

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
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W0000	<p>This visit was for an investigation of complaint #IN00108347.</p> <p>Complaint #IN00108347 - Substantiated. Federal/State deficiencies related to the allegations are cited at W149, W154, W157 and W249.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: June 6, 7 and 12, 2012.</p> <p>Facility number: 004000 Provider Number: 15G715 AIM Number: 200481990</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 18, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000			

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the governing body failed to exercise operating direction over the facility by not ensuring the carpet was cleaned or replaced.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/12/12 from 9:10 AM to 10:48 AM. During the observation, the carpet in the front living room of the home and hallway to the left of the living room was soiled and stained. This affected clients A, B, C, D, E and F.</p> <p>An interview with Direct Care Staff (DCS) #2 was conducted on 6/12/12 at 9:17 AM. DCS #2 indicated the carpets needed to be cleaned or replaced. DCS #2 indicated the carpets were stained from client D trying to take drinks to his room and spilling the contents on the carpet. DCS #2 indicated the carpets were dirty.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:19 AM. The PD indicated the home was due for its annual carpet cleaning. The PD</p>	W0104	<p>The carpet will be cleaned or the process will be started to have the carpet replaced if cleaning cannot be completed. Documentation of actions completed will be on file at the LifeDesigns, Inc office.</p>	07/31/2012			

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	<p>indicated the carpets had not been cleaned and needed to be cleaned.</p> <p>9-3-1(a)</p>			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 1 of 28 incident/investigative reports reviewed affecting client B and one additional incident of elopement not documented on an incident report, the facility failed to implement its policies and procedures to prevent neglect of the client in regard to elopement.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. On 5/9/12 at 6:30 PM, client B eloped from the group home. Client B was returned to the group home by two women and one police officer. At the time the neighbors and police officer knocked on the group home door to return client B, the 3 direct care staff (#1, #2 and #5) were unaware client B was not in the home. The investigative report indicated, "[Client B's] behavior plan indicates the door alarms and the gate locks are in place for her High Risk Elopement plan. The alarm not functioning and gates not tightly secured did not allow for these supports to be appropriately used." The investigative Determination section</p>	W0149	<p>LifeDesigns will continue to complete and monitor the recommendations of the investigations #25912 and #253012. 25912) The Director of Human Resources will inform David Morrow he is allowed to return to work. David will be informed he is not to work alone or be assigned to Feliz Fleenor until he completes all required training. 2) The Program Director will issue a corrective action to David Morrow for failure to follow policy and procedure. The policies violated include following program plans as written, and providing active treatment. 3) The Program Director will retrain all group home staff on active treatment and ensuring each individual is accounted for at all times. This training should include involving individuals in assisting with cleaning and chores. The training should emphasize that cleaning is not to affect providing active treatment to the individuals. 4) The Program Director will retrain all staff completing overnight shifts on deep cleaning responsibilities and completing an overnight cleaning checklist. The checklist will be reviewed by the Program Director in order to hold overnight staff accountable for</p>	07/12/2012			

