than food. PROCEDURE: Throughout the day staff will encourage communication with [client #4] regarding things other than food choices. Staff will offer choice boards, picture cards, or use sign language. Goal will be met if [client #4] communicates any want, need, desire that is not associated with food."</p>						

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	<p>A review of client #5's record was conducted on 4/30/13 at 12:45 PM. Client #5's IPP, dated May 2012, indicated, in part, "[Client #5] will utilize more ways of communication to be able to effectively communicate with more people and more easily express her wants and needs. CURRENT LEVEL: [Client #5] is non-verbal and communicates by leading people to what she wants or simply going to the item and taking it. NEXT STEP: [Client #5] will utilize PEC cards and Choice Boards in her daily communication. PROCEDURE: During the appropriate time each day staff will ensure that PEC Cards or Choice Boards are available and offer the appropriate level of prompts to encourage [client #5] to utilize them. The goal will be marked as met regardless of which is used, or what was indicated."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/2/13 at 10:33 AM. The QIDP indicated there was no reference book in the home for staff. The QIDP indicated the PEC system cards for emotions were missing.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/3/13 at 10:07 AM. The DRS indicated there used to be a</p>						

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	<p>reference sign language book in the home. The DRS indicated she was made aware yesterday (5/2/13) some of the boards and PEC systems were not in the home for the clients' use. The DRS indicated the home was missing PEC cards and communication boards. The DRS indicated the communication adaptive equipment should be in the home for the clients to use. The DRS indicated the QIDP was aware of the missing equipment and should have replaced it.</p> <p>9-3-7(a)</p>			

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W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview for 5 of 5 clients observed to eat dinner (#1, #2, #3, #4 and #5), the facility failed to ensure staff provided spoons and knives during the meal.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/29/13 from 2:53 PM to 6:09 PM. Dinner started at 5:41 PM. Clients #1, #2, #3, #4 and #5 were not provided spoons or knives during the meal. The clients were served chicken, bread, margarine, macaroni, mixed vegetables and mandarin oranges. At 6:00 PM, client #2 was given a spoon to use. Client #1 used his fingers to eat his meal.</p> <p>On 5/3/13 at 10:07 AM, the Director of Residential Services (DRS) stated, "I think they should have the utensils required to eat their meal."</p> <p>9-3-8(a)</p>	W000484	<p>TM-R for the home will train all staff on ensuring that appropriate utensils are present at each meal. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Compliance will be monitored through twice weekly meal time observations for 30 days and monthly thereafter by QDDP, ND-R, and/or other supervisory staff. Any issues noted during the observation will be addressed verbally and immediately, follow up will include written documentation of corrective action taken. These observations will be submitted to DORS. Observations of meals during the 30 day period will also be submitted to QAD for the POC file.</p>	06/14/2013			

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