

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408
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W 000 Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Survey dates: March 23, 24, 25, 26 and 27, 2015</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyors: Steven Schwing, QIDP-TC Paul Rowe, Federal Contract Surveyor</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/2/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104 Bldg. 00	<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, record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the governing body failed to exercise operating direction over the facility to</p>	W 104	To correct the deficient practice related to the facility, all bathrooms in the home have been stocked with hand soap and towels. The floor in the kitchen has been temporarily repaired	04/26/2015

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>ensure a well maintained and sanitary environment. The governing body failed to ensure an effective system for the local school district to quickly contact agency staff for an emergency situation identified by the high school for 1 of 1 client (client #1) for whom an emergency was identified.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/23/15 from 2:00 PM to 6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. An observation was completed of the facility's environment which included the following:</p> <p>1. The downstairs bathroom and the bathroom in client #3's bedroom did not include hand soap or towels to sanitize hands after using the facilities during multiple observations on 3/23/15 and 3/24/15. Client #4's bedroom was located in the basement of the residence and the bathroom was located adjacent to his bedroom. No provisions were available to wash hands in the basement during the survey.</p> <p>On 3/24/15 at 4:00 PM an interview was conducted with staff #2 who indicated he was unaware of the absence of hand soap and towels in the bathrooms.</p>		<p>(space in front of sink reinforced and tiles replaced), and a plan in place to completely replace the flooring in the kitchen, the area off the kitchen, and client #1's bedroom. The missing drawer fronts have been replaced. The kitchen cabinet counter top to the left of the stove has been sealed and attached to the cabinet, and will be covered with a large cutting board. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Team Manager (TM) and Network Director/QDDP (ND/Q) will be re-trained on their responsibilities related to closely monitoring the home for maintenance needs, and the maintenance request process. All maintenance needs, and follow up that occurs, will be included on the Residential Services Team Manager Weekly Report. The TM Weekly Report is submitted to the ND/Q, the Director of Residential Services (DORS), the Chief Services Officer (CSO), the Chief Executive Officer (CEO) and the Director of Support Services (DOSS) for review. To correct the deficient practice related to school communication and ensure it does not continue, a new contact list will be developed that will include the LifeDesigns main office as the main daytime contact. This will allow the school to have one point of contact, and the receptionist can transfer any call to the appropriate home staff.</p>	

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	<p>2. The floor of the kitchen was in poor repair as evidenced by a depression directly in front of the kitchen sink cabinet where the flooring was not solid. This area of the floor was springy and sagging underfoot. The ceramic tile covering this area was broken into pieces exposing the subflooring. There were multiple gaps between tiles across the floor exposing the subflooring. In the places where the subflooring was exposed built up debris was accumulated. Unfinished coves (where the floor met the cabinets) existed at the side of cabinet located left of the sink and around the floor to ceiling cabinet located on the wall between the kitchen and the living room. In these areas the subflooring was exposed allowing an accumulation of debris. This affected clients #1, #2, #3 and #4.</p> <p>3. Missing drawers were evident in the kitchen cabinet to the left of the sink and in the built in buffet in the living room. This affected clients #1, #2, #3 and #4.</p> <p>4. The kitchen cabinet counter top to the left of the stove was comprised of a piece of porous wood which could not be sanitized. This wooden piece was not firmly attached to the cabinet and could be lifted off the cabinet. The counter to</p>		<p>The contact list will be shared with school staff. The DORS will work with the TM and ND/Q to develop a clear plan on how to handle situations that may arise with individuals during the day to ensure a prompt response. Ongoing monitoring will be accomplished by the ND/Q contacting the school no less than monthly to discuss any issues/ concerns.</p>	

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	<p>the left of the sink was not attached to the cabinet below and could be lifted off the cabinet. This affected clients #1, #2, #3 and #4.</p> <p>5. The flooring of the kitchen and the room between the kitchen and dining room were covered with different aged vinyl tile which was porous and stained. This affected clients #1, #2, #3 and #4.</p> <p>6. On the first floor in the last bedroom on the left at the end of the hallway (client #1's room) the linoleum flooring was scuffed and stained across the floor surface.</p> <p>On 3/25/15 at 1:55 PM, the facility did not provide documentation, as requested, of maintenance requests being submitted for the issues identified in items 2 through 6 above.</p> <p>On 3/24/15 at 3:00 PM an interview was conducted with the Team Manager and the Network Director/QIDP (Qualified Intellectual Disabilities Professional). Both indicated the presence of the conditions identified in items 2 through 6 above.</p> <p>On 3/25/15 at 1:55 PM, the Administrative Director (AD) indicated she was aware of the environmental</p>			

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	<p>conditions at the group home involving the kitchen cabinets, flooring, countertops and plumbing. The AD indicated the facility applied for a grant to assist with paying for repairs at the group home. The AD indicated the group home was in need of repairs.</p> <p>7. On 3/24/15 at 2:00 PM an interview was conducted with the high school Special Education teacher for client #1. He indicated on 3/23/15 at 8:15 AM client #1 was discovered to have red marks across the back of his neck, his back and his chest and on his left ear. The school nurse examined the red marks, suspected scabies and advised the teacher to contact facility staff to pick up client #1 and take him to his doctor for further examination. On 3/23/15 at 8:30 AM the teacher called the first the emergency contact number (for staff #2, the Medical Coordinator) and received no answer. He left a message on voice mail. The teacher called the second emergency contact number (for staff #1, the Team Manager) and received no answer. He left a message on voice mail. The teacher called the third emergency contact number (for the QIDP) and received no answer. He left a message on voice mail. On 3/23/15 at 11:00 AM the QIDP returned the teacher's call and reported he was out of town and would come to pick</p>						

