STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G604	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	339 W JEFFERSON ST SPENCER, IN 47460

(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	This visit was for a post certification revisit (PCR) to the full recertification and state licensure survey completed on 6/2/14. This visit was in conjunction with the investigation of complaint #IN00152369. Survey Dates: July 14, 15 and 16, 2014 Facility Number: 001118 Provider Number: 15G604 AIM Number: 100245630 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/23/14 by Ruth Shackelford, QIDP.	W000000		
W000120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, interview and record review for 4 of 4 clients who	W000120	In order to correct the deficient practice, the new Network	08/15/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	attended the outside services day program (#1, #2, #4 and #6), the facility failed to ensure the outside services day program met the needs of the clients. Findings include: On 7/14/14 from 2:40 PM to 3:30 PM, an observation was conducted at the day program clients #1, #2, #4 and #6 attended. The clients were present during the observation. An interview with the Day Program Manager (DPM) was conducted on 7/14/14 at 2:58 PM. The DPM indicated there have been no staff from the group home at the day program conducting observations. The DPM indicated since the surveyor's last visit (5/20/14) to the day program, former client #5 stopped attending the day program due to moving and client #1 restarted attending the day program. The DPM indicated the day program and the group home staff did not convene to discuss the changes in the clients' programming. The DPM indicated she had not received any updated plans for the clients. A review of the day program records was conducted on 7/14/14 at 2:40 PM and indicated the following:		Director/QIDP (NDQ) and the new Team Manager (TM), both hired in mid-July,will implement a regular observation schedule at the Day Programs at least two times each month. The new NDQ will introduce herself to the Day Program Manager and ensure that all plans are updated. The NDQ and TM will keep a log of their observations in the group home. To ensure that the deficient practice does not recur, the observation notes will be forwarded to the Director of Residential Services (DRS), who will also monitor during ongoing regularly scheduled supervisory sessions with the NDQ.	

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	Client #1 (group home record was reviewed on 7/14/14 at 3:58 PM): -The Individual Program Plan (IPP) at the day program was dated 4/30/11. Client #1's current IPP was dated 4/4/13. -The Replacement Skills Plan (RSP) at the day program was dated 4/26/12. Client #1's current RSP was dated 4/4/13. -The Nursing Care Plan (NCP) at the day program was dated 4/5/13. Client #1's current NCP was dated 4/22/14. Client #2 (group home record was reviewed on 7/14/14 at 4:08 PM): -The IPP at the day program was dated 11/21/11. Client #2's current IPP was dated 12/26/13. -The RSP at the day program was dated 12/26/12. Client #2's current RSP was dated 12/26/13. -The NCP at the day program was dated 4/5/13. Client #2's current NCP was dated 5/3/14. Client #4 (group home record was reviewed on 7/14/14 at 4:05 PM): -The IPP at the day program was dated 2/24/12. Client #4's current IPP was dated 2/23/13. -The RSP at the day program was dated 2/2012. Client #4's current RSP was dated 2/23/13. -The NCP at the day program was dated 4/5/13. Client #4's current NCP was			

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	dated 5/7/14. Client #6 (group home record was reviewed on 7/14/14 at 4:06 PM): -The NCP at the day program was dated 10/18/13. Client #6's current NCP was dated 5/7/14. On 7/15/14 at 11:18 AM, the Network Director (ND) indicated she had not conducted observations and interviews at the day program to ensure the services met the needs of the clients. The ND indicated the Home Manager (HM) was supposed to conduct observations at the day program. The ND indicated the day program should have the clients' current program plans including IPPs, RSPs, and NCPs. On 7/15/14 at 11:15 AM, the HM indicated she had not conducted observations and interviews at the day program. The HM indicated she assumed the Director of Residential Services and the Network Director were conducting the observations. The HM indicated the DRS and ND told her they were taking care of the observations at the day program. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	9-3-1(a)			
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to 1) review and monitor the program of the clients' progress toward completing their program plan training objectives and 2) obtain the specially constituted committee's (HRC - Human Rights Committee) approval to start two psychotropic medications ordered by the psychiatrist for client #1. Findings include: 1) A review of client #1's record was conducted on 7/14/14 at 3:58 PM. Client #1's record did not contain documentation the training objectives in his 4/4/13 Individualized Program Plan (IPP) were reviewed monthly. Client #1's record did not contain documentation the QIDP reviewed and monitored the progress of his IPP since August 2013.	W000159	In order to correct this deficiency, the data collection tallies have been completed and analyzed. To ensure that the deficient practice does not recur, the new NDQ will monitor all plans and progress and document as required. The new NDQ will also utilize the QA checklist to document her monthly reviews have been done. These checklists are forwarded to the Quality Assurance Director (QAD) and will be reviewed with the DRS during ongoing regularly scheduled supervisory sessions. The two psychotropic medications ordered by the psychiatrist for client #1, have since been determined to be unnecessary as the behaviors they were meant to address are no longer in evidence. The psychiatrist has been contacted to change the order and HRC approval will not be necessary. However, to ensure this deficient practice does not recur, and that no other customers are affected, the QAD will retrain the NDQs on HRC	08/15/2014