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	<p>indicated, "It is clear that [client B] was able to successfully elope from the [name of group home]. It is unclear exactly how long she was gone. The most concise timeframe was given by the officer indicating he responded in 5 minutes and it took an additional 20 minutes to get [client B] in a vehicle. According to the distance traveled, [client B] could have reached the destination with 10 minutes walking. Only one staff could account for the approximate time of last seeing [client B] (6:15 PM) and the officer and neighbors arriving (6:45 PM). It would appear from the estimations given that [client B] was gone for 30 minutes without any staff being aware. It does not appear intentional that [staff #5] did not know where [client B] was at all times. He was engaged in cleaning the kitchen after dinner. The door that [client B] appeared to have used does not have a functional alarm and would have assisted [staff #5] while continuing to clean the kitchen after dinner." The facility substantiated neglect without intent to cause abuse/harm/injury.</p> <p>A review of client B's Replacement Skills Plan (RSP), dated 3/14/12, was conducted on 6/6/12 at 3:27 PM. The RSP indicated client B had a High Risk Plan for Elopement. Elopement was defined as leaving the property or staff's sight</p>		<p>deep cleaning. Lack of completing tasks will result in corrective action for the overnight staff. 5) The QDDP will ensure outside PEC cards are available for use of Feliz's IPP goal. The QDDP will follow up with staff on the meaning of why most of the trials are "not met" and make revisions as needed. 6) The QDDP will retrain David Morrow on all individual's program plans (IPPs and RSPs). This training should include how to properly use environmental supports listed in the behavior support plans and their intent for being utilized. 7) The Program Director will ensure that David Morrow, once informed he is able to return to work, will not be assigned to Feliz Fleenor until all required training has been completed. Copies of the staff assignment sheet will be forwarded to Stephanie Bryant each week until all training has been completed. 8) The QDDP will retrain all Parklane Group Home staff on Feliz Fleenor's program plans. The training should include appropriate use of environmental supports and their intent for being utilized. 9) The QDDP will retrain all Parklane Group Home staff on each individual's program plans and ensuring environmental supports are utilized appropriately. 10) The Program Director will coordinate with Jillian East, Employee Development Coordinator on scheduling David</p>				

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	<p>without permission. The Environmental Supports for the Behavior was defined as locks on gates (front and back) and alarms on the front and back doors.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 6/6/12 at 1:32 PM. The policy indicated, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report." The policy defined neglect as the failure to provide goods or services necessary to avoid physical or psychological harm. Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm."</p>		<p>Morrow's training on Respectful Supports and Protection and Advocacy all classes. 11) The Director of Residential Services will review with Ricky Tanner, Program Director completing comprehensive PD Audits and ensuring window and door alarms are operational and reporting to maintenance if there is noted a malfunction. 2530121. The QDDP will revise Feliz's behavior plan to indicate within the definition of her Elopement plan, "going outside without staff's knowledge." The behavior plan shall also include in the reactive measures, any time Feliz is outside without supervision, the Administrator on-call for Abuse and Neglect must be notified. 2. The QDDP will retrain on the revised behavior plan. A copy of the behavior plan and training sheet should be forwarded to Stephanie Bryant.</p>		

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	<p>An interview with staff #2 was conducted on 6/12/12 at 9:20 AM. Staff #2 indicated she was working on 5/9/12 when client B eloped. Staff #2 indicated she was not aware client B left the group home until 2 women and a police officer knocked on the door. Staff #2 indicated the alarms were on at the time but the back door alarm was not working. Staff #2 indicated client B could run fast.</p> <p>An interview with staff #1 was conducted on 6/12/12 at 10:20 AM. Staff #1 indicated she was working on 5/9/12 when client B eloped from the group home. Staff #1 indicated the 3 staff were not aware client B eloped from the group home until 2 women and a police officer knocked on the door. Staff #1 indicated the alarm on the back door was not working. Staff #1 indicated if the alarm had been working, client B would not been able to elope from the home. Staff #1 indicated the alarm was found to be not working after the incident.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:26 AM. The PD indicated he received a call from staff #2 while driving. Staff #2 indicated the police were at the home and wanted to speak to him. The PD indicated the officer indicated he was</p>			

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	<p>frustrated since the 3 staff working at the group home did not know client B was not in the home. The PD indicated the incident should not have happened since the staff should have known client B's location at all times. The PD indicated any time one of the clients went outside, staff should go out with them. At 9:53 AM, the PD indicated the facility prohibited abuse and neglect of the clients. The PD indicated the policy for abuse and neglect should be implemented. The PD indicated the staff should have implemented client B's plan as written.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. There was no documentation of an incident/investigative report conducted for an incident of elopement on 5/30/12.</p> <p>A review of client B's Behavior Observations dated 5/30/12 was conducted on 6/12/12 at 9:50 AM. The document indicated, "Behavior during shift (Fair was circled). Rationale: darting/attempted elopement. The narrative former staff #1 documented indicated, "[Client B] woke up and put on [client F's] clothes not her own. Was food seeking all day. Darted out in the road while supervised... then twice after that tried to elope...."</p>						