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W 120 Bldg. 00	<p>up client #1. On 3/23/15 at 12:30 PM the QIDP arrived to pick up client #1. The teacher indicated the four hour response time from 8:30 AM to 12:30 PM was not consistent with school expectations for an emergency response. The teacher indicated no other contact numbers were identified for the agency that operated the residence, but he had tried in the past to reach anyone at the agency and received no answer to his call.</p> <p>On 3/25/15 at 2:10 PM, the Chief Services Officer (CSO) indicated the group home and school needed to have a system in place for the school to be able to contact the group home staff. The CSO indicated the group home needed a plan for the school to know who to contact, including the group home's main office. The CSO indicated there was no system in place at this time.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to</p>	W 120	To correct the deficient practice and ensure is does not continue, the TM and ND/Q will complete school observations by 4/24/15,	04/24/2015			

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	<p>ensure the schools (2) met the needs of the clients by failing to conduct routine observations and meetings with the schools.</p> <p>Findings include:</p> <p>On 3/23/15 at 1:00 PM, an interview with the Special Education Coordinator (SEC) indicated there were issues with client #4's gait and increased self-injurious behavior at the school. The SEC indicated when client #4 returned to school after summer break in 2014, his gait was unsteady and he engaged in increased self-injurious behaviors. The SEC indicated the school had repeatedly requested medical information from the group home regarding client #4's medical appointments with a neurologist. The SEC indicated the school did not receive the requested medical information. The SEC indicated the school met with the group home recently but had to reschedule the meeting due to the group home staff not bringing the requested information. At the rescheduled meeting, the SEC indicated the group home staff again arrived with no information regarding client #4's medical history, as requested. The SEC indicated the information the Network Director took to the school was incorrect (information did not pertain to client #4). The SEC</p>		<p>and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/Q and TM for each home. Additionally, the date of the last day program observation is documented on the Residential Services Team Manager Weekly Report, which is forwarded to the ND/Q, DORS, DOSS, CSO and CEO for review. A communication log is currently shared between school and residential staff, and goes back and forth each day. Staff will be re-trained to use this to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it each day when the individuals return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to</p>	

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	<p>indicated the meeting had to be rescheduled. The SEC indicated the 3rd meeting had not occurred but was scheduled.</p> <p>On 3/25/15 at 11:02 AM, a review of client #1's record indicated there was no documentation regarding observations being conducted at his school by the group home staff.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's record indicated there was no documentation regarding observations being conducted at his school by the group home staff.</p> <p>On 3/25/15 at 11:09 AM, a review of client #3's record indicated there was no documentation regarding observations being conducted at his school by the group home staff.</p> <p>On 3/25/15 at 11:13 AM, a review of client #4's record indicated there was no documentation regarding observations being conducted at his school by the group home staff.</p> <p>On 3/25/15 at 11:07 AM, the Team Manager provided documentation of an observation conducted at client #4's school on 10/17/14. The School Observation form indicated client #4's</p>		communicate all relevant issues.	

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	<p>teacher had several concerns: Client #4 wore the same clothes on consecutive days a few times. The clothes were unclean on the second day. Client #4 arrived to school with toothpaste all over his mouth recently. Client #4 needed a belt for his pants daily. The form indicated client #4's armpits and hair "routinely smelled bad." A teacher applied deodorant and used cologne on client #4 when he arrived to school each day. Client #4 did not wear weather appropriate clothing at times.</p> <p>There was no documentation provided indicating observations were conducted at the school clients #1, #2 and #3 attended during the past 12 months.</p> <p>On 3/25/15 at 6:02 AM, the Network Director indicated in an email, "I attached the only school observation that I've put on a doc. The others are handwritten to be completed on a doc...I simply haven't done it yet." The handwritten observations were not made available for review during the survey.</p> <p>On 3/25/15 at 11:07 AM, the Team Manager indicated she conducted observations at school. The TM indicated when she conducted observations, she put the documentation in the Quality Assurance binder at the</p>			

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W 125 Bldg. 00	<p>group home. The TM indicated there was no documentation she conducted observations at the schools during the past 12 months. The TM indicated she and the Network Director were responsible for conducting observations. The TM indicated the group home and the schools did not have regularly scheduled meetings. The TM indicated observations at the schools were to be completed monthly.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 1 of 2 non-sampled clients (#1), the facility failed to ensure the client had the right to due process in regard to the use of frosting (unable to see in or out) on his bedroom windows.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/23/15 from 4:00 PM to</p>	W 125	To correct the deficient practice, the frosting on the window in client #1's bedroom will be removed. To ensure the deficient practice does not continue, all TMs and ND/Qs will be re-trained on individual rights, including the right to due process. Ongoing monitoring will be accomplished through the ND/Q's completion of quarterly Quality Assurance checks, which includes reviewing all restrictive measures in the home and ensuring appropriate	04/26/2015

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W 137	<p>6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. During the observations, client #1's bedroom windows were covered in a material applied to the window obstructing the view from the windows. The frosting on the windows prevented client #1 from being able to see out the window. Client #1's bedroom windows had curtains which were pulled closed.</p> <p>On 3/25/15 at 11:02 AM, a review of client #1's record indicated there was no documentation in his Individual Support Plan, dated 6/14/13, and Behavioral Support Plan, dated 7/24/14, indicating he needed the windows in his bedroom frosted.</p> <p>On 3/25/15 at 11:38 AM, the Team Manager (TM) indicated there was no plan for client #1's bedroom windows to be frosted. The TM indicated the frosted windows did not allow client #1 to look out his windows. The TM indicated there was no reason for the windows to be frosted. The TM indicated client #1's windows had curtains he could use if he was undressing.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p>		plans are in place and consents have been obtained if restrictive measures are in place.				

