

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 15, 16, 17 and 18, 2015</p> <p>Facility Number: 000894 Provider Number: 15G380 AIM Number: 100239710</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 12/28/15 by #09182.</p>	W 0000		
W 0120 Bldg. 00	<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 observation, interview and record review for 1 of 1 client who attended an outside services day program (#4), the facility failed to ensure the outside services met the needs of client #4.</p> <p>Findings include:</p> <p>1) On 12/16/15 from 8:32 AM to 9:23 AM, an observation was conducted at the</p>	W 0120	To correct the deficient practice and ensure it does not continue, group home staff will be more diligent in regularly communicating with the day service providers. A communication book is now in place that travels between the group home and day program in order to share relevant information regarding each individual. Group home supervisory staff, including the Network Director/ QIDP (ND/Q)	01/17/2016

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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	<p>outside services day program client #4 attended. Client #4 arrived to the day program at 8:32 AM. At 8:41 AM, client #4 entered a van to go on a van ride with three peers and one staff.</p> <p>On 12/16/15 at 8:41 AM, the day program Coordinator indicated client #4 was going on a van ride down to a lake. On 12/16/15 at 8:45 AM, the Coordinator indicated client #4 was going for a ride down the newly opened interstate and then to a lake. On 12/16/15 at 9:17 AM, the day program Coordinator indicated a van ride was client #4's preferred activity.</p> <p>On 12/16/15 at 8:47 AM, the day program staff driving the van indicated client #4 was going on a van ride. The staff indicated she did not know where they were going. The staff indicated she started driving and allowed the clients to tell her where to go. The staff indicated the van ride would be until 10:15 AM when she would return to pick up another client and the group would go out again on a ride until lunch time.</p> <p>On 12/16/15 at 8:53 AM, the day program administrator indicated a van ride was not an appropriate activity for client #4. The administrator stated the "only way it was appropriate was if there was a place to go." The administrator</p>		<p>and Team Manager (TM), will do weekly observations at the day program and will continue for no less than 2 months. As long as no concerns are noted, day program observations will then reduce to no less than once monthly on an ongoing basis. To provide ongoing monitoring, group home staff are meeting at least once monthly for the next 6 months to update on progress and discuss any concerns. Meetings will be on a quarterly basis once the ND/Q has determined things are going smoothly and monthly meetings are no longer necessary.</p>	

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	<p>stated a van ride was "not appropriate."</p> <p>2) On 12/16/15 from 6:40 AM to 8:20 AM, an observation was conducted at the group home. At 6:40 AM, staff #5 indicated client #4 had been awake since 2:30 AM.</p> <p>On 12/16/15 from 8:32 AM to 9:23 AM, an observation was conducted at the outside services day program client #4 attended. At 8:32 AM, client #4 was waiting in the van for the day program door to be unlocked. Client #4 was falling asleep while sitting in the van. When the Manager took client #4 into the day program, the Manager did not communicate to the day program staff that client #4 had been awake since 2:30 AM. During the observation, the surveyor was unable to locate a communication book to review the communication between the group home and the day program.</p> <p>The day program Coordinator indicated on 12/16/15 at 9:17 AM there was no communication book between client #4's group home and the day program.</p> <p>On 12/16/15 at 1:45 PM, the group home Manager indicated there was no communication book in use between the group home and the day program. The</p>			

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	<p>Manager stated he "thought" he communicated to the day program staff that client #4 had been awake since 2:30 AM. The Manager indicated a communication book between the group home and day program was needed.</p> <p>On 12/16/15 at 1:45 PM, the Network Director (ND) indicated there was no communication book between the group home and client #4's day program. The ND indicated the group home staff verbally communicated information to the day program. The ND indicated the group home used emails to communicate with the day program. The ND stated, "we communicate but not effectively all the time."</p> <p>3) On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>a) On 6/5/15 at 2:00 PM while at an outside services day program, client #4 was in the van. A peer bit client #4 on the right leg. The outside service's Investigation Summary indicated, "On the way there [name of peer] began laughing and making loud noises. The more he was asked to stop the louder he got. Which in turn started upsetting [client #4] who then began started (sic) to</p>			

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	<p>make loud noises. As we pulled into the park [name of peer] began screaming. As I turned around I saw him taking off his seat belt and was going after [name of peer]. I pulled the van over and got out and opened the back sliding door. [Name of peer] had already bit (sic) and scratched [name of peer]. He then bit [client #4] on his left shin...."</p> <p>b) On 7/16/15 at 1:20 PM while at an outside services day program, client #4 was observed to enter a car in the parking lot by a security guard. Client #4 entered the car and put on his seat belt. The security guard contacted the day program administrator and staff assisted client #4 to exit the car. The 7/24/15 Investigation Summary indicated, "[Client #4] was at [name of provider] day program. He left the facility and got into a community members (sic) car. A security guard noticed this occurring and called the day program to come assist. Allegation is neglect." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The narrative indicated, "It was found that on 7/16/15 (at) roughly 1:20 PM [client #4] was sitting in the day program building listening to music towards the back of the class room roughly 25 yards from the front door (there are two unlocked exits one in the</p>			

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	<p>back and one in the front of the building). The staff designated to monitor [client #4] was in the back of the class room working with others. At some point (no specified time of last visual check of [client #4]) staff looked up to check on [client #4] and he was not in his seat listening to music. The other staff that was present then went to look for [client #4]. He was found in an [name of school] student's car outside of the building. [Client #4] must have gone out the front door as this was the side of the building he was found on. From the report given and BDDS (Bureau of Developmental Disabilities Services) report [client #4] must have been missing for a least three to five minutes as a security guard at [name of school] had seen the situation and walked over to [name of provider] to inform them, and the police had been notified. Once [name of provider] was aware they immediately were with [client #4] and police were called off. [Client #4] was then brought back into the building and monitored...."</p> <p>c) On 10/21/15 at 12:15 PM while at the outside services day program, client #4 went into the medication room with another client and one staff. Another client entered the medication room to take the staff's purse. Staff did not allow the client to take her purse. The client</p>						

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	<p>began to choke the staff. The staff got free. The client grabbed client #4's throat and pushed him against the filing cabinet for a "split second." Staff removed client #4 from the medication room. The Investigation Summary for Peer to Peer Incidents indicated there was willful intent to cause harm to client #4.</p> <p>d) On 11/5/15 at 11:00 AM while at the outside services day program, client #4's staff left the room for "a minute" and client #4 walked out the door and got into a visitor's car. When the staff returned to the room, he asked where client #4 was located and no one knew his location. As the staff walked out the front door, another staff was walking in with client #4.</p> <p>The outside services' 11/9/15 Investigation Summary indicated in day program staff #1's interview, "I was leaving for the day and had clocked out. [Day program staff #3] was supervising clients in the program room during lunch. She was told several times to keep an eye on [client #4]. When I walked back in the room before leaving, [staff #3] was eating her lunch. I asked her where [client #4] was because he was not in the room. [Staff #3] said that she did not know. I ran out the front door and saw [day program staff #2] the nurse helping</p>						

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	<p>him out of a ladies (sic) car in the parking lot. I took [client #4] back into the building and again explained how important it is to keep an eye on him at all times. I called PC (Program Coordinator) and reported it." The Investigation Summary's interview with staff #2 indicated, "I was walking into the building from the parking lot. A lady parked over by the karate place asked if I could help her. She said someone was in her backseat and thought that maybe he belonged in the building. I helped him out of her car. That is when [staff #1] came out and got him and took him back inside the building. We apologized to the lady who was very nice about it..." The Investigation Summary's interview with staff #3 indicated, "I was told by one of the staff to help feed one of the clients (client #4's peer) and keep an eye on [client #4]. I was still helping that client [name] eat. [Staff #1] came in and asked where [client #4] was. I told her I thought he was still over there where he was. She went out the door and came back in with him. She told me that I have to keep a close eye on him. I didn't know that he had left. Nobody said anything else so I just worked the rest of my shift." The outside services' Investigation Conclusion indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow</p>			

