

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 532 RIDGEVIEW COLUMBUS, IN 47203
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit resulted in an immediate jeopardy which was not removed.</p> <p>Dates of Survey: August 26, 27, 28, 29, September 8, 9, 10, 11 and 12, 2014.</p> <p>Facility number: 000995 Provider number: 15G481 AIM number: 100235470</p> <p>Surveyors: Susan Reichert, QIDP-TC Steve Corya, Surveyor Supervisor Steven Schwing, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/15/14 by Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review, observation and interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The governing body failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The governing body failed to implement policy and procedures to protect 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to report incidents 2 of 2 incidents of sexual assault and failed to develop and implement effective corrective action to address client #3's physically aggressive behavior.</p>	W000102	<p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors,</p>	09/26/2014

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	<p>Findings include:</p> <p>1. The facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients #1 and #2), and for 2 additional clients (clients #3 and #4). The governing body failed to provide oversight and direction to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The governing body failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The governing body failed to implement policy and procedure to protect 1 additional client (client #3) by failing to report incidents of sexual assault and failed to develop and implement effective corrective action to address his physically aggressive behavior. Please see W122.</p> <p>2. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and</p>		<p>patterns, and how he responds to specific consequences. An incident report and BDDS report has been completed for the events on 8/26/14. Staff have been re-trained on documentation of negative behaviors, and completing incident reports. The Team Manager was trained on BDDS incident reporting procedures on 9/24/14. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance.</p>	

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	<p>#2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The governing body failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The governing body failed to implement policy and procedure to protect 1 additional client (client #3) by failing to report incidents of sexual assault and failed to develop and implement effective corrective action to address his physically aggressive behavior. Please see W104.</p> <p>9-3-1(a)</p>		<p>The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the</p>		

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon observation, interview and record review, the governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The governing body failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The governing body failed to implement policy and procedure to protect 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to report incidents 2 of 2 incidents of sexual assault and failed to develop and implement effective corrective action to address client #3's physically aggressive behavior.</p> <p>Findings include:</p>	W000104	<p>CEO will do an on-site visit at least quarterly.</p> <p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to</p>	09/26/2014			

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	<p>1. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The governing body failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The governing body failed to implement policy and procedure to protect 1 additional client (client #3) by failing to report incidents of sexual assault and failed to develop and implement effective corrective action to address his physically aggressive behavior. Please see W149.</p> <p>2. The governing body failed to implement its policy and procedures to prevent abuse and neglect for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to timely report incidents 2 of 2 incidents of sexual assault in accordance to state law. Please see W153.</p> <p>3. The governing body failed to develop and implement effective corrective action</p>		<p>specific consequences. An incident report and BDDS report has been completed for the events on 8/26/14. Staff have been re-trained on documentation of negative behaviors, and completing incident reports. The Team Manager was trained on BDDS incident reporting procedures on 9/24/14. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home</p>				

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	<p>to address the physically aggressive and intimidating behavior of clients #1 and #2 after a history of their behavior had been identified. The governing body failed to develop and implement effective corrective action to address client #3's physically aggressive behavior. Please see W157.</p> <p>9-3-1(a)</p>		<p>has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at</p>		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based upon observation, record review, and interview, the facility failed to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The facility failed to implement policy and procedure to protect 1 additional client (client #3) by failing to report incidents of sexual assault and failed to develop and implement effective corrective action to address his physically aggressive behavior.</p> <p>This noncompliance resulted in an IMMEDIATE JEOPARDY. The IMMEDIATE JEOPARDY began on 5/25/14. The Immediate Jeopardy was identified on 8/27/14 at 3:28 PM. The Network Director/Qualified</p>	W000122	<p>least quarterly.</p> <p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to specific consequences. To ensure the deficient practice does</p>	09/26/2014

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	<p>Developmental Disabilities Professional (NDQ) was notified of the Immediate Jeopardy on 8/27/14 at 3:28 PM.</p> <p>The facility submitted a plan of action to remove the Immediate Jeopardy on 8/29/14 at 5:23 PM. The plan indicated client #2 (identified as client #1 in the plan of action) "was removed from the setting immediately (8/27/14) and placed with two staff members in the [hotel name]...pending hospitalization." The plan indicated attempts at "emergency hospitalization...have been unsuccessful, beginning on 8/4/14. On 8/28/14, an attempt to hospitalize him at [hospital name] in [city] failed because he was 'not actively suicidal or homicidal' despite having attempted to exit the vehicle transporting him while traveling on the interstate highway. Efforts to locate a facility willing to admit him continue...Emergency IDT (interdisciplinary team meetings) have been held on 8/5/14 and again on 8/28/14, and 8/29/14 for [client #2]...A waiver for Supported Living in a smaller setting has been secured and the process to choose a Case Manager and Provider has begun. A roommate had been identified and an apartment is being sought...An emergency IDT meeting for [client #1] was held on 8/13/14. The following plan was agreed to be (sic)</p>		<p>not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance</p>				

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	those participating: Director of Quality Assurance (DQA) will work 10:00-8:00 (AM/PM not identified) Mondays and Tuesdays. Behavior Specialist (BS) will work 10:00-4:00 (AM/PM not identified), Director of Residential Services (DRS) will work Thursdays and Fridays. [DQA] will focus on individual goals and 1:1 (one on one) community involvement, as well as staff training and development. BS will focus on behavior strategies as staff training and development. [DRS] will focus on work with [client #1] and one peer in and around the house. She will reinforce positive interactions and pro-social behavior. She will also work with staff to train (sic)...Staff: Client ratio to remain at 2:3 on all shifts until behavioral issues are reduced to baseline levels. An agency BS had observed in the milieu on numerous occasions at the request of the NDQ (Network Director Qualified Intellectual Disabilities Professional) and DRS and has provided feedback and suggestions. BS will provide de-escalation and crisis intervention training to the [group home] team. CPI (Crisis Prevention Institute) Trainer will review physical intervention training with staff again as new staff join the team there. Administrative oversight will continue with daily written observations as well as a sign-in sheet at the house to		and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.	

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	<p>be utilized by the new TM (team manager), NDQ, DRS, DSS, and CEO (Chief Executive Officer). Daily for two weeks and then three times a week for two months."</p> <p>During observations at the group home on 8/28/14 from 5:40 PM until 6:40 PM, client #3 was in the living room looking at a magazine. Client #1 watched staff #1 fry hamburgers and declined to participate in preparing the meal when staff #1 asked if he wanted to assist. The DQA (Director of Quality Assurance) worked with client #4 on looking up items on an electronic tablet. The NDQ and the DQA left the home during the observation.</p> <p>Staff #1 was interviewed on 8/28/14 at 5:45 PM and indicated client #3 did not attend school that day as he had received sedative medication earlier that day to attend a medical appointment.</p> <p>The NDQ was interviewed on 8/28/14 at 6:25 PM and stated staff had called for assistance by them to assist with client #2 who was being housed in a hotel nearby as he was becoming "agitated."</p> <p>Observations were completed at the group home on 8/29/14 from 10:15 AM until 11:00 AM. Client #1 watched a</p>				

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	<p>movie, and client #3 looked out the window of his bedroom. Neither client #2 nor client #4 was present during the observation. The interim house manager carried torn shoes into the office and placed them on the floor. The interim house manager asked client #3 if he wanted his door shut. When client #3 stated, "Yes," she closed the door to his room.</p> <p>The interim house manager was interviewed on 8/29/14 at 10:15 AM and indicated the shoes were client #4's. She stated client #3 "tore them up," and "He usually goes after electricals." She stated client #3 "Will go after staff," and indicated he would remove female staff shirts and bras. She indicated client #3 had removed her shirt and bra within the last week. She indicated staff brought extra clothing and bras to work in the event client #3 removed their shirts and bras. When asked if an incident report had been completed regarding the incident, she stated, "I'm trying to find time. I haven't done it yet." She indicated she did not feel she was in harms way when client #3 removed her shirt. She stated client #1 "has been very, very calm" since client #2 was removed from the home. She stated "When [client #2] was here I felt I was in danger. He (client #2) likes to get them riled up. When he</p>						

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	<p>gets [client #1] riled up, it's crazy."</p> <p>Observations were completed at a guest group home for client #2 on 8/29/14 from 1:00 PM until 1:15 PM. Client #2 was the only client in the home and was watching TV with staff #7. His medications were unlocked in a duffle bag with client #2's clothing. Staff #7 was relieved by the interim house manager at 1:15 PM.</p> <p>Client #2 was interviewed on 8/29/14 at 1:10 PM. He indicated he had refused his medications of Latuda and Depakote last evening. He stated the Depakote "make you fat," as he had looked up the side effects and Latuda "makes me shaky."</p> <p>The interim house manager was interviewed on 8/29/14 at 1:15 PM and indicated client #2 was not going to return to the group home.</p> <p>A Leaving Services Summary dated 9/5/14 was reviewed on 9/5/14 at 2:15 PM and indicated client #2's last service date was on 8/29/14 and client #2 had been discharged from the group home in preparation to a move to another setting. The summary indicated client #2 had been removed from the home on 8/27/14 and had entered a mental health facility on 8/29/14 to evaluate his mental status</p>			

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	<p>and medication regime, and was discharged from the mental health facility on 9/4/14.</p> <p>Observations were completed on 9/5/14 from 1:30 PM until 2:17 PM at the hotel where client #2 was staying. Client #2's medications were unlocked on the table. Client #2's glasses had tape on both ear pieces at the hinge.</p> <p>Client #2 was interviewed on 9/5/14 at 1:30 PM and stated he "was afraid of staff" and "feel like going in to a behavior," and "they lied to me." He indicated he had been taken out of school. He indicated his medications had been adjusted and stated, "They lied about a lot of stuff, said I was suicidal, told me to go into behaviors."</p> <p>Observations were completed on 9/8/14 from 8:20 PM until 8:45 PM. Staff #11 indicated the clients were all in bed.</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the weekend and had cleaned it up. When</p>						

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	<p>asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the weekend as well. When asked what client #3's plan was when he aggressed, she stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against him." When asked if the behavior</p>			

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	<p>could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated that an Unusual Incident Report had been filled out, but a BDDS report had not been done. The NDQ indicated she was unable to write effective behavior plans for clients #1 and #3 and needed a behavior specialist to help with their plans.</p> <p>Management rounds in the home were completed during the observation period on 9/9/14 from 9:10 AM to 10:05 AM and indicated a sign in time for the rounds was noted, but in only one case was an exit time noted indicating an observation period of 45 minutes.</p> <p>The NDQ was interviewed on 9/8/14 at 4:05 PM and stated client #1 had "behaviors" over the weekend. During the interview, the surveyor asked for documentation of the behaviors.</p> <p>The NDQ was interviewed on 9/10/14 at 1:52 PM and stated client #1 had "behaviors" that afternoon.</p> <p>Incident reports regarding client #1's behaviors since 8/29/14 were requested on 9/10/14 at 5:42 PM. No incident reports or documentation were provided.</p> <p>Staff training records for the staff</p>				

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	<p>working at the group home were reviewed on 9/10/14 at 7:10 PM. A Continuing Education Record dated 9/2/14 indicated the interim house manager, BS, staff #10, #3, #11, #12, #13, #1, #14, #15 and #6 had been inserviced on CPI Review, De-Eculation (sic) Training, Update [client #2], meet TM (Team Manager), [client #3] Behaviors/Manic Episodes...."</p> <p>The IMMEDIATE JEOPARDY was not removed due to the facility's failure to demonstrate a facility system that prevented abuse, neglect and mistreatment.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2. The facility failed to implement policy and procedure to protect 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to</p>						

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	<p>report incidents 2 of 2 incidents of sexual assault and failed to develop and implement effective corrective action to address client #3's physically aggressive behavior. Please see W149.</p> <p>2. The facility failed to implement its policy and procedures to prevent abuse and neglect for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to timely report incidents 2 of 2 incidents of sexual assault in accordance to state law. Please see W153.</p> <p>3. The facility failed to develop and implement effective corrective action to address the physically aggressive and intimidating behavior of clients #1 and #2 after a history of their behavior had been identified. The facility failed to develop and implement effective corrective action to address client #3's physically aggressive behavior. Please see W157.</p> <p>9-3-2(a)</p>						

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W000149	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 upon observation, record review, and interview, the facility failed to implement	W000149	Client #2 was moved from the group home and with the assistance of BDDS, received a	09/26/2014

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	<p>its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive and intimidating behavior of clients #1 and #2. The facility failed to implement policy and procedure to protect 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) by failing to report incidents 2 of 2 incidents of sexual assault and failed to develop and implement effective corrective action to address client #3's physically aggressive behavior.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2</p>		<p>CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to specific consequences. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and</p>				

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	<p>stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and</p>		<p>client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all</p>	

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	<p>completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p>		<p>Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>	

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	<p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The interim house manager was interviewed on 8/26/14 at 8:30 PM and indicated client #1 had urinated on the floor and was mopping it up.</p>				

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	<p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and took a shower. Staff #2 was alone with clients #1 and #2 from 7:15 AM until the conclusion of the observation.</p> <p>Staff #3 was interviewed again on 8/27/14 at 6:50 AM and indicated sometimes clients #1 and #2 would get up at night, but would watch TV.</p> <p>Staff #2 was interviewed on 8/27/14 at 7:28 AM. She indicated staff usually works alone from 7:00 AM to 12:00 PM unless there were three clients in the home at which time another staff would be brought in to work in the home. She indicated she was covering the shift for the interim house manager and she would arrive at 9:00 AM to relieve her (staff #2).</p> <p>Behavior and medical observations (progress notes) were reviewed on 8/27/14 at 8:53 AM and indicated the following:</p> <p>For client #1:</p> <p>8/26/14 from 3:00 PM until 9:00 PM; "He got a little worked up today, but calmed himself down."</p>						

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	<p>8/21/14; "Multiple behaviors this evening from 2:45 PM until 7:45 PM...Incredibly inappropriate on several different occasions tonight."</p> <p>6/24/14; "Threatened to kill cops, urinated on floor."</p> <p>6/24/14; "Threatened to kill kid" and "taken to [mental health facility]."</p> <p>6/23/14; "Showed private parts out window."</p> <p>6/8/14; "Called cops and placed in hand cuffs."</p> <p>For client #2:</p> <p>8/26/14; 1:00 PM until 8:00 PM; arguing with staff, ...did not give personal space...."</p> <p>8/18/14; "argumentative; glasses broken by another individual...."</p> <p>8/4/14; "had behavior, went to the hospital...."</p> <p>8/3/14; "was in a behavior when staff got here...."</p> <p>7/28/14; "attacked staff and breaking things...."</p>			

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	<p>6/17/14; "Tried going into [client #1's room]."</p> <p>6/11/14; "Yelling, screaming and throwing items."</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/27/14 at 1:45 PM and included the following:</p> <p>For client #1:</p> <p>A BDDS report dated 5/25/14 indicated client #1 was aggressive, hitting, spitting, throwing objects and attempting to urinate on staff. Staff called 911 and police handcuffed and transported him to the hospital to be evaluated. The report indicated client #1's hip was x-rayed due to an earlier fall, and had not received his evening medications "due to spitting them out at staff." Client #1 was transported back home by ambulance "due to trying to work back up in a behavior and threatening to crash my (Team Manager) car." Corrective action indicated a plan was being generated to address his behavior and prevent future incidents.</p> <p>A BDDS report dated 6/7/14 indicated</p>			

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	<p>client #1 called 911 after "escalating into behaviors." The report indicated staff called the security system to notify them it was a false alarm so fire trucks would not arrive. Plan to resolve indicated client #1 "Has many proactive measures written into his behavior plan. Staff were following his plan during the incident. [Client #1] currently does not have a psychiatrist and Life Designs has been looking for one for him. He has been turned down by four different facilities/offices." The report indicated client #1's primary care physician had ordered increases in medications which are awaiting Human Rights Committee (HRC) approval. "Life Designs has also explored possible in-patient facilities to look into [client #1's] medication regimen (sic), but has been unsuccessful in locating a facility that is willing to admit [client #1]. Staff will continue to follow [client #1's] behavior plan and Life Designs will continue to locate a psychiatrist to manager [client #1's] medication and continue to explore in-patient options."</p> <p>A BDDS report dated 6/24/14 indicated client #1 was physically aggressive and inappropriate with staff. The police were called and hand cuffed client #1 after he threatened to use their guns to kill them. Client #1 was placed in a spit proof mask</p>						

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	<p>and transported to the hospital after he tried to urinate on the police officers. Client #1 was admitted to a mental health facility. Corrective action indicated the mental health facility would monitor client #1. The report indicated client #1 was admitted for 7 days and his psychiatric medications had been adjusted.</p> <p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p> <p>A BDDS report dated 8/11/14 indicated client #2 told client #1 the dessert looked like "sperm." The report indicated client #1 yelled "sperm" throughout the house and urinated on the floor. Client #1 scratched client #2 leaving four superficial scratch marks and picked up a table leg and attempted to hit client #2 with it. The report indicated client #2 continued to "agitate" client #1 and client #1 "refused to leave [client #2] alone." Client #1 "was screaming at [client #2] through the door...At one point, [client</p>			

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	<p>#2] came downstairs and continued to agitate [client #1]. [Client #1's] behavior continued for another hour or two with periods of calm and then re-escalation." The report indicated an IDT (interdisciplinary team) meeting would be scheduled for 8/13/14 to address the incident.</p> <p>A BDDS report dated 8/12/14 indicated throughout the morning client #1 "was having behaviors," and would calm periodically. He attempted to "go after a roommate, but was blocked by staff." He intentionally had a bowel movement in the hallway and threw feces at staff. Client #1 attempted to grab staff sexually between her legs and attempted to push past staff to get at his roommate (unidentified). A second staff was called to assist and the unidentified client was placed in a room to keep him away from client #1. Client #1 attempted to put utensils under the locked door including a knife. 911 was called and client #1 was arrested and the police "were pressing charges that included two counts of battery with bodily fluid and one count of sexual battery." The report indicated client #1's relative posted bond and he spent the evening at their home. Corrective action indicated there was an emergency IDT planned for 8/13/14 to address the situation.</p>				

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	<p>A Plan for Extra Support dated 8/13/14 was reviewed on 9/8/14 at 4:00 PM and indicated the following:</p> <p>"Short Term-[Director of Quality Assurance] will work 10:00-8:00 (AM/PM not indicated) Mon. and Tues. [Behavior Specialist] will work 10:00-4:00 (AM/PM not indicated) on Wed. [Director of Residential Services (DoRS)] will work Thurs and Fri (time not indicated).</p> <p>[DQA] will focus on individual goals and 1:1 community involvement, as well as staff training and development, [BS] will focus on behavior strategies and interventions, as well as staff training and development. [DoRS] will focus on work with [client #1] and one peer doing daily activities in and around the house. She will reinforce positive interactions and pro-social behavior. She will also work with staff to train (sic)."</p> <p>Mid Term: The plan indicated new staff members would be hired including a Team Manager, Team Lead and Medical Coordinator. The CEO (Chief Executive Officer) "is exploring ...Day Program Services. She is following up with the [police department]. [NDQ] is contacting</p>			

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	<p>[psychiatric services provider], to determine what resources are available...for emergency care. [DoRS] is following up with [staff at mental health provider] to determine what resources are available through her agency for emergency care. She is [mental health provider's] liaison with the Police Department.</p> <p>Longer Term: Begin exploration of a waiver setting for Supported Living in a smaller setting."</p> <p>For client #2:</p> <p>A BDDS report dated 6/10/14 indicated client #2 had "behavior issues most of the day." Client #2 "followed clients around the house saying inappropriate things about them." Client #2 was "yelling at peers," and "stomping through the house," and hitting the walls. Client #2 knocked over a beverage into the other clients' pizza by pushing the table as they were eating and pounded the table with his hands. Client #2 pushed staff to the floor. Client #2 threatened to call police. It was "questionable" if client #2 pushed client #4, as staff saw client #4 take a step backwards "as if he was pushed" by client #2. The report indicated client #4 could not speak for himself. The report indicated client #2 continued to bang on</p>						