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	<p>An interview with staff #2 was conducted on 6/12/12 at 9:32 AM. Staff #2 indicated client B eloped on 5/30/12. Staff #2 indicated as she was walking past the front door, which was open and the alarm was not sounding, she observed client B on the outside of the fenced in area by the mailbox. Staff #2 indicated she yelled to the other staff client B was out and went outside to get her. Staff #2 indicated client B took off running and staff #2 was able to stay with her and bring her back to the home. Staff #2 indicated there were no other staff outside with client B. Staff #2 indicated the assigned staff, former staff #1, was assisting client C in the shower.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:34 AM. The PD indicated he was not sure if an incident report and investigation was conducted regarding client B's elopement on 5/30/12. The PD indicated the information he received verbally from staff and the daily note indicated client B was supervised the entire time during the incident. The PD indicated the staff should have been with client B at the time of the incident. At 9:53 AM, the PD indicated he was told the staff were with client B on 5/30/12. The PD indicated he asked the staff why the alarm did not</p>				

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	<p>sound when client B went outside; staff indicated the door was open. The PD indicated he was not informed client B was outside unsupervised; he indicated when it was reported to him it was an attempted elopement. He indicated from staff #2's interview, the incident was elopement. The PD indicated the former staff assigned to client B on 5/30/12 did not follow policy and procedure for supervising the client, the door should not have been left open and the staff failed to implement her Replacement Skills Plan as written. The PD indicated darting was when a client took off with a staff with them and elopement was when a client took off unsupervised. The PD indicated staff should have been with client B when she went outside. The PD stated former staff #1 was "...negligent in the sense she was not accountable for her individual."</p> <p>This federal tag relates to complaint #IN00108347.</p> <p>9-3-2(a)</p>				

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W0154	<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 an incident not documented on an incident report or investigated (1 of 29 incident/investigative reports affecting client B), the facility failed to conduct a thorough investigation into elopement on 5/30/12.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. There was no documentation of an incident/investigative report conducted for an incident of elopement on 5/30/12.</p> <p>A review of client B's Behavior Observations dated 5/30/12 was conducted on 6/12/12 at 9:50 AM. The document indicated, "Behavior during shift (Fair was circled). Rationale: darting/attempted elopement. The narrative former staff #1 documented indicated, "[Client B] woke up and put on [client F's] clothes not her own. Was food seeking all day. Dashed out in the road while supervised... then twice after that tried to elope...."</p>	W0154	<p>LifeDesigns will continue to complete and monitor the recommendations of the investigations #25912 and #253012. 259121) The Director of Human Resources will inform David Morrow he is allowed to return to work. David will be informed he is not to work alone or be assigned to Feliz Fleenor until he completes all required training. .2) The Program Director will issue a corrective action to David Morrow for failure to follow policy and procedure. The policies violated include following program plans as written, and providing active treatment. 3) The Program Director will retrain all group home staff on active treatment and ensuring each individual is accounted for at all times. This training should include involving individuals in assisting with cleaning and chores. The training should emphasize that cleaning is not to affect providing active treatment to the individuals. 4) The Program Director will retrain all staff completing overnight shifts on deep cleaning responsibilities and completing an overnight cleaning checklist. The checklist will be reviewed by the Program Director in order to hold overnight staff accountable for deep cleaning. Lack of</p>	07/12/2012			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 28 incident/investigative reports reviewed affecting client B and one additional incident of elopement not documented on an incident report, the facility failed to implement appropriate corrective action in regard to elopement.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. On 5/9/12 at 6:30 PM, client B eloped from the group home. Client B was returned to the group home by two women and one police officer. At the time the neighbors and police officer knocked on the group home door to return client B, the 3 direct care staff (#1, #2 and #5) were unaware client B was not in the home. The investigative report indicated, "[Client B's] behavior plan indicates the door alarms and the gate locks are in place for her High Risk Elopement plan. The alarm not functioning and gates not tightly secured did not allow for these supports to be appropriately used." The investigative Determination section indicated, "It is clear that [client B] was</p>	W0157	<p>An IDT was held on June 14th, 2012. A copy of this IDT is on file at the LifeDesigns, Inc office. LifeDesigns will continue to complete and monitor the recommendations of the investigations #25912 and #253012. 1) The Director of Human Resources will inform David Morrow he is allowed to return to work. David will be informed he is not to work alone or be assigned to Feliz Fleenor until he completes all required training. .2) The Program Director will issue a corrective action to David Morrow for failure to follow policy and procedure. The policies violated include following program plans as written, and providing active treatment. 3) The Program Director will retrain all group home staff on active treatment and ensuring each individual is accounted for at all times. This training should include involving individuals in assisting with cleaning and chores. The training should emphasize that cleaning is not to affect providing active treatment to the individuals. 4) The Program Director will retrain all staff completing overnight shifts on deep cleaning responsibilities and completing an overnight cleaning checklist. The checklist will be reviewed by the</p>	07/12/2012			