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	<p>protocol(s)." The LifeDesigns Network Director noted on the investigation, "Paddel (sic) locks and alarms have been added to doors at day program. Continue once monthly observations."</p> <p>On 12/16/15 at 8:53 AM, the day program Administrator indicated client #4 had eloped from the day program on two occasions. The Administrator stated client #4 had been involved in a "few" incidents of client to client abuse. The Administrator stated it "Concerns me when [client #4] involved in client to client when [client #4] was not an instigator or aggressor." The Administrator indicated client #4 was involved in a client to client incident on 12/15/15 however the staff in charge of the day program had not responded to the Administrator's request for additional information about the incident. The Administrator indicated he spoke to and observed the Network Director for the group home at the day program regularly. The Administrator indicated the Network Director did a great job of following up on incidents and issues and he used the Network Director as an example to his staff on how to follow up on incidents/issues.</p> <p>On 12/15/15 at 2:38 PM, the Network Director indicated the facility was</p>			

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W 0148 Bldg. 00	<p>responsible for ensuring outside services met the needs of the clients.</p> <p>On 12/15/15 at 2:38 PM, the Director of Residential Services indicated the facility was responsible for ensuring outside services met the needs of the clients.</p> <p>9-3-1(a)</p> <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 1 of 2 non-sampled clients (#4), the facility failed to ensure client #4's guardian was notified of an incident of elopement at the outside services day program on 11/5/15.</p> <p>Findings include:</p> <p>On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the</p>	W 0148	To correct the deficient practice and prevent it from recurring, all ND/Qs will be re-trained on the requirement to inform guardians of significant incidents, or changes in the client's condition. ND/Qs will also be reminded to thoroughly review all reports submitted by outside service providers to ensure all pertinent information is included. This information will also be provided to all outside service providers, and the ND/Qs will ensure day program providers have current	01/17/2016

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	<p>following: On 11/5/15 at 11:00 AM while at the outside services day program, client #4's staff left the room for "a minute" and client #4 walked out the door and got into a visitor's car. When the staff returned to the room, he asked where client #4 was located and no one knew his location. As the staff walked out the front door, another staff was walking in with client #4.</p> <p>The outside services' 11/9/15 Investigation Summary indicated in day program staff #1's interview, "I was leaving for the day and had clocked out. [Day program staff #3] was supervising clients in the program room during lunch. She was told several times to keep an eye on [client #4]. When I walked back in the room before leaving, [staff #3] was eating her lunch. I asked her where [client #4] was because he was not in the room. [Staff #3] said that she did not know. I ran out the front door and saw [staff #2] the nurse helping him out of a ladies (sic) car in the parking lot. I took [client #4] back into the building and again explained how important it is to keep an eye on him at all times. I called PC (Program Coordinator) and reported it." The Investigation Summary's interview with staff #2 indicated, "I was walking into the building from the parking lot. A lady parked over by the</p>		guardian contact information. Ongoing monitoring will be accomplished through the review of all BDDS incident reports by the Director of Residential Services. Additionally, all reportable incidents are included on the Residential Services Monthly Report for each individual, which is provided to the guardian.				

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	<p>karate place asked if I could help her. She said someone was in her backseat and thought that maybe he belonged in the building. I helped him out of her car. That is when [staff #1] came out and got him and took him back inside the building. We apologized to the lady who was very nice about it..." The Investigation Summary's interview with staff #3 indicated, "I was told by one of the staff to help feed one of the clients (client #4's peer) and keep an eye on [client #4]. I was still helping that client [name] eat. [Staff #1] came in and asked where [client #4] was. I told her I thought he was still over there where he was. She went out the door and came back in with him. She told me that I have to keep a close eye on him. I didn't know that he had left. Nobody said anything else so I just worked the rest of my shift." The outside services' Investigation Conclusion indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff will be returned to work due to no evidence of training on client (sic) plan, training and corrective action to be done for staff." The LifeDesigns Network Director noted on the investigation, "Paddel (sic) locks and alarms have been added to doors at day program. Continue once monthly</p>						

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W 0149 Bldg. 00	<p>observations."</p> <p>The 11/6/15 Bureau of Developmental Disabilities Services (BDDS) report indicated "N/A" in the legal guardian notification section.</p> <p>On 12/15/15 at 6:35 PM, a review of client #4's 6/30/15 Individualized Support Plan indicated he had a guardian.</p> <p>On 12/18/15 at 10:24 AM, client #4's guardian indicated she was not informed of client #4 eloping from the outside services day program on 11/5/15. Client #4's guardian indicated she wanted to be notified of incidents such as this.</p> <p>On 12/18/15 at 10:37 AM, the Network Director (ND) indicated he thought the outside services day program staff made guardian contact. The ND indicated he thought the BDDS report indicated the guardian was notified. The ND indicated client #4's guardian should have been notified.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>						

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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview for 14 of 17 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and former client #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations, ensure client #4 did not elope from the group home and day program and ensure client #6 did not elope from the facility-operated day program staff, ensure an incident was reported to the Bureau of Developmental Disabilities Services in a timely manner and ensure the results of investigations were received by the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/5/15 at 11:15 AM at the facility-operated day program, former client #6 was at a community setting showing signs of anxiety. Client #2 went over and gave client #6 a hug. During the hug, client #6 bent client #2's fingers. Client #2 indicated to staff he was hurt.</p>	W 0149	To correct the deficient practice, investigations were completed, and all recommendations implemented, for the incidents that occurred on 2/5/15, 2/12/15, 2/23/15, 2/24/15, 3/16/15, 3/26/15, 4/21/15, 6/5/15,6/30/15, 7/16/15, 9/6/15, 9/23/15, 10/21/15 and 11/5/15. To ensure the deficient practice does not continue, staff in the setting will be retrained on policies related to ANE and their role in the prevention of ANE, including prevention of peer to peer incidents. Supervisory staff who complete investigations will review the policies related to incident reporting and investigations, including the requirement to report all incidents to BDDS within 24 hours, and to complete all investigations within 5 days. Ongoing monitoring will be accomplished through the Director of Support Services review and monitoring of all BDDS reports and investigations for timeliness. Additionally, the Services Leadership Team, including all Directors of Services, Chief Services Officer (CSO) and Chief Executive Officer (CEO), meet no less than twice monthly to review all BDDS reports and investigations for trends and status (including who is assigned to the investigation, current status if ongoing, and status of completion of recommendations if already complete), and make	01/17/2016			

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	<p>On 12/15/15 at 2:42 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the Director of Support Services (DSS) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 2/12/15 at 12:30 PM at the facility-operated day program, client #3 hit a staff on the arm. The staff asked client #3 to hit to calm down. Another client reported client #3 hit a peer. The peer who was hit confirmed client #3 hit him in the chest but was not injured.</p> <p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent</p>		recommendations as necessary.		