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	<p>walls of the home, "yell" and attempted to wake clients up after they were in their bedrooms. Client #2 "yelled at [client #1] and he started crying." Client #1 went to the office to eat his dinner, and client #2 started "ramming" into staff to get to client #1. Client #1 began "crying uncontrollably." Corrective action indicated client #2 had been admitted to the group home on 5/2/14 and the facility was attempting to secure psychiatric services to address client #2's behaviors. Staff will continue to follow client #2's behavior plan to address his behaviors and take action to prevent peers from experiencing verbal and physical abuse. The report indicated an investigation would be completed into the incident.</p> <p>A BDDS report indicated client #2 "had been upset for much of the day on 8/2/14. He had pushed group home staff and a temporary staff on different occasions through out the day...Around 7:45 PM staff called NDQ and reported that [client #2] had threatened to hurt himself and staff and was threatening to get a knife. NDQ advised the staff to hang up and call 911. Just after hanging up with the group home staff, the temporary agency staff called the NDQ and told her [client #2] had a knife and was trying to get in the locked office door." The temporary staff and client #1 were locked in the</p>						

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	<p>office, and "the group home staff (who was in the common area of the house with [client #2] managed to get [client #2] to give her the knife and slid it under the locked office door." Police arrived and client #2 agreed to go to his room. The police indicated to the NDQ they could not transport client #2 to the hospital for evaluation. Corrective action indicated sharps would now be locked in the home and an Interdisciplinary (IDT) team meeting would be held to discuss the incident "and what changes can be made to ensure all remain safe." The NDQ "will review [client #2's] behavior plan to determine what changes need to be made."</p> <p>A BDDS report dated 8/4/14 indicated client #2 hit client #1 on his back and pinched his neck while traveling in the van. Client #2 was "flipping off" (obscene gesture) other drivers, attempted to open the van door while it was moving and "at one point he acted as if he was going to grab the wheel of the vehicle while it was moving and stated he didn't care if they all died in a crash." After returning home "the behavior continued. He blocked staff (unidentified) in the bathroom and would not let her get past him." Corrective action indicated the NDQ was conducting an IDT meeting regarding the incident on 8/2/14 when</p>			

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	<p>she was informed of the current incident and advised staff to call 911. The NDQ met the police at the home and requested they transport client #2 to the hospital for evaluation and treatment. Once at the hospital, client #2 refused treatment and since he is his own guardian the hospital could not admit him. The discharge orders from the hospital indicated if client #2 became aggressive again, staff should call police and have client #2 arrested/jailed. Client #1 did not sustain injury during the incident. Corrective action indicated an IDT would be scheduled to address the incidents.</p> <p>A BDDS report dated 8/18/14 indicated client #2 told staff while watching a movie client #1 had put his hands down client #2's pants and touched his penis and tried to put his hands down the back of his pants "to smell his poop." Shortly after the incident client #1 broke client #2's glasses. Corrective action indicated the clients were not to be left in a room alone without supervision and an investigation would be completed.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of</p>			

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	<p>physical aggression. There was no evidence of a revision of client #1's plan since 9/13/13. There was no evidence of a functional analysis of client #1's behavior by a behavior specialist. There was no evidence of involvement of a behavior specialist in the development or implementation of his plan to address his behavior.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14. There was no evidence of a functional analysis of client #2's behavior by a behavior specialist. There was no evidence of involvement of a behavior specialist in the development or implementation of his plan to address his behavior.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic. I've had to call the police 5 times in 3 weeks. The behavior is escalating. On Saturday, August 2, (2014), he (client #2) threatened staff. They barricaded themselves in the office. He grabbed a</p>			

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	<p>butcher knife and tried to pry open the door. [Client #1] was locked in the office too. They (clients #1 and #2) terrorize each other and everyone else in the house." She indicated client #2 slapped client #1 and pushed staff in the past. She indicated client #1 now spoke of sexual issues and stated client #1 "had no sexual talk before [client #2] came here (to the group home)." She stated while shopping at a store client #2 talked to client #1 to "solicit" an 8 year old girl and then picked up the phone and used the F*** word over the intercom repeatedly. She said the 8 year old girl's mother was with her and no harm came to the girl. Client #2 "admitted he had egged [client #1] on" later. We're trying to do everything we can here. When asked about a behavioral specialist, she indicated she had attempted to involve a behavior specialist, but stated, "it hasn't been solidified." The NDQ indicated she (NDQ) wrote the plans, and the behavior specialist had visited the home, but the clients had not exhibited maladaptive behavior during her visit. She indicated the behavior specialist was scheduled to come to the home today, but was unable to come due to unknown reasons. She stated, "I can't keep up with the plans. Their behaviors are escalating" and in regards to the involvement of a behavioral specialist "It's really needed."</p>			

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	<p>She indicated client #1 was arrested on 8/12/14 and taken to jail for sexual battery to staff. She indicated client #1's psychiatrist wanted to take him off medication to address his behaviors, but the guardian didn't agree. She stated client #2 was his own guardian and says he "runs the house." When asked if the clients injured one another during behaviors, she stated, "I would say it's more emotional abuse." She indicated both clients #1 and #2 had threatened each other with a butcher knife and the knives were now locked up in the house. She indicated there were no IDT meetings available to address the situation. She indicated the meeting on 8/4/14 had been interrupted by the behavior incident on 8/4/14. She indicated client #2's plan did not address physical aggression as she had not been able to update the plan as yet.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30 PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1</p>						

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	<p>asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There was no evidence of the Behavior Specialist in the home during the observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing."</p> <p>The NDQ was interviewed on 8/27/14 at 12:50 PM and indicated she was attempting to secure employment for client #2, and stated, "He won't cooperate."</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>An investigation dated 5/30/14 indicated client #1's father had dropped the money off on 5/16/14 and left the money with staff #8. Staff (unidentified) placed the money in the Team Manager's (TM) desk drawer. When staff #8 came back to work on 5/19/14, he told the TM the money was in the desk drawer, but it was not found. The investigation indicated the</p>			

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	<p>whereabouts of the missing money had not been determined and would be reimbursed to client #1 by the facility. The investigation indicated "Transactions appear to be only documented by TM. Services Administrative Assistant [name] reported that she has not gotten complete financial documentation from customers at [group home], and what she has received is not well organized...."</p> <p>Findings of the investigation indicated "Based on review of financial records, as well as report from the Team Manager, customer finances in the home are not being maintained in accordance with Life Designs' policies. Staff received money for a customer, but did not document receipt of that money, and did not document it as a deposit into the customer's house account. This makes it impossible to determine what may have happened to it. This incident was reported late-it was realized that the money was missing on 5/19/14 by the TM, however it was not reported to the ND/Q until 5/21/14, who completed at (sic) BDDS report on 5/22/14." An attached BDDS report dated 5/21/14 indicated \$40.00 left by client #1's father at the group home was missing and would be investigated.</p> <p>An investigation dated 6/12/14 indicated on 6/10/14 client #2 "was in a poor mood</p>			

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	<p>due to feeling like he was being blamed for things. He started yelling at a staff member while another staff was gone, pushing her and trying to knock her over. At one point they think he might have possibly pushed [client #4]...He was verbally abusing staff and roommates yelling obscenities and saying they were all stupid." Recommendations indicated "Staff to continue following behavior plan. Medical coordinator to continue to look for a psychiatrist for [client #2]."</p> <p>An investigation dated 7/1/14 indicated the allegation was unsubstantiated "Based upon the discrepancies in [client #1's] interview and his agitated state during the described incident, this writer cannot substantiate the allegation of verbal abuse. Investigator noted through observation and subsequent interviews that [staff #9's] overall tone when interacting with customers is quite loud and overbearing, which in direct opposition to the stated steps in [client #1's] Behavior Support Plan. Recommendations included "Behavior Specialist will complete an observation of a shift when [staff #9] is working to assess her communication style and interactions with the customers. She will then provide additional training based on her observations. Behavioral Specialist and ND/Q will review the Behavior</p>						

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	<p>Support Plan and retrain staff to ensure consistency of implementation. Retraining will include ways to effectively communicate with individuals in both a proactive and reactive way. DoRS (Director of Residential Services), DoSS, and QAD will perform follow up observations weekly for a period of one month and will share findings with ND/Q, Behavior Specialist, and other positions completing observations. A Behavioral Observations and Recommendations dated 7/17/14 indicated "It appears that the interactions between [client #1] and [staff #9] are appropriate. Behaviorist will follow up with the home as needed to ensure that the staff and customers interact and work well together. It is recommended that if concerns continue to arise, the behaviorist be informed and a training be held for staff to educate them on respectful and proactive approaches to use with clients." Observations dated 7/9/14 from the QAD and on 7/4/14 from the DoRS were included in the investigative packet. A BDDS report included in the investigation dated 6/24/14 indicated client #1 alleged staff #9 had told him to "shut up ****" and had stated to his mother after being asked if the group home was the right place for him stated, "No, they don't know how to handle me." The report indicated the</p>			

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	<p>incident would be investigated.</p> <p>A BDDS report included with an investigation dated 7/8/14 indicated client #1's relative sent an e-mail with receipt to a BDDS Generalist for items she purchased for client #1 "attached is a receipt for [client #1's] basic needs which are not being met by Life Designs for: shoes, allergy meds (medications), shaver, light bulb for room, frames for correct prescription glasses and a haircut." The report indicated client #1's relative indicated he had "NEVER" been taken for a haircut in seven months and he had been wearing "old (wrong script (prescription)) glasses." He was taken to hospital for a week with "NO glasses and has very poor vision. I have been told his glasses are taken off his face to 'gain compliance." The report indicated client #1's relative indicated he had a broken femur and "not believed after I begged for him to see a dr (sic) for three weeks! Was made to kneel for hours because he wouldn't get up with a broken bone. Was made to walk to bathroom on a broken femur (sic) the reply to my concern by male RN (registered nurse) was 'we don't have a urinal here.' For [client #1] is very symptomatic because he has not had his physician ordered allergy meds for a week, because they were 'out.' Has a blister on his foot from sandals that don't</p>			

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	<p>fit. When I tried to find his athletic shoes(he had two pairs grey and black) he has one black tennis shoe. He has had \$60.00 stolen from him and has been told by staff he has no money because he has broken stuff. Has had numerous dvd's (sic) stolen. Please take him swimming once a month! I have asked from day one in sept (sic) to get him a library card. Still no library card. He loves books and movies!... The basic lack of needs being met have (sic) brought me to a breaking point. I have tried to be supportive of staff but I feel like no one really cares or wants to put in the effort. That is sad and frustrating for a parent." Corrective action indicated an unannounced visit was being planned for 7/9/14. An investigation into the incident dated 7/11/14 indicated the allegations were "Partially substantiated, the findings support part of how the alleged event was described, but not entirely. HAD BEEN SUBSTANTIATED IN PREVIOUS INVESTIGATION...It appears that there was missing money, [client #1] did not have glasses during a period of time, hair cut appointment was not scheduled regularly, and since leaving day program there has not been a set activity schedule. There was no broken leg and [client #1's] hip problem related (sic) to the growth plate issue. The money issue was dealt with in May, but recommendations have</p>			

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	<p>not been completed at the time of this investigation. Investigation notes dated 1/10/14 (sic) indicated client #1's fracture was a congenital problem where his femur bone slid off his growth plate, and [client #1's] glasses had been removed to prevent breakage during behavior. [Client #1] was on his way to the optometrist when he was hospitalized and glasses have since been replaced." Shoes were lost during behavior (date unspecified), but has just had new ones purchased. "It does not appear that [client #1] has had a haircut during his time at [group home] according to reports from staff and NDQ" Recommendations indicated in part "Establish an activity schedule and share with his parents, include library in weekly activities," complete recommendations from 6/24/14 regarding staff interactions, and complete recommendations from 5/23/14 investigation (regarding missing money).</p> <p>Client #1's activity schedule was reviewed on 9/8/14 at 4:00 PM and failed to include weekly library time as indicated in the recommendation of the investigation dated 7/11/14.</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she</p>			

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	went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. Writer (DSS) asked her if she reported the incident to anyone, and she said she included it on an incident report that she left on the desk in the group home office. This writer could not locate the incident report, and neither could the [NDQ]. An investigation is underway. The group home is 2-story, and both [client #1 and #2's] bedrooms are on the second floor. [Client #1's] (sic) is on the main floor. Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision." The investigation into the incident dated 8/7/14 indicated during interview on 8/6/14 with staff #9 indicated client #1 had said "vulgar things in the past including having sex with children and police			

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	<p>officers, screaming 'penis' and 'vagina' and rubbing his genitals on open windows," and staff #9 "believes that [client #1's] sexual advances are sincere." Staff #9 indicated she had completed an Unusual Incident Report and placed it on a desk in the group home office. Staff #10 indicated she had witnessed client #1 come downstairs, but had not seen him go into any rooms upstairs. She indicated all four of the clients remained in the living room watching TV. She stated "That's how I do it when it's just me-I wanna keep my eyes on all of them." A note included in the investigation regarding client #2's behavior dated 8/2/14 "describes a litany of threats and inappropriate actions made by [client #2] on that day. Those relevant to this investigation are as follows: ...[Client #2] keeps talking about having sex with [client #1], saying that he's going to take his clothes off and stand in front of [client #1's] door telling him to come have sex with him...This account establishes what appears to be a pattern for [client #2's] behaviors-he becomes upset, begins acting out, then uses the incident to make an appeal about his living situation. It also establishes the sexual nature of [client #2's] comments and behaviors, specifically that he is initiating them towards [client #1]...." The investigation indicated the allegation</p>			

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	<p>was not substantiated, "Given [client #2's] history of lying, the specific nature of this allegation, and the testimony of [client #1's] [relative] who was called on the phone during the incident, it seems extremely unlikely that the even occurred as [client #2] describes...[client #1] did invade the privacy of the other roommates in the house by entering their rooms, but was by all accounts an act meant to bother, not abuse...It is apparent to this writer (DQA) that [client #2] is a high functioning individual with a strong grasp on sexual activities and their meanings. It is also well documented that he continually tries to provoke reactions from roommates and specifically targets [client #1]. It is also the opinion of this writer that [client #2] has a very poor grasp of sexual activities and their meanings, and is very persuadable given his level of functioning. Indeed in this writer's casual interactions with residents at [group home] over the past few weeks, it has almost always been [client #2] engaging [client #1]-not the other way around. Coupled with the intensity of their individual behaviors and the many issues that have arisen between these two at [group home] over the past month it is strongly recommended that the placement of these two individuals in the same setting be seriously questioned...."</p> <p>Actions taken included: An IDT will</p>			

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	<p>convene to seriously consider alternative placement for [client #2]... The [group home] staff should begin meeting at least once every one to two weeks to discuss current behaviors and strategies for addressing them. Involvement by all members of the team including DoRS, QAD, and Behaviorist is recommended." The report indicated staff #9 had left employment of the facility and her file would be marked ineligible for rehire due to her failure to report abuse/neglect.</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his penis and attempted to put his hands down the back of client #2's] pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately. Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete</p>			

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	<p>this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the [IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised. Additionally they should be retrained on the updated BSPs (Behavior Support Plans) by the [NDQ] after revisions are completed."</p> <p>During observations at the group home on 8/28/14 from 5:40 PM until 6:40 PM, client #3 was in the living room looking at a magazine. Client #1 watched staff #1 fry hamburgers and declined to participate in preparing the meal when staff #1 asked if he wanted to assist. The DQA worked with client #4 on looking up items on an electronic tablet. The NDQ and the DQA left the home during the observation.</p> <p>Staff #1 was interviewed on 8/28/14 at 5:45 PM and indicated client #3 did not attend school that day as he had received sedative medication earlier that day to attend a medical appointment.</p>				

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	<p>The NDQ was interviewed on 8/28/14 at 6:25 PM and stated staff had called for assistance by them to assist with client #2 who was being housed in a hotel nearby as he was becoming "agitated."</p> <p>Observations were completed at the group home on 8/29/14 from 10:15 AM until 11:00 AM. Client #1 watched a movie, and client #3 looked out the window of his bedroom. Neither client #2 or client #4 were present during the observation. The interim house manager carried torn shoes into the office and placed them on the floor. The interim house manager asked client #3 if he wanted his door shut. When client #3 stated, "Yes," she closed the door to his room.</p> <p>The interim house manager was interviewed on 8/29/14 at 10:15 AM and indicated the shoes were client #4's. She stated client #3 "tore them up," and "He usually goes after electricals." She stated client #3 "Will go after staff," and indicated he would remove female staff shirts and bras. She indicated client #3 had removed her shirt and bra within the last week. She indicated staff brought extra clothing and bras to work in the event client #3 removed their shirts and bras. When asked if an incident report</p>			

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	<p>had been completed regarding the incident, she stated, "I'm trying to find time. I haven't done it yet." She indicated she did not feel she was in harms way when client #3 removed her shirt. She stated client #1 "has been very, very calm" since client #2 was removed from the home. She stated "When [client #2] was here I felt I was in danger. He (client #2) likes to get them riled up. When he gets [client #1] riled up, it's crazy."</p> <p>Observations were completed at a guest group home for client #2 on 8/29/14 from 1:00 PM until 1:15 PM. Client #2 was the only client in the home and was watching TV with staff #7. His medications were unlocked in a duffle bag with client #2's clothing. Staff #7 was relieved by the interim house manager at 1:15 PM.</p> <p>Client #2 was interviewed on 8/29/14 at 1:10 PM. He indicated he had refused his medications of Latuda and Depakote last evening. He stated the Depakote "make you fat," as he had looked up the side effects and Latuda "makes me shaky."</p> <p>The interim house manager was interviewed on 8/29/14 at 1:15 PM and indicated client #2 was not going to return to the group home.</p> <p>Observations were completed on 9/5/14</p>			

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	<p>from 1:30 PM until 2:17 PM at the hotel where client #2 was staying. Client #2's medications were unlocked on the table. Client #2's glasses had tape on both ear pieces at the hinge.</p> <p>Client #2 was interviewed on 9/5/14 at 1:30 PM and stated he "was afraid of staff" and "feel like going in to a behavior," and "they lied to me." He indicated he had been taken out of school. He indicated his medications had been adjusted and stated, "They lied about a lot of stuff, said I was suicidal, told me to go into behaviors."</p> <p>Observations were completed on 9/8/14 from 8:20 PM until 8:45 PM. Staff #11 indicated the clients were all in bed.</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the weekend and had cleaned it up. When asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the</p>				

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	<p>weekend as well. When asked what client #3's plan was when he aggressed, she stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against him." When asked if the behavior could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated that an Unusual Incident Report had been filled out, but a BDDS report had not been done. The NDQ indicated</p>				

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	<p>she was unable to write effective behavior plans for clients #1 and #3 and needed a behavior specialist to help with their plans.</p> <p>Management rounds in the home were completed during the observation period on 9/9/14 from 9:10 AM to 10:05 AM and indicated a sign in time for the rounds was noted, but in only one case was an exit time noted indicating an observation period of 45 minutes.</p> <p>A BDDS report dated 8/29/14 was reviewed on 9/9/14 at 4:30 PM and indicated after returning from an outing client #3 "suddenly lunged at staff and ripped her shirt off. Second staff ran to the house to get assistance and an extra shirt for staff. As [client #3] came up the walk, the NDQ was at the setting and asked client #3 to go to his room and calm. He came in the back door and then lunged for the NDQ and ripped her shirt off of her and pulled her hair. After she was exposed, he lunged for a third staff who was having a meeting with the NDQ. He managed to pull this male staff to the ground and ripped his shirt off. He then kept attacking the male staff and they ended up on the floor in several areas of the office while the male staff was trying to get away from him. NDQ called the police for assistance in getting [client #3]</p>						

