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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G481 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/02/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE DESIGNS INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>532 RIDGEVIEW<br>COLUMBUS, IN 47203 |
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| W000000            | <p>This visit was for a 23 day revisit survey to the full recertification and state licensure survey which resulted in an Immediate Jeopardy that was not removed prior to exit on 9/12/14.</p> <p>Dates of Survey: September 29, 30, October 1 and 2, 2014.</p> <p>Facility number: 000995<br/>Provider number: 15G481<br/>AIM number: 100235470</p> <p>Surveyors:<br/>Susan Reichert, QIDP-TC<br/>Steve Corya, Surveyor Supervisor</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br/>Quality Review completed 10/9/14 by Ruth Shackelford, QIDP.</p> | W000000       |   |                      |
| W000122            | <p>483.420<br/>CLIENT PROTECTIONS<br/>The facility must ensure that specific client</p>  |               |   |                      |

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

TITLE

(X6) DATE

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

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|  | <p>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 Developmental Disabilities Professional (NDQ) was notified of the Immediate Jeopardy on 8/27/14 at 3:28 PM.</p> | W000122   | 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 not recur, and to provide ongoing monitoring, administrative staff (including the CEO, Director of Support Services, Behavior Specialist) have been conducting | 10/02/2014   |  |   |  |

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|                    | <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) those participating: Director of Quality Assurance (DQA) will work 10:00-8:00 (AM/PM not identified) Mondays and Tuesdays. Behavior Specialist (BS) will</p> |               | <p>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 included in observation schedules and expected to supervise the</p> |                      |

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|                    | 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 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 |               | 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>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 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</p> |   |   |  |  |   |  |

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|  | <p>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 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</p> |   |   |                      |   |

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|  | <p>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 and medication regime, and was discharged from the mental health facility on 9/4/14.</p> |   |   |  |  |   |  |

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|  | <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 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</p> |   |   |  |  |   |  |

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|                    | <p>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 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</p> |               |   |                      |

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|  | <p>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 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</p> |   |   |                      |   |

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|  | <p>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 at the exit on 9/12/14 for the recertification survey due to the facility's failure to demonstrate a facility system that prevented abuse, neglect and mistreatment.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 9/29/14 from 2:50 PM until 6:00 PM. An activity scheduled was posted on a whiteboard in the front hallway of the group home. Client #3 came home from school and had a drink on the front porch and got a snack from the refrigerator. Client #1 played video games and assisted staff #4 and the QAD prepare dinner by slicing oranges. Client #4 got coffee and prepared it. Client #4's voice became raised and he was directed to his room by the TM and the QAD at 4:55 PM. Client #4 returned downstairs at 5:02 PM and was prompted to wash his hands. Client #3 went for a walk with the TM.</p> |   |   |                      |   |

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|  | The Director of Quality Assurance (Director of Quality Assurance) was interviewed on 9/29/14 at 2:55 PM and indicated the previous Network Director (ND)/QIDP (Qualified Intellectual Disabilities Professional) had been reassigned to another group home as she had not been effective in completing her duties as a QIDP and a new ND/QIDP had been hired who possessed previous related experience and would start working at the group home next week. A new Team Manager (TM) had been hired to fill a previous vacancy in the home during the last visit who had previous related experience. He indicated staff #4 was new to the house and had just completed training. He indicated the home had been reorganized and clutter had been eliminated in the office and the medication room had been moved upstairs to prevent congestion and the presence of clients in the office area during medication administration. The QAD indicated there were always two staff on duty at the home with the exception of overnight hours and the TM stayed until dinner at 5:00 or 6:00 PM. He indicated clients #1, #3 and #4's plans had been revised by the behavior specialist (BS) after the BS had completed functional behavioral assessments. He indicated client #3's new behavior plan included psychotropic |   |   |  |  |   |  |

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|                    | <p>medication to address his physical aggression. He indicated client #3's behavior of destroying property had been more easily redirected. The QAD indicated there were IDT (interdisciplinary team) meetings weekly or as needed to discuss client plans and progress. He stated he worked in the home "just about daily" to assist while all staff positions had been filled and staff fully trained.</p> <p>Staff training records were reviewed on 9/29/14 at 4:25 PM and indicated staff #1, #2, #3, #4, the TM and TL had received training on clients #1, #2, and #3's Behavior Support Plans (BSP) on 9/16/14 and again on 9/29/14 by the Behavior Specialist (BS).</p> <p>Client #1's BSP dated September, 2014 was reviewed on 9/29/14 at 5:00 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "baselines" for targeted behaviors were being collected and measured and the "BSP</p> |               |   |                      |

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|  | <p>would be reviewed at any time if the IDT determined the need." The record included a functional behavior assessment completed by the BS dated September, 2014.</p> <p>Client #3's BSP dated September, 2014 was reviewed on 9/29/14 at 4:50 PM. Targeted behaviors indicated physical aggression (pulling shirt off of others), self injurious behavior (rubbing fingers together until they are raw), elopement (climbing out of windows, running away from staff). The plan included the use of Vistaril 25 mg (milligrams) as needed for insomnia and Ativan .5 mg one tablet by mouth every 6 hours as needed for agitation. The plan indicated "baselines" for targeted behaviors were being collected and measured and the "BSP would be reviewed at any time if the IDT determined the need." The record included a functional behavior assessment completed by the BS dated September, 2014.</p> <p>Client #4's BSP dated September, 2014 was reviewed on 9/29/14 at 4:30 PM. Targeted behaviors indicated physical display of frustration (screaming, crying, jumping up and down, yelling "no"), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as</p> |   |   |  |  |   |  |