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	<p>abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 2/23/15 at 11:45 AM at the facility-operated day program, former client #6 pinched a peer on the cheek. The peer had a small pinch mark on his right cheek.</p> <p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>4) On 2/24/15 at 12:45 PM at the facility-operated day program, former client #6 pinched client #2 on the face. Staff did not witness the incident. Client #2 reported the incident to staff. Client #2 indicated he grabbed client #6's lunchbox to give it to client #6 and client #6 pinched him on the cheek.</p> <p>On 12/15/15 at 2:42 PM, the ND</p>			

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 3/16/15 at 9:30 AM at the facility-operated day program, former client #6 pinched a peer and scratched another peer's face.</p> <p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>6) On 3/26/15 at 1:45 PM at the facility-operated day program, former</p>				

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	<p>client #6 arrived to a community setting. The group went into the building and staff noticed client #6 was not with the group. The staff found client #6 in the van in the parking lot. Client #6 was not supervised for 5 minutes from the time he was discovered missing until he was located in the van.</p> <p>The 3/30/15 Investigation Summary indicated, in part, "Based on information available, it does appear that staff followed the procedures in place and that [client #6] did exit the van, but somehow slipped away while walking into the [name of community setting]. He does not have a targeted behavior of elopement, but may be anxious about his upcoming move and exhibiting this in different ways (i.e. an increase in aggression towards other). Additionally, it was reported that he does not particularly like going to the [name of community setting], and only recently started going back there with [name of day program]."</p> <p>On 12/15/15 at 2:13 PM, the ND indicated client #6 went with the group to a community setting. The ND indicated client #6 did not make it into the community setting. The ND indicated client #6 went back to the van where staff located him listening to music.</p>			

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	<p>7) On 4/21/15 at 7:15 PM, client #4 was in the front yard of the group home listening to music. The 4/22/15 BDDS report indicated staff observed him in the yard at "roughly 7:00 PM." Staff reported they went to check on client #4 five minutes later and he was not in the front yard. Staff searched the property and he was not on the property. One staff called the on-call staff and the second staff went searching for client #4. Two minutes passed when a police officer stopped the staff and asked if they were looking for someone. The officer indicated another officer had client #4 a quarter of a mile down the road. The officer took the staff to get client #4. Two minutes later, staff arrived to client #4. Staff escorted client #4 back to the group home. The Group Home Director and Home Manager arrived to assist with the situation. Client #4 was out of line of sight of staff for a total of 9 minutes. Client #4 had a darting targeted behavior in his Behavioral Support Plan. The current plan did not indicate client #4 must be kept in eye sight while in the yard of the home or a designated amount of time staff needed to check on him. The plan indicated client #4 should be offered daily outside time to avoid darting incidents. The plan included the use of bungee cords on the gates to the</p>			

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	<p>fence which were in place at the time of the incident. Staff indicated they believed client #4 jumped over the fence. Client #4 did not sustain injuries and was not restrained by the police. The BDDS report indicated, "The director of Group homes assessed the situation onsite and deemed it not neglectful due to staff were following the current written plan. However several recommendations were made. Immediately: [Client #4] is too (sic) be in eye sight during waking hours until the team meets to discuss further action. Long term: The IDT (interdisciplinary team) will meet 4-23-15 at 1pm to discuss the current plan and possible revision. The team will look into having [client #4] with in (sic) staffs (sic) sight while outside of the group home. Staff will be retrained on any revisions made to the plan."</p> <p>The 4/23/15 BDDS Follow-Up Report indicated, in part, "...[Client #4] has not had an elopement incident without staff knowledge in many years. He has run from the staff into the road 2-3 times over the past 2 years. However staff was with him each time. [Client #4] also had an attempted elopement 4-22-15 but staff was able to stop before he could hop the fence. [Client #4] has also under gone (sic) a med decrease of Seroquel and clonidine starting 4-15-15 per the</p>			

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	<p>psychiatrist. Guardian was contacted 4-22-15 and cannot attend 4-23-15 meeting. She did give a recommendation. She would like for him to be accompanied when outside in the front yard or at the very least in eye sight. Items to keep [client #4] safe: 1. Revise plan to state that [client #4] should be in staffs (sic) line of sight when in the yard of the group home. Staff should accompany [client #4] outside when in the front yard being with in (sic) 10 ft (feet) of [client #4]. Encourage [client #4] to listen to his music in the back yard.</p> <p>2. Build a partition fence along the side of the house separating the front and back yard. Secure the back yard gate better as it is higher and would be harder to jump.</p> <p>3. Allow more opportunities to release energy outside of the group. Possibly at the [name of community setting] or fenced in parks. 4. Consult with Psychiatrist if problems occur over month. 5. Retrain staff on revised plans...."</p> <p>The 4/21/15 LifeDesigns Unusual Incident Report (UIR) indicated in the Incident Follow-Up section: "Does incident require investigation? No." The Findings section indicated, "Staff followed protocol after questioning staff. [Client #4] did not have a plan to be monitored at all times outside." The</p>				

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	<p>Action Taken section indicated, "IDT met 4-23-15. Review IDT notes."</p> <p>The 4/23/15 Special Support Team Meeting form indicated, "[Client #4] had an elopement incident on 4-21-15 where he left the facility without staff knowing for about 10 minutes. [Client #4] has not had an elopement incident without staff knowledge in many years. He had run from the staff into the road 2-3 times over the past 2 years. However staff was with him each time. [Client #4] also had an attempted elopement 4-22-15 but staff was able to stop before he could hop the fence. [Client #4] had also under gone a med decrease of Seroquel and clonidine starting 4-15-15 per the psychiatrist...."</p> <p>On 12/15/15 at 2:13 PM, the Network Director (ND) indicated the facility did not conduct an investigation. The ND indicated he documented his follow-up to the incident on the UIR. The ND indicated an IDT was held. The ND indicated he interviewed staff. The ND stated staff "wasn't neglectful." The ND stated "there wasn't neglect." The ND indicated he completed everything except the investigation form. The ND indicated the staff followed client #4's protocol due to client #4 not having to be monitored at all times. The ND indicated the Group Home Director (GHD) did not deem it</p>			

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	<p>neglect. The ND stated, "An investigation was conducted but not on an investigation (document)."</p> <p>On 12/15/15 at 2:15 PM, the GHD indicated the staff observed client #4 in the front yard and a few minutes later they could not locate him. The GHD indicated an investigation was conducted but not on an investigation form.</p> <p>On 12/18/15 at 10:57 AM, the DSS stated the Director of Residential Services (DRS) was present and did an "on the spot investigation." The DSS indicated there was no investigation summary form completed. The DRS stated "I guess" when asked if the incident should have been documented on an investigation summary. The DSS indicated she thought it was an immediate investigation completed by the DRS.</p> <p>8) On 6/5/15 at 2:00 PM while at an outside services day program, client #4 was in the van. A peer bit client #4 on the right leg. The outside service's Investigation Summary indicated, "On the way there [name of peer] began laughing and making loud noises. The more he was asked to stop the louder he got. Which in turn started upsetting [client #4] who then began started (sic) to</p>			

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	<p>make loud noises. As we pulled into the park [name of peer] began screaming. As I turned around I saw him taking off his seat belt and was going after [name of peer]. I pulled the van over and got out and opened the back sliding door. [Name of peer] had already bit and scratched [name of peer]. He then bit [client #4] on his left shin...."</p> <p>There was no documentation the group home conducted an investigation. The day program investigation included conflicting information regarding the location of the bite (right leg and left shin).</p> <p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients. On 12/18/15 at 11:15 AM, DSS indicated the facility's use of the outside services' investigation was acceptable if the investigation was thorough.</p>						