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	<p>calm." Corrective action indicated client #3 was given a glass of water to help him calm down. The police arrived just after he was calm and stayed with her for about 30 minutes to ensure he would not have any more aggression. Staff started a movie for him and turned on a fan for him to help him cool off. He remained calm but slightly agitated for the remainder of the evening. [Client #3] has a history of 'cycling' during seasonal changes and when holidays are coming up. He was in the van and may have been hot from being out in the community. This is a targeted behavior included in his plan and staff followed the plan by giving up their shirts. To ensure safety, a second staff member was called in to work the overnight shift so that two staff were present in case he was to become aggressive again. [Client #1] was not injured."</p> <p>Client #3's Replacement Skills Plan dated 5/13 was reviewed on 8/29/14 at 10:00 AM and indicated target behaviors of physical aggression (pulling shirts, pulling hair, scratching, grabbing others). Client #3's plan indicated he was to be offered sensory stimulation throughout the day, and "Do not tell [client #3] 'NO,' This agitates him and could lead to physical aggression. Instead, redirect him from the unwanted behavior to another</p>						

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	<p>task...If aggression occurs, ask [client #3] to 'STOP.' Do NOT attempt a CPI-approved escort. This further agitates [client #3] and may escalate the aggression. If [client #3] grabs staff by the shirt front, staff should drop to the ground and remain still until [client #3] is done grabbing. It is thought that [client #3] is not trying to hurt staff, but is attempting to gain control in the situation. Offer [client #3] something to put in his hand (like a drink of water). This may encourage him to let go of the staff member he is aggressing on. If aggression continues staff may need further staff assistance by either helping physically or calling for help."</p> <p>A Report of Observation dated 8/20/14 written by the BS was reviewed on 9/10/14 at 12:21 PM and indicated the BS had spent 6 hours at the group home on 8/20/14. Recommendations included "After speaking with [clients #1 and #2], this behaviorist has significant concerns regarding [clients #1 and #2] living together in the group home. Although [clients #1 and #2] are around the same age, they are at different developmental levels. [Client #2] is teaching things to [client #1] that he is not at the developmental level to handle at this time which is contributing to behavioral outbursts. This behaviorist recommends</p>			

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	<p>that [client #2] move into a supported living site where he can receive individualized attention from staff and maximize his opportunities in the community...individual counseling is necessary for [client #2] to process through trauma from his past. Due to reports of concern regarding sexual abuse trauma, individual therapy with a certified sexual abuse therapist would be the most appropriate therapist to begin working with him. There should be regular staff meetings held to provide continuing education and training on appropriate proactive approaches to use when interacting with the customers. These staff meetings should be held weekly. There should be daily schedules developed for each customer to create a meaningful day for them. There should also be daily outings built into each customer's schedule...."</p> <p>The DoRS was interviewed on 9/10/14 at 10:55 AM and indicated it was the responsibility of the CEO, DSS, DoRS, QAD, the TM and the NDQ to ensure policy and procedures were implemented to protect clients and to ensure corrective action was implemented as recommended in investigations.</p> <p>The facility's Reporting of Abuse and Neglect dated 9/13 was reviewed on</p>						

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	<p>8/28/14 at 2:00 PM and indicated all incidents of abuse and neglect would be reported and investigated. The policy indicated the investigation process would include "A resolution for the investigation including recommended actions and policy/procedure changes."</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based upon observation, record review, and interview, the facility failed for 2 of 2</p>	W000153	An incident report and BDDS report has been completed for the events on 8/26/14. Staff have	09/26/2014	

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	<p>sampled clients (clients #1 and #2) and for 1 additional client (client #3) by failing to timely report allegations of sexual assault, client to client aggression, property destruction and an allegation of missing money in accordance to state law.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2</p>		<p>been re-trained on documentation of negative behaviors, and completing incident reports. The Team Manager was trained on BDDS incident reporting procedures on 9/24/14. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all</p>		

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	<p>raised his shirt exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced</p>		<p>recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and followup. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>		

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	<p>back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p>						

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	<p>The interim house manager was interviewed on 8/26/14 at 8:30 PM and indicated client #1 had urinated on the floor and was mopping it up.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and took a shower. Staff #2 was alone with clients #1 and #2 from 7:15 AM until the conclusion of the observation.</p> <p>During observations at the group home on 8/27/14 from 7:10 AM until 9:30 AM, client #1 made himself a bowl of cereal. He had 2 bruises quarter sized on his upper left arm and lower left arm.</p> <p>Staff #3 was interviewed on 8/27/14 at 7:10 AM and stated the bruises were from a fall "last Friday. He was trying to get to [client #2], spilled water, slipped and fell."</p> <p>Behavior and medical observations (progress notes) were reviewed on 8/27/14 at 8:53 AM and indicated the following:</p> <p>For client #1: 8/26/14 from 3:00 PM until 9:00 PM; "He got a little worked up today, but calmed himself down."</p>			

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	<p>For client #2: 8/26/14; 1:00 PM until 8:00 PM; arguing with staff, ...did not give personal space...."</p> <p>There was no evidence of an incident report for client #1's property destruction, inappropriate language, threats to throw feces, poke his eyes out or of his urination on the floor. There was no evidence of an incident report for client #2's sexual assault, physical aggression, or inappropriate language.</p> <p>The interim house manager was interviewed on 8/27/14 at 9:15 AM and indicated there had not been a report filled out for clients #1 and #2 regarding their behaviors on 8/26/14 from 7:15 PM until 8:28 AM. No report of the incident was provided.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic." She indicated staff had difficulty finding the time to complete incident reports with the behaviors in the home and that there was an issue with reports being destroyed by clients.</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and</p>				

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	<p>indicated the following:</p> <p>An investigation dated 5/30/14 indicated client #1's father had dropped the money off on 5/16/14 and left the money with staff #8. Staff (unidentified) placed the money in the Team Manager's (TM) desk drawer. When staff #8 came back to work on 5/19/14, he told the TM the money was in the desk drawer, but it was not found. The investigation indicated the whereabouts of the missing money had not been determined and would be reimbursed to client #1 by the facility. This incident was reported late-it was realized that the money was missing on 5/19/14 by the TM, however it was not reported to the ND/Q until 5/21/14, who completed at (sic) BDDS report on 5/22/14." An attached BDDS report dated 5/21/14 indicated \$40.00 left by client #1's father and found missing on 5/19/14 at the group home was missing and would be investigated.</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed</p>						

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	<p>on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. Writer (DSS) asked her if she reported the incident to anyone, and she said she included it on an incident report that she left on the desk in the group home office. This writer could not locate the incident report, and neither could the [NDQ]. An investigation is underway. The report indicated staff #9 had left employment of the facility and her file would be marked ineligible for rehire due to her failure to report abuse/neglect.</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an</p>			

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W000157	<p>antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against him." When asked if the behavior could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated that an Unusual Incident Report had been filled out, but a BDDS report had not been completed.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon observation, record review, and interview for 2 of 2 sampled clients (#1 and</p>	W000157	Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now	09/26/2014

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	<p>#2) plus 1 additional client (#3), the facility failed to develop and implement effective corrective action to address the physically aggressive and intimidating behavior of clients #1 and #2 after a history of their behavior had been identified. The facility failed to develop and implement effective corrective action to address client #3's physically aggressive behavior.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit</p>		<p>receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to specific consequences. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data</p>				

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	<p>arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in</p>		<p>on behaviors,review of communication log for issues and concerns, facility issues, finances,and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct,on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality</p>				

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	<p>the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p> <p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of</p>		<p>Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>	

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	<p>the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The interim house manager was interviewed on 8/26/14 at 8:30 PM and indicated client #1 had urinated on the floor and was mopping it up.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and took a shower. Staff #2 was alone with clients #1 and #2 from 7:15 AM until the conclusion of the observation.</p> <p>Staff #3 was interviewed again on 8/27/14 at 6:50 AM and indicated sometimes clients #1 and #2 would get</p>			

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	<p>up at night, but would watch TV.</p> <p>Staff #2 was interviewed on 8/27/14 at 7:28 AM. She indicated staff usually works alone from 7:00 AM to 12:00 PM unless there were three clients in the home at which time another staff would be brought in to work in the home. She indicated she was covering the shift for the interim house manager and she would arrive at 9:00 AM to relieve her (staff #2).</p> <p>Behavior and medical observations (progress notes) were reviewed on 8/27/14 at 8:53 AM and indicated the following:</p> <p>For client #1:</p> <p>8/26/14 from 3:00 PM until 9:00 PM; "He got a little worked up today, but calmed himself down."</p> <p>8/21/14; "Multiple behaviors this evening from 2:45 PM until 7:45 PM...Incredibly inappropriate on several different occasions tonight."</p> <p>6/24/14; "Threatened to kill cops, urinated on floor."</p> <p>6/24/14; "Threatened to kill kid" and "taken to [mental health facility]."</p>			

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	<p>6/23/14; "Showed private parts out window."</p> <p>6/8/14; "Called cops and placed in hand cuffs."</p> <p>For client #2:</p> <p>8/26/14; 1:00 PM until 8:00 PM; arguing with staff, ...did not give personal space...."</p> <p>8/18/14; "argumentative; glasses broken by another individual...."</p> <p>8/4/14; "had behavior, went to the hospital...."</p> <p>8/3/14; "was in a behavior when staff got here...."</p> <p>7/28/14; "attacked staff and breaking things...."</p> <p>6/17/14; "Tried going into [client #1's room]."</p> <p>6/11/14; "Yelling, screaming and throwing items."</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on</p>			

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	<p>8/27/14 at 1:45 PM and included the following:</p> <p>For client #1:</p> <p>A BDDS report dated 5/25/14 indicated client #1 was aggressive, hitting, spitting, throwing objects and attempting to urinate on staff. Staff called 911 and police handcuffed and transported him to the hospital to be evaluated. The report indicated client #1's hip was x-rayed due to an earlier fall, and had not received his evening medications "due to spitting them out at staff." Client #1 was transported back home by ambulance "due to trying to work back up in a behavior and threatening to crash my (Team Manager) car." Corrective action indicated a plan was being generated to address his behavior and prevent future incidents.</p> <p>A BDDS report dated 6/7/14 indicated client #1 called 911 after "escalating into behaviors." The report indicated staff called the security system to notify them it was a false alarm so fire trucks would not arrive. Plan to resolve indicated client #1 "Has many proactive measures written into his behavior plan. Staff were following his plan during the incident. [Client #1] currently does not have a psychiatrist and Life Designs has been</p>						

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	<p>looking for one for him. He has been turned down by four different facilities/offices." The report indicated client #1's primary care physician had ordered increases in medications which are awaiting Human Rights Committee (HRC) approval. "Life Designs has also explored possible in-patient facilities to look into [client #1's] medication regimen (sic), but has been unsuccessful in locating a facility that is willing to admit [client #1]. Staff will continue to follow [client #1's] behavior plan and Life Designs will continue to locate a psychiatrist to manage [client #1's] medication and continue to explore in-patient options."</p> <p>A BDDS report dated 6/24/14 indicated client #1 was physically aggressive and inappropriate with staff. The police were called and hand cuffed client #1 after he threatened to use their guns to kill them. Client #1 was placed in a spit proof mask and transported to the hospital after he tried to urinate on the police officers. Client #1 was admitted to a mental health facility. Corrective action indicated the mental health facility would monitor client #1. The report indicated client #1 was admitted for 7 days and his psychiatric medications had been adjusted.</p>			

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	<p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p> <p>A BDDS report dated 8/11/14 indicated client #2 told client #1 the dessert looked like "sperm." The report indicated client #1 yelled "sperm" throughout the house and urinated on the floor. Client #1 scratched client #2 leaving four superficial scratch marks and picked up a table leg and attempted to hit client #2 with it. The report indicated client #2 continued to "agitate" client #1 and client #1 "refused to leave [client #2] alone." Client #1 "was screaming at [client #2] through the door...At one point, [client #2] came downstairs and continued to agitate [client #1]. [Client #1's] behavior continued for another hour or two with periods of calm and then re-escalation." The report indicated an IDT (interdisciplinary team) meeting would be scheduled for 8/13/14 to address the incident.</p> <p>A BDDS report dated 8/12/14 indicated</p>				

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	<p>throughout the morning client #1 "was having behaviors," and would calm periodically. He attempted to "go after a roommate, but was blocked by staff." He intentionally had a bowel movement in the hallway and threw feces at staff. Client #1 attempted to grab staff sexually between her legs and attempted to push past staff to get at his roommate (unidentified). A second staff was called to assist and the unidentified client was placed in a room to keep him away from client #1. Client #1 attempted to put utensils under the locked door including a knife. 911 was called and client #1 was arrested and the police "were pressing charges that included two counts of battery with bodily fluid and one count of sexual battery." The report indicated client #1's relative posted bond and he spent the evening at their home. Corrective action indicated there was an emergency IDT planned for 8/13/14 to address the situation.</p> <p>A Plan for Extra Support dated 8/13/14 was reviewed on 9/8/14 at 4:00 PM and indicated the following:</p> <p>"Short Term-[Director of Quality Assurance] will work 10:00-8:00 (AM/PM not indicated) Mon. and Tues. [Behavior Specialist] will work 10:00-4:00 (AM/PM not indicated) on</p>				

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	<p>Wed. [Director of Residential Services (DoRS) will work Thurs and Fri (time not indicated).</p> <p>[DQA] will focus on individual goals and 1:1 community involvement, as well as staff training and development, [BS] will focus on behavior strategies and interventions, as well as staff training and development. [DoRS] will focus on work with [client #1] and one peer doing daily activities in and around the house. She will reinforce positive interactions and pro-social behavior. She will also work with staff to train (sic)."</p> <p>Mid Term: The plan indicated new staff members would be hired including a Team Manager, Team Lead and Medical Coordinator. The CEO (Chief Executive Officer) "is exploring ...Day Program Services. She is following up with the [police department]. [NDQ] is contacting [psychiatric services provider], to determine what resources are available...for emergency care. [DoRS] is following up with [staff at mental health provider] to determine what resources are available through her agency for emergency care. She is [mental health provider's] liaison with the Police Department.</p>			

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	<p>Longer Term: Begin exploration of a waiver setting for Supported Living in a smaller setting."</p> <p>For client #2:</p> <p>A BDDS report dated 6/10/14 indicated client #2 had "behavior issues most of the day." Client #2 "followed clients around the house saying inappropriate things about them." Client #2 was "yelling at peers," and "stomping through the house," and hitting the walls. Client #2 knocked over a beverage into the other clients' pizza by pushing the table as they were eating and pounded the table with his hands. Client #2 pushed staff to the floor. Client #2 threatened to call police. It was "questionable" if client #2 pushed client #4, as staff saw client #4 take a step backwards "as if he was pushed" by client #2. The report indicated client #4 could not speak for himself. The report indicated client #2 continued to bang on walls of the home, "yell" and attempted to wake clients up after they were in their bedrooms. Client #2 "yelled at [client #1] and he started crying." Client #1 went to the office to eat his dinner, and client #2 started "ramming" into staff to get to client #1. Client #1 began "crying uncontrollably." Corrective action indicated client #2 had been admitted to the group home on 5/2/14 and the facility</p>			

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	<p>was attempting to secure psychiatric services to address client #2's behaviors. Staff will continue to follow client #2's behavior plan to address his behaviors and take action to prevent peers from experiencing verbal and physical abuse.</p> <p>A BDDS report indicated client #2 "had been upset for much of the day on 8/2/14. He had pushed group home staff and a temporary staff on different occasions through out the day...Around 7:45 PM staff called NDQ and reported that [client #2] had threatened to hurt himself and staff and was threatening to get a knife. NDQ advised the staff to hang up and call 911. Just after hanging up with the group home staff, the temporary agency staff called the NDQ and told her [client #2] had a knife and was trying to get in the locked office door." The temporary staff and client #1 were locked in the office, and "the group home staff (who was in the common area of the house with [client #2] managed to get [client #2] to give her the knife and slid it under the locked office door." Police arrived and client #2 agreed to go to his room. The police indicated to the NDQ they could not transport client #2 to the hospital for evaluation. Corrective action indicated sharps would now be locked in the home and an Interdisciplinary (IDT) team meeting would be held to discuss</p>			

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	<p>the incident "and what changes can be made to ensure all remain safe." The NDQ "will review [client #2's] behavior plan to determine what changes need to be made."</p> <p>A BDDS report dated 8/4/14 indicated client #2 hit client #1 on his back and pinched his neck while traveling in the van. Client #2 was "flipping off" (obscene gesture) other drivers, attempted to open the van door while it was moving and "at one point he acted as if he was going to grab the wheel of the vehicle while it was moving and stated he didn't care if they all died in a crash." After returning home "the behavior continued. He blocked staff (unidentified) in the bathroom and would not let her get past him." Corrective action indicated the NDQ was conducting an IDT meeting regarding the incident on 8/2/14 when she was informed of the current incident and advised staff to call 911. The NDQ met the police at the home and requested they transport client #2 to the hospital for evaluation and treatment. Once at the hospital, client #2 refused treatment and since he is his own guardian the hospital could not admit him. The discharge orders from the hospital indicated if client #2 became aggressive again, staff should call police and have client #2 arrested/jailed. Client #1 did not sustain</p>				

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	<p>injury during the incident. Corrective action indicated an IDT would be scheduled to address the incidents.</p> <p>A BDDS report dated 8/18/14 indicated client #2 told staff while watching a movie client #1 had put his hands down client #2's pants and touched his penis and tried to put his hands down the back of his pants "to smell his poop." Shortly after the incident client #1 broke client #2's glasses. Corrective action indicated the clients were not to be left in a room alone without supervision and an investigation would be completed.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. There was no evidence of a revision of client #1's plan since 9/13/13.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14.</p> <p>The Network Director/Qualified</p>			

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	<p>Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic. I've had to call the police 5 times in 3 weeks. The behavior is escalating. On Saturday, August 2, (2014), he (client #2) threatened staff. They barricaded themselves in the office. He grabbed a butcher knife and tried to pry open the door. [Client #1] was locked in the office too. They (clients #1 and #2) terrorize each other and everyone else in the house." She indicated client #2 slapped client #1 and pushed staff in the past. She indicated client #1 now spoke of sexual issues and stated client #1 "had no sexual talk before [client #2] came here (to the group home)." She stated while shopping at a store client #2 talked to client #1 to "solicit" an 8 year old girl and then picked up the phone and used the F*** word over the intercom repeatedly. She said the 8 year old girl's mother was with her and no harm came to the girl. Client #2 "admitted he had egged [client #1] on" later. We're trying to do everything we can here. When asked about a behavioral specialist, she indicated she had attempted to involve a behavior specialist, but stated, "it hasn't been solidified." The NDQ indicated she (NDQ) wrote the plans, and the behavior specialist had visited the home, but the</p>			

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	<p>clients had not exhibited maladaptive behavior during her visit. She indicated the behavior specialist was scheduled to come to the home today, but was unable to come due to unknown reasons. She stated, "I can't keep up with the plans. Their behaviors are escalating" and in regards to the involvement of a behavioral specialist "It's really needed." She indicated client #1 was arrested on 8/12/14 and taken to jail for sexual battery to staff. She indicated client #1's psychiatrist wanted to take him off medication to address his behaviors, but the guardian didn't agree. She stated client #2 was his own guardian and says he "runs the house." When asked if the clients injured one another during behaviors, she stated, "I would say it's more emotional abuse." She indicated both clients #1 and #2 had threatened each other with a butcher knife and the knives were now locked up in the house. She indicated there were no IDT meetings available to address the situation. She indicated the meeting on 8/4/14 had been interrupted by the behavior incident on 8/4/14. She indicated client #2's plan did not address physical aggression as she had not been able to update the plan as yet.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30</p>			