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	<p>able to successfully elope from the [name of group home]. It is unclear exactly how long she was gone. The most concise timeframe was given by the officer indicating he responded in 5 minutes and it took an additional 20 minutes to get [client B] in a vehicle. According to the distance traveled, [client B] could have reached the destination with 10 minutes walking. Only one staff could account for the approximate time of last seeing [client B] (6:15 PM) and the officer and neighbors arriving (6:45 PM). It would appear from the estimations given that [client B] was gone for 30 minutes without any staff being aware. It does not appear intentional that [staff #5] did not know where [client B] was at all times. He was engaged in cleaning the kitchen after dinner. The door that [client B] appeared to have used does not have a functional alarm and would have assisted [staff #5] while continuing to clean the kitchen after dinner." The facility substantiated neglect without intent to cause abuse/harm/injury. The facility was unable to provide documentation the team met to discuss client B's elopement after the incident.</p> <p>A review of client B's Replacement Skills Plan (RSP), dated 3/14/12, was conducted on 6/6/12 at 3:27 PM. The RSP indicated client B had a High Risk Plan for</p>		<p>Program Director in order to hold overnight staff accountable for deep cleaning. Lack of completing tasks will result in corrective action for the overnight staff. 5) The QDDP will ensure outside PEC cards are available for use of Feliz's IPP goal. The QDDP will follow up with staff on the meaning of why most of the trials are "not met" and make revisions as needed. 6) The QDDP will retrain David Morrow on all individual's program plans (IPPs and RSPs). This training should include how to properly use environmental supports listed in the behavior support plans and their intent for being utilized. 7) The Program Director will ensure that David Morrow, once informed he is able to return to work, will not be assigned to Feliz Fleenor until all required training has been completed. Copies of the staff assignment sheet will be forwarded to Stephanie Bryant each week until all training has been completed. 8) The QDDP will retrain all Parklane Group Home staff on Feliz Fleenor's program plans. The training should include appropriate use of environmental supports and their intent for being utilized. 9) The QDDP will retrain all Parklane Group Home staff on each individual's program plans and ensuring environmental supports are utilized appropriately. 10) The Program Director will coordinate with Jillian East,</p>				