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	A review of client #2's record was conducted on 7/14/14 at 4:08 PM. Client #2's record did not contain documentation the training objectives in his 12/26/13 IPP were reviewed monthly. Client #2's record did not contain documentation the QIDP reviewed and monitored the progress of his IPP since August 2013. A review of client #3's record was conducted on 7/14/14 at 4:02 PM. Client #3's record did not contain documentation the training objectives in her 2/24/13 IPP were reviewed monthly. Client #3's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013. A review of client #4's record was conducted on 7/14/14 at 4:05 PM. Client #4's record did not contain documentation the training objectives in her 2/23/13 IPP were reviewed monthly. Client #4's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013. A review of client #6's record was conducted on 7/14/14 at 4:06 PM. Client #6's record did not contain		policies and procedures, to include the use of the psychiatric consult form to trigger a request for new or changed medications. All psychotropic medications used by all customers in thehouse will also be reviewed by the MC, LPN and NDQ to ensure that properapprovals by families/guardians and the HRC have been sought and secured. Ongoing monitoring will beaccomplished through regular documented weekly meetings with MC, LPN and NDQ todiscuss medication changes and then reviewed by the NDQ with the DRS.	

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	documentation the training objectives in her 12/17/13 IPP were reviewed monthly. Client #6's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013. On 7/15/14 at 11:18 AM, the QIDP indicated the clients' progress on their program plans had not been completed since the survey exited on 6/2/14. The QIDP indicated it was to be completed monthly however the facility was going to change the monthly review to a quarterly review in the future. 2) A review of client #1's record was conducted on 7/15/14 at 10:49 AM. Client #1's record did not include his most recent psychiatric appointment consultation documentation. The Medical Coordinator (MC) was able to locate client #1's most recent psychiatric appointment form documentation in the group home office. The Psychotropic Medication Management Review form, dated 5/20/14, indicated, in part, "On-going mania. Try to normalize sleep (with) (adding) Ativan 1 mg (milligram) QHS (every hour of sleep) cont (continue) Mellaril. (Add) Lamictal (mood stab) grad (gradual) titration to 100 mg QHS... MD (medical doctor) Recommendations: ongoing mania:			

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	titrate lamictal to 100 mg (given conduction concerns with increasing mellaril). Continue mellaril. Add ativan 1mg qhs for sleep normalization, improving mania." On 7/15/14 at 10:55 AM, the Medical Coordinator (MC) indicated she was waiting on the QIDP to obtain consent from the facility's HRC prior to starting the medications. The MC indicated she did not know why it was taking so long to obtain HRC consent. The MC indicated the QIDP was trying to obtain HRC consent. The MC indicated client #1's Ativan was in the group home to give however it had not been started due to not having HRC consent. The MC indicated she followed up with the QIDP on several occasions to find out if the QIDP obtained HRC consent. The MC indicated she informed the Health Care Coordinator (HCC) who told her to keep following up with the QIDP since the HCC did not obtain HRC consent for medications. On 7/15/14 at 2:48 PM, the Health Care Coordinator (HCC) stated client #1's orders for two new psychotropic medications were "stuck" in HRC for now. The HCC indicated the pharmacy had the orders but they were on hold until the HRC approves the medications. The			

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	HCC indicated the QIDP was working on getting the medications through the HRC to obtain consent so the medications could be started. On 7/15/14 at 11:18 AM, the QIDP indicated she was waiting to obtain HRC approval before starting client #1's new psychotropic medications. The QIDP indicated the HRC did not convene in June 2014. The QIDP indicated she needed to obtain HRC consent prior to client #1's medications being started. The QIDP indicated she sent the HRC members an email in an attempt to obtain their consent for client #1's medications however not enough of the HRC members responded in order to start the medications. The QIDP stated, "There's not much else I can do until the HRC approves." This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the			