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Bldg. 00	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review, the facility failed to assure aggressive and secure maintenance of a personal clothing item purchased by his teacher for 1 of 1 client with a missing coat (client #4).</p> <p>Findings include:</p> <p>On 3/23/15 at 2:00 PM, an observation was conducted of client #4 at the Junior High where he attended school. He was engaged in classroom activities. On 3/23/15 at 2:30 PM an interview was conducted with the Special Education Teacher in client #4's classroom. She reported last winter (2013) client #4 arrived at school on very cold days wearing a coat with a zipper front that did not work. As a result client #4 was more exposed to the very cold conditions when outside the school loading on and off the school bus. The teacher indicated she communicated the condition to staff of the residence to call it to their attention, but no action was taken. The teacher added she purchased an insulated denim jacket for client #4 to help keep him warm and he began wearing it on cold winter days. As the days became colder</p>	W 137	<p>To correct the deficient practice, client #4 does have a coat. The teacher will be reimbursed for the one that she purchased. Property inventories will be updated for all individuals living in the home. To ensure the deficient practice does not continue, all staff will be re-trained on the process for completing and updating property inventories, and for supporting individuals to dress appropriately for the weather. Ongoing monitoring will be accomplished through the ND/Q's completion of quarterly Quality Assurance checks, which includes reviewing the property inventories to ensure they are complete and current for each individual in the home. Additionally, the ND/Q will have regular and frequent communication with the teachers to ensure all identified issues and concerns are addressed in a timely manner.</p>	04/24/2015			

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	<p>in the fall and winter of 2014 client #4 did not wear the purchased coat to school. The teacher communicated with residential staff and asked why he was not wearing the coat. She indicated she was told the coat was missing and no one knew what happened to it.</p> <p>On 3/24/15 at 6:00 AM, an observation was conducted for client #4 during his morning preparations to depart for school. At 6:30 AM, staff #4 assisted client #4 to put on a light cotton jacket in preparation for going outside to board the bus for school. The temperature outside was 32 degrees Fahrenheit as documented by AccuWeather.com. As client #4 waited, staff #3, interacted with him. Staff #3 was asked if client #4 had a coat. Staff #3 asked if the surveyor wanted him to put a coat on client #4. The surveyor responded that the temperature outside was 32 degrees Fahrenheit and asked staff #3 what his practice would be to prepare client #4 for going outside during cold weather. Staff #3 and client #4 moved into the hallway where coats were hung and returned with client #4 wearing a winter coat, but not the coat identified by client #4's teacher.</p> <p>On 3/24/15 at 7:40 AM, an interview was conducted with staff #4. She indicated she was aware of the missing coat</p>			

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W 148 Bldg. 00	<p>provided for client #4 by his teacher: She indicated she had searched for it but had not found it.</p> <p>On 3/24/15 at 9:00 AM, an interview was conducted with staff #1, the Team Manager, regarding the missing coat. She indicated having been notified the coat was missing and indicated she searched every place she could think of to locate it to no avail. She indicated the coat may have been worn to client #4's mother's or father's house, as he visits with them frequently, and not returned. The Team Manager indicated she had not contacted either parent in her search for the coat. She indicated the facility/agency had not paid to replace the coat.</p> <p>On 3/24/15 at 10:30 AM a record review was conducted for client #4. No documentation was present in the record to document the missing coat. No documentation was present in the record to document the facility/agency had replaced the coat.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p>						

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	<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 clients in the sample (#4), the facility failed to promptly notify the client's guardian of upcoming medical appointments and the outcome of the appointments.</p> <p>Findings include:</p> <p>On 3/23/15 at 1:23 PM, client #4's guardian indicated she was not being notified of upcoming medical appointments and the outcomes of his appointments consistently. The guardian indicated she wanted to be notified of appointments and the outcome of appointments.</p> <p>On 3/25/15 at 11:13 AM, a review of client #4's Individual Support Plan, dated 12/16/14, indicated client #4 had a guardian. There was no documentation regarding contact with client #4's guardian in client #4's record.</p> <p>On 3/25/15 at 2:34 PM, the Chief Services Officer (CSO) indicated the client's guardian should be notified of anything they want to be notified of</p>	W 148	<p>The previous Medical Coordinator, who was responsible for communicating appointment information to the guardian, is no longer in his position. The new Medical Coordinator will be trained on the expected workflow and communication related to appointments, which includes notifying guardians in advance of upcoming appointments, as well as providing information related to the outcome of appointments. A space will be added to the Medical Appointment Form to document guardian communication. Ongoing monitoring will be accomplished through the ND/Q monthly review of all medical appointment documentation to ensure guardian contact is documented. Additionally, the assigned nurse, Medical Coordinator, TM and ND/Q will meet monthly to review all appointments for the month and ensure adequate follow up and communication has occurred. Additionally, the ND/Q completes a Residential Services Monthly Report for each individual living in the home that includes a summary of all appointments and dates of upcoming appointments. The Monthly Report is submitted to the DORS, DOSS, CSO and</p>	04/26/2015