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	<p>PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1 asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There was no evidence of the Behavior Specialist in the home during the observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing."</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>An investigation dated 5/30/14 indicated client #1's father had dropped the money off on 5/16/14 and left the money with staff #8. Staff (unidentified) placed the money in the Team Manager's (TM) desk drawer. When staff #8 came back to work</p>						

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	<p>on 5/19/14, he told the TM the money was in the desk drawer, but it was not found. The investigation indicated the whereabouts of the missing money had not been determined and would be reimbursed to client #1 by the facility. The investigation indicated "Transactions appear to be only documented by TM. Services Administrative Assistant [name] reported that she has not gotten complete financial documentation from customers at [group home], and what she has received is not well organized...."</p> <p>Findings of the investigation indicated "Based on review of financial records, as well as report from the Team Manager, customer finances in the home are not being maintained in accordance with Life Designs' policies. Staff received money for a customer, but did not document receipt of that money, and did not document it as a deposit into the customer's house account. This makes it impossible to determine what may have happened to it...." Recommendations indicated staff would be retrained and implement management of client finances in accordance with facility procedures and the NDQ would be trained on on-call reporting procedures.</p> <p>An investigation dated 6/12/14 indicated on 6/10/14 client #2 "was in a poor mood due to feeling like he was being blamed</p>			

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	<p>for things. He started yelling at a staff member while another staff was gone, pushing her and trying to knock her over. At one point they think he might have possibly pushed [client #4]...He was verbally abusing staff and roommates yelling obscenities and saying they were all stupid." Recommendations indicated "Staff to continue following behavior plan. Medical coordinator to continue to look for a psychiatrist for [client #2]."</p> <p>An investigation dated 7/1/14 indicated the allegation was unsubstantiated "Based upon the discrepancies in [client #1's] interview and his agitated state during the described incident, this writer cannot substantiate the allegation of verbal abuse. Investigator noted through observation and subsequent interviews that [staff #9's] overall tone when interacting with customers is quite loud and overbearing, which in direct opposition to the stated steps in [client #1's] Behavior Support Plan. Recommendations included "Behavior Specialist will complete an observation of a shift when [staff #9] is working to assess her communication style and interactions with the customers. She will then provide additional training based on her observations. Behavioral Specialist and ND/Q will review the Behavior Support Plan and retrain staff to ensure</p>						

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	<p>consistency of implementation. Retraining will include ways to effectively communicate with individuals in both a proactive and reactive way. DoRS (Director of Residential Services), DoSS, and QAD will perform follow up observations weekly for a period of one month and will share findings with ND/Q, Behavior Specialist, and other positions completing observations. A Behavioral Observations and Recommendations dated 7/17/14 indicated "It appears that the interactions between [client #1] and [staff #9] are appropriate. Behaviorist will follow up with the home as needed to ensure that the staff and customers interact and work well together. It is recommended that if concerns continue to arise, the behaviorist be informed and a training be held for staff to educate them on respectful and proactive approaches to use with clients." Observations dated 7/9/14 from the QAD and on 7/4/24 from the DoRS were included in the investigative packet. A BDDS report included in the investigation dated 6/24/14 indicated client #1 alleged staff #9 had told him to "shut up ****" and had stated to his mother after being asked if the group home was the right place for him stated, "No, they don't know how to handle me." The report indicated the incident would be investigated.</p>			

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	<p>A BDDS report included with an investigation dated 7/8/14 indicated client #1's relative sent an e-mail with receipt to a BDDS Generalist for items she purchased for client #1 "attached is a receipt for [client #1's] basic needs which are not being met by Life Designs for: shoes, allergy meds (medications), shaver, light bulb for room, frames for correct prescription glasses and a haircut." The report indicated client #1's relative indicated he had "NEVER" been taken for a haircut in seven months and he had been wearing "old (wrong script (prescription)) glasses." He was taken to hospital for a week with "NO glasses and has very poor vision. I have been told his glasses are taken off his face to 'gain compliance." The report indicated client #1's relative indicated he had a broken femur and "not believed after I begged for him to see a dr (sic) for three weeks! Was made to kneel for hours because he wouldn't get up with a broken bone. Was made to walk to bathroom on a broken femur (sic) the reply to my concern by male RN (registered nurse) was 'we don't have a urinal here.' For [client #1] is very symptomatic because he has not had his physician ordered allergy meds for a week, because they were 'out.' Has a blister on his foot from sandals that don't fit. When I tried to find his athletic</p>			
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	shoes(he had two pairs grey and black) he has one black tennis shoe. He has had \$60.00 stolen from him and has been told by staff he has no money because he has broken stuff. Has had numerous dvd's (sic) stolen. Please take him swimming once a month! I have asked from day one in sept (sic) to get him a library card. Still no library card. He loves books and movies!... The basic lack of needs being met have (sic) brought me to a breaking point. I have tried to be supportive of staff but I feel like no one really cares or wants to put in the effort. That is sad and frustrating for a parent." Corrective action indicated an unannounced visit was being planned for 7/9/14. An investigation into the incident dated 7/11/14 indicated the allegations were "Partially substantiated, the findings support part of how the alleged event was described, but not entirely. HAD BEEN SUBSTANTIATED IN PREVIOUS INVESTIGATION...It appears that there was missing money, [client #1] did not have glasses during a period of time, hair cut appointment was not scheduled regularly, and since leaving day program there has not been a set activity schedule. There was no broken leg and [client #1's] hip problem related (sic) to the growth plate issue. The money issue was dealt with in May, but recommendations have not been completed at the time of this			

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	<p>investigation. Investigation notes dated 1/10/14 (sic) indicated client #1's fracture was a congenital problem where his femur bone slid off his growth plate, and [client #1's] glasses had been removed to prevent breakage during behavior. [Client #1] was on his way to the optometrist when he was hospitalized and glasses have since been replaced." Shoes were lost during behavior (date unspecified), but has just had new ones purchased. "It does not appear that [client #1] has had a haircut during his time at [group home] according to reports from staff and NDQ" Recommendations indicated in part "Establish an activity schedule and share with his parents, include library in weekly activities," complete recommendations from 6/24/14 regarding staff interactions, and complete recommendations from 5/23/14 investigation (regarding missing money).</p> <p>Client #1's activity schedule was reviewed on 9/8/14 at 4:00 PM and failed to include weekly library time as indicated in the recommendation of the investigation dated 7/11/14.</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2]</p>						

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	made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. Writer (DSS) asked her if she reported the incident to anyone, and she said she included it on an incident report that she left on the desk in the group home office. This writer could not locate the incident report, and neither could the [NDQ]. An investigation is underway. The group home is 2-story, and both [client #1 and #2's] bedrooms are on the second floor. [Client #1's] (sic) is on the main floor. Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision." The investigation into the incident dated 8/7/14 indicated during interview on 8/6/14 with staff #9 indicated client #1 had said "vulgar things in the past including having sex with children and police officers, screaming 'penis' and 'vagina' and			

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	<p>rubbing his genitals on open windows," and staff #9 "believes that [client #1's] sexual advances are sincere." Staff #9 indicated she had completed an Unusual Incident Report and placed it on a desk in the group home office. Staff #10 indicated she had witnessed client #1 come downstairs, but had not seen him go into any rooms upstairs. She indicated all four of the clients remained in the living room watching TV. She stated "That's how I do it when it's just me-I wanna keep my eyes on all of them." A note included in the investigation regarding client #2's behavior dated 8/2/14 "describes a litany of threats and inappropriate actions made by [client #2] on that day. Those relevant to this investigation are as follows: ...[Client #2] keeps talking about having sex with [client #1], saying that he's going to take his clothes off and stand in front of [client #1's] door telling him to come have sex with him...This account establishes what appears to be a pattern for [client #2's] behaviors-he becomes upset, begins acting out, then uses the incident to make an appeal about his living situation. It also establishes the sexual nature of [client #2's] comments and behaviors, specifically that he is initiating them towards [client #1]...." The investigation indicated the allegation was not substantiated, "Given [client</p>			

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	<p>#2's] history of lying, the specific nature of this allegation, and the testimony of [client #'1's] [relative] who was called on the phone during the incident, it seems extremely unlikely that the even occurred as [client #2] describes...[client #1] did invade the privacy of the other roommates in the house by entering their rooms, but was by all accounts an act meant to bother, not abuse...It is apparent to this writer (DQA) that [client #2] is a high functioning individual with a strong grasp on sexual activities and their meanings. It is also well documented that he continually tries to provoke reactions from roommates and specifically targets [client #1]. It is also the opinion of this writer that [client #2] has a very poor grasp of sexual activities and their meanings, and is very persuadable given his level of functioning. Indeed in this writer's casual interactions with residents at [group home] over the past few weeks, it has almost always been [client #2] engaging [client #1]-not the other way around. Coupled with the intensity of their individual behaviors and the many issues that have arisen between these two at [group home] over the past month it is strongly recommended that the placement of these two individuals in the same setting be seriously questioned...."</p> <p>Actions taken included: An IDT will convene to seriously consider alternative</p>			

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	<p>placement for [client #2]... The [group home] staff should begin meeting at least once every one to two weeks to discuss current behaviors and strategies for addressing them. Involvement by all members of the team including DoRS, QAD, and Behaviorist is recommended."</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his penis and attempted to put his hands down the back of client #2's] pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately. Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the [IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A</p>			

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	<p>proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised. Additionally they should be retrained on the updated BSPs (Behavior Support Plans) by the [NDQ] after revisions are completed."</p> <p>Observations were completed at the group home on 8/29/14 from 10:15 AM until 11:00 AM. Client #1 watched a movie, and client #3 looked out the window of his bedroom. Neither client #2 or client #4 were present during the observation. The interim house manager carried torn shoes into the office and placed them on the floor. The interim house manager asked client #3 if he wanted his door shut. When client #3 stated, "Yes," she closed the door to his room.</p> <p>The interim house manager was interviewed on 8/29/14 at 10:15 AM and indicated the shoes were client #4's. She stated client #3 "tore them up," and "He usually goes after electricals." She stated client #3 "Will go after staff," and indicated he would remove female staff shirts and bras. She indicated client #3</p>			

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	<p>had removed her shirt and bra within the last week. She indicated staff brought extra clothing and bras to work in the event client #3 removed their shirts and bras. When asked if an incident report had been completed regarding the incident, she stated, "I'm trying to find time. I haven't done it yet." She indicated she did not feel she was in harms way when client #3 removed her shirt. She stated client #1 "has been very, very calm" since client #2 was removed from the home. She stated "When [client #2] was here I felt I was in danger. He (client #2) likes to get them riled up. When he gets [client #1] riled up, it's crazy."</p> <p>Observations were completed at a guest group home for client #2 on 8/29/14 from 1:00 PM until 1:15 PM. Client #2 was the only client in the home and was watching TV with staff #7. His medications were unlocked in a duffle bag with client #2's clothing. Staff #7 was relieved by the interim house manager at 1:15 PM.</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the</p>			

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	<p>weekend and had cleaned it up. When asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the weekend as well. When asked what client #3's plan was when he aggressed, she stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against</p>			

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	<p>him." When asked if the behavior could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated she was unable to write effective behavior plans for clients #1 and #3 and needed a behavior specialist to help with their plans.</p> <p>Management rounds in the home were completed during the observation period on 9/9/14 from 9:10 AM to 10:05 AM and indicated a sign in time for the rounds was noted, but in only one case was an exit time noted indicating an observation period of 45 minutes.</p> <p>A BDDS report dated 8/29/14 was reviewed on 9/9/14 at 4:30 PM and indicated after returning from an outing client #3 "suddenly lunged at staff and ripped her shirt off. Second staff ran to the house to get assistance and an extra shirt for staff. As [client #3] came up the walk, the NDQ was at the setting and asked client #3 to go to his room and calm. He came in the back door and then lunged for the NDQ and ripped her shirt off of her and pulled her hair. After she was exposed, he lunged for a third staff who was having a meeting with the NDQ. He managed to pull this male staff to the ground and ripped his shirt off. He then kept attacking the male staff and they ended up on the floor in several areas of</p>						

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	<p>the office while the male staff was trying to get away from him. NDQ called the police for assistance in getting [client #3] calm." Corrective action indicated client #3 was given a glass of water to help him calm down. The police arrived just after he was calm and stayed with her for about 30 minutes to ensure he would not have any more aggression. Staff started a movie for him and turned on a fan for him to help him cool off. He remained calm but slightly agitated for the remainder of the evening. [Client #3] has a history of 'cycling' during seasonal changes and when holidays are coming up. He was in the van and may have been hot from being out in the community. This is a targeted behavior included in his plan and staff followed the plan by giving up their shirts. To ensure safety, a second staff member was called in to work the overnight shift so that two staff were present in case he was to become aggressive again. [Client #1] was not injured."</p> <p>Client #3's Replacement Skills Plan dated 5/13 was reviewed on 8/29/14 at 10:00 AM and indicated target behaviors of physical aggression (pulling shirts, pulling hair, scratching, grabbing others). Client #3's plan indicated he was to be offered sensory stimulation throughout the day, and "Do not tell [client #3] 'NO,'</p>			

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	<p>This agitates him and could lead to physical aggression. Instead, redirect him from the unwanted behavior to another task...If aggression occurs, ask [client #3] to 'STOP.' Do NOT attempt a CPI-approved escort. This further agitates [client #3] and may escalate the aggression. If [client #3] grabs staff by the shirt front, staff should drop to the ground and remain still until [client #3] is done grabbing. It is thought that [client #3] is not trying to hurt staff, but is attempting to gain control in the situation. Offer [client #3] something to put in his hand (like a drink of water). This may encourage him to let go of the staff member he is aggressing on. If aggression continues staff may need further staff assistance by either helping physically or calling for help."</p> <p>A Report of Observation dated 8/20/14 written by the BS was reviewed on 9/10/14 at 12:21 PM and indicated the BS had spent 6 hours at the group home on 8/20/14. Recommendations included "After speaking with [clients #1 and #2], this behaviorist has significant concerns regarding [clients #1 and #2] living together in the group home. Although [clients #1 and #2] are around the same age, they are at different developmental levels. [Client #2] is teaching things to [client #1] that he is not at the</p>				

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	<p>developmental level to handle at this time which is contributing to behavioral outbursts. This behaviorist recommends that [client #2] move into a supported living site where he can receive individualized attention from staff and maximize his opportunities in the community...individual counseling is necessary for [client #2] to process through trauma from his past. Due to reports of concern regarding sexual abuse trauma, individual therapy with a certified sexual abuse therapist would be the most appropriate therapist to begin working with him. There should be regular staff meetings held to provide continuing education and training on appropriate proactive approaches to use when interacting with the customers. These staff meetings should be held weekly. There should be daily schedules developed for each customer to create a meaningful day for them. There should also be daily outings built into each customer's schedule...."</p> <p>The DoRS was interviewed on 9/10/14 at 10:55 AM and indicated it was the responsibility of the CEO, DSS, DoRS, QAD, the TM and the NDQ to ensure policy and procedures were implemented to protect clients and to ensure corrective action was implemented as recommended in investigations.</p>						

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W000159	<p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2) to ensure the QIDP (Qualified Intellectual Disabilities Professional) completed periodic reviews of their ISP (Individual Support Plans) objectives, failed to ensure updated schedules were available to staff, failed to ensure staff were trained to implement client plans, failed to ensure behavior data was collected and failed to ensure the human rights committee reviewed client plans with restrictive interventions.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/27/14 at 12:20 PM. His ISP dated 9/21/13 indicated objectives to make a side dish, call mom and discuss three topics, choose activity of choice, return receipt after purchase, chew food appropriately, and pop out medication</p>	W000159	Active treatment schedules are now in place for all individuals living in the home, and staff have been trained on implementation, including the importance of supporting the clients to be actively engaged in activities throughout the day. The schedules are reviewed regularly at team meetings to ensure they remain relevant and consistent with the interests and ISP goals of each individual. Functional assessments have been revised for all clients in the home, and will be reviewed at the next 2 support team meetings to develop relevant, meaningful goals. Staff will in turn be trained on the goals in order to implement them in a consistent way. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as for client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior	09/26/2014	

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	<p>from dispenser pack. There was no evidence of a Qualified Intellectual Disabilities Professional (QIDP) review of the progress of client #1's objectives.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. Client #2's ISP dated included 5/8/14 indicated "complete laundry, maintain schedule on a schedule board, communicate accurate information, respect other's boundaries and personal space, complete transaction and return receipt, learn address, phone number and provider name, pop out medication from packet and into med (medication) cup, brush teeth twice daily, and exercise by walking 20-30 minutes weekly." There was no evidence of a Qualified Intellectual Disabilities Professional review of the progress of client #2's objectives.</p> <p>The Network Director/Qualified Intellectual Disabilities Professional indicated on 9/9/14 at 3:28 PM there were no reviews of the clients' objectives by the QIDP to review. She stated, "They are behind."</p> <p>2. The QIDP failed to ensure staff demonstrated competency to implement 2 of 2 sampled clients' (clients #1 and #2) supervision level to address maladaptive behavior, and failed to demonstrate</p>		<p>Consultant has trained staff on the revised plans. The Behavior Consultant has participated in weekly team meetings to gather additional feedback from staff related to behaviors, as well as spent time with staff observing interactions with clients. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides</p>	

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	<p>competency to implement 1 additional client's behavior plan (client #3). Please see W191.</p> <p>3. The QIDP failed for 2 of 2 sampled clients (#1 and #2), to provide an updated active treatment schedule for staff to follow. Please see W250.</p> <p>4. The QIDP failed for 2 of 2 sampled clients (clients #1 and #2) to ensure their behavior program data was documented. Please see W252.</p> <p>5. The QIDP failed for 2 of 2 sampled clients (clients #1 and #2), to ensure the facility's Human Rights Committee (HRC) reviewed and approved plans that included the use of medication to address behavior. Please see W262.</p> <p>9-3-3(a)</p>		<p>direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. A monthly report has been developed, to be completed by the ND/Q for each individual, summarizing services they have received. It includes data related to behavior, including the date of the Behavior Support Plan, and when HRC approval was obtained. Each monthly report will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The ND/Q will</p>				

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W000164	483.430(b)(1)		complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. 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, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.		

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	<p>PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (clients #1 and #2), and for 2 additional clients (clients #3 and #4), the facility failed to assure the professional program services clinician (behavioral consultant) was available in the group home to develop and ensure implementation of their behavior plans.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when</p>	W000164	Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. From 9/28 to 10/4 the Behavior consultant will provide 6 days on site for 3 to 6 hours- she has already been on site Sunday, Monday, Tuesday, Wednesday and Thursday of this week, and will be there again either Saturday or Sunday. She will provide support from 10/5 forward to train new staff, assess performance of all and monitor effectiveness of strategies. A competency based	09/26/2014

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	they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff		assessment will be used to evaluate staff knowledge and ability to implement behavior support plans. All new staff will receive training from the behavior specialist before they are able to work alone. Staff support needs will be discussed at team meetings to determine where continued help is needed. Continued behavior support will be two days per week (3 hours minimum) plus weekly team meetings with all staff. Additionally, the LifeDesigns Behavior Consultant will train Stephanie Bryant (currently working as trainer for Team Manager) to provide additional support to staff. Stephanie is a former Quality Assurance Director who is Q qualified, facilitated the LIFEDesigns Human Rights Committee and has worked for group homes for 9 plus years. She was the Interim Residential Director from October 2013 to February 2014. Stephanie will work under the supervision of the Behavior Specialist. To prevent the deficient practice from recurrence, LifeDesigns' policy 3.3.3-Behavior Support has been revised to include a clear referral process in order to initiate involvement of a behavior specialist in situations where a new interfering behaviors occurs, or existing behaviors increase in frequency or intensity. The expectations and outcomes of the	

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	<p>#1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p> <p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p>		<p>behavior specialist involvement have been clearly defined. The referral process can be initiated by any support team member at any time. Additionally, the group home ND/Qs meet at least twice monthly with the Director of Residential Services, and their discussion includes a review of recent incidents related to behavior to ensure an adequate plan to address issues is in place, and if not, to develop a plan to address those issues, including, but not limited to, direct involvement from the behavior specialist. The Director of Support Services, who reviews all BDDS incident reports, meets with the behavior specialists at least monthly to review status of individuals on their caseloads. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review incident reports and investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of</p>		

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	<p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The interim house manager was interviewed on 8/26/14 at 8:30 PM and indicated client #1 had urinated on the floor and was mopping it up.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and took a shower. Staff #2 was alone with clients #1 and #2 from 7:15 AM until the</p>		Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.				