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	comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 had a plan to regularly visit her husband. Findings include: On 7/14/14 at 2:59 PM, client #4 indicated she had not been to visit her husband since April 2014. Client #4 indicated she did not have a date scheduled to visit her husband. Client #4 indicated she did not know when she would be able to visit her husband again. Client #4 indicated she wanted a set schedule to visit her husband. Client #4 indicated she missed her husband. A review of client #4's Replacement Skills Plan (RSP), dated 2/23/13, was conducted on 7/14/14 at 4:05 PM. Client #4's RSP indicated, in part, "[Client #4] moved to the [name] Group home in February 2012 after temporarily living at [name of facility], a long term care facility. [Client #4] was staying there because her husband, [name], had been admitted because of health issues. [Client #4] and [name of husband] has (sic) been married for years and lived in an apartment with minimal help. [Name of husband] has since moved to a long	W000227	In order to correct the deficient practice, the new NetworkDirector/QIDP (NDQ) and the new Team Manager (TM), both hired in mid-July, will implement a regular visitation schedule immediately. The NDQ will compose a goal to address the issue and staff will track progress. The NDQ will monitor monthly and through the use of the quarterly QA reports.	08/15/2014

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	term care facility in [name of city]." Client #4 did not have a regular, consistent schedule developed to visit her husband. On 7/14/14 at 3:50 PM, staff #6 indicated client #4 did not have a plan to regularly visit her husband. On 7/14/14 at 3:50 PM, staff #5 indicated client #4 did not have a plan to regularly visit her husband. On 7/15/14 at 11:18 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 did not have a written plan to visit her husband on a regular basis. The QIDP indicated client #4 needed a written plan to visit her husband. The QIDP indicated client #4's next visit with her husband had been scheduled. The QIDP indicated she was not sure if staff informed client #4 of the upcoming visit. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN			

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	The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 2 non-sampled clients (#1), the facility failed to develop written instructions to staff about the supports to be provided for client #1's supervised oral care. Findings include: A review of client #1's record was conducted on 7/14/14 at 3:58 PM. Client #1's Nursing Care Plan (NCP), dated 4/22/14, indicated, in part, "At Risk for Pain/Discomfort/Infection Due to Dental Decay. Staff Responsibilities: Ensure routine oral hygiene is completed twice daily. Monitor for pain/discomfort of mouth/teeth. Document and notify nurse via voicemail. Ensure routine and as needed dental visits are completed. Ensure healthy diet is followed with no concentrated sweets and plenty of fresh fruits and vegetables. Nursing Responsibilities: Nurse complete assessment of mouth with each visit and as needed. Nurse to refer to dentist for any problems noted." The NCP did not	W000240	In order to correct the deficient practice, the Health Care Coordinator (HCC) has updated the Nursing Care Plan (NCP) to include specific recommendations from client #1's dentist. She will also train house staff on the revised plan. Ongoing monitoring will be accomplished through monthly data collection and quarterly QA reports. The newly hired LPN assigned to the house will also monitor through regular reviews of the nursing plan.	08/15/2014

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	include written instructions to staff regarding how long client #1 was to brush his teeth, the kind of toothbrush and toothpaste client #1 was supposed to use and whether or not routine oral hygiene included flossing. On 7/15/14 at 2:48 PM, the Health Care Coordinator (HCC) indicated oral care was added to client #1's Medication Administration Record to ensure he received supervised oral care two times per day. The HCC indicated at client #1's next dental appointment, the facility would obtain the recommendations from client #1's dentist for how long he was to brush his teeth, the kind of toothbrush and toothpaste he was supposed to use and whether or not routine oral hygiene included flossing. The HCC indicated after client #1's next dental appointment, client #1's plan would be updated to include the recommendations from client #1's dentist. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	9-3-4(a)			
W000250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to develop an active treatment schedule outlining the current active treatment program due to client #3 no longer attending the day program. Findings include: Observations were conducted at the group home on 7/14/14 from 3:43 PM to 5:45 PM and 7/15/14 from 10:26 AM to 11:34 AM. During the observations, client #3 was at home. Client #3, on 7/14/14, was in the recliner watching television until 3:39 PM when she was transferred to her wheelchair. From 3:39 PM until 5:45 PM, client #3 sat in her wheelchair in the living room either watching the fish in the fish tank or watching the television. On 7/15/14, client #3 was at home. After being	W000250	In order to correct the deficient practice, the new NDQ will create activity schedules and train all house staff on their use. To ensure that the deficient practice does not recur, the NDQ will review the schedules regularly as part of the house meeting agenda. They will also be monitored through observations by the TM and NDQ twice weekly for one month.	08/15/2014

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	assisted in the shower, client #3 was assisted to her recliner in the living room. The television was on and client #3 was asleep. A review of client #3's record was conducted on 7/14/14 at 4:02 PM. Client #3 did not have an active treatment schedule addressing the times she was no longer attending the day program (Monday through Friday, 8:00 AM to 3:30 PM). On 7/15/14 at 11:18 AM the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3 did not have an active treatment schedule developed for the time she was spending at the group home during the day when her peers went to the day program. The QIDP indicated the facility was working to develop an active treatment schedule for client #3. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000260	483.440(f)(2) PROGRAM MONITORING & CHANGE			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G604	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	339 W JEFFERSON ST SPENCER, IN 47460