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	<p>9) On 6/30/15 at 2:30 PM at the facility-operated day program, client #2 reported to staff that client #1 had touched him on the bottom and private area while changing in the locker room at a community setting. Staff did not witness the incident. The incident was investigation as peer abuse.</p> <p>The 7/2/15 Investigation Summary indicated, "Staff was immediately instructed to keep [client #1] in line of sight, unless alone in his room." The investigation indicated in day program staff #1's interview, "[Staff #1] stated that he was in the locker room with [clients #1 and #2], but around the corner from them, changing after swimming. He said they (sic) customers were out of eye sight for about 1 minute. He said that [client #2] approached him and reported that [client #1] had touched him on the butt and privates. He said he couldn't discern if [client #2] said was touched on the butt and that is a private area, or if he stated that he was touched on the butt and privates. [Staff #1] stated that [client #2] was partially dressed at that time and [client #1] was still in his swim trunks. [Staff #1] prompted [client #2] to report the incident to [client #1's] staff (outside of the locker room), while he checked on [client #1]. [Client #1] was finishing</p>			
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	<p>getting dressed and it was noted that he had an erection. [Staff #1] said he talked to [client #1] about inappropriate touch and that [client #1] agreed that touching privates area of others is inappropriate. [Staff #1] did not directly ask if [client #1] had touched [client #2] inappropriately." The interview with client #2 indicated, "Writer asked [client #2] to describe what happened at the [name of community setting] in the locker room. He stated that [client #1] touched him on his privates and his butt several times. [Client #2] told [client #1] he did not like it and to stop touching him, but he did not. Since [client #1] would not listen to [client #2] he went and told staff. Writer asked [client #2] if [client #1] had touched his penis and he said 'yes, several times.' Writer asked if [client #2] had his clothes on when he was touched and he said 'yes.' Client #1's interview in the investigation indicated, "[Client #1] told writer that he tried to give [client #2] a hug while in the locker room at the [name of community setting]. He stated that [client #2] did not like it and was mad at him. Writer asked if he touched [client #2] in the private areas and [client #1] said yes. Writer asked specifically if he touched [client #2's] but and penis, and he said 'yes.' He then said 'no, no don't touch there,' 'that's not good.' Writer attempted to ask if [client #2] was</p>			

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	<p>naked when [client #1] touched him, but [client #1] stood on his bed and talked about hi broken curtains. Writer attempted to redirect [client #1] to the conversation but he turned up the volume on his music player." The Findings section of the investigation indicated, "Substantiated, the findings support the alleged event as described. All accounts are consistent and support that [client #1] touched [client #2] inappropriately while in the locker room."</p> <p>On 12/15/15 at 1:34 PM, the Network Director (ND) indicated inappropriate touch was in the plan at the time of the incident since it was in his plan at his former placement. The ND indicated the former staff indicated client #1 did not have sexual intent with his touches. The former placement indicated it was not an on-going issue but the facility documented it when it happened. The ND indicated line of sight was implemented when client #1 was in the common areas of the group home with his peers. The ND indicated a training objective was added to client #1's Individualized Support Plan to ask others prior to touching them.</p> <p>10) On 7/16/15 at 1:20 PM while at an outside services day program, client #4 was observed to enter the car in the</p>			

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	<p>parking lot by a security guard. Client #4 entered the car and put on his seat belt. The security guard contacted the day program administrator and staff assisted client #4 to exit the car. The 7/24/15 Investigation Summary indicated, "[Client #4] was at [name of provider] day program. He left the facility and got into a community members (sic) car. A security guard noticed this occurring and called the day program to come assist. Allegation is neglect." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The narrative indicated, "It was found that on 7/16/15 roughly 1:20 PM [client #4] was sitting in the day program building listening to music towards the back of the class room roughly 25 yards from the front door (there are two unlocked exits one in the back and one in the front of the building). The staff designated to monitor [client #4] was in the back of the class room working with others. At some point (no specified time of last visual check of [client #4]) staff looked up to check on [client #4] and he was not in his seat listening to music. The other staff that was present then went to look for [client #4]. He was found in an [name of school] student's car outside of the building. [Client #4] must have gone out the front door as this was the side of the</p>			

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	<p>building he was found on. From the report given and BDDS (Bureau of Developmental Disabilities Services) report [client #4] must have been missing for a least three to five minutes as a security guard at [name of school] had seen the situation and walked over to [name of provider] to inform them, and the police had been notified. Once [name of provider] was aware they immediately were with [client #4] and police were called off. [Client #4] was then brought back into the building and monitored..."</p> <p>The group home investigation indicated in the Findings section, "[Name of day program] reported to Life Designs staff who picked [client #4] up that day on 7-16-15 that [client #4] had gotten into another person's car and they were able to get him out prior to police showing, and [client #4] was safe the entire time. [Name of day program] did not inform Life Designs that [client #4] had been missing/unsupervised for a period of time until a 7-20-15 BDDS report was sent."</p> <p>The 7/16/15 incident was reported to BDDS on 7/20/15 by the day program. The BDDS report indicated, "Note: There was some confusion on if this had been reported already and was discovered today (7/20/15) that it had not."</p> <p>On 12/15/15 at 2:42 PM, the ND</p>			

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	<p>indicated BDDS reports should be submitted within 24 hours.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated BDDS reports should be submitted within 24 hours.</p> <p>11) On 9/6/15 at 10:05 AM, client #1 was sitting in a recliner in the living room with one staff and client #4. Client #4 was asleep on the couch. Staff left the room to use the restroom for approximately three minutes. When staff returned, client #1 had his roommate's left arm held back with his right arm and client #1's hand was down the front of client #4's pants. Client #1 denied anything was going on and was verbally redirected. Client #4 fell back asleep.</p> <p>The 9/30/15 Investigation Summary for Peer to Peer Incidents indicated the staffing pattern was not adequate according to the clients' plans. The Summary of Incident indicated, "It was found that [client #1] had stuck his hands in [client #4's] pants while he was asleep on the couch and staff was not present. Staff failed to follow [client #1's] eyesight protocol due to (sic) not being a second staff there." The Summary section indicated, "[Client #1] was on one side of the couch, [client #4] asleep on the other side, [staff #6] was walking</p>						

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	<p>around the living room. [Staff #6] went to the restroom for approximately three minutes. When he came back he saw that [client #1] had his right hand over [client #4's] shoulder and his left hand down [client #4's] pants. [Staff #6] states [client #4] was trying to stop [client #1] [Staff #6] told [client #1] to stop and take a break in his room and he did. [Staff #6] checked [client #4] out and he was fine. [Client #4] then laid back down. [Staff #6] then called supervisors. [Staff #3] then came in to be a 2nd staff for the rest of the day to ensure [client #1] was in eyesight per BSP." The Recommendations section indicated, "All staff will be retrained on the importance of having [client #1] in eyesight per his BSP. [Staff #6] will receive a counseling memorandum for failing to keep [client #1] in eyesight. [Staff #1] will be retrained on proper staff ratios specifically looking at customer plan." The investigation was not completed within 5 business days.</p> <p>On 12/15/15 at 2:33 PM, the Director of Residential Services (DRS) indicated the timeframe for conducting investigations was 5 business days.</p> <p>On 12/15/15 at 1:34 PM, the Network Director (ND) indicated client #1, at the time of the incident, was to be within line</p>			

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	<p>of sight when in the common areas of the group home. The ND indicated the staff failed to implement client #1's plan as written. On 12/15/15 at 2:33 PM, the ND indicated he was off during this time. The ND stated the "ball got dropped" while he was off. The ND indicated he completed the investigation when he returned. The ND indicated the timeframe for conducting investigations with 5 working days.</p> <p>12) On 9/23/15 at 7:50 PM, client #3 was sitting on the couch and client #1 was sitting on the floor on the other side of the room. Staff #4 walked out of the room to grab a book. Another staff was standing in the hallway within line of sight of clients #1 and #3. While talking to another client and looking away, client #2 reported that client #3 hit client #1. Client #3 was asked if he hit client #1 and he said "yes." Client #3 indicated in the BDDS report, dated 9/24/15, "he did not like [client #1]."</p> <p>The 9/30/15 Investigation Summary for Peer to Peer Incidents incident there was willful intent to cause harm. The investigation indicated, "After interviewing staff and customers it was found that [client #3] hit [client #1] on the top of the head. No injuries were sustained."</p>			