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W 149 Bldg. 00	<p>(illness, incidents, police involvement and medical appointments). The CSO stated, "If they want to be informed we should inform them." The CSO indicated the facility should have documentation of guardian contact.</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 mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 14 incident/investigative reports reviewed affecting clients #2, #3 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse and report the results of an investigation of neglect to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 3/23/15 at 11:15 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/18/15 at 5:30 AM, client #4</p>			W 149	<p>CEO for review, and is then disseminated to the Individualized Support Team, which includes the guardian.</p> <p>Investigations were completed for each of the above listed incidents, and the Director of Support Services (DOSS) will review each investigation to ensure all recommendations have been completed and documented in the investigation file. To prevent the deficient practice from recurring, all staff will be retrained at the next staff meeting on LifeDesigns policies related to abuse and neglect. Per LifeDesigns' policy 3.1.5.3 Investigations, each investigation will include recommendations that explicitly define who isto complete the recommendation and the timeframe for completion, and who is to receive and monitor the completed recommendations (Director of Services and Human</p>		04/24/2015

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	<p>returned to the group home following a home visit. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/19/15 indicated, in part, staff observed yellow bruising of unknown origin measuring 1/2 inch by 1/2 inch on his upper right side near his armpit and yellow bruising measuring 1.25 inch by 1/2 inch on his upper left side near his armpit. The investigation, signed by the administrator on 1/24/15 (should have been reviewed on 1/23/15), indicated, in the Conclusion section, "To my knowledge, there was not a claim of physical abuse. The bruising was likely caused by [client #4's] father catching him when he was unsteady on the stairs. The location of the bruise marks is consistent with the way [client #4's] father described catching him. [Name of client #4's father] didn't notify staff about the extent to which he needed to protect [client #4] from severely injuring himself on the stairway when [client #4] repeatedly attempted to go downstairs throughout the early morning of Sunday, 01/18/2015. [Father's name] indicated that he will notify staff in the future if there's a likelihood of injury secondary to interventions needed to prevent serious injury. As of this date, I haven't received communication from CPS (Child Protection Services) with the results of</p>		<p>Resources, if applicable). The person responsible for monitoring will ensure the actions are completed within the time frame, all concerns/ issues reported ore discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. All staff who complete and review investigations (this includes all ND/Qs, Directors of Services, Quality Assurance Director, CSO and CEO) will be re-trained on the requirement to complete all investigations within 5 working days of the incident. Ongoing monitoring will be accomplished with the Services Leadership Team, which includes the CEO, Directors of Services, and Quality Assurance Director, who review investigations at least twice monthly to ensure all recommendations are completed. Additionally, the DOSS does a quarterly analysis of all agency investigations and makes recommendations for organizational improvements based on overall trends identified.</p>	

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	<p>their inquiry. No follow-up is recommended at this time unless results of the CPS inquiry indicate otherwise."</p> <p>The facility failed to ensure the results of the investigation were reported to the administrator within 5 working days.</p> <p>On 3/25/15 at 2:15 PM, the Chief Services Officer (CSO) indicated the results of investigations should be reported to the administrator within 5 working days.</p> <p>2) On 7/17/14 at 12:30 PM at the facility operated summer camp, the BDDS incident report, dated 7/18/14, indicated, in part, "[Client #3] was riding in the van and wanted to get out of the van. [Client #3] became upset that he could not get out and kicked [name of summer camp] camper #1 (did not indicate who) two times in the leg. Staff intervened and switched seats to separate [client #3] and camper #1. Staff conducted body scan on camper #1 and no markings on legs or other area from kicks were found."</p> <p>3) On 7/14/14 at 1:20 PM at the facility operated summer camp, the BDDS incident report, dated 7/15/14, indicated, in part, "[Name of non-group home camper] slapped at [name of summer camp] staff person. The staff person</p>			

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	<p>responded with 'nice hands.' [Name of camper] continued to slap the staff person, then redirected her aggression toward [client #4]. [Client #4] was sitting next to her then. [Staff] separated [name of camper] and [client #4]. A body scan was done on [client #4] No injuries of any nature were observed...."</p> <p>4) On 7/2/14 at 12:15 PM at the facility operated summer camp, the BDDS incident report, dated 7/3/14, indicated, in part, "During a [name of summer camp] field trip at the [name of zoo], [client #3] was punched on the top left side of his head by another [name of summer camp] customer who does not live at the [name of group home]... [Client #3], according to the UIR (Unusual Incident Report), seemed in pain and was upset for about an hour. [Client #3] evidenced no signs of concussion or other serious head injury...."</p> <p>5) On 7/1/14 at 12:00 PM at the facility operated summer camp, the BDDS incident report, dated 7/2/14, indicated, in part, "...The frustrated customer next to [client #4] began to get aggressive. He punched [client #4] in the face twice, got head-butted three times, was fiercely grabbed on the leg twice, and was bitten once in the arm. The bite didn't break the</p>			