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	<p>Elopement. Elopement was defined as leaving the property or staff's sight without permission. The Environmental Supports for the Behavior was defined as locks on gates (front and back) and alarms on the front and back doors.</p> <p>On 6/12/12 at 1:38 PM, Administrative Staff #1 sent an email indicating, "We did not convene an IDT (interdisciplinary team meeting) for [client B]."</p> <p>An interview with staff #2 was conducted on 6/12/12 at 9:20 AM. Staff #2 indicated she was working on 5/9/12 when client B eloped. Staff #2 indicated she was not aware client B left the group home until 2 women and a police officer knocked on the door. Staff #2 indicated the alarms were on at the time but the back door alarm was not working. Staff #2 indicated client B could run fast.</p> <p>An interview with staff #1 was conducted on 6/12/12 at 10:20 AM. Staff #1 indicated she was working on 5/9/12 when client B eloped from the group home. Staff #1 indicated the 3 staff were not aware client B eloped from the group home until 2 women and a police officer knocked on the door. Staff #1 indicated the alarm on the back door was not working. Staff #1 indicated if the alarm had been working, client B would not</p>		<p>Employee Development Coordinator on scheduling David Morrow's training on Respectful Supports and Protection and Advocacy all classes. 11) The Director of Residential Services will review with Ricky Tanner, Program Director completing comprehensive PD Audits and ensuring window and door alarms are operational and reporting to maintenance if there is noted a malfunction. 2530121. The QDDP will revise Feliz's behavior plan to indicate within the definition of her Elopement plan, "going outside without staff's knowledge." The behavior plan shall also include in the reactive measures, any time Feliz is outside without supervision, the Administrator on-call for Abuse and Neglect must be notified. 2. The QDDP will retrain on the revised behavior plan. A copy of the behavior plan and training sheet should be forwarded to Stephanie Bryant.</p>		

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	<p>been able to elope from the home. Staff #1 indicated the alarm was found to be not working after the incident.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:26 AM. The PD indicated he received a call from staff #2 while driving. Staff #2 indicated the police were at the home and wanted to speak to him. The PD indicated the officer indicated he was frustrated since the 3 staff working at the group home did not know client B was not in the home. The PD indicated the incident should not have happened since the staff should have known client B's location at all times. The PD indicated any time one of the clients went outside, staff should go out with them. At 9:53 AM, the PD indicated the staff should have implemented client B's plan as written.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. There was no documentation of an incident/investigative report conducted for an incident of elopement on 5/30/12.</p> <p>A review of client B's Behavior Observations dated 5/30/12 was conducted on 6/12/12 at 9:50 AM. The document indicated, "Behavior during</p>						

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	<p>shift (Fair was circled). Rationale: darting/attempted elopement. The narrative former staff #1 documented indicated, "[Client B] woke up and put on [client F's] clothes not her own. Was food seeking all day. Darterd out in the road while supervised... then twice after that tried to elope...."</p> <p>An interview with staff #2 was conducted on 6/12/12 at 9:32 AM. Staff #2 indicated client B eloped on 5/30/12. Staff #2 indicated as she was walking past the front door, which was open and the alarm was not sounding, she observed client B on the outside of fenced in area by the mailbox. Staff #2 indicated she yelled to the other staff client B was out and went outside to get her. Staff #2 indicated client B took off running and staff #2 was able to stay with her and bring her back to the home. Staff #2 indicated there were no other staff outside with client B. Staff #2 indicated the assigned staff, former staff #1, was assisting client C in the shower.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:34 AM. The PD indicated the staff should have been with client B when she went outside. The PD indicated the former staff assigned to client B on 5/30/12 did not follow policy and procedure for</p>						

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	<p>supervising the client, the door should not have been left open and the staff failed to implement her Replacement Skills Plan as written to prevent elopement.</p> <p>This federal tag relates to complaint #IN00108347.</p> <p>9-3-2(a)</p>			