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	<p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>13) On 10/21/15 at 12:15 PM while at the outside services day program, client #4 went into the medication room with another client and one staff. Another client entered the medication room to take the staff's purse. Staff did not allow the client to take her purse. The client began to choke the staff. The staff got free. The client grabbed client #4's throat and pushed him against the filing cabinet for a "split second." Staff removed client #4 from the medication room.</p> <p>The Investigation Summary for Peer to Peer Incidents indicated there was willful intent to cause harm to client #4.</p> <p>On 12/15/15 at 2:42 PM, the ND indicated client to client aggression was</p>			

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	<p>abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 12/18/15 at 11:06 AM, the DSS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The DSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>14) On 11/5/15 at 11:00 AM while at the outside services day program, client #4's staff left the room for "a minute" and client #4 walked out the door and got into a visitor's car. When the staff returned to the room, he asked where client #4 was located and no one knew his location. As the staff walked out the front door, another staff was walking in with client #4.</p> <p>The outside services' 11/9/15 Investigation Summary indicated in day program staff #1's interview, "I was leaving for the day and had clocked out. [Day program staff #3] was supervising clients in the program room during lunch. She was told several times to keep an eye on [client #4]. When I walked back in the room before leaving, [staff #3] was eating her lunch. I asked her where [client #4] was because he was not in the</p>			

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	<p>room. [Staff #3] said that she did not know. I ran out the front door and saw [staff #2] the nurse helping him out of a ladies (sic) car in the parking lot. I took [client #4] back into the building and again explained how important it is to keep an eye on him at all times. I called PC (Program Coordinator) and reported it." The Investigation Summary's interview with staff #2 indicated, "I was walking into the building from the parking lot. A lady parked over by the karate place asked if I could help her. She said someone was in her backseat and thought that maybe he belonged in the building. I helped him out of her car. That is when [staff #1] came out and got him and took him back inside the building. We apologized to the lady who was very nice about it..." The Investigation Summary's interview with staff #3 indicated, "I was told by one of the staff to help feed one of the clients (client #4's peer) and keep an eye on [client #4]. I was still helping that client [name] eat. [Staff #1] came in and asked where [client #4] was. I told her I thought he was still over there where he was. She went out the door and came back in with him. She told me that I have to keep a close eye on him. I didn't know that he had left. Nobody said anything else so I just worked the rest of my shift." The outside services' Investigation</p>			

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	<p>Conclusion indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff will be returned to work due to no evidence of training on client (sic) plan, training and corrective action to be done for staff." The LifeDesigns Network Director noted on the investigation, "Paddel (sic) locks and alarms have been added to doors at day program. Continue once monthly observations."</p> <p>There was no documentation when the Network Director received and reviewed the day program's investigation. There was no documentation the group home conducted an investigation into the incident.</p> <p>On 12/16/15 at 8:53 AM, the day program Administrator indicated client #4 had eloped from the day program on two occasions. The Administrator stated client #4 had been involved in a "few" incidents of client to client abuse. The Administrator stated it "Concerns me when [client #4] involved in client to client when [client #4] was not an instigator or aggressor." The Administrator indicated client #4 was involved in a client to client incident on 12/15/15 however the staff in charge of</p>				

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	<p>the day program had not responded to the Administrator's request for additional information about the incident. The Administrator indicated he spoke and observed the Network Director for the group home at the day program regularly. The Administrator indicated the Network Director did a great job of following up on incidents and issues and he used the Network Director as an example to his staff on how to follow up on incidents/issues.</p> <p>On 12/18/15 at 11:15 AM, the Director of Support Services (DSS) indicated the ND should have dated when he received and reviewed the outside services' investigation. The DSS indicated the facility's use of the outside services' investigation was acceptable if the investigation was thorough.</p> <p>On 12/15/15 at 2:32 PM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect</p>						

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	<p>with recognition of his/her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support</p>			

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W 0153 Bldg. 00	<p>Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator...."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 17 incident reports reviewed affecting client #4, the facility failed to ensure an incident of elopement was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/16/15 at 1:20 PM while at an outside services day program, client #4 was observed to enter the car in the</p>	W 0153	To correct the deficient practice and ensure it does not continue, the day services provider has been reminded to report all BDDS reportable incidents to BDDS within 24 hours. All BDDS reports will be reviewed for timeliness to ensure no others were affected by the deficient practice. To provide ongoing monitoring, a communication log has been implemented to travel between the group home and day services to record any significant events or areas of concern. Staff review the communication log each day, and have been trained to contact the Team Manager or ND/Q if something reportable is noted in the communication log.	01/17/2016

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	<p>parking lot by a security guard. Client #4 entered the car and put on his seat belt. The security guard contacted the day program administrator and staff assisted client #4 to exit the car. The 7/24/15 Investigation Summary indicated, "[Client #4] was at [name of provider] day program. He left the facility and got into a community members (sic) car. A security guard noticed this occurring and called the day program to come assist. Allegation is neglect." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The narrative indicated, "It was found that on 7/16/15 roughly 1:20 PM [client #4] was sitting in the day program building listening to music towards the back of the class room roughly 25 yards from the front door (there are two unlocked exits one in the back and one in the front of the building). The staff designated to monitor [client #4] was in the back of the class room working with others. At some point (no specified time of last visual check of [client #4]) staff looked up to check on [client #4] and he was not in his seat listening to music. The other staff that was present then went to look for [client #4]. He was found in an [name of school] student's car outside of the building. [Client #4] must have gone out the front door as this was the side of the</p>		<p>Additionally, the TM will review the communication log no less than weekly.</p>	

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	<p>building he was found on. From the report given and BDDS (Bureau of Developmental Disabilities Services) report [client #4] must have been missing for a least three to five minutes as a security guard at [name of school] had seen the situation and walked over to [name of provider] to inform them, and the police had been notified. Once [name of provider] was aware they immediately were with [client #4] and police were called off. [Client #4] was then brought back into the building and monitored...."</p> <p>The group home investigation indicated in the Findings section, "[Name of day program] reported to Life Designs staff who picked [client #4] up that day on 7-16-15 that [client #4] had gotten into another person's car and they were able to get him out prior to police showing, and [client #4] was safe the entire time. [Name of day program] did not inform Life Designs that [client #4] had been missing/unsupervised for a period of time until a 7-20-15 BDDS report was sent."</p> <p>The 7/16/15 incident was reported to BDDS on 7/20/15 by the day program. The BDDS report indicated, "Note: There was some confusion on if this had been reported already and was discovered today (7/20/15) that it had not."</p>			

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W 0154 Bldg. 00	<p>On 12/15/15 at 2:42 PM, the ND (Network Director) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 12/18/15 at 11:06 AM, the DSS (Director of Support Services) indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-2(a)</p> <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 3 of 17 incident/investigative reports reviewed affecting client #4, the facility failed to ensure thorough investigations were conducted.</p> <p>Findings include:</p> <p>On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/21/15 at 7:15 PM, client #4 was</p>			W 0154	<p>To correct the deficient practice and ensure it does not continue, supervisory staff who complete investigations will review the policies related to incident reporting and investigations, including the requirement to report all incidents to BDDS within 24 hours, and to complete all investigations within 5 days. Additionally, the agency investigation policy will be reviewed in regards to investigations completed by outside services to ensure a thorough and timely review of any outside investigation, and the requirement to gather additional</p>		01/17/2016