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	<p>skin...."</p> <p>On 3/25/15 at 10:49 AM, the Team Manager (TM) indicated there were many client to client incidents during the summer camp last summer involving the group home clients and non-group home clients. The TM indicated client to client aggression was considered abuse and should be prevented. The TM indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 3/25/15 at 2:11 PM, the CSO indicated the facility should prevent abuse of the clients. The CSO indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 3/23/15 at 11:08 AM, 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 with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical</p>						

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W 156 Bldg. 00	<p>abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary physical or chemical restraints or isolation, practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities, application of painful or noxious stimuli and punishment resulting in physical harm or pain. 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."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for</p>	W 156	To correct the deficient practice,	04/24/2015			

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	<p>1 of 14 incident/investigative reports reviewed affecting client #4, the facility failed to report the results of an investigation to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 3/23/15 at 11:15 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/18/15 at 5:30 AM, client #4 returned to the group home following a home visit. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/19/15 indicated, in part, staff observed yellow bruising of unknown origin measuring 1/2 inch by 1/2 inch on his upper right side near his armpit and yellow bruising measuring 1.25 inch by 1/2 inch on his upper left side near his armpit. The investigation, signed by the administrator on 1/24/15 (should have been reviewed on 1/23/15), indicated, in the Conclusion section, "To my knowledge, there was not a claim of physical abuse. The bruising was likely caused by [client #4's] father catching him when he was unsteady on the stairs. The location of the bruise marks is consistent with the way [client #4's] father described catching him. [Name of client #4's father] didn't notify staff about the extent</p>		<p>all staff who complete and review investigations (this includes all ND/Qs, Directors of Services, Quality Assurance Director, CSO and CEO) will be re-trained on the requirement to complete all investigations within 5 working days of the incident. Ongoing monitoring will be accomplished by the DOSS, who reviews and tracks completion for all investigations. The DOSS will follow up on any investigation that has not been received by the end of day 4 to ensure it will be completed and reviewed by the end of the 5th working day.</p>	

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W 208 Bldg. 00	<p>to which he needed to protect [client #4] from severely injuring himself on the stairway when [client #4] repeatedly attempted to go downstairs throughout the early morning of Sunday, 01/18/2015. [Father's name] indicated that he will notify staff in the future if there's a likelihood of injury secondary to interventions needed to prevent serious injury. As of this date, I haven't received communication from CPS (Child Protection Services) with the results of their inquiry. No follow-up is recommended at this time unless results of the CPS inquiry indicate otherwise."</p> <p>The facility failed to ensure the results of the investigation were reported to the administrator within 5 working days.</p> <p>On 3/25/15 at 2:15 PM, the Chief Services Officer (CSO) indicated the results of investigations should be reported to the administrator within 5 working days.</p> <p>9-3-2(a)</p> <p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by other agencies serving the client is encouraged. Based on interview and record review,</p>	W 208	To correct the deficient practice	04/26/2015

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	<p>the facility failed to adequately encourage the participation of school staff in monitoring health care concerns for 1 of 1 client who demonstrated physical regression (client #4).</p> <p>Findings include:</p> <p>On 3/23/15 at 2:30 PM, an interview was conducted with the Special Education Teacher teaching client #4's class at the Junior High he attended. She indicated an ongoing concern she had that had not been resolved despite repeated attempts to do so with facility staff. She indicated in the fall of 2013 she observed a marked change in client #4's status in that he developed an ataxic gait (gait disorder characterized by unsteady, wide-based steps, incoordination, staggering, and decomposition of movements), weakness in his hands and regression in his speech. She contacted the Medical Coordinator for the facility and reported the change in client #4's status. She indicated her concern that client #4 may have experienced a stroke and asked the facility to follow up medically to determine if a cerebral incident was responsible for the change in client #4's status.</p> <p>The teacher indicated staff #2, the Medical Coordinator, gave her minimal</p>		<p>and ensure is does not continue, the TM and ND/Q will complete school observations by 4/24/15, and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations and communication with outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/Q and TM for each home. Additionally, the date of the last day program observation is documented on the Residential Services Team Manager Weekly Report, which is forwarded to the ND/Q, DORS, DOSS, CSO and CEO for review. . The new Medical Coordinator will be trained on the expected workflow and communication related to appointments, which includes sharing any pertinent medical information with school staff (or other outside service providers). A communication log is currently shared between school and residential staff, and goes back and forth each day. Staff will be re-trained to use this</p>	

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	<p>information in 2013, 2014 and 2015 about the medical follow up efforts to determine a cause for the change in status for client #4. At some point in the past staff #2 told her it had been determined that client #4 had experienced a stroke. The teacher asked for additional information about the stroke in order for school staff to be more fully aware of client #4's condition and to be able to train school staff on identifying signs or symptoms that might help them quickly identify any future stroke. Additional information was not forthcoming.</p> <p>In January 2015 the teacher asked for a meeting with residential staff to obtain additional information about client #4's stroke and to develop monitoring guidelines for school staff. On the date the meeting was scheduled no one from the residence attended. The teacher connected with staff #1, the Team Manager, who listened to the teacher's request for additional information and agreed to arrange a follow up meeting.</p> <p>In February 2015 the teacher attended a meeting where client #4's QIDP (Qualified Intellectual Disabilities Professional), staff #1, Team Manager, and staff #2, the Medical Coordinator, were present. The teacher said the only documentary evidence provided was an</p>		to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it each day when the individuals return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to communicate all relevant issues.	