(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
	At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on interview and record review for 2 of 3 clients in the sample (#3 and #4) and one additional client (#1), the facility failed to update the individual support plans annually or as warranted based on the individualized needs of the clients. Findings include: A review of client #1's Individual Program Plan (IPP) was conducted on 7/14/14 at 3:58 PM. Client #1's current IPP was dated 4/4/13. There was no documentation in client #1's record indicating his IPP was updated or revised since 4/4/13. A review of client #3's IPP was conducted on 7/14/14 at 4:02 PM. Client #3's current IPP was dated 2/24/13. There was no documentation in client #3's record indicating her IPP was updated or revised since 2/24/13. A review of client #4's IPP was conducted on 7/14/14 at 4:05 PM. Client #4's current IPP was dated 2/23/13.	W000260	In order to correct the deficient practice, the new Network Director/QIDP (NDQ) will finish updating all ISPs and oversee their implementation. To ensure that the deficient practice does not recur, the Director of Residential Services (DRS), will monitor during ongoing regularly scheduled supervisory sessions with the NDQ and utilize an ISP calendar to better track due dates and provide reminders.	08/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460	

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	There was no documentation in client #4's record indicating her IPP was updated or revised since 2/23/13. On 7/15/14 at 11:18 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients' IPPs should be revised and updated at least annually. The QIDP indicated the clients' IPPs had not been updated or revised since the survey conducted on 6/2/14. The QIDP indicated she had until 7/18/14 to revise and update the clients' IPPs. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000262	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 observation, interview and record review for 2 of 3 clients in the sample (#3 and #6) and one additional client (#1), the facility's specially	W000262	In order to correct the deficient practice, the Network Director/QIDP (NDQ) has secured HRC approval for the use of door alarms for all	08/15/2014

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	constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the use of door alarms and bells on the group home's exit doors for clients #1 and #3 and client #6's restrictive behavior plan. Findings include: Observations were conducted at the group home on 7/14/14 from 3:43 PM to 5:45 PM and 7/15/14 from 10:26 AM to 11:34 AM. During the observations, when an exit door was opened, an audible alarm or bells sounded. This affected clients #1, #3 and #6. A review of client #1's record was conducted on 7/14/14 at 3:58 PM. There was no documentation the facility's HRC reviewed, approved and monitored the use of door alarms and bells in client #1's record. The facility was unable to provide documentation indicating the facility's HRC reviewed, approved and monitored the use of door alarms and bells. A review of client #3's record was conducted on 7/14/14 at 4:02 PM. There was no documentation the facility's HRC reviewed, approved and monitored the use of door alarms and bells in client #3's record. The facility was unable to		customers. To ensure this deficient practice does not recur, the QAD will retrain the NDQs on HRC policies and procedures. The Director of Residential Services (DRS), will monitor restrictive practices during ongoing regularly scheduled supervisory sessions with the NDQ.	

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	provide documentation indicating the facility's HRC reviewed, approved and monitored the use of door alarms and bells. A review of client #6's record was conducted on 7/14/14 at 4:06 PM. Client #6's behavior plan, dated 12/17/13, indicated she had a targeted behavior of self-injurious behavior/anxiety (defined as skin picking, rectal digging, cutting skin, making herself vomit and calling 911). Client #6's plan indicated she took two psychotropic medications (Latuda and Trazodone) to address the behavior. A plan for elopement, dated 11/25/13, indicated, in part, "Targeted Behavior: Elopement defined as walking out of staff's sight in the community, from the group home, day program, or attempting to leave the property or the location in the community where [client #6] is with her staff with no intention of returning or informing staff of where she is going. Physical Supports for this Behavior: Door alarms and bells on exterior doors." There was no documentation in client #6's record indicating the facility's HRC reviewed, approved and monitored the use of psychotropic medications to address self-injurious behavior/anxiety and the use of door alarms and bells on exterior doors.			

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	An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/15/14 at 11:18 AM. The QIDP indicated the HRC had not met since the survey was completed on 6/2/14. The QIDP indicated she attempted to get approval from the HRC however a majority of the HRC members did not respond to her emails to warrant obtaining HRC approval. The QIDP indicated the HRC was scheduled to meet on 7/25/14. The QIDP indicated the facility had not obtained HRC approval for the client #6's restrictive behavior plan and the use of bells and alarms on the doors. This deficiency was cited on 6/2/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W009999		W009999	There was no citation	08/15/2014