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	<p>in the front yard of the group home listening to music. The 4/22/15 BDDS (Bureau of Developmental Disabilities Services) report indicated staff observed him in the yard at "roughly 7:00 PM." Staff reported they went to check on client #4 five minutes later and he was not in the front yard. Staff searched the property and he was not on the property. One staff called the on-call staff and the second staff went searching for client #4. Two minutes passed when a police officer stopped the staff and asked if they were looking for someone. The officer indicated another officer had client #4 a quarter of a mile down the road. The officer took the staff to get client #4. Two minutes later, staff arrived to client #4. Staff escorted client #4 back to the group home. The Group Home Director and Home Manager arrived to assist with the situation. Client #4 was out of line of sight of staff for a total of 9 minutes. Client #4 had a darting targeted behavior in his Behavioral Support Plan. The current plan did not indicate client #4 must be kept in eye sight while in the yard of the home or a designated amount of time staff needed to check on him. The plan indicated client #4 should be offered daily outside time to avoid darting incidents. The plan included the use of bungee cords on the gates to the fence which were in place at the time of</p>		<p>information if the outside services investigation is not thorough. Ongoing monitoring will be accomplished through the Director of Support Services review and monitoring of all BDDS reports and investigations for timeliness. Additionally, the Services Leadership Team, including all Directors of Services, Chief Services Officer (CSO) and Chief Executive Officer (CEO), meet no less than twice monthly to review all BDDS reports and investigations for trends and status (including who is assigned to the investigation, current status if ongoing, and status of completion of recommendations if already complete), and make recommendations as necessary.</p>	

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	<p>the incident. Staff indicated they believed client #4 jumped over the fence. Client #4 did not sustain injuries and was not restrained by the police. The BDDS report indicated, "The director of Group homes assessed the situation onsite and deemed it not neglectful due to staff were following the current written plan. However several recommendations were made. Immediately: [Client #4] is too (sic) be in eye sight during waking hours until the team meets to discuss further action. Long term: The IDT (interdisciplinary team) will meet 4-23-15 at 1pm to discuss the current plan and possible revision. The team will look into having [client #4] with in (sic) staffs (sic) sight while outside of the group home. Staff will be retrained on any revisions made to the plan."</p> <p>The 4/23/15 BDDS Follow-Up Report indicated, in part, "...[Client #4] has not had an elopement incident without staff knowledge in many years. He has run from the staff into the road 2-3 times over the past 2 years. However staff was with him each time. [Client #4] also had an attempted elopement 4-22-15 but staff was able to stop before he could hop the fence. [Client #4] has also under gone (sic) a med decrease of Seroquel and clonidine starting 4-15-15 per the psychiatrist. Guardian was contacted</p>			

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	<p>4-22-15 and cannot attend 4-23-15 meeting. She did give a recommendation. She would like for him to be accompanied when outside in the front yard or at the very least in eye sight. Items to keep [client #4] safe: 1. Revise plan to state that [client #4] should be in staffs (sic) line of sight when in the yard of the group home. Staff should accompany [client #4] outside when in the front yard being with in (sic) 10 ft (feet) of [client #4]. Encourage [client #4] to listen to his music in the back yard. 2. Build a partition fence along the side of the house separating the front and back yard. Secure the back yard gate better as it is higher and would be harder to jump. 3. Allow more opportunities to release energy outside of the group. Possibly at the [name of community setting] or fenced in parks. 4. Consult with Psychiatrist if problems occur over month. 5. Retrain staff on revised plans...."</p> <p>The 4/21/15 LifeDesigns Unusual Incident Report (UIR) indicated in the Incident Follow-Up section: "Does incident require investigation? No." The Findings section indicated, "Staff followed protocol after questioning staff. [Client #4] did not have a plan to be monitored at all times outside." The Action Taken section indicated, "IDT met</p>			

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	<p>4-23-15. Review IDT notes."</p> <p>The 4/23/15 Special Support Team Meeting form indicated, "[Client #4] had an elopement incident on 4-21-15 where he left the facility without staff knowing for about 10 minutes. [Client #4] has not had an elopement incident without staff knowledge in many years. He had run from the staff into the road 2-3 times over the past 2 years. However staff was with him each time. [Client #4] also had an attempted elopement 4-22-15 but staff was able to stop before he could hop the fence. [Client #4] had also under gone a med decrease of Seroquel and clonidine starting 4-15-15 per the psychiatrist...."</p> <p>On 12/15/15 at 2:13 PM, the Network Director (ND) indicated the facility did not conduct an investigation. The ND indicated he documented his follow-up to the incident on the UIR. The ND indicated an IDT was held. The ND indicated he interviewed staff. The ND stated staff "wasn't neglectful." The ND stated "there wasn't neglect." The ND indicated he completed everything except the investigation form. The ND indicated the staff followed client #4's protocol due to client #4 not having to be monitored at all times. The ND indicated the Group Home Director (GHD) did not deem it neglect. The ND stated, "An</p>				

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	<p>investigation was conducted but not on an investigation (document)."</p> <p>On 12/15/15 at 2:15 PM, the GHD indicated the staff observed client #4 in the front yard and a few minutes later they could not locate him. The GHD indicated an investigation was conducted but not on an investigation form.</p> <p>On 12/18/15 at 10:57 AM, the DSS (Director of Support Services) stated the Director of Residential Services (DRS) was present and did an "on the spot investigation." The DSS indicated there was no investigation summary form completed. The DRS stated "I guess" when asked if the incident should have been documented on an investigation summary. The DSS indicated she thought it was an immediate investigation completed by the DRS.</p> <p>2) On 6/5/15 at 2:00 PM while at an outside services day program, client #4 was in the van. A peer bit client #4 on the right leg. The outside service's Investigation Summary indicated, "On the way there [name of peer] began laughing and making loud noises. The more he was asked to stop the louder he got. Which in turn started upsetting [client #4] who then began started (sic) to make loud noises. As we pulled into the</p>						

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	<p>park [name of peer] began screaming. As I turned around I saw him taking off his seat belt and was going after [name of peer]. I pulled the van over and got out and opened the back sliding door. [Name of peer] had already bit (sic) and scratched [name of peer]. He then bit [client #4] on his left shin...."</p> <p>There was no documentation the group home conducted an investigation. The day program investigation included conflicting information regarding the location of the bite (right leg and left shin). There was no documentation the group home implemented corrective action following the incident.</p> <p>On 12/18/15 at 11:15 AM, the Director of Support Services (DSS) indicated the facility's use of the outside services' investigation was acceptable if the investigation was thorough.</p> <p>3) On 11/5/15 at 11:00 AM while at the outside services day program, client #4's staff left the room for "a minute" and client #4 walked out the door and got into a visitor's car. When the staff returned to the room, he asked where client #4 was located and no one knew his location. As the staff walked out the front door, another staff was walking in with client #4.</p>			

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	<p>The outside services' 11/9/15 Investigation Summary indicated in day program staff #1's interview, "I was leaving for the day and had clocked out. [Day program staff #3] was supervising clients in the program room during lunch. She was told several times to keep an eye on [client #4]. When I walked back in the room before leaving, [staff #3] was eating her lunch. I asked her where [client #4] was because he was not in the room. [Staff #3] said that she did not know. I ran out the front door and saw [staff #2] the nurse helping him out of a ladies (sic) car in the parking lot. I took [client #4] back into the building and again explained how important it is to keep an eye on him at all times. I called PC (Program Coordinator) and reported it." The Investigation Summary's interview with staff #2 indicated, "I was walking into the building from the parking lot. A lady parked over by the karate place asked if I could help her. She said someone was in her backseat and thought that maybe he belonged in the building. I helped him out of her car. That is when [staff #1] came out and got him and took him back inside the building. We apologized to the lady who was very nice about it..." The Investigation Summary's interview with staff #3 indicated, "I was told by one of</p>			
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	<p>the staff to help feed one of the clients (client #4's peer) and keep an eye on [client #4]. I was still helping that client [name] eat. [Staff #1] came in and asked where [client #4] was. I told her I thought he was still over there where he was. She went out the door and came back in with him. She told me that I have to keep a close eye on him. I didn't know that he had left. Nobody said anything else so I just worked the rest of my shift." The outside services' Investigation Conclusion indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff will be returned to work due to no evidence of training on client (sic) plan, training and corrective action to be done for staff." The LifeDesigns ND noted on the investigation, "Paddel (sic) locks and alarms have been added to doors at day program. Continue once monthly observations."</p> <p>There was no documentation when the Network Director received and reviewed the day program's investigation. There was no documentation the group home conducted an investigation into the incident.</p> <p>On 12/16/15 at 8:53 AM, the day</p>			