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	<p>out of date Health Care Plan, a copy of an EEG (electroencephalogram - a test that detects electrical activity in your brain using small, flat metal discs (electrodes) attached to your scalp) and a copy of a Neurology Consult. None of these documents provided information about the reported stroke. The teacher again explained the reason for her request for information and agreed to attend a follow up meeting, scheduled for the end of March 2015, where the requested information was promised to be provided.</p> <p>On 3/24/15 at 8:20 AM, a record review was conducted for client #4. The Medical section of his record included a thorough description of the change in his status and many medical follow ups to determine the cause of his change in gait, loss of hand strength and slurred speech. Repeated brain imaging, EEG's and laboratory testing, as well as active and ongoing monitoring by his primary care physician, neurologist and psychiatrist was documented in the record. There was no documentation in client #4's record indicating he experienced a stroke.</p> <p>On 3/24/15 at 9:15 AM, an interview was conducted with the QIDP. He stated the history of meetings and follow up with the teacher was an "embarrassment" to</p>				

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	<p>the agency. He added when he became aware of the teacher's request for information about client #4's change in status, he directed staff #2 to draft a timeline starting with client #4's change in status then all the actions/medical follow ups which occurred afterwards to try to determine the cause for the change in status. This timeline was supposed to be presented at the February 2015 meeting with school staff. During the February meeting with school staff, staff #2 presented 3 documents which did not include the information requested by the teacher. After the meeting the QIDP said he advised staff #2 he would no longer be involved in medical issues for client #4, that the QIDP would assume responsibility for client #4's medical follow up.</p> <p>On 3/24/15 at 3:10 PM, an interview was conducted with staff #2. The above circumstances were discussed with him. He was asked if there was anything he could have done to prevent the conflict with client #4's teacher over the follow up to client #4's change in status. He said he could have kept client #4's teacher better informed. When asked if he had ever told the teacher that client #4 had experienced a stroke, staff #2 indicated he told her that. The surveyor asked staff #2 to demonstrate in the record where the</p>			

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W 262 Bldg. 00	<p>evidence existed that client #4 had experienced a stroke. Staff #2 said there was no such evidence in the record. When asked where he obtained that information he said staff #1, the Team Manager told him at some point in the past that she had received a call from staff at client #4's Neurologist's office who told her a test revealed client #4 had experienced a stroke. Staff #1 reported he had not followed up with the Neurologist's office to obtain documentary evidence of the referenced test although such follow up would be consistent with his duties as the Medical Coordinator for the residence.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the use of door alarms affecting clients #1, #2, #3</p>	W 262	To correct the deficient practice, the ISTs will review all restrictive measures for each individual living in the home. If they are determined to still be necessary, approval will be obtained for each restriction from the individual's guardian, as well as the Human Rights Committee (HRC). To	04/26/2015

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	<p>and #4, audible monitor affecting client #3 and a harness used by client #2 while on the bus.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 3/23/15 from 4:00 PM to 6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. During the observations, the exterior doors of the group home had alarms that sounded when the exterior door was opened. This affected clients #1, #2, #3 and #4.</p> <p>On 3/25/15 at 11:02 AM, a review of client #1's record indicated there was no documentation the HRC reviewed, approved and monitored the use of the door alarms. There was no documentation in client #1's Individual Support Plan, dated 6/14/13, or his Behavior Support Plan, dated 7/24/14, indicating the need for door alarms.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's record indicated there was no documentation the HRC reviewed, approved and monitored the use of the door alarms. Client #2's 7/8/14 Individual Support Plan indicated, in part, "Door Alarms approved by LIFE<i>Designs</i>' Human Rights Committee. Environmental restrictions due to</p>		<p>ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.</p>				

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	<p>darting/elopement risk of other peers in current setting."</p> <p>On 3/25/15 at 11:09 AM, a review of client #3's record indicated there was no documentation the HRC reviewed, approved and monitored the use of the door alarms. Client #3's 2/28/15 Individual Support Plan indicated, in part, "Door + Window Alarms approved by LIFE<i>Designs</i>' Human Rights Committee. Environmental restrictions due to darting/elopement risk of another peer in current setting."</p> <p>On 3/25/15 at 11:13 AM, a review of client #4's record indicated there was no documentation the HRC reviewed, approved and monitored the use of the door alarms. Client #4's Individual Support Plan, dated 12/16/14, indicated, in part, "Door Alarms approved by LIFE<i>Designs</i>' Human Rights Committee. Environmental restrictions due to darting/elopement risk of other peers in current setting." The Behavior Support Plan, dated 4/11/14, did not indicate the need for door alarms.</p> <p>On 3/25/15 at 10:54 AM, the Team Manager indicated clients #1, #2, #3 and #4 had elopement issues requiring the use of door alarms. The TM indicated on 3/25/15 at 10:54 AM the facility should</p>			

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	<p>obtain HRC consent annually for the use of door alarms.</p> <p>2) Observations were conducted at the group home on 3/23/15 from 4:00 PM to 6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. During the observations, client #3's bedroom was being monitored audibly in the dining room and living room using two portable monitors. The monitors relayed the sounds from client #3's bedroom to the monitors in the living and dining rooms. The monitor was on during both observations.</p> <p>On 3/25/15 at 11:09 AM, a review of client #3's record indicated there was no documentation the HRC reviewed, approved and monitored the use of the monitor. There was no documentation in client #3's 2/28/15 Individual Support Plan, 3/12/14 Behavior Support Plan and 1/15/15 Nursing Care Plan indicating a need for the monitor. A guardian consent form, dated 4/18/13, indicated, "Use of baby monitor (sic) more closely monitor [client #3] for seizures and/or vomit episode (due to GERD - gastroesophageal reflux disease) only while he is sleeping."</p> <p>On 3/25/15 at 10:54 AM, the Team Manager indicated the facility should obtain HRC approval for the use of the</p>			