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|  | <p>paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc.), taking food/drinks (taking food/drink from others during meals or food/drink sitting out), public masturbation (touching genital area when in public or around others). The plan indicated "baselines" for targeted behaviors were being collected and measured and the "BSP would be reviewed at any time if the IDT determined the need." The record included a functional behavior assessment completed by the BS dated September, 2014.</p> <p>The TM was interviewed on 9/29/14 at 5:15 PM and indicated he had started working in the group home two weeks ago. He indicated he was undergoing training for the TM position by a previous house manager and had been trained by the Behavior Specialist (BS) that morning on clients #1, #3 and #4's behavior Support Plans (BSP).</p> <p>Staff #4 was interviewed on 9/29/14 at 5:40 PM and indicated she had started working in the home 4 days ago and had been trained on client behavior plans by the behavioral specialist that morning.</p> <p>Observation Checklists for the group home monitoring were reviewed on 9/29/14 at 3:42 PM and indicated the</p> |   |   |  |  |   |  |

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|                    | <p>QAD (Quality Assurance Director) had completed observations at the home on 9/11/14 from 11:26 AM until 4:05 PM, and on 9/23/14 from 10:00 AM until 5:00 PM with no maladaptive behavioral issues noted.</p> <p>The Director of Support Services completed observations at the home on 9/20/14 from 5:45 PM until 7:10 PM and on 9/21/14 from 6:00 to 7:00 PM. There were no behavioral issues noted.</p> <p>The CEO (Chief Executive Officer) completed observations at the home on 9/22/14 from 9:30 (AM/PM not indicated) until 12:00 (AM/PM not indicated) and on 9/27/14 from 2:45 PM until 4:15 PM. There were no behavioral issues noted.</p> <p>The TM (Team Manager) had completed observations at the home on 9/24/14 from 2:00 PM until 6:00 PM. There were no behavioral issues noted.</p> <p>The Behavior Specialist completed observations at the home on 9/25/14 from 3:00 to 4:30 PM and on 9/28/14 from 1:15 PM until 2:40 PM. There were no behavioral issues noted.</p> <p>An incident report dated 9/29/14 was reviewed on 9/30/14 at 6:55 AM and</p> |               |   |                      |

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|  | <p>indicated client #1 began speaking a phrase "which had been the trigger of a previous behavior incident and reached for his shorts. [Client #1] was instructed not to pee on the floor, it was time for bed." The report indicated client #1 was successfully redirected back to bed after using calming techniques in his plan.</p> <p>Observations were completed at the group home on 9/30/14 from 6:25 AM until 8:20 AM. Client #3 ate his breakfast and went to school at 7:01 AM. Client #1 was redirected from eating more than one helping of cereal. The CEO arrived at the home at 7:55 AM and reviewed incident reports. Staff #4 praised client #1 for calming down last evening.</p> <p>Staff #4 was interviewed on 9/30/14 at 7:14 AM and indicated she had received adequate training and the BS had provided telephone support during the incident with client #1 on 9/29/14 to ensure his plan was implemented as written.</p> <p>Client #1's records in the group home were reviewed on 9/30/14 at 8:20 AM. The record included collection of antecedent, behavior and consequence (ABC) data. A September calendar of activities included entries on all but one day from 9/12/14 to 9/30/14.</p> |   |   |  |  |   |  |

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|                    | <p>Client #3's records in the group home were reviewed on 9/30/14 at 7:51 AM. The record included collection of antecedent, behavior and consequence (ABC) data. A September calendar of activities included entries on all but one day from 9/12/14 to 9/30/14.</p> <p>Client #4's records in the group home were reviewed on 9/30/14 at 8:05 AM. The record included collection of antecedent, behavior and consequence (ABC) data. A September calendar of activities included entries on all but one day from 9/12/14 to 9/30/14.</p> <p>The CEO was interviewed on 9/30/14 at 8:30 AM and stated the BS "was here numerous times," and data analysis and ABC data was now being collected. She indicated frequency data only had previously been collected. She stated the QAD is "here almost everyday," and the IDT was currently meeting weekly to address new issues and revise plans as needed.</p> <p>The BS was interviewed on 9/30/14 at 6:40 PM and she indicated she was in the process of completing observations as part of the functional behavior assessments. She indicated the IDT had met that morning and determined some of</p> |               |   |                      |

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|                    | <p>the clients' behaviors were triggered by additional unfamiliar people visiting the home and staff were to ensure proactive strategies were implemented prior to client #1's behaviors escalating. She indicated arrangements had been made to ensure client #1 was asleep prior to leaving the overnight shift alone.</p> <p>Observations were completed at the group home on 9/30/14 from 6:50 PM until 7:07 PM. The BS was present in the home during the observation. Client #3 assisted with preparing the dinner and client #1 talked about an invitation he received to attend a Halloween party. Client #3 sat on the sofa watching TV.</p> <p>The TM was interviewed on 9/30/14 at 7:07 PM and indicated there would now be two staff working on the overnight shift.</p> <p>The BS indicated in an e-mail on 9/30/14 at 9:19 PM she planned to continue "several more days of onsite training to staff (including one day out of the weekend) to make sure that all of the staff are able to implement the plans successfully. While in the house, I will also assess how well each of the staff understand the plans as I watch them interacting with the customers. Along with these observations, I plan to</p> |               |   |                      |

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|  | <p>continue attending the weekly team meeting and review observations to see where more training is needed. I will be in the house two times per week after this initial training period to re-train or address specific issues and revise plans when needed."</p> <p>Observations were completed at the group home on 10/1/14 from 7:00 AM until 8:10 AM. The Director of