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	<p>program Administrator indicated client #4 had eloped from the day program on two occasions. The Administrator stated client #4 had been involved in a "few" incidents of client to client abuse. The Administrator stated it "Concerns me when [client #4] involved in client to client when [client #4] was not an instigator or aggressor." The Administrator indicated client #4 was involved in a client to client incident on 12/15/15 however the staff in charge of the day program had not responded to the Administrator's request for additional information about the incident. The Administrator indicated he spoke and observed the Network Director for the group home at the day program regularly. The Administrator indicated the Network Director did a great job of following up on incidents and issues and he used the Network Director as an example to his staff on how to follow up on incidents/issues.</p> <p>On 12/18/15 at 11:15 AM, the Director of Support Services (DSS) indicated the ND should have dated when he received and reviewed the outside services' investigation. The DSS indicated the facility's use of the outside services' investigation was acceptable if the investigation was thorough.</p>			

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W 0156 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 2 of 17 incident/investigative reports reviewed affecting clients #1 and #4, the facility failed to ensure the results of investigations were received by the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>On 12/15/15 at 1:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 9/6/15 at 10:05 AM, client #1 was sitting in a recliner in the living room with one staff and client #4. Client #4 was asleep on the couch. Staff left the room to use the restroom for approximately three minutes. When staff returned, client #1 had his roommate's left arm held back with his right arm and</p>	W 0156	To correct the deficient practice and ensure it does not continue, supervisory staff who complete investigations will review the policies related to incident reporting and investigations, including the requirement to report all incidents to BDDS within 24 hours, and to complete all investigations within 5 days. Additionally, the agency investigation policy will be reviewed in regards to investigations completed by outside services to ensure a thorough and timely review of any outside investigation, and the requirement to gather additional information if the outside services investigation is not thorough. Ongoing monitoring will be accomplished through the Director of Support Services review and monitoring of all BDDS reports and investigations for timeliness. Additionally, the Services Leadership Team, including all Directors of Services, Chief Services Officer	01/17/2016

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	<p>client #1's hand was down the front of client #4's pants. Client #1 denied anything was going on and was verbally redirected. Client #4 fell back asleep.</p> <p>The 9/30/15 Investigation Summary for Peer to Peer Incidents indicated the staffing pattern was not adequate according to the clients' plans. The Summary of Incident indicated, "It was found that [client #1] had stuck his hands in [client #4's] pants while he was asleep on the couch and staff was not present. Staff failed to follow [client #1's] eyesight protocol due to (sic) not being a second staff there." The Summary section indicated, "[Client #1] was on one side of the couch, [client #4] asleep on the other side, [staff #6] was walking around the living room. [Staff #6] went to the restroom for approximately three minutes. When he came back he saw that [client #1] had his right hand over [client #4's] shoulder and his left hand down [client #4's] pants. [Staff #6] states [client #4] was trying to stop [client #1] [Staff #6] told [client #1] to stop and take a break in his room and he did. [Staff #6] checked [client #4] out and he was fine. [Client #4] then laid back down. [Staff #6] then called supervisors. [Staff #3] then came in to be a 2nd staff for the rest of the day to ensure [client #1] was in eyesight per BSP (Behavioral Support</p>		(CSO)and Chief Executive Officer (CEO), meet no less than twice monthly to review all BDDS reports and investigations for trends and status (including who is assigned to the investigation, current status if ongoing, and status of completion of recommendations if already complete), and make recommendations as necessary.	

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	<p>Plan)." The Recommendations section indicated, "All staff will be retrained on the importance of having [client #1] in eyesight per his BSP. [Staff #6] will receive a counseling memorandum for failing to keep [client #1] in eyesight. [Staff #1] will be retrained on proper staff ratios specifically looking at customer plan." The investigation was not completed within 5 business days.</p> <p>On 12/15/15 at 2:33 PM, the Director of Residential Services (DRS) indicated the timeframe for conducting investigations was 5 business days.</p> <p>On 12/15/15 at 1:34 PM, the Network Director (ND) indicated the timeframe for conducting investigations with 5 working days.</p> <p>2) On 11/5/15 at 11:00 AM while at the outside services day program, client #4's staff left the room for "a minute" and client #4 walked out the door and got into a visitor's car. When the staff returned to the room, he asked where client #4 was located and no one knew his location. As the staff walked out the front door, another staff was walking in with client #4.</p> <p>The outside services' 11/9/15 Investigation Summary indicated in day</p>				

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	<p>program staff #1's interview, "I was leaving for the day and had clocked out. [Day program staff #3] was supervising clients in the program room during lunch. She was told several times to keep an eye on [client #4]. When I walked back in the room before leaving, [staff #3] was eating her lunch. I asked her where [client #4] was because he was not in the room. [Staff #3] said that she did not know. I ran out the front door and saw [staff #2] the nurse helping him out of a ladies (sic) car in the parking lot. I took [client #4] back into the building and again explained how important it is to keep an eye on him at all times. I called PC (Program Coordinator) and reported it." The Investigation Summary's interview with staff #2 indicated, "I was walking into the building from the parking lot. A lady parked over by the karate place asked if I could help her. She said someone was in her backseat and thought that maybe he belonged in the building. I helped him out of her car. That is when [staff #1] came out and got him and took him back inside the building. We apologized to the lady who was very nice about it..." The Investigation Summary's interview with staff #3 indicated, "I was told by one of the staff to help feed one of the clients (client #4's peer) and keep an eye on [client #4]. I was still helping that client</p>			

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	<p>[name] eat. [Staff #1] came in and asked where [client #4] was. I told her I thought he was still over there where he was. She went out the door and came back in with him. She told me that I have to keep a close eye on him. I didn't know that he had left. Nobody said anything else so I just worked the rest of my shift." The outside services' Investigation Conclusion indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff will be returned to work due to no evidence of training on client (sic) plan, training and corrective action to be done for staff." The LifeDesigns Network Director noted on the investigation, "Paddel (sic) locks and alarms have been added to doors at day program. Continue once monthly observations."</p> <p>There was no documentation when the Network Director received and reviewed the day program's investigation.</p> <p>On 12/15/15 at 2:33 PM, the Director of Residential Services (DRS) indicated the timeframe for conducting investigations was 5 business days.</p> <p>On 12/18/15 at 11:15 AM, the Director of Support Services (DSS) indicated the</p>			

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W 0249 Bldg. 00	<p>ND should have dated when he received and reviewed the outside services' investigation. The DSS indicated the timeframe for reporting the results of an investigation was within 5 business days.</p> <p>9-3-2(a)</p> <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 1 of 2 non-sampled clients (#4), the facility failed to ensure staff implemented client #4's vehicle protocol as written.</p> <p>Findings include:</p> <p>On 12/16/15 from 6:40 AM to 8:20 AM, an observation was conducted at the group home. On 12/16/15 at 8:13 AM, client #4 and staff #1 entered the van. Client #4 sat in the front passenger seat with staff #1 driving the van. Client #4 was not wearing a harness.</p>	W 0249	To correct the deficient practice and ensure it does not continue, the IDT has reviewed the vehicle protocol for client #4, and all staff have been retrained on the revised protocol. To ensure no others were affected by the deficient practice, the ND/Q will also review other individual protocols to ensure they are still current and relevant, and make any necessary revisions. Ongoing monitoring will be accomplished by the ND/Q or Director of Residential Services completing observations four times per week for one month during transition times. Additionally, the Team Manager is the direct on-site supervisor for the staff and works	01/17/2016