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	<p>conclusion of the observation.</p> <p>Staff #3 was interviewed again on 8/27/14 at 6:50 AM and indicated sometimes clients #1 and #2 would get up at night, but would watch TV.</p> <p>Staff #2 was interviewed on 8/27/14 at 7:28 AM. She indicated staff usually works alone from 7:00 AM to 12:00 PM unless there were three clients in the home at which time another staff would be brought in to work in the home. She indicated she was covering the shift for the interim house manager and she would arrive at 9:00 AM to relieve her (staff #2).</p> <p>Behavior and medical observations (progress notes) were reviewed on 8/27/14 at 8:53 AM and indicated the following:</p> <p>For client #1:</p> <p>8/26/14 from 3:00 PM until 9:00 PM; "He got a little worked up today, but calmed himself down."</p> <p>8/21/14; "Multiple behaviors this evening from 2:45 PM until 7:45 PM...Incredibly inappropriate on several different occasions tonight."</p>						

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	<p>6/24/14; "Threatened to kill cops, urinated on floor."</p> <p>6/24/14; "Threatened to kill kid" and "taken to [mental health facility]."</p> <p>6/23/14; "Showed private parts out window."</p> <p>6/8/14; "Called cops and placed in hand cuffs."</p> <p>For client #2:</p> <p>8/26/14; 1:00 PM until 8:00 PM; arguing with staff, ...did not give personal space...."</p> <p>8/18/14; "argumentative; glasses broken by another individual...."</p> <p>8/4/14; "had behavior, went to the hospital...."</p> <p>8/3/14; "was in a behavior when staff got here...."</p> <p>7/28/14; "attacked staff and breaking things...."</p> <p>6/17/14; "Tried going into [client #1's room]."</p> <p>6/11/14; "Yelling, screaming and</p>						

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	<p>throwing items."</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/27/14 at 1:45 PM and included the following:</p> <p>For client #1:</p> <p>A BDDS report dated 5/25/14 indicated client #1 was aggressive, hitting, spitting, throwing objects and attempting to urinate on staff. Staff called 911 and police handcuffed and transported him to the hospital to be evaluated. The report indicated client #1's hip was x-rayed due to an earlier fall, and had not received his evening medications "due to spitting them out at staff." Client #1 was transported back home by ambulance "due to trying to work back up in a behavior and threatening to crash my (Team Manager) car." Corrective action indicated a plan was being generated to address his behavior and prevent future incidents.</p> <p>A BDDS report dated 6/7/14 indicated client #1 called 911 after "escalating into behaviors." The report indicated staff called the security system to notify them it was a false alarm so fire trucks would not arrive. Plan to resolve indicated client</p>						

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	<p>#1 "Has many proactive measures written into his behavior plan. Staff were following his plan during the incident. [Client #1] currently does not have a psychiatrist and Life Designs has been looking for one for him. He has been turned down by four different facilities/offices." The report indicated client #1's primary care physician had ordered increases in medications which are awaiting Human Rights Committee (HRC) approval. "Life Designs has also explored possible in-patient facilities to look into [client #1's] medication regimen (sic), but has been unsuccessful in locating a facility that is willing to admit [client #1]. Staff will continue to follow [client #1's] behavior plan and Life Designs will continue to locate a psychiatrist to manager [client #1's] medication and continue to explore in-patient options."</p> <p>A BDDS report dated 6/24/14 indicated client #1 was physically aggressive and inappropriate with staff. The police were called and hand cuffed client #1 after he threatened to use their guns to kill them. Client #1 was placed in a spit proof mask and transported to the hospital after he tried to urinate on the police officers. Client #1 was admitted to a mental health facility. Corrective action indicated the mental health facility would monitor</p>				

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	<p>client #1. The report indicated client #1 was admitted for 7 days and his psychiatric medications had been adjusted.</p> <p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p> <p>A BDDS report dated 8/11/14 indicated client #2 told client #1 the dessert looked like "sperm." The report indicated client #1 yelled "sperm" throughout the house and urinated on the floor. Client #1 scratched client #2 leaving four superficial scratch marks and picked up a table leg and attempted to hit client #2 with it. The report indicated client #2 continued to "agitate" client #1 and client #1 "refused to leave [client #2] alone." Client #1 "was screaming at [client #2] through the door...At one point, [client #2] came downstairs and continued to agitate [client #1]. [Client #1's] behavior continued for another hour or two with periods of calm and then re-escalation." The report indicated an IDT</p>			

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	<p>(interdisciplinary team) meeting would be scheduled for 8/13/14 to address the incident.</p> <p>A BDDS report dated 8/12/14 indicated throughout the morning client #1 "was having behaviors," and would calm periodically. He attempted to "go after a roommate, but was blocked by staff." He intentionally had a bowel movement in the hallway and threw feces at staff. Client #1 attempted to grab staff sexually between her legs and attempted to push past staff to get at his roommate (unidentified). A second staff was called to assist and the unidentified client was placed in a room to keep him away from client #1. Client #1 attempted to put utensils under the locked door including a knife. 911 was called and client #1 was arrested and the police "were pressing charges that included two counts of battery with bodily fluid and one count of sexual battery." The report indicated client #1's relative posted bond and he spent the evening at their home. Corrective action indicated there was an emergency IDT planned for 8/13/14 to address the situation.</p> <p>A Plan for Extra Support dated 8/13/14 was reviewed on 9/8/14 at 4:00 PM and indicated the following:</p>						

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	<p>[Behavior Specialist] will work 10:00-4:00 (AM/PM not indicated) on Wed.</p> <p>Longer Term: Begin exploration of a waiver setting for Supported Living in a smaller setting."</p> <p>For client #2:</p> <p>A BDDS report dated 6/10/14 indicated client #2 had "behavior issues most of the day." Client #2 "followed clients around the house saying inappropriate things about them." Client #2 was "yelling at peers," and "stomping through the house," and hitting the walls. Client #2 knocked over a beverage into the other clients' pizza by pushing the table as they were eating and pounded the table with his hands. Client #2 pushed staff to the floor. Client #2 threatened to call police. It was "questionable" if client #2 pushed client #4, as staff saw client #4 take a step backwards "as if he was pushed" by client #2. The report indicated client #4 could not speak for himself. The report indicated client #2 continued to bang on walls of the home, "yell" and attempted to wake clients up after they were in their bedrooms. Client #2 "yelled at [client #1] and he started crying." Client #1 went to the office to eat his dinner, and client #2 started "ramming" into staff to get to</p>			

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	<p>client #1. Client #1 began "crying uncontrollably." Corrective action indicated client #2 had been admitted to the group home on 5/2/14 and the facility was attempting to secure psychiatric services to address client #2's behaviors. Staff will continue to follow client #2's behavior plan to address his behaviors and take action to prevent peers from experiencing verbal and physical abuse. The report indicated an investigation would be completed into the incident.</p> <p>A BDDS report indicated client #2 "had been upset for much of the day on 8/2/14. He had pushed group home staff and a temporary staff on different occasions through out the day...Around 7:45 PM staff called NDQ and reported that [client #2] had threatened to hurt himself and staff and was threatening to get a knife. NDQ advised the staff to hang up and call 911. Just after hanging up with the group home staff, the temporary agency staff called the NDQ and told her [client #2] had a knife and was trying to get in the locked office door." The temporary staff and client #1 were locked in the office, and "the group home staff (who was in the common area of the house with [client #2] managed to get [client #2] to give her the knife and slid it under the locked office door." Police arrived and client #2 agreed to go to his room.</p>						

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	<p>The police indicated to the NDQ they could not transport client #2 to the hospital for evaluation. Corrective action indicated sharps would now be locked in the home and an Interdisciplinary (IDT) team meeting would be held to discuss the incident "and what changes can be made to ensure all remain safe." The NDQ "will review [client #2's] behavior plan to determine what changes need to be made."</p> <p>A BDDS report dated 8/4/14 indicated client #2 hit client #1 on his back and pinched his neck while traveling in the van. Client #2 was "flipping off" (obscene gesture) other drivers, attempted to open the van door while it was moving and "at one point he acted as if he was going to grab the wheel of the vehicle while it was moving and stated he didn't care if they all died in a crash." After returning home "the behavior continued. He blocked staff (unidentified) in the bathroom and would not let her get past him." Corrective action indicated the NDQ was conducting an IDT meeting regarding the incident on 8/2/14 when she was informed of the current incident and advised staff to call 911. The NDQ met the police at the home and requested they transport client #2 to the hospital for evaluation and treatment. Once at the hospital, client #2 refused treatment and</p>			

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	<p>since he is his own guardian the hospital could not admit him. The discharge orders from the hospital indicated if client #2 became aggressive again, staff should call police and have client #2 arrested/jailed. Client #1 did not sustain injury during the incident. Corrective action indicated an IDT would be scheduled to address the incidents.</p> <p>A BDDS report dated 8/18/14 indicated client #2 told staff while watching a movie client #1 had put his hands down client #2's pants and touched his penis and tried to put his hands down the back of his pants "to smell his poop." Shortly after the incident client #1 broke client #2's glasses. Corrective action indicated the clients were not to be left in a room alone without supervision and an investigation would be completed.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. There was no evidence of a revision of client #1's plan since 9/13/13. There was no evidence of a functional analysis of client #1's behavior by a behavior specialist. There was no evidence of involvement of a</p>						

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	<p>behavior specialist in the development or implementation of his plan to address his behavior.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14. There was no evidence of a functional analysis of client #2's behavior by a behavior specialist. There was no evidence of involvement of a behavior specialist in the development or implementation of his plan to address his behavior.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30 PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1 asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There was no evidence of the Behavior Specialist in the home during the</p>			

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	<p>observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing." There was no evidence of the presence of a behavioral specialist in the group home during the observation.</p> <p>The NDQ was interviewed on 8/27/14 at 12:50 PM and indicated she was attempting to secure employment for client #2, and stated, "He won't cooperate."</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>An investigation dated 6/12/14 indicated on 6/10/14 client #2 "was in a poor mood due to feeling like he was being blamed for things. He started yelling at a staff member while another staff was gone, pushing her and trying to knock her over. At one point they think he might have possibly pushed [client #4]...He was verbally abusing staff and roommates yelling obscenities and saying they were all stupid." Recommendations indicated "Staff to continue following behavior</p>						

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	<p>plan. Medical coordinator to continue to look for a psychiatrist for [client #2]."</p> <p>An investigation dated 7/1/14 indicated the allegation was unsubstantiated "Based upon the discrepancies in [client #1's] interview and his agitated state during the described incident, this writer cannot substantiate the allegation of verbal abuse. Investigator noted through observation and subsequent interviews that [staff #9's] overall tone when interacting with customers is quite loud and overbearing, which in direct opposition to the stated steps in [client #1's] Behavior Support Plan. Recommendations included "Behavior Specialist will complete an observation of a shift when [staff #9] is working to assess her communication style and interactions with the customers. She will then provide additional training based on her observations. Behavioral Specialist and ND/Q will review the Behavior Support Plan and retrain staff to ensure consistency of implementation. Retraining will include ways to effectively communicate with individuals in both a proactive and reactive way....DoRS (Director of Residential Services), DoSS, and QAD will perform follow up observations weekly for a period of one month and will share findings with ND/Q, Behavior Specialist,</p>			

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	<p>and other positions completing observations. A Behavioral Observations and Recommendations dated 7/17/14 indicated "It appears that the interactions between [client #1] and [staff #9] are appropriate. Behaviorist will follow up with the home as needed to ensure that the staff and customers interact and work well together. It is recommended that if concerns continue to arise, the behaviorist be informed and a training be held for staff to educate them on respectful and proactive approaches to use with clients." Observations dated 7/9/14 from the QAD and on 7/4/24 from the DoRS were included in the investigative packet. A BDDS report included in the investigation dated 6/24/14 indicated client #1 alleged staff #9 had told him to "shut up ****" and had stated to his mother after being asked if the group home was the right place for him stated, "No, they don't know how to handle me."</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed</p>			

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	<p>on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. The group home is 2-story, and both [client #1 and #2's] bedrooms are on the second floor. [Client #1's] (sic) is on the main floor. Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision." The investigation into the incident dated 8/7/14 indicated during interview on 8/6/14 with staff #9 indicated client #1 had said "vulgar things in the past including having sex with children and police officers, screaming 'penis' and 'vagina' and rubbing his genitals on open windows," and staff #9 "believes that [client #1's] sexual advances are sincere." Staff #9 indicated she had completed an Unusual Incident Report and placed it on a desk in the group home office. Staff #10 indicated she had witnessed client #1 come downstairs, but had not seen him go into any rooms upstairs. She indicated all four of the clients remained in the living room watching TV. She stated</p>				

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	"That's how I do it when it's just me-I wanna keep my eyes on all of them." A note included in the investigation regarding client #2's behavior dated 8/2/14 "describes a litany of threats and inappropriate actions made by [client #2] on that day. Those relevant to this investigation are as follows: ...[Client #2] keeps talking about having sex with [client #1], saying that he's going to take his clothes off and stand in front of [client #1's] door telling him to come have sex with him...This account establishes what appears to be a pattern for [client #2's] behaviors-he becomes upset, begins acting out, then uses the incident to make an appeal about his living situation. It also establishes the sexual nature of [client #2's] comments and behaviors, specifically that he is initiating them towards [client #1]...." The investigation indicated the allegation was not substantiated, "Given [client #2's] history of lying, the specific nature of this allegation, and the testimony of [client #1's] [relative] who was called on the phone during the incident, it seems extremely unlikely that the even occurred as [client #2] describes...[client #1] did invade the privacy of the other roommates in the house by entering their rooms, but was by all accounts an act meant to bother, not abuse...It is apparent to this writer (DQA) that [client #2] is a						

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	<p>high functioning individual with a strong grasp on sexual activities and their meanings. It is also well documented that he continually tries to provoke reactions from roommates and specifically targets [client #1]. It is also the opinion of this writer that [client #2] has a very poor grasp of sexual activities and their meanings, and is very persuadable given his level of functioning. Indeed in this writer's casual interactions with residents at [group home] over the past few weeks, it has almost always been [client #2] engaging [client #1]-not the other way around. Coupled with the intensity of their individual behaviors and the many issues that have arisen between these two at [group home] over the past month it is strongly recommended that the placement of these two individuals in the same setting be seriously questioned...."</p> <p>Actions taken included: An IDT will convene to seriously consider alternative placement for [client #2]... The [group home] staff should begin meeting at least once every one to two weeks to discuss current behaviors and strategies for addressing them. Involvement by all members of the team including DoRS, QAD, and Behaviorist is recommended."</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his</p>			

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	<p>penis and attempted to put his hands down the back of client #2's pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately. Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the [IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised. Additionally they should be retrained on the updated BSPs (Behavior Support Plans) by the [NDQ] after revisions are completed."</p>			

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	<p>During observations at the group home on 8/28/14 from 5:40 PM until 6:40 PM, client #3 was in the living room looking at a magazine. Client #1 watched staff #1 fry hamburgers and declined to participate in preparing the meal when staff #1 asked if he wanted to assist. The DQA worked with client #4 on looking up items on an electronic tablet. The NDQ and the DQA left the home during the observation.</p> <p>Staff #1 was interviewed on 8/28/14 at 5:45 PM and indicated client #3 did not attend school that day as he had received sedative medication earlier that day to attend a medical appointment.</p> <p>The NDQ was interviewed on 8/28/14 at 6:25 PM and stated staff had called for assistance by them to assist with client #2 who was being housed in a hotel nearby as he was becoming "agitated."</p> <p>Observations were completed at the group home on 8/29/14 from 10:15 AM until 11:00 AM. Client #1 watched a movie, and client #3 looked out the window of his bedroom. Neither client #2 or client #4 were present during the observation. The interim house manager carried torn shoes into the office and placed them on the floor. The interim</p>			
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	<p>house manager asked client #3 if he wanted his door shut. When client #3 stated, "Yes," she closed the door to his room.</p> <p>The interim house manager was interviewed on 8/29/14 at 10:15 AM and indicated the shoes were client #4's. She stated client #3 "tore them up," and "He usually goes after electricals." She stated client #3 "Will go after staff," and indicated he would remove female staff shirts and bras. She indicated client #3 had removed her shirt and bra within the last week. She indicated staff brought extra clothing and bras to work in the event client #3 removed their shirts and bras. When asked if an incident report had been completed regarding the incident, she stated, "I'm trying to find time. I haven't done it yet." She indicated she did not feel she was in harms way when client #3 removed her shirt. She stated client #1 "has been very, very calm" since client #2 was removed from the home. She stated "When [client #2] was here I felt I was in danger. He (client #2) likes to get them riled up. When he gets [client #1] riled up, it's crazy."</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further</p>						

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	<p>stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the weekend and had cleaned it up. When asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the weekend as well. When asked what client #3's plan was when he aggressed, she stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that</p>			

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	<p>client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against him." When asked if the behavior could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated that an Unusual Incident Report had been filled out, but a BDDS report had not been done. The NDQ indicated she was unable to write effective behavior plans for clients #1 and #3 and needed a behavior specialist to help with their plans.</p> <p>Management rounds in the home were completed during the observation period on 9/9/14 from 9:10 AM to 10:05 AM and indicated a sign in time for the rounds was noted, but in only one case was an exit time noted indicating an observation period of 45 minutes.</p> <p>A BDDS report dated 8/29/14 was reviewed on 9/9/14 at 4:30 PM and indicated after returning from an outing client #3 "suddenly lunged at staff and ripped her shirt off. Second staff ran to the house to get assistance and an extra shirt for staff. As [client #3] came up the walk, the NDQ was at the setting and asked client #3 to go to his room and calm. He came in the back door and then lunged for the NDQ and ripped her shirt</p>						

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	<p>off of her and pulled her hair. After she was exposed, he lunged for a third staff who was having a meeting with the N DQ. He managed to pull this male staff to the ground and ripped his shirt off. He then kept attacking the male staff and they ended up on the floor in several areas of the office while the male staff was trying to get away from him. NDQ called the police for assistance in getting [client #3] calm." Corrective action indicated client #3 was given a glass of water to help him calm down. The police arrived just after he was calm and stayed with her for about 30 minutes to ensure he would not have any more aggression. Staff started a movie for him and turned on a fan for him to help him cool off. He remained calm but slightly agitated for the remainder of the evening. [Client #3] has a history of 'cycling' during seasonal changes and when holidays are coming up. He was in the van and may have been hot from being out in the community. This is a targeted behavior included in his plan and staff followed the plan by giving up their shirts. To ensure safety, a second staff member was called in to work the overnight shift so that two staff were present in case he was to become aggressive again. [Client #1] was not injured."</p> <p>Client #3's Replacement Skills Plan dated</p>			

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	<p>5/13 was reviewed on 8/29/14 at 10:00 AM and indicated target behaviors of physical aggression (pulling shirts, pulling hair, scratching, grabbing others). Client #3's plan indicated he was to be offered sensory stimulation throughout the day, and "Do not tell [client #3] 'NO,' This agitates him and could lead to physical aggression. Instead, redirect him from the unwanted behavior to another task...If aggression occurs, ask [client #3] to 'STOP.' Do NOT attempt a CPI-approved escort. This further agitates [client #3] and may escalate the aggression. If [client #3] grabs staff by the shirt front, staff should drop to the ground and remain still until [client #3] is done grabbing. It is thought that [client #3] is not trying to hurt staff, but is attempting to gain control in the situation. Offer [client #3] something to put in his hand (like a drink of water). This may encourage him to let go of the staff member he is aggressing on. If aggression continues staff may need further staff assistance by either helping physically or calling for help."</p> <p>A Report of Observation dated 8/20/14 written by the BS was reviewed on 9/10/14 at 12:21 PM and indicated the BS had spent 6 hours at the group home on 8/20/14. Recommendations included "After speaking with [clients #1 and #2],</p>			