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	<p>monitor.</p> <p>On 3/25/15 at 2:20 PM, the Chief Services Officer indicated the facility should obtain HRC consent at least annually.</p> <p>3) An observation was conducted at the group home on 3/24/15 from 5:52 AM to 7:12 AM. At 7:07 AM, client #2 was wearing a harness (harness went over shoulders, across his chest and back and under his legs). Staff #4 indicated client #2 wore the harness during transport on the bus to and from school.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's record indicated there was no documentation in his 7/8/14 Individual Support Plan and Behavior Support Plan regarding the use of the harness. Client #2's most recent HRC consent for the use of the harness was dated 11/15/12. The HRC Request Form, dated 8/8/12, indicated, in part, "Harness for the school bus due to refusals to stay seated while bus is moving." The approval length indicated, "1 year." There was no documentation the HRC reviewed, approved and monitored the use of the harness since 2012.</p> <p>On 3/25/15 at 2:20 PM, the Chief Services Officer indicated the facility</p>			

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W 263 Bldg. 00	<p>should obtain HRC consent at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure written informed consent was obtained from the clients' guardians for the use of door alarms affecting clients #1, #2, #3 and #4, audible monitor affecting client #3 and a harness used by client #2 while on the bus.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 3/23/15 from 4:00 PM to 6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. During the observations, the exterior doors of the group home had alarms that sounded when the exterior door was opened. This affected clients #1, #2, #3 and #4.</p>	W 263	To correct the deficient practice, the ISTs will review all restrictive measures for each individual living in the home. If they are determined to still be necessary, approval will be obtained for each restriction from the individual's guardian, as well as the Human Rights Committee (HRC). To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.	04/26/2015

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	<p>On 3/25/15 at 11:02 AM, a review of client #1's record indicated there was no documentation the HRC ensured the facility obtained written informed consent from client #1's guardian for the use of the door alarms. There was no documentation in client #1's Individual Support Plan, dated 6/14/13, or his Behavior Support Plan, dated 7/24/14, indicating the need for door alarms.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's record indicated there was no documentation the HRC ensured the facility obtained written informed consent from client #2's guardian for the use of the door alarms. Client #2's 7/8/14 Individual Support Plan indicated he had a guardian.</p> <p>On 3/25/15 at 11:09 AM, a review of client #3's record indicated the facility obtained written informed consent from client #3's guardian on 8/29/11. There was no documentation the HRC ensured the facility obtained written informed consent from client #3's guardian for the use of the door alarms since 8/29/11. Client #3's 2/28/15 Individual Support Plan indicated he had a guardian.</p> <p>On 3/25/15 at 11:13 AM, a review of client #4's record indicated there was no</p>			

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	<p>documentation the HRC ensured the facility obtained written informed consent from client #4's guardian for the use of the door alarms. Client #4's Individual Support Plan, dated 12/16/14, indicated client #4 had a guardian.</p> <p>On 3/25/15 at 10:54 AM, the Team Manager indicated clients #1, #2, #3 and #4 had elopement issues requiring the use of door alarms. The TM indicated on 3/25/15 at 10:54 AM the facility should obtain written informed consent annually for the use of door alarms.</p> <p>2) Observations were conducted at the group home on 3/23/15 from 4:00 PM to 6:09 PM and 3/24/15 from 5:52 AM to 7:12 AM. During the observations, client #3's bedroom was being monitored audibly in the dining room and living room using two portable monitors. The monitors relayed the sounds from client #3's bedroom to the monitors in the living and dining rooms. The monitor was on during both observations.</p> <p>On 3/25/15 at 11:09 AM, a review of client #3's record indicated there was no documentation in his 2/28/15 Individual Support Plan, 3/12/14 Behavior Support Plan and 1/15/15 Nursing Care Plan indicating a need for the monitor. A guardian consent form, dated 4/18/13,</p>				

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	<p>indicated, "Use of baby monitor (sic) more closely monitor [client #3] for seizures and/or vomit episode (due to GERD - gastroesophageal reflux disease) only while he is sleeping." The guardian signed the consent form on 5/3/13. There was no documentation the facility obtained written informed consent from client #3's guardian since 5/3/13.</p> <p>On 3/25/15 at 10:54 AM, the Team Manager indicated the facility should obtain written informed consent for the use of the monitor annually.</p> <p>On 3/25/15 at 2:20 PM, the Chief Services Officer indicated the facility should obtain written informed consent at least annually.</p> <p>3) An observation was conducted at the group home on 3/24/15 from 5:52 AM to 7:12 AM. At 7:07 AM, client #2 was wearing a harness (harness went over shoulders, across his chest and back and under his legs). Staff #4 indicated client #2 wore the harness during transport on the bus to and from school.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's record indicated there was no documentation in his 7/8/14 Individual Support Plan and Behavior Support Plan regarding the use of the harness. Client</p>			