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	<p>On 12/16/15 from 8:32 AM to 9:23 AM, an observation was conducted at the day program client #4 attended. At 8:32 AM, client #4 was in the front passenger seat of the van with staff #1 in the driver's seat. Client #4 was waiting in the van for the day program staff to unlock the door. Client #4 was not wearing a harness.</p> <p>On 12/17/15 at 3:57 PM, a review of client #4's 6/30/15 Behavioral Support Plan indicated he had a Vehicle Protocol. The protocol indicated, in part, "Over the years, [client #4] has worked on vehicle safety while riding in the van (and bus when he was in school). [Client #4] has not successfully met these goals over the years. Sometimes while in the van, [client #4] will jump out of his seat and attempt to change the radio or grab the driver's wrist or hand. If other individuals are in the vehicle, [client #4] will simply jump over the top of them and climb the seats to get to the front of the vehicle. He will do this when he is displaying excitable behavior (mania), tantrum, or agitation/anxiety. 1. [Client #4] should wear his harness, along with seatbelt clips whenever he is being transported to prevent him from unbuckling his seatbelt with only one staff present. 2. If two staff are present [client #4] should not need harness as a staff can sit with or in front of him to</p>		<p>in the home full-time, providing ongoing support and supervision as necessary. On an ongoing basis, the ND/Q is in the setting no less than once weekly, and the Director of Residential Services is on site no less than monthly to ensure all plans are implemented as written.</p>	

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W 0331 Bldg. 00	<p>help prevent seat hopping. 3. When available, child safety locks should be utilized when transporting [client #4]. 4. [Client #4] should always be sitting in the very back bench seat and be seated closest to the door. 5. A staff member should sit directly in front of him in the bench seat during transports. In case of an emergency, the staff member will be close to [client #4] and able to assist him, if needed."</p> <p>On 12/18/15 at 10:37 AM, the Network Director indicated client #4's protocol should be implemented as written.</p> <p>On 12/18/15 at 10:57 AM, the Director of Support Services indicated client #4's protocol should be implemented as written.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 clients in the sample (#2) and one additional client (#4), the facility's nursing services failed to ensure the pharmacist's recommendations were implemented.</p>	W 0331	To correct the deficient practice and ensure it does not continue, the pharmacy recommendations have now been implemented. The Director of Health Services will review with the nurses current agency practices related to pharmacy recommendations to ensure there is clear	01/17/2016			

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	<p>Findings include:</p> <p>On 12/16/15 at 1:06 PM, a review of the pharmacist's recommendations for client #4 were reviewed. On 9/22/15, the pharmacist recommended for client #4, "His Miralax (constipation) order just says to give 1 tbsp (tablespoon) at 8p and to increase to 1 capful at day 5 if no bowel movement. 1. I would recommend if the 1 capful portion of the order is not valid that we have it removed from the order. He had taken this since 2009 so I would think it is not. 2. The manufacturer recommendations are 'mix with 4-8 ounces of liquid and drink.' I would have this added to the order for clarity to avoid a potential medication error."</p> <p>On 12/16/15 at 1:42 PM, the nurse indicated the pharmacist's recommendations were not addressed by the facility. The nurse indicated client #4's orders were not changed. The nurse indicated client #4's orders should have been changed to address the pharmacist's recommendations.</p> <p>A 9/22/15 pharmacist's Note To Attending Physician/Prescriber for client #4 indicated, "[Client #4] receives Clonidine 0.1 mg (milligram) QAM (every morning) and 0.2 mg QHS (every</p>				<p>communication and followup, and make changes as necessary, and then train ND/Qs, TMs and Medical Coordinators on the process . Ongoing monitoring will occur through the nurse's collection of documentation from the medical coordinator confirming completion of any recommendations.</p>		

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	<p>night) for behavioral control. He has received this long term. He still had BPs (blood pressure) checked prior to each dose with hold orders if BP (less than) 90/60. He is not getting low at all, typically ranging from about 105-150/70-100. Since he is never getting low can we stop the hold orders and BID (twice a day) BPs and just change him to a weekly BP and Pulse to monitor?"</p> <p>On 12/16/15 at 2:13 PM, the nurse provided a fax cover sheet dated 9/28/15 at 2:22 PM when she sent the following message to staff #2: "Can you make the changes recommended to the MAR (medication administration record) and fax [client #4's] to his PCP (primary care physician)...."</p> <p>On 12/16/15 at 1:41 PM, the nurse indicated the pharmacist's recommendations were not addressed by the facility. The nurse indicated there was no change in client #4's blood pressure monitoring.</p> <p>On 12/16/15 at 1:31 PM, a review of client #2's 9/22/15 Consultant Pharmacist's Medication Regimen Review was conducted. The recommendations indicated, "I did not see any labs scheduled on him. Please</p>						

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	<p>ensure that with his medication use we have at least the following scheduled: CBC (complete blood count), BMP (basic metabolic panel), Lipid Panel q (every) 12 months." There was no documentation the labs were conducted as ordered.</p> <p>On 12/16/15 at 1:31 PM, the nurse indicated client #2 did not have lab work completed and no lab work had been ordered as recommended by the pharmacist.</p> <p>On 12/16/15 at 1:24 PM, the nurse indicated when she obtained the pharmacist's recommendations, she reviewed the recommendations and sent the recommendations to the Medical Coordinator (staff #2) at the group home. The nurse indicated the Medical Coordinator was supposed to send the recommendations to the clients' doctor for review. The doctor would then agree or disagree with the pharmacist's recommendations. The nurse indicated there was no documentation indicating she reviewed the pharmacist's recommendations or implemented the recommendations.</p> <p>9-3-6(a)</p>			

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W 0369 Bldg. 00	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 8 medications administered to client #3, the facility failed to ensure staff administered client #3's acne medication as ordered.</p> <p>Findings include:</p> <p>On 12/16/15 from 6:40 AM to 8:20 AM, an observation was conducted at the group home. At 7:32 AM, client #3 received Clindamycin 1% gel for acne on his face. Client #3 applied the gel to his face. Client #3 was not prompted or assisted by staff #2 to apply the gel to his back. The instructions on the Clindamycin indicated to apply the gel to his face and back every morning.</p> <p>On 12/16/15 at 8:13 AM, a review of client #3's 9/30/15 Physician's Orders indicated he was prescribed Clindamycin 1% gel. The order indicated, "Apply topically to face and back every morning."</p> <p>On 12/16/15 at 8:11 AM, staff #2 indicated she did not apply client #3's gel to his back.</p>	W 0369	To correct the deficient practice and ensure it does not continue, staff #2 has received corrective action for failing to administer client #3's acne medication as ordered. The nurse will review with all staff the procedures for medication administration, with an emphasis on the importance of administering medications as ordered, including topical medications. To ensure no others were affected by the deficient practice, the nurse will complete a medication pass audit on all staff working in the setting. Ongoing monitoring will be accomplished through supervisory med pass observations at least once weekly for one month. Additionally, the Team Manager is the direct on-site supervisor for the staff and works in the home full-time, providing ongoing support and supervision as necessary. The ND/Q is in the setting no less than once weekly, and the Director of Residential Services is on site no less than monthly to ensure agency procedures are implemented as written.	01/17/2016

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	<p>On 12/16/15 at 8:11 AM, the Network Director indicated client #3's gel should have been administered as written.</p> <p>On 12/16/15 at 12:57 PM, the nurse indicated client #3's physician's order should be implemented as written. On 12/16/15 at 1:18 PM, the nurse indicated client #3 not receiving his medication as ordered was a medication error.</p> <p>9-3-6(a)</p>				