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	<p>this behaviorist has significant concerns regarding [clients #1 and #2] living together in the group home. Although [clients #1 and #2] are around the same age, they are at different developmental levels. [Client #2] is teaching things to [client #1] that he is not at the developmental level to handle at this time which is contributing to behavioral outbursts. This behaviorist recommends that [client #2] move into a supported living site where he can receive individualized attention from staff and maximize his opportunities in the community...individual counseling is necessary for [client #2] to process through trauma from his past. Due to reports of concern regarding sexual abuse trauma, individual therapy with a certified sexual abuse therapist would be the most appropriate therapist to begin working with him. There should be regular staff meetings held to provide continuing education and training on appropriate proactive approaches to use when interacting with the customers. These staff meetings should be held weekly. There should be daily schedules developed for each customer to create a meaningful day for them. There should also be daily outings built into each customer's schedule...." There was no evidence the recommendations by the BS had been implemented.</p>						

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	The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic. I've had to call the police 5 times in 3 weeks. The behavior is escalating. On Saturday, August 2, (2014), he (client #2) threatened staff. They barricaded themselves in the office. He grabbed a butcher knife and tried to pry open the door. [Client #1] was locked in the office too. They (clients #1 and #2) terrorize each other and everyone else in the house." She indicated client #2 slapped client #1 and pushed staff in the past. She indicated client #1 now spoke of sexual issues and stated client #1 "had no sexual talk before [client #2] came here (to the group home)." She stated while shopping at a store client #2 talked to client #1 to "solicit" an 8 year old girl and then picked up the phone and used the F*** word over the intercom repeatedly. She said the 8 year old girl's mother was with her and no harm came to the girl. Client #2 "admitted he had egged [client #1] on" later. We're trying to do everything we can here. When asked about a behavioral specialist, she indicated she had attempted to involve a behavior specialist, but stated, "it hasn't been solidified." The NDQ indicated she						

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	(NDQ) wrote the plans, and the behavior specialist had visited the home, but the clients had not exhibited maladaptive behavior during her visit. She indicated the behavior specialist was scheduled to come to the home today, but was unable to come due to unknown reasons. She stated, "I can't keep up with the plans. Their behaviors are escalating" and in regards to the involvement of a behavioral specialist "It's really needed." She indicated client #1 was arrested on 8/12/14 and taken to jail for sexual battery to staff. She indicated client #1's psychiatrist wanted to take him off medication to address his behaviors, but the guardian didn't agree. She stated client #2 was his own guardian and says he "runs the house." When asked if the clients injured one another during behaviors, she stated, "I would say it's more emotional abuse." She indicated both clients #1 and #2 had threatened each other with a butcher knife and the knives were now locked up in the house. She indicated there were no IDT meetings available to address the situation. She indicated the meeting on 8/4/14 had been interrupted by the behavior incident on 8/4/14. She indicated client #2's plan did not address physical aggression as she had not been able to update the plan as yet.			

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W000186	<p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2) and for 2 additional clients (clients #3 and #4), the facility failed to ensure there were adequate staff to meet the clients' behavioral/programming needs.</p> <p>Findings included:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2</p>	W000186	<p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. New staff have been hired and trained for the home, and the Team Manager will maintain a staff schedule to ensure sufficient staff at all times. The team will review the schedule weekly at meetings. Staff were retrained on physical intervention strategies and how to keep safe by the CPI Trainer. Additionally, staff have been trained by the Behavior Specialist on the revised BSPs. A Crisis Intervention Plan has been developed and posted, outlining who staff should call for assistance in instances of</p>	09/26/2014			

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	<p>stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and</p>		<p>extreme aggression. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the</p>	

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	<p>completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p>		<p>ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>	

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	<p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>A BDDS report included in an</p>						

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	<p>investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. ...Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision." The investigation indicated staff #10 had witnessed client #1 come downstairs, but had not seen him go into any rooms upstairs. She indicated all four of the clients remained in the living room watching TV. She stated "That's how I do it when it's just me-I wanna keep my eyes on all of them." A note included in the investigation regarding client #2's behavior dated 8/2/14 "describes a litany of threats and inappropriate actions made by [client #2] on that day...This account establishes what appears to be a pattern for [client #2's] behaviors-he becomes upset, begins acting out, then uses the</p>			

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	<p>incident to make an appeal about his living situation. It also establishes the sexual nature of [client #2's] comments and behaviors, specifically that he is initiating them towards [client #1]...."</p> <p>The investigation indicated ...[client #1] did invade the privacy of the other roommates in the house by entering their rooms, but was by all accounts an act meant to bother, not abuse...It is apparent to this writer (DQA) that [client #2] is a high functioning individual with a strong grasp on sexual activities and their meanings. It is also well documented that he continually tries to provoke reactions from roommates and specifically targets [client #1]. It is also the opinion of this writer that [client #2] has a very poor grasp of sexual activities and their meanings, and is very persuadable given his level of functioning. Indeed in this writer's casual interactions with residents at [group home] over the past few weeks, it has almost always been [client #2] engaging [client #1]-not the other way around. Coupled with the intensity of their individual behaviors and the many issues that have arisen between these two at [group home] over the past month it is strongly recommended that the placement of these two individuals in the same setting be seriously questioned...."</p> <p>Actions taken included: An IDT will convene to seriously consider alternative</p>			

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W000191	<p>placement for [client #2]...."</p> <p>The staffing schedule of the home was reviewed on 9/10/14 at 11:26 AM and indicated staff on the overnight shift (10:00 PM-8:00 AM) worked alone.</p> <p>The DoRS (Director of Residential Services) was interviewed on 9/10/14 at 10:55 AM and indicated there had not been a history of client behaviors on the overnight shift and if a behavior did arise, assistance by other staff were 15 minutes away. When asked if 15 minutes was adequate to protect the safety of the clients given the history and severity of client behaviors in the group home, she indicated there was no history of client behaviors occurring at night.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. Based upon record review and interview, the facility failed to ensure staff</p>	W000191	Client #2 was moved from the group home and with the	09/26/2014	

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	<p>demonstrated competency to implement 2 of 2 sampled clients' (clients #1 and #2) supervision level to address maladaptive behavior, and failed to demonstrate competency to implement 1 additional client's behavior plan (client #3).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and</p>		<p>assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as for client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. The Behavior Consultant has participated in weekly team meetings to gather additional feedback from staff related to behaviors, as well as spent time with staff observing interactions with clients. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of</p>	

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	squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house		communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will	

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	<p>manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p> <p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p>		<p>meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>				

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	<p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/27/14 at 1:45 PM and indicated the following:</p> <p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p> <p>The facility's investigations were</p>			

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	<p>reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision."</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his penis and attempted to put his hands down the back of client #2's] pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately.</p>				

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	<p>Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the [IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised. Additionally they should be retrained on the updated BSPs (Behavior Support Plans) by the [NDQ] after revisions are completed."</p> <p>The facility's training records from 5/14-8/27/14 were reviewed on 9/10/14 at 4:10 PM and indicated staff #3, #1, #9, #6, #13, #11, and the interim house</p>			

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	<p>manager had been inserviced on "[group home] Behaviors/Recent Incidents, Staff and Restrictional Restriction (sic)...."</p> <p>There was no evidence of the content of the training or of competency based training for client behavior plans.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic. I've had to call the police 5 times in 3 weeks. The behavior is escalating. On Saturday, August 2, (2014), he (client #2) threatened staff. They barricaded themselves in the office. He grabbed a butcher knife and tried to pry open the door. [Client #1] was locked in the office too. They (clients #1 and #2) terrorize each other and everyone else in the house." She indicated client #2 slapped client #1 and pushed staff in the past. She indicated client #1 now spoke of sexual issues and stated client #1 "had no sexual talk before [client #2] came here (to the group home)." She indicated a behavior specialist was to be involved with assessing the client's behaviors, developing plans and assisting with staff training to address the client behaviors, and stated it hadn't been "solidified" as yet. She indicated clients #1 and #2 should not have been left alone as</p>			

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	<p>observed on 8/27/14 during the 7:05 PM to 8:30 PM observation period.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. Reactive strategies included redirecting client #1 to his room to calm down, take a shower, and use a neutral attitude when client #1 was upset.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14. Reactive measures when client #2 was in other client's bedrooms included "active ignoral (sic) as much as possible, only interacting with [client #2] to prompt him to leave the room", and place their arms to the side if client #2 attempted to hug them.</p> <p>Client #3's Replacement Skills Plan dated 5/13 was reviewed on 8/29/14 at 10:00 AM and indicated target behaviors of physical aggression (pulling shirts, pulling hair, scratching, grabbing others). Client #3's plan indicated he was to be</p>			

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	<p>offered sensory stimulation throughout the day, and "Do not tell [client #3] 'NO,' This agitates him and could lead to physical aggression. Instead, redirect him from the unwanted behavior to another task...If aggression occurs, ask [client #3] to 'STOP.' Do NOT attempt a CPI (Crisis Prevention Institute)-approved escort. This further agitates [client #3] and may escalate the aggression. If [client #3] grabs staff by the shirt front, staff should drop to the ground and remain still until [client #3] is done grabbing. It is thought that [client #3] is not trying to hurt staff, but is attempting to gain control in the situation. Offer [client #3] something to put in his hand (like a drink of water). This may encourage him to let go of the staff member he is aggressing on. If aggression continues staff may need further staff assistance by either helping physically or calling for help."</p> <p>Observations were completed on 9/8/14 from 8:20 PM until 8:45 PM. Staff #11 indicated the clients were all in bed.</p> <p>A BDDS report dated 8/29/14 was reviewed on 8/9/14 at 4:30 PM and indicated after returning from an outing client #3 "suddenly lunged at staff and ripped her shirt off. Second staff ran to the house to get assistance and an extra shirt for staff. As [client #3] came up the</p>			

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	walk, the NDQ was at the setting and asked client #3 to go to his room and calm. He came in the back door and then lunged for the NDQ and ripped her shirt off of her and pulled her hair. After she was exposed, he lunged for a third staff who was having a meeting with the NDQ. He managed to pull this male staff to the ground and ripped his shirt off. He then kept attacking the male staff and they ended up on the floor in several areas of the office while the male staff was trying to get away from him. NDQ called the police for assistance in getting [client #3] calm." Corrective action indicated client #3 was given a glass of water to help him calm down. The police arrived just after he was calm and stayed with her for about 30 minutes to ensure he would not have any more aggression. Staff started a movie for him and turned on a fan for him to help him cool off. He remained calm but slightly agitated for the remainder of the evening. [Client #3] has a history of 'cycling' during seasonal changes and when holidays are coming up. He was in the van and may have been hot from being out in the community. This is a targeted behavior included in his plan and staff followed the plan by giving up their shirts. To ensure safety, a second staff member was called in to work the overnight shift so that two staff were present in case he was						

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	<p>to become aggressive again. [Client #1] was not injured."</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the weekend and had cleaned it up. When asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the weekend as well. When asked what client #3's plan was when he aggressed, she stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>9-3-3(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 upon record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility failed to ensure staff implemented clients' plans to address maladaptive behavior, and individual support plans (ISPs).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client</p>	W000249	<p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as for client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. The Behavior Consultant has participated in weekly team meetings to gather additional feedback from staff</p>	09/26/2014	

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	#1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior		related to behaviors, as well as spent time with staff observing interactions with clients. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new				

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	<p>resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of</p>		<p>ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>	

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	<p>the Director of Quality Assurance (DQA) during the observation.</p> <p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM,</p>						

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	<p>client #1 poured his cereal and ate it without staff supervision. He then and took a shower. Client #2 slept during the observation period except when staff prompted him to take his medications. Client #2 was given his medications without prompting client #2 to push out his medication from the packet.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30 PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1 asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There was no evidence of the Behavior Specialist in the home during the observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing."</p>			

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	<p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/27/14 at 1:45 PM and indicated the following:</p> <p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p> <p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room</p>			
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	<p>the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting. Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision."</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his penis and attempted to put his hands down the back of client #2's pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately. Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the</p>			

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	<p>[IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. Reactive strategies included redirecting client #1 to his room to calm down, take a shower, and use a neutral attitude when client #1 was upset. His ISP dated 9/21/13 indicated objectives to make a side dish, call mom and discuss three topics, choose activity of choice, return receipt after purchase, chew food appropriately, and pop out medication from dispenser pack.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14.</p>						

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	<p>Reactive measures when client#2 was in other client's bedrooms included "active ignoral (sic) as much as possible, only interacting with [client #2] to prompt him to leave the room," and place their arms to the side if client #2 attempted to hug them. Client #2's ISP dated included 5/8/14 indicated complete laundry, maintain schedule on a schedule board, communicate accurate information, respect other's boundaries and personal space, complete transaction and return receipt, learn address, phone number and provider name, pop out medication from packet and into med (medication) cup, brush teeth twice daily, and exercise by walking 20-30 minutes weekly.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and indicated clients #1 and #2 should not have been left alone as observed on 8/27/14 during the 7:05 PM to 8:30 PM observation period. She indicated it was difficult to implement individual support plans due to the clients' behaviors and the clients would remove the active treatment schedules posted in the home.</p> <p>9-3-4(a)</p>						

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), and for 2 additional clients (clients #3 and #4), the facility failed to provide an updated active treatment schedule for staff to follow.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation,</p>	W000250	<p>Active treatment schedules are now in place for all individuals living in the home, and staff have been trained on implementation, including the importance of supporting the clients to be actively engaged in activities throughout the day. The schedules are reviewed regularly at team meetings to ensure they remain relevant and consistent with the interests and ISP goals of each individual. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Behavior</p>	09/26/2014

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	<p>clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to</p>		<p>Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be</p>				

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	<p>force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4, "I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1</p>		<p>included in observation schedules and expected to supervise the home. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p>	

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	<p>wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. The whiteboard with client schedules in the hallway by the kitchen had been erased.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and ate it without staff supervision. He then and took a shower. Client #2 slept during the observation period except when staff prompted him to take his medications. Client #2 was given his medications without prompting client #2 to push out his medication from the packet. The white board with client schedules in the hallway by the kitchen had been erased.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30 PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1 asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There</p>			

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	<p>was no evidence of the Behavior Specialist in the home during the observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing." The white board with client schedules in the hallway by the kitchen had been erased.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and indicated clients #1 and #2 should not have been left alone as observed on 8/27/14 during the 7:05 PM to 8:30 PM observation period. She indicated the clients would remove the active treatment schedules posted in the home.</p> <p>Client #1's schedule was reviewed on 9/8/14 at 4:00 PM and indicated from 8:00 AM until 8:00 PM in half hour blocks, he was to receive medications, free time, breakfast, clean up and wash table, clean room and sweep, hygiene, TV time, meal preparation, lunch, clean up, wash table and push in chairs, free time, community, medications, meal</p>			

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	<p>preparation, dinner, clean up, wash table and push in chairs, hygiene, feed and water animals, free time (6:45 PM until 7:45 PM), medications and free time at 8:00 PM.</p> <p>Client #2's schedule was reviewed on 8/29/14 at 9:43 AM and indicated from 7:00 AM until 8:15 PM in half hour blocks, he was to get up and dress, take medications, free time, breakfast, clean up, free choice, crafts, community, free choice, lunch/medications, chores, TV time, exercise of choice, take medications, clean room, social stories/client rights, get ready for dinner, dinner, clean up, current events, free time, medications, and bedtime/free time.</p> <p>The NDQ indicated on 8/29/14 in an e-mail at 9:43 PM in regards to client schedules, "We used to have these laminated on the hallway wall, but they've been destroyed. We'll get them replaced soon."</p> <p>9-3-4(a)</p>			

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2) to ensure their behavior program data was documented.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. There was no evidence of behavior rates documentation in the record.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14. There was no evidence of behavior rates documentation in the record.</p> <p>The Network Director/Qualified Intellectual Disabilities Professional indicated on 9/9/14 at 3:28 PM there was</p>	W000252	The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as for client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. The Behavior Consultant has participated in weekly team meetings to gather additional feedback from staff related to behaviors, as well as spent time with staff observing interactions with clients. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. A monthly report has been developed, to be completed by the ND/Q for each individual, summarizing services they have received. It will include data related to interfering behaviors and progress on objectives. Each monthly report will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the	09/26/2014	

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	no behavior data to review. 9-3-4(a)		CEO. The monthly report will be disseminated to Individual Support Team members for review as well. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the	

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients #1 and #2), the facility failed to ensure the facility's Human Rights Committee (HRC) reviewed and approved plans that included the use of medication to address behavior.</p>	W000262	<p>individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p> <p>The BSPs for all clients living in the home have been revised, and written HRC approval was obtained on 9/25/14. To ensure the deficient practice does not recur, and to provide ongoing monitoring, a monthly report has been developed, to be completed by the ND/Q for each individual, summarizing services</p>	09/26/2014	

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	<p>Findings include:</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. The record indicated client #2 was his own guardian. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. Client #1's plan included the use of Seroquel 800 mg (milligrams) for agitation, Alprazolam 6 mg for anxiety, Luvox 450 mg for obsessive compulsive disorder, Risperidone 1 mg for agitation and Depakote 1000 mg. There was no evidence of review and approval by the facility's Human Rights Committee (HRC) for client #1's behavior plan.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. Client #2's plan included the use of Depakote 1,000 mg for mood stabilization, Latuda 40 mg for mood stabilization and Prozac 20 mg for depression. There was no evidence of informed consent or evidence of review and approval by the facility's (HRC) for client #2's behavior plan.</p> <p>The Network Director/Qualified Intellectual</p>		<p>they have received. It includes data related to behavior, including the date of the Behavior Support Plan, and when HRC approval was obtained. Each monthly report will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The ND/Q will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. 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, investigation outcomes and recommendations, survey status and general concerns/issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each</p>				

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W000266	<p>Disabilities Professional indicated on 9/9/14 at 11:50 AM there was no review of the facility's HRC for client #1 and #2's plans.</p> <p>9-3-4(a)</p> <p>483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.</p> <p>Based on observation, record review, and interview for 2 of 2 sampled clients (clients #1 and #2), and for 2 additional clients (clients #3 and #4), the facility failed to meet the Condition of Participation: Client Behavior and Facility Practices. The facility failed to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The facility failed to implement policy and procedure to</p>	W000266	<p>month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.</p> <p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for all clients in the home, as well as for client #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. The Behavior Consultant has participated in weekly team meetings to gather additional feedback from staff related to behaviors, as well as spent time with staff observing interactions with clients. New</p>	09/26/2014

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	<p>protect 1 additional client (client #3) by failing to develop and implement effective corrective action to address his physically aggressive behavior.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure staff demonstrated competency to implement 2 of 2 sampled clients' (clients #1 and #2) supervision level to address maladaptive behavior, and failed to demonstrate competency to implement 1 additional client's behavior plan (client #3). Please refer to W191. 2. The facility failed for 2 of 2 sampled clients (clients #1 and #2) to ensure staff implemented clients' plans to address maladaptive behavior. Please refer to W249. 3. The facility failed to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had 		<p>tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to specific consequences. From 9/28 to 10/4 the Behavior consultant will provide 6days on site for 3 to 6 hours- she has already been on site Sunday, Monday, Tuesday, Wednesday and Thursday of this week, and will be there again either Saturday or Sunday. She will provide support from 10/5 forward to train newstaff, assess performance of all and monitor effectiveness of strategies. Acompetency based assessment will be used to evaluate staff knowledge andability to implement behavior support plans. All new staff will receivetraining from the behavior specialist before they are able to work alone. Staffsupport needs will be discussed at team meetings to determine where continuedhelp is needed. Continued behavior support will be two days per week (3 hoursminimum) plus weekly team meetings withall staff.</p>				