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W 440 Bldg. 00	<p>#2's most recent written informed consent for the use of the harness was dated 8/16/12. The HRC Request Form, dated 8/8/12, indicated, in part, "Harness for the school bus due to refusals to stay seated while bus is moving."</p> <p>On 3/25/15 at 2:20 PM, the Chief Services Officer indicated the facility should obtain written informed consent at least annually.</p> <p>9-3-4(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to complete a quarterly evacuation drill for each shift of staff.</p> <p>Findings include:</p> <p>On 3/23/15 at 8:00 AM, a review was conducted of the evacuation drills documented by the facility for the period of time from 1/1/14 through 12/31/14. No evidence existed of an evacuation</p>	W 440	To correct the deficient practice,a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed. To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager, ND/Q will meet weekly at the home to review current status of individuals living in the home, support needs of	04/24/2015			

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W 460 Bldg. 00	<p>drill for the overnight shift (10:00 PM to 6:00 AM) of staff during the quarter of the year beginning 4/1/14 through 6/30/14. This affected clients #1, #2, #3 and #4.</p> <p>On 3/23/15 at 8:45 AM, an interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP). He searched and provided copies of two additional drills, neither of which was for the overnight shift of staff during the quarter of the year beginning 4/1/14 through 6/30/14.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure client #2's nutritional supplement was available for administration at the group home.</p> <p>Findings include:</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's Medication Administration Record (MAR) for March 2015 indicated</p>	W 460	<p>staff and to ensure follow up related to any identified issues or concerns. The ND/Q will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.</p> <p>The Ensure pudding was not in the home due unavailability from the manufacturer. It has since been obtained, and a revised order from client #2's physician was obtained so he may now have the liquid form of Ensure in lieu of the pudding. To prevent the deficient practice from occurring again, all staff will be re-trained on steps to take if an ordered item is not available in the home. Additionally, the new Medical Coordinator will be</p>	04/24/2015

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W 999 Bldg. 00	<p>on 3/22/15, 3/23/15, 3/24/15 and 3/25/15 (8:00 AM) the staff initialed and circled the MAR for client #2's Ensure pudding at 8:00 AM and 4:00 PM. The back of the MAR indicated, "unavailable."</p> <p>A review of client #2's record was conducted on 3/25/15 at 11:17 AM. Client #2's Physician's Orders, dated 11/7/14, indicated on 8/18/14 Ensure pudding was ordered 1-2 times a day (nutritional supplement). A Medical Appointment Record, dated 8/13/14, indicated Ensure was ordered for weight gain. The order indicated, "Ensure pudding 1 - 4 oz (ounce) one - two times daily/may mix (with) regular pudding."</p> <p>On 3/25/15 at 11:11 AM, the Team Manager (TM) indicated client #2 did not have Ensure pudding in the home to give to client #2 for the past 4 days.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not</p>	W 999	<p>trained to monitor the supply of all medications and treatment-related items to ensure when an item is almost out, appropriate steps are taken to get more of the item, or an approved substitution, prior to an item running out. Ongoing monitoring will be accomplished through a weekly review of all medications and supplies by the Medical Coordinator, as well as a weekly review of the MAR by the Team Manager. Any identified errors, or notes related to supply of an item, will be immediately resolved by the Team Manager.</p> <p>A BDDS Incident Report was submitted for this incident on 3/27/15, and the ND/Q investigated the situation to determine where the breakdown occurred, resulting in the</p>	04/24/2015	

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	<p>met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>16. A medication error or medical treatment error as follows: c. missed medication - not given.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) for missed nutritional supplement as ordered by the physician for client #2.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/23/15 at 11:15 AM. There were no BDDS reports for client #2's missed nutritional supplement.</p> <p>On 3/25/15 at 11:17 AM, a review of client #2's Medication Administration Record (MAR) for March 2015 indicated</p>		<p>unavailability of client #2's nutritional supplement. To ensure no others were affected by the deficient practice, the agency nurse will review Medication Administration Records for all individuals living in the home to ensure if other errors did occur, those incidents are reported in accordance with BDDS Incident Reporting policies. To prevent the deficient practice from occurring in the future, all supervisory staff will be retrained on agency Incident Reporting policies, including criteria under which a report should be submitted, as well as required timeframes. On an ongoing basis, the Team Manager works in the home full-time alongside other staff, and is responsible to identify or receive reports of any reportable incident. The ND/Q will be in the home no less than twice weekly to ensure services provided are in line with support plans that are in place, and that all reportable incidents are reported within 24 hours of the incident. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports and general concerns/ issues related to all service areas</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408		
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	<p>on 3/22/15, 3/23/15, 3/24/15 and 3/25/15 (8:00 AM) the staff initialed and circled the record for client #2's Ensure pudding at 8:00 AM and 4:00 PM. The back of the MAR indicated, "unavailable."</p> <p>A review of client #2's record was conducted on 3/25/15 at 11:17 AM. Client #2's Physician's Orders, dated 11/7/14, indicated on 8/18/14 Ensure pudding was ordered 1-2 times a day (nutritional supplement).</p> <p>On 3/25/15 at 11:11 AM, the Team Manager (TM) indicated client #2 did not have Ensure pudding in the home to give to client #2 for the past 4 days. The TM indicated it was a medication error. The TM indicated no one had documented the medication error or submitted incident reports to BDDS.</p> <p>On 3/25/15 at 2:41 PM, the Chief Services Officer (CSO) indicated it was a medication error and should have been reported to BDDS.</p> <p>9-3-1(b)</p>				