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W0249	<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 record review and interview for 1 of 3 clients in the sample (B), the facility failed to adequately supervise client B to prevent elopement.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 6/6/12 at 1:58 PM. On 5/9/12 at 6:30 PM, client B eloped from the group home. Client B was returned to the group home by two women and one police officer. At the time the neighbors and police officer knocked on the group home door to return client B, the 3 direct care staff (#1, #2 and #5) were unaware client B was not in the home. The investigative report indicated, "[Client B's] behavior plan indicates the door alarms and the gate locks are in place for her High Risk Elopement plan. The alarm not functioning and gates not tightly secured did not allow for these supports to be appropriately used." The investigative Determination section</p>	W0249	<p>An IDT was held on June 14th, 2012. A copy of this IDT is on file at teh LifeDesigns, Inc office. LifeDesigns will continue to complete and monitor the recommendations of the investigations #25912 and #253012. 259121) The Director of Human Resources will inform David Morrow he is allowed to return to work. David will be informed he is not to work alone or be assigned to Feliz Fleenor until he completes all required training. .2) The Program Director will issue a corrective action to David Morrow for failure to follow policy and procedure. The policies violated include following program plans as written, and providing active treatment. 3) The Program Director will retrain all group home staff on active treatment and ensuring each individual is accounted for at all times. This training should include involving individuals in assisting with cleaning and chores. The training should emphasize that cleaning is not to affect providing active treatment to the individuals. 4)</p>	07/12/2012			

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	<p>indicated, "It is clear that [client B] was able to successfully elope from the [name of group home]. It is unclear exactly how long she was gone. The most concise timeframe was given by the officer indicating he responded in 5 minutes and it took an additional 20 minutes to get [client B] in a vehicle. According to the distance traveled, [client B] could have reached the destination with 10 minutes walking. Only one staff could account for the approximate time of last seeing [client B] (6:15 PM) and the officer and neighbors arriving (6:45 PM). It would appear from the estimations given that [client B] was gone for 30 minutes without any staff being aware. It does not appear intentional that [staff #5] did not know where [client B] was at all times. He was engaged in cleaning the kitchen after dinner. The door that [client B] appeared to have used does not have a functional alarm and would have assisted [staff #5] while continuing to clean the kitchen after dinner." The facility substantiated neglect without intent to cause abuse/harm/injury. The facility was unable to provide documentation the team met to discuss client B's elopement after the incident.</p> <p>A review of client B's Replacement Skills Plan (RSP), dated 3/14/12, was conducted on 6/6/12 at 3:27 PM. The RSP indicated</p>		<p>The Program Director will retrain all staff completing overnight shifts on deep cleaning responsibilities and completing an overnight cleaning checklist. The checklist will be reviewed by the Program Director in order to hold overnight staff accountable for deep cleaning. Lack of completing tasks will result in corrective action for the overnight staff. 5) The QDDP will ensure outside PEC cards are available for use of Feliz's IPP goal. The QDDP will follow up with staff on the meaning of why most of the trials are "not met" and make revisions as needed. 6) The QDDP will retrain David Morrow on all individual's program plans (IPPs and RSPs). This training should include how to properly use environmental supports listed in the behavior support plans and their intent for being utilized. 7) The Program Director will ensure that David Morrow, once informed he is able to return to work, will not be assigned to Feliz Fleenor until all required training has been completed. Copies of the staff assignment sheet will be forwarded to Stephanie Bryant each week until all training has been completed. 8) The QDDP will retrain all Parklane Group Home staff on Feliz Fleenor's program plans. The training should include appropriate use of environmental supports and their intent for being utilized. 9) The QDDP will retrain all Parklane</p>		