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	<p>been identified. The facility failed to implement policy and procedure to protect 1 additional client (client #3) by failing to develop and implement effective corrective action to address his physically aggressive behavior. Please refer to W274.</p> <p>9-3-5(a)</p>		<p>Additionally, the LifeDesigns Behavior Consultant will trainStephanie Bryant (currently working as trainer for Team Manager) to provideadditional support to staff. Stephanieis a former Quality Assurance Director who is Q qualified, facilitated theLIFEDesigns Human Rights Committee and has worked for group homes for 9 plusyears. She was the Interim ResidentialDirector from October 2013 to February 2014.</p> <p>Stephanie will work under the supervision ofthe Behavior Specialist. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to</p>		

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			<p>extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues</p>	

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W000274	<p>483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior.</p> <p>Based on record review and interview, the facility failed to implement its policy and procedures to prevent neglect by failing to protect 2 of 2 sampled (clients #1 and #2) and 2 additional clients (clients #3 and #4) from physically aggressive behavior of clients #1 and #2 resulting in injury and intimidation. The facility failed to develop and implement effective corrective action to address the physically aggressive behavior of clients #1 and #2 after a history of aggressive behavior had been identified. The facility failed to implement policy and procedure to protect 1 additional client (client #3) by failing to report incidents of sexual assault and failed to develop and implement effective corrective action to address his physically aggressive behavior.</p>	W000274	<p>and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at least quarterly.</p> <p>Client #2 was moved from the group home and with the assistance of BDDS, received a CIH Medicaid Waiver. He is now receiving supported living services, and since his exit from the group home, there has been an exponential decrease in negative behaviors exhibited, especially from client #1. The Behavior Consultant has revised the Functional Behavior Assessments (FBA) and Behavior Support Plans (BSP) for clients #1, #3 and #2. Guardian consent and Human Rights Committee approval has been obtained, and Behavior Consultant has trained staff on the revised plans. New tracking has been implemented to gather more comprehensive information related to behaviors, so that data can be used to make revisions to the plans on an ongoing basis. An investigation was completed for</p>	09/26/2014

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	<p>Findings include:</p> <p>Observations were completed at the group home on 8/26/14 from 7:05 PM until 8:30 PM. Staff #1 opened the door after unlocking a door alarm attached to the front door. During the observation, clients #1 and #2 sat on a sofa watching a movie. Client #2's glasses had tape around each of the ear pieces at the hinges. Client #2 attempted to kiss client #1 and to take a picture of him on his cell phone. When staff #2 intervened stating he should ask permission, client #2 stated, "Why?, It's not pornography." Clients #3 and #4 were redirected from the room by staff #1 and #2 when client #1 dug at his rectum through his shorts. Clients #1 and #2 were left alone when they did not leave the room when directed to do so by staff #1 and #2. Staff #1 stated to clients #3 and #4, clients #1 and #2 "did not need an audience." Client #1 then took 2 oranges from a fruit arrangement on the kitchen counter and pressed them to his breasts, then client #2 raised his shirt, exposing his breasts and squeezed them. Clients #1 and #2 took items from the kitchen drawers and threw them on the floor. Staff #3 and client #4 remained in the medication administration room/office while clients #1 and #2 continued to raise their voices. Client #3 opened the door to his bedroom</p>		<p>the incident that occurred on 8/29/14 with client #3. As mentioned previously, client #3's BSP has been revised, and new tracking is in place to gather more useful data to determine antecedents to behaviors, patterns, and how he responds to specific consequences. From 9/28 to 10/4 the Behavior consultant will provide 6 days on site for 3 to 6 hours- she has already been on site Sunday, Monday, Tuesday, Wednesday and Thursday of this week, and will be there again either Saturday or Sunday. She will provide support from 10/5 forward to train new staff, assess performance of all and monitor effectiveness of strategies. A competency based assessment will be used to evaluate staff knowledge and ability to implement behavior support plans. All new staff will receive training from the behavior specialist before they are able to work alone. Staff support needs will be discussed at team meetings to determine where continued help is needed. Continued behavior support will be two days per week (3 hours minimum) plus weekly team meetings with all staff. Additionally, the LifeDesigns Behavior Consultant will train Stephanie Bryant (currently working as trainer for Team Manager) to provide additional support to staff. Stephanie is a former Quality Assurance</p>				

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	and attempted to step into the adjacent kitchen where clients #1 and #2 were, but was redirected back into his bedroom by staff #1 and #2. Client #2 grabbed staff #2 and tried to kiss her, then pushed her into a wall. Client #1 placed a 3 inch action figure in his mouth and tried to force the entire figure into his mouth. Client #2 stated to staff #1 and #2, "I didn't have my meds (medications) today," and indicated his behavior resulted from a failure to receive the medications. At 8:00 PM, staff #3 arrived for her overnight shift and completed medication administration for client #4 started by staff #1 at 7:55 PM. Staff #2 left the medication administration area leaving staff #3 with client #4, stating, "I can't leave her (staff #1) alone out there," and indicated staff #1 needed assistance. Clients #1 and #2 raised their voices loudly to each other, and client #1 threatened to poke his eyes out and throw feces. Staff #3 stayed in the medication administration area/office of the home with client #4 who paced back and forth. An interim house manager arrived from another house at 8:00 PM to assist with client #1 and #2's behavior. Client #4 paced from 7:55 PM until 8:25 PM and was redirected from leaving the medication room until staff #3 indicated it was safe for client #4 to leave the area. Staff #3 stated to client #4,		Director who is Q qualified, facilitated the LIFE Designs Human Rights Committee and has worked for group homes for 9 plus years. She was the Interim Residential Director from October 2013 to February 2014. Stephanie will work under the supervision of the Behavior Specialist. To ensure the deficient practice does not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Quality Assurance Director, Team Manager, Behavior Specialist) have been conducting daily observations at the home, which includes observation of staff and client interactions, review of data on behaviors, review of communication log for issues and concerns, facility issues, finances, and interviews with staff regarding their ability to implement the behavior support plans. Daily observations with the above listed administrative staff will continue through 10/31, unless issues continue to be noted during weekly onsite meeting of CEO, ND/Q, and Team Manager. Minutes of those meetings will indicate need to extend observations and length of extension. The Team Manager designated for the home provides direct, on-site supervision of staff in the setting, and will provide ongoing training and guidance. The previous ND/Q for the home				

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	<p>"I know you want to leave, but it isn't safe." The acting Network Director/Qualified Developmental Disabilities Professional (NDQ) talked on the phone to client #1. After clients #1 and #2's voices lowered, client #4 left the medication administration area. Client #1 wiped up a wet area in the kitchen at 8:30 PM with the interim house manager's supervision. Staff #1 indicated client #2 was upstairs. There was no evidence of the Director of Quality Assurance (DQA) during the observation.</p> <p>Staff #1 was interviewed on 8/26/14 at 7:05 PM and indicated the door was alarmed to notify staff if the clients left the home.</p> <p>Staff #1 and #2 were interviewed on 8/26/14 at 7:55 PM, and indicated client #1 and #2's behavior occurred frequently and they had been re-assigned from another home due to the staff turnover of the home. They indicated staff that had previously worked in the home had left employment of the facility.</p> <p>Staff #3 was interviewed on 8/26/14 at 8:01 PM. She apologized to the surveyor for client #1 and #2's behavior and stated, "They feed off each other." When asked if client #1 and #2's behavior was common, she stated, "Yes." She stated</p>		<p>has been reassigned, and a new ND/Q has been hired. The Quality Assurance Director is acting as ND/Q on an interim basis while the new ND/Q completes training and becomes familiar with the individuals and staff in the home. The ND/Q will be in the home no less than twice per week (the ND/Q is responsible for 2 homes) to provide supervision, guidance and oversight to staff. Once the new person demonstrates competency with the individual's support and behavior plans to the QAD and CEO, she will be included in observation schedules and expected to supervise the home. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly, and the CEO will do an on-site visit at</p>		

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	<p>client #4's pacing behavior indicated he was "agitated." She indicated she worked alone at night from 8:00 PM until 8:00 AM and if she needed help, a neighboring group home would send staff 15 minutes away. She indicated client #2 had pushed staff into the wall, but had not hurt clients.</p> <p>The interim house manager was interviewed on 8/26/14 at 8:30 PM and indicated client #1 had urinated on the floor and was mopping it up.</p> <p>During observation at the group home on 8/27/14 from 6:25 AM until 8:53 AM, client #1 poured his cereal and took a shower. Staff #2 was alone with clients #1 and #2 from 7:15 AM until the conclusion of the observation.</p> <p>Staff #3 was interviewed again on 8/27/14 at 6:50 AM and indicated sometimes clients #1 and #2 would get up at night, but would watch TV.</p> <p>Staff #2 was interviewed on 8/27/14 at 7:28 AM. She indicated staff usually works alone from 7:00 AM to 12:00 PM unless there were three clients in the home at which time another staff would be brought in to work in the home. She indicated she was covering the shift for the interim house manager and she would</p>		least quarterly.				

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	<p>arrive at 9:00 AM to relieve her (staff #2).</p> <p>Behavior and medical observations (progress notes) were reviewed on 8/27/14 at 8:53 AM and indicated the following:</p> <p>For client #1:</p> <p>8/26/14 from 3:00 PM until 9:00 PM; "He got a little worked up today, but calmed himself down."</p> <p>8/21/14; "Multiple behaviors this evening from 2:45 PM until 7:45 PM...Incredibly inappropriate on several different occasions tonight."</p> <p>6/24/14; "Threatened to kill cops, urinated on floor."</p> <p>6/24/14; "Threatened to kill kid" and "taken to [mental health facility]."</p> <p>6/23/14; "Showed private parts out window."</p> <p>6/8/14; "Called cops and placed in hand cuffs."</p> <p>For client #2:</p> <p>8/26/14; 1:00 PM until 8:00 PM; arguing</p>						

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	<p>with staff, ...did not give personal space...."</p> <p>8/18/14; "argumentative; glasses broken by another individual...."</p> <p>8/4/14; "had behavior, went to the hospital...."</p> <p>8/3/14; "was in a behavior when staff got here...."</p> <p>7/28/14; "attacked staff and breaking things...."</p> <p>6/17/14; "Tried going into [client #1's room]."</p> <p>6/11/14; "Yelling, screaming and throwing items."</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/27/14 at 1:45 PM and included the following:</p> <p>For client #1:</p> <p>A BDDS report dated 5/25/14 indicated client #1 was aggressive, hitting, spitting, throwing objects and attempting to urinate on staff. Staff called 911 and police handcuffed and transported him to</p>			

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	<p>the hospital to be evaluated. The report indicated client #1's hip was x-rayed due to an earlier fall, and had not received his evening medications "due to spitting them out at staff." Client #1 was transported back home by ambulance "due to trying to work back up in a behavior and threatening to crash my (Team Manager) car." Corrective action indicated a plan was being generated to address his behavior and prevent future incidents.</p> <p>A BDDS report dated 6/7/14 indicated client #1 called 911 after "escalating into behaviors." The report indicated staff called the security system to notify them it was a false alarm so fire trucks would not arrive. Plan to resolve indicated client #1 "Has many proactive measures written into his behavior plan. Staff were following his plan during the incident. [Client #1] currently does not have a psychiatrist and Life Designs has been looking for one for him. He has been turned down by four different facilities/offices." The report indicated client #1's primary care physician had ordered increases in medications which are awaiting Human Rights Committee (HRC) approval. "Life Designs has also explored possible in-patient facilities to look into [client #1's] medication regimen (sic), but has been unsuccessful in</p>			

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	<p>locating a facility that is willing to admit [client #1]. Staff will continue to follow [client #1's] behavior plan and Life Designs will continue to locate a psychiatrist to manager [client #1's] medication and continue to explore in-patient options."</p> <p>A BDDS report dated 6/24/14 indicated client #1 was physically aggressive and inappropriate with staff. The police were called and hand cuffed client #1 after he threatened to use their guns to kill them. Client #1 was placed in a spit proof mask and transported to the hospital after he tried to urinate on the police officers. Client #1 was admitted to a mental health facility. Corrective action indicated the mental health facility would monitor client #1. The report indicated client #1 was admitted for 7 days and his psychiatric medications had been adjusted.</p> <p>A BDDS report dated 7/27/14 indicated client #1's relative asked client #2 if he had touched client #1 inappropriately and client #2 indicated client #1 had touched him inappropriately. Corrective action indicated the incident would be investigated and "Life Designs will ensure the roommate and [client #2] are not left alone in a room without supervision at anytime...."</p>			

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	<p>A BDDS report dated 8/11/14 indicated client #2 told client #1 the dessert looked like "sperm." The report indicated client #1 yelled "sperm" throughout the house and urinated on the floor. Client #1 scratched client #2 leaving four superficial scratch marks and picked up a table leg and attempted to hit client #2 with it. The report indicated client #2 continued to "agitate" client #1 and client #1 "refused to leave [client #2] alone." Client #1 "was screaming at [client #2] through the door...At one point, [client #2] came downstairs and continued to agitate [client #1]. [Client #1's] behavior continued for another hour or two with periods of calm and then re-escalation." The report indicated an IDT (interdisciplinary team) meeting would be scheduled for 8/13/14 to address the incident.</p> <p>A BDDS report dated 8/12/14 indicated throughout the morning client #1 "was having behaviors," and would calm periodically. He attempted to "go after a roommate, but was blocked by staff." He intentionally had a bowel movement in the hallway and threw feces at staff. Client #1 attempted to grab staff sexually between her legs and attempted to push past staff to get at his roommate (unidentified). A second staff was called</p>				

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	<p>to assist and the unidentified client was placed in a room to keep him away from client #1. Client #1 attempted to put utensils under the locked door including a knife. 911 was called and client #1 was arrested and the police "were pressing charges that included two counts of battery with bodily fluid and one count of sexual battery." The report indicated client #1's relative posted bond and he spent the evening at their home. Corrective action indicated there was an emergency IDT planned for 8/13/14 to address the situation.</p> <p>A Plan for Extra Support dated 8/13/14 was reviewed on 9/8/14 at 4:00 PM and indicated the following:</p> <p>"Short Term-[Director of Quality Assurance] will work 10:00-8:00 (AM/PM not indicated) Mon. and Tues. [Behavior Specialist] will work 10:00-4:00 (AM/PM not indicated) on Wed. [Director of Residential Services (DoRS)] will work Thurs and Fri (time not indicated).</p> <p>[DQA] will focus on individual goals and 1:1 community involvement, as well as staff training and development, [BS] will focus on behavior strategies and interventions, as well as staff training and</p>						

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	<p>development. [DoRS] will focus on work with [client #1] and one peer doing daily activities in and around the house. She will reinforce positive interactions and pro-social behavior. She will also work with staff to train (sic)."</p> <p>Mid Term: The plan indicated new staff members would be hired including a Team Manager, Team Lead and Medical Coordinator. The CEO (Chief Executive Officer) "is exploring ...Day Program Services. She is following up with the [police department]. [NDQ] is contacting [psychiatric services provider], to determine what resources are available...for emergency care. [DoRS] is following up with [staff at mental health provider] to determine what resources are available through her agency for emergency care. She is [mental health provider's] liaison with the Police Department.</p> <p>Longer Term: Begin exploration of a waiver setting for Supported Living in a smaller setting."</p> <p>For client #2:</p> <p>A BDDS report dated 6/10/14 indicated client #2 had "behavior issues most of the day." Client #2 "followed clients around the house saying inappropriate things</p>						

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	<p>about them." Client #2 was "yelling at peers," and "stomping through the house," and hitting the walls. Client #2 knocked over a beverage into the other clients' pizza by pushing the table as they were eating and pounded the table with his hands. Client #2 pushed staff to the floor. Client #2 threatened to call police. It was "questionable" if client #2 pushed client #4, as staff saw client #4 take a step backwards "as if he was pushed" by client #2. The report indicated client #4 could not speak for himself. The report indicated client #2 continued to bang on walls of the home, "yell" and attempted to wake clients up after they were in their bedrooms. Client #2 "yelled at [client #1] and he started crying." Client #1 went to the office to eat his dinner, and client #2 started "ramming" into staff to get to client #1. Client #1 began "crying uncontrollably." Corrective action indicated client #2 had been admitted to the group home on 5/2/14 and the facility was attempting to secure psychiatric services to address client #2's behaviors. Staff will continue to follow client #2's behavior plan to address his behaviors and take action to prevent peers from experiencing verbal and physical abuse. The report indicated an investigation would be completed into the incident.</p> <p>A BDDS report indicated client #2 "had</p>						

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	<p>been upset for much of the day on 8/2/14. He had pushed group home staff and a temporary staff on different occasions through out the day...Around 7:45 PM staff called NDQ and reported that [client #2] had threatened to hurt himself and staff and was threatening to get a knife. NDQ advised the staff to hang up and call 911. Just after hanging up with the group home staff, the temporary agency staff called the NDQ and told her [client #2] had a knife and was trying to get in the locked office door." The temporary staff and client #1 were locked in the office, and "the group home staff (who was in the common area of the house with [client #2] managed to get [client #2] to give her the knife and slid it under the locked office door." Police arrived and client #2 agreed to go to his room. The police indicated to the NDQ they could not transport client #2 to the hospital for evaluation. Corrective action indicated sharps would now be locked in the home and an Interdisciplinary (IDT) team meeting would be held to discuss the incident "and what changes can be made to ensure all remain safe." The NDQ "will review [client #2's] behavior plan to determine what changes need to be made."</p> <p>A BDDS report dated 8/4/14 indicated client #2 hit client #1 on his back and</p>				

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	<p>pinched his neck while traveling in the van. Client #2 was "flipping off" (obscene gesture) other drivers, attempted to open the van door while it was moving and "at one point he acted as if he was going to grab the wheel of the vehicle while it was moving and stated he didn't care if they all died in a crash." After returning home "the behavior continued. He blocked staff (unidentified) in the bathroom and would not let her get past him." Corrective action indicated the NDQ was conducting an IDT meeting regarding the incident on 8/2/14 when she was informed of the current incident and advised staff to call 911. The NDQ met the police at the home and requested they transport client #2 to the hospital for evaluation and treatment. Once at the hospital, client #2 refused treatment and since he is his own guardian the hospital could not admit him. The discharge orders from the hospital indicated if client #2 became aggressive again, staff should call police and have client #2 arrested/jailed. Client #1 did not sustain injury during the incident. Corrective action indicated an IDT would be scheduled to address the incidents.</p> <p>A BDDS report dated 8/18/14 indicated client #2 told staff while watching a movie client #1 had put his hands down client #2's pants and touched his penis</p>			

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	<p>and tried to put his hands down the back of his pants "to smell his poop." Shortly after the incident client #1 broke client #2's glasses. Corrective action indicated the clients were not to be left in a room alone without supervision and an investigation would be completed.</p> <p>Client #1's record was reviewed on 8/27/14 at 12:20 PM. A Replacement Skills Plan (RSP) dated 9/13/13 indicated target behaviors of ruminating, anxiety, non-compliance, verbal/non-verbal threats, physical aggression/threats of physical aggression. There was no evidence of a revision of client #1's plan since 9/13/13. There was no evidence of a functional analysis of client #1's behavior by a behavior specialist. There was no evidence of involvement of a behavior specialist in the development or implementation of his plan to address his behavior.</p> <p>Client #2's record was reviewed on 8/27/14 at 12:20 PM. A RSP dated 5/8/14 indicated target behaviors of tantrum, property destruction and verbal aggression. There was no evidence of revision to client #2's plan since 5/8/14. There was no evidence of a functional analysis of client #2's behavior by a behavior specialist. There was no evidence of involvement of a behavior</p>						