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	<p>client B had a High Risk Plan for Elopement. Elopement was defined as leaving the property or staff's sight without permission. The Environmental Support for the Behavior was defined as boundaries social story, locks on gates (front and back), alarm on front and back doors, and "outside" picture cards. The proactive measures section indicated, "Staff will praise [client B] for all attempts at communication. Staff will rehearse with [client B] her social story one time daily. Staff will ensure that "outside" picture cards are available. Staff will honor requests made by [client B] whenever possible. If request cannot be met at that time, staff will let [client B] know when request can be met." The Reactive Measures section indicated, in part, "An IDT (interdisciplinary team meeting) will be held the next business day after any successful elopement to make needed revisions to High Risk Plan."</p> <p>On 6/12/12 at 1:38 PM, Administrative Staff #1 sent an email indicating, "We did not convene an IDT (interdisciplinary team meeting) for [client B]."</p> <p>An interview with staff #2 was conducted on 6/12/12 at 9:20 AM. Staff #2 indicated she was working on 5/9/12 when client B eloped. Staff #2 indicated</p>		<p>Group Home staff on each individual's program plans and ensuring environmental supports are utilized appropriately. 10) The Program Director will coordinate with Jillian East, Employee Development Coordinator on scheduling David Morrow's training on Respectful Supports and Protection and Advocacy all classes. 11) The Director of Residential Services will review with Ricky Tanner, Program Director completing comprehensive PD Audits and ensuring window and door alarms are operational and reporting to maintenance if there is noted a malfunction. 2530121. The QDDP will revise Feliz's behavior plan to indicate within the definition of her Elopement plan, "going outside without staff's knowledge." The behavior plan shall also include in the reactive measures, any time Feliz is outside without supervision, the Administrator on-call for Abuse and Neglect must be notified. 2. The QDDP will retrain on the revised behavior plan. A copy of the behavior plan and training sheet should be forwarded to Stephanie Bryant.</p>				

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	<p>she was not aware client B left the group home until 2 women and a police officer knocked on the door. Staff #2 indicated the alarms were on at the time but the back door alarm was not working. Staff #2 indicated client B could run fast.</p> <p>An interview with staff #1 was conducted on 6/12/12 at 10:20 AM. Staff #1 indicated she was working on 5/9/12 when client B eloped from the group home. Staff #1 indicated the 3 staff were not aware client B eloped from the group home until 2 women and a police officer knocked on the door. Staff #1 indicated the alarm on the back door was not working. Staff #1 indicated if the alarm had been working, client B would not been able to elope from the home. Staff #1 indicated the alarm was found to be not working after the incident.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:26 AM. The PD indicated he received a call from staff #2 while driving. Staff #2 indicated the police were at the home and wanted to speak to him. The PD indicated the officer indicated he was frustrated since the 3 staff working at the group home did not know client B was not in the home. The PD indicated the incident should not have happened since the staff should have known client B's</p>				

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	<p>location at all times. The PD indicated any time one of the clients went outside, staff should go out with them. At 9:53 AM, the PD indicated the staff should have implemented client B's plan as written.</p> <p>2) An interview with staff #2 was conducted on 6/12/12 at 9:32 AM. Staff #2 indicated client B eloped on 5/30/12. Staff #2 indicated as she was walking past the front door, which was open and the alarm was not sounding, she observed client B on the outside of the fenced in area by the mailbox. Staff #2 indicated she yelled to the other staff client B was out and went outside to get her. Staff #2 indicated client B took off running and staff #2 was able to stay with her and bring her back to the home. Staff #2 indicated there were no other staff outside with client B.</p> <p>An interview with the Program Director (PD) was conducted on 6/12/12 at 9:34 AM. The PD indicated the staff should have been with client B at the time of the incident. At 9:53 AM, the PD indicated he was told the staff were with client B on 5/30/12. The PD indicated he asked the staff why the alarm did not sound when client B went outside. The PD indicated he was not informed client B was outside unsupervised; he indicated when it was</p>						

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	<p>reported to him it was an attempted elopement. He indicated from staff #2's interview, the incident was elopement. The PD indicated the former staff assigned to client B on 5/30/12 did not follow policy and procedure for supervising the client, the door should not have been left open and the staff failed to implement her Replacement Skills Plan as written. The PD indicated darting was when a client took off with a staff with them and elopement was when a client took off unsupervised. The PD indicated staff should have been with client B when she went outside.</p> <p>This federal tag relates to complaint #IN00108347.</p> <p>9-3-4(a)</p>			