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	<p>specialist in the development or implementation of his plan to address his behavior.</p> <p>The Network Director/Qualified Developmental Disabilities Professional (NDQ) was interviewed on 8/27/14 at 11:00 AM and stated, "This behavior is every other day. Everything is chaotic. I've had to call the police 5 times in 3 weeks. The behavior is escalating. On Saturday, August 2, (2014), he (client #2) threatened staff. They barricaded themselves in the office. He grabbed a butcher knife and tried to pry open the door. [Client #1] was locked in the office too. They (clients #1 and #2) terrorize each other and everyone else in the house." She indicated client #2 slapped client #1 and pushed staff in the past. She indicated client #1 now spoke of sexual issues and stated client #1 "had no sexual talk before [client #2] came here (to the group home)." She stated while shopping at a store client #2 talked to client #1 to "solicit" an 8 year old girl and then picked up the phone and used the F*** word over the intercom repeatedly. She said the 8 year old girl's mother was with her and no harm came to the girl. Client #2 "admitted he had egged [client #1] on" later. We're trying to do everything we can here. When asked about a behavioral specialist, she indicated she had</p>				

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	<p>attempted to involve a behavior specialist, but stated, "it hasn't been solidified." The NDQ indicated she (NDQ) wrote the plans, and the behavior specialist had visited the home, but the clients had not exhibited maladaptive behavior during her visit. She indicated the behavior specialist was scheduled to come to the home today, but was unable to come due to unknown reasons. She stated, "I can't keep up with the plans. Their behaviors are escalating" and in regards to the involvement of a behavioral specialist "It's really needed." She indicated client #1 was arrested on 8/12/14 and taken to jail for sexual battery to staff. She indicated client #1's psychiatrist wanted to take him off medication to address his behaviors, but the guardian didn't agree. She stated client #2 was his own guardian and says he "runs the house." When asked if the clients injured one another during behaviors, she stated, "I would say it's more emotional abuse." She indicated both clients #1 and #2 had threatened each other with a butcher knife and the knives were now locked up in the house. She indicated there were no IDT meetings available to address the situation. She indicated the meeting on 8/4/14 had been interrupted by the behavior incident on 8/4/14. She indicated client #2's plan did not address</p>			

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	<p>physical aggression as she had not been able to update the plan as yet.</p> <p>During observations at the group home on 8/27/14 from 12:25 PM until 1:30 PM, clients #1, #2, and #3 were present in the home. Client #2 pursed his lips as if he would spit out whipped cream during lunch. Client #2 repeatedly knocked on the office door and raised his voice to ask to go on an outing and stated, "They say I'm provocative." During the observation, client #2 repeatedly banged on the door. Client #1 asked client #2 to stop banging on the door. The interim house manager and the NDQ were present in the home. There was no evidence of the Behavior Specialist in the home during the observations. Client #2 stated "**** no" when asked if he wanted a job by the NDQ. At 1:05 PM, client #2 crushed a Styrofoam cup in his hand while standing in the office. He then grabbed his program book and began reading it. He stated as he read the book "I didn't lie," and "[Staff #3] has beautiful hand writing."</p> <p>The NDQ was interviewed on 8/27/14 at 12:50 PM and indicated she was attempting to secure employment for client #2, and stated, "He won't cooperate."</p>				

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	<p>The facility's investigations were reviewed on 8/28/14 at 3:40 PM and indicated the following:</p> <p>An investigation dated 6/12/14 indicated on 6/10/14 client #2 "was in a poor mood due to feeling like he was being blamed for things. He started yelling at a staff member while another staff was gone, pushing her and trying to knock her over. At one point they think he might have possibly pushed [client #4]...He was verbally abusing staff and roommates yelling obscenities and saying they were all stupid." Recommendations indicated "Staff to continue following behavior plan. Medical coordinator to continue to look for a psychiatrist for [client #2]."</p> <p>An investigation dated 7/1/14 indicated the allegation was unsubstantiated "Based upon the discrepancies in [client #1's] interview and his agitated state during the described incident, this writer cannot substantiate the allegation of verbal abuse. Investigator noted through observation and subsequent interviews that [staff #9's] overall tone when interacting with customers is quite loud and overbearing, which in direct opposition to the stated steps in [client #1's] Behavior Support Plan. Recommendations included "Behavior</p>						

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	<p>Specialist will complete an observation of a shift when [staff #9] is working to assess her communication style and interactions with the customers. She will then provide additional training based on her observations. Behavioral Specialist and ND/Q will review the Behavior Support Plan and retrain staff to ensure consistency of implementation. Retraining will include ways to effectively communicate with individuals in both a proactive and reactive way. DoRS (Director of Residential Services), DoSS, and QAD will perform follow up observations weekly for a period of one month and will share findings with ND/Q, Behavior Specialist, and other positions completing observations. A Behavioral Observations and Recommendations dated 7/17/14 indicated "It appears that the interactions between [client #1] and [staff #9] are appropriate. Behaviorist will follow up with the home as needed to ensure that the staff and customers interact and work well together. It is recommended that if concerns continue to arise, the behaviorist be informed and a training be held for staff to educate them on respectful and proactive approaches to use with clients." Observations dated 7/9/14 from the QAD and on 7/4/24 from the DoRS were included in the investigative packet. A BDDS report</p>						

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	<p>included in the investigation dated 6/24/14 indicated client #1 alleged staff #9 had told him to "shut up ****" and had stated to his mother after being asked if the group home was the right place for him stated, "No, they don't know how to handle me." The report indicated the incident would be investigated.</p> <p>A BDDS report included in an investigation dated 8/7/14 indicated staff #9 notified the Director of Support Services (DSS) on 7/31/14 that when she went to work on 7/23/14, [client #2] made allegations that his roommate, [client #1] came into his room and touched his penis, and that he went into another housemates' room and climbed on top of him, trying to touch his penis. [Staff #9] relayed that according to [client #2], [client #1] came into his room the night before and wouldn't leave, and was talking about sex, and staff had to get [client #1] out of [client #2's] room and [client #4's] room. [Staff #9] said she wasn't there, that this was reported to her by [client #2]. [Client #2] does have a history of inaccurate communication and false reporting....Staff will be instructed to be on the same floor as [client #1] at all times to ensure adequate supervision." The investigation into the incident dated 8/7/14 indicated during interview on 8/6/14 with staff #9 indicated client #1</p>			

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	<p>had said "vulgar things in the past including having sex with children and police officers, screaming 'penis' and 'vagina' and rubbing his genitals on open windows," and staff #9 "believes that [client #1's] sexual advances are sincere." Staff #9 indicated she had completed an Unusual Incident Report and placed it on a desk in the group home office. Staff #10 indicated she had witnessed client #1 come downstairs, but had not seen him go into any rooms upstairs. She indicated all four of the clients remained in the living room watching TV. She stated "That's how I do it when it's just me-I wanna keep my eyes on all of them." A note included in the investigation regarding client #2's behavior dated 8/2/14 "describes a litany of threats and inappropriate actions made by [client #2] on that day. Those relevant to this investigation are as follows: ...[Client #2] keeps talking about having sex with [client #1], saying that he's going to take his clothes off and stand in front of [client #1's] door telling him to come have sex with him... This account establishes what appears to be a pattern for [client #2's] behaviors-he becomes upset, begins acting out, then uses the incident to make an appeal about his living situation. It also establishes the sexual nature of [client #2's] comments and behaviors, specifically that he is</p>			

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	<p>initiating them towards [client #1]...."</p> <p>The investigation indicated the allegation was not substantiated, "Given [client #2's] history of lying, the specific nature of this allegation, and the testimony of [client #'1's] [relative] who was called on the phone during the incident, it seems extremely unlikely that the even occurred as [client #2] describes...[client #1] did invade the privacy of the other roommates in the house by entering their rooms, but was by all accounts an act meant to bother, not abuse...It is apparent to this writer (DQA) that [client #2] is a high functioning individual with a strong grasp on sexual activities and their meanings. It is also well documented that he continually tries to provoke reactions from roommates and specifically targets [client #1]. It is also the opinion of this writer that [client #2] has a very poor grasp of sexual activities and their meanings, and is very persuadable given his level of functioning. Indeed in this writer's casual interactions with residents at [group home] over the past few weeks, it has almost always been [client #2] engaging [client #1]-not the other way around. Coupled with the intensity of their individual behaviors and the many issues that have arisen between these two at [group home] over the past month it is strongly recommended that the placement of these two individuals in the same</p>						

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	<p>setting be seriously questioned...."</p> <p>Actions taken included: An IDT will convene to seriously consider alternative placement for [client #2]... The [group home] staff should begin meeting at least once every one to two weeks to discuss current behaviors and strategies for addressing them. Involvement by all members of the team including DoRS, QAD, and Behaviorist is recommended."</p> <p>An investigation dated 8/22/14 into the incident involving client #2's allegation on 8/18/14 that client #1 had touched his penis and attempted to put his hands down the back of client #2's pants indicated "Based on [client #1's] own admission, it is substantiated that he touched [client #2] inappropriately. Throughout the evening, [client #2] engaged in persistent behaviors in order to provoke a negative reaction from [client #1]. During the time of the event, there were 2 staff on shift, one working with another individual in the home and the other preparing to pass medications." Recommendations included "Behavior Plan for [client #1] should be reviewed by the [IDT], with at a minimum, a proactive strategy added that indicates he should not be unsupervised with [client #2] at any time. [NDQ] should complete this by 9/5/14. Behavior Support Plan for [client #2] should be reviewed by the</p>			

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	<p>[IDT], with particular attention to strategies related to verbal aggression (which includes teasing others). A proactive strategy should be added that indicated he should not be left unsupervised with [client #1] at any time. [NDQ] should complete this by 9/5/14. All staff should be immediately instructed that [client #1] and [client #2] should not be left together unsupervised. Additionally they should be retrained on the updated BSPs (Behavior Support Plans) by the [NDQ] after revisions are completed."</p> <p>During observations at the group home on 8/28/14 from 5:40 PM until 6:40 PM, client #3 was in the living room looking at a magazine. Client #1 watched staff #1 fry hamburgers and declined to participate in preparing the meal when staff #1 asked if he wanted to assist. The DQA worked with client #4 on looking up items on an electronic tablet. The NDQ and the DQA left the home during the observation.</p> <p>Staff #1 was interviewed on 8/28/14 at 5:45 PM and indicated client #3 did not attend school that day as he had received sedative medication earlier that day to attend a medical appointment.</p> <p>The NDQ was interviewed on 8/28/14 at</p>						

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	<p>6:25 PM and stated staff had called for assistance by them to assist with client #2 who was being housed in a hotel nearby as he was becoming "agitated."</p> <p>Observations were completed at the group home on 8/29/14 from 10:15 AM until 11:00 AM. Client #1 watched a movie, and client #3 looked out the window of his bedroom. Neither client #2 or client #4 were present during the observation. The interim house manager carried torn shoes into the office and placed them on the floor. The interim house manager asked client #3 if he wanted his door shut. When client #3 stated, "Yes," she closed the door to his room.</p> <p>The interim house manager was interviewed on 8/29/14 at 10:15 AM and indicated the shoes were client #4's. She stated client #3 "tore them up," and "He usually goes after electricals." She stated client #3 "Will go after staff," and indicated he would remove female staff shirts and bras. She indicated client #3 had removed her shirt and bra within the last week. She indicated staff brought extra clothing and bras to work in the event client #3 removed their shirts and bras. When asked if an incident report had been completed regarding the incident, she stated, "I'm trying to find</p>						

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	<p>time. I haven't done it yet." She indicated she did not feel she was in harms way when client #3 removed her shirt. She stated client #1 "has been very, very calm" since client #2 was removed from the home. She stated "When [client #2] was here I felt I was in danger. He (client #2) likes to get them riled up. When he gets [client #1] riled up, it's crazy."</p> <p>Observations were completed at a guest group home for client #2 on 8/29/14 from 1:00 PM until 1:15 PM. Client #2 was the only client in the home and was watching TV with staff #7. His medications were unlocked in a duffle bag with client #2's clothing. Staff #7 was relieved by the interim house manager at 1:15 PM.</p> <p>Client #2 was interviewed on 8/29/14 at 1:10 PM. He indicated he had refused his medications of Latuda and Depakote last evening. He stated the Depakote "make you fat," as he had looked up the side effects and Latuda "makes me shaky."</p> <p>The interim house manager was interviewed on 8/29/14 at 1:15 PM and indicated client #2 was not going to return to the group home.</p> <p>Observations were completed on 9/5/14 from 1:30 PM until 2:17 PM at the hotel where client #2 was staying. Client #2's</p>						

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	<p>medications were unlocked on the table. Client #2's glasses had tape on both ear pieces at the hinge.</p> <p>Client #2 was interviewed on 9/5/14 at 1:30 PM and stated he "was afraid of staff" and "feel like going in to a behavior," and "they lied to me." He indicated he had been taken out of school. He indicated his medications had been adjusted and stated, "They lied about a lot of stuff, said I was suicidal, told me to go into behaviors."</p> <p>Observations were completed on 9/8/14 from 8:20 PM until 8:45 PM. Staff #11 indicated the clients were all in bed.</p> <p>Staff #11 was interviewed on 9/8/14 at 8:30 PM and stated the house "was much calmer and the tension level had decreased significantly." She further stated "[Client #1's] behaviors had significantly decreased since he left the home." She indicated client #1 had an incident of urinating on the floor over the weekend and had cleaned it up. When asked what his plan was, she stated "Staff made him clean it up and then mopped the area after he had left the room." Staff #11 indicated client #3 had an incident of removing 3 staff's shirts over the weekend as well. When asked what client #3's plan was when he aggressed, she</p>						

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	<p>stated "He has never aggressed against me so I don't know what his plan is." When asked if she should know it in case client #3 aggressed against her, she stated "It would be a good idea."</p> <p>Observations were completed on 9/9/14 from 9:10 AM until 10:05 AM. The NDQ, the home manager, and clients #1 and #3 were present in the home. Client #1 played video games, and client #3 was in his room until staff prompted him to go to the store with her. The NDQ stated client #3 was in the group home "Because he didn't get at least 7 hours of sleep and it is in his behavior plan that anything less than 7 hours of sleep is an antecedent of his behaviors." The NDQ stated that client #3 "cycles with his behavior of removing shirts from women, but lately he removes shirts from both men and women." The NDQ stated that client #3 "gets a hold of a person's shirt and won't let go until he has removed it and a female's bra. She stated it is "Just easier to let him have it than fighting against him." When asked if the behavior could be considered sexual assault, she stated, "I hadn't thought of it as that." The NDQ indicated that an Unusual Incident Report had been filled out, but a BDDS report had not been done. The NDQ indicated she was unable to write effective behavior plans for clients #1 and #3 and</p>						

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	<p>needed a behavior specialist to help with their plans.</p> <p>Management rounds in the home were completed during the observation period on 9/9/14 from 9:10 AM to 10:05 AM and indicated a sign in time for the rounds was noted, but in only one case was an exit time noted indicating an observation period of 45 minutes.</p> <p>A BDDS report dated 8/29/14 was reviewed on 9/9/14 at 4:30 PM and indicated after returning from an outing client #3 "suddenly lunged at staff and ripped her shirt off. Second staff ran to the house to get assistance and an extra shirt for staff. As [client #3] came up the walk, the NDQ was at the setting and asked client #3 to go to his room and calm. He came in the back door and then lunged for the NDQ and ripped her shirt off of her and pulled her hair. After she was exposed, he lunged for a third staff who was having a meeting with the NDQ. He managed to pull this male staff to the ground and ripped his shirt off. He then kept attacking the male staff and they ended up on the floor in several areas of the office while the male staff was trying to get away from him. NDQ called the police for assistance in getting [client #3] calm." Corrective action indicated client #3 was given a glass of water to help him</p>						

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	<p>calm down. The police arrived just after he was calm and stayed with her for about 30 minutes to ensure he would not have any more aggression. Staff started a movie for him and turned on a fan for him to help him cool off. He remained calm but slightly agitated for the remainder of the evening. [Client #3] has a history of 'cycling' during seasonal changes and when holidays are coming up. He was in the van and may have been hot from being out in the community. This is a targeted behavior included in his plan and staff followed the plan by giving up their shirts. To ensure safety, a second staff member was called in to work the overnight shift so that two staff were present in case he was to become aggressive again. [Client #1] was not injured."</p> <p>Client #3's Replacement Skills Plan dated 5/13 was reviewed on 8/29/14 at 10:00 AM and indicated target behaviors of physical aggression (pulling shirts, pulling hair, scratching, grabbing others). Client #3's plan indicated he was to be offered sensory stimulation throughout the day, and "Do not tell [client #3] 'NO,' This agitates him and could lead to physical aggression. Instead, redirect him from the unwanted behavior to another task...If aggression occurs, ask [client #3] to 'STOP.' Do NOT attempt a</p>						

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	<p>CPI-approved escort. This further agitates [client #3] and may escalate the aggression. If [client #3] grabs staff by the shirt front, staff should drop to the ground and remain still until [client #3] is done grabbing. It is thought that [client #3] is not trying to hurt staff, but is attempting to gain control in the situation. Offer [client #3] something to put in his hand (like a drink of water). This may encourage him to let go of the staff member he is aggressing on. If aggression continues staff may need further staff assistance by either helping physically or calling for help."</p> <p>A Report of Observation dated 8/20/14 written by the BS was reviewed on 9/10/14 at 12:21 PM and indicated the BS had spent 6 hours at the group home on 8/20/14. Recommendations included "After speaking with [clients #1 and #2], this behaviorist has significant concerns regarding [clients #1 and #2] living together in the group home. Although [clients #1 and #2] are around the same age, they are at different developmental levels. [Client #2] is teaching things to [client #1] that he is not at the developmental level to handle at this time which is contributing to behavioral outbursts. This behaviorist recommends that [client #2] move into a supported living site where he can receive</p>				

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	<p>individualized attention from staff and maximize his opportunities in the community...individual counseling is necessary for [client #2] to process through trauma from his past. Due to reports of concern regarding sexual abuse trauma, individual therapy with a certified sexual abuse therapist would be the most appropriate therapist to begin working with him. There should be regular staff meetings held to provide continuing education and training on appropriate proactive approaches to use when interacting with the customers. These staff meetings should be held weekly. There should be daily schedules developed for each customer to create a meaningful day for them. There should also be daily outings built into each customer's schedule...."</p> <p>The DoRS was interviewed on 9/10/14 at 10:55 AM and indicated it was the responsibility of the CEO, DSS, DoRS, QAD, the TM and the NDQ to ensure policy and procedures were implemented to protect clients and manage behaviors.</p> <p>The facility's Behavior Support policy dated January, 2014 was reviewed on 9/11/14 at 1:15 PM and indicated "LifeDesigns believes that all individuals can and should be part of their communities. In accordance with our</p>						

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W000440	<p>beliefs, behavior support provided must focus on building the individual's skills and not just eliminating negative behaviors. LifeDesigns will employ only those behavior support techniques, which are the least restrictive and intrusive, support the individual to gain access to the community, and are the most effective for the individual.</p> <p>9-3-5(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2), and for 2 additional clients (clients #3 and #4) to conduct quarterly evacuation drills for the 6:00 AM to 2:00 PM shift..</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 8/29/14 at 11:10 AM. The</p>	W000440	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, NDQ and CEO will meet weekly at the home to review current status of	09/26/2014

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	<p>review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3 and #4 for the 6:00 AM to 2:00 PM shift from 7/2013- 2/20/14.</p> <p>The Network Director/Qualified Intellectual Disabilities indicated on 9/9/14 at 11:50 AM there were no additional drills.</p> <p>9-3-7(a)</p>		<p>individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ, with CEO participation quarterly. The NDQ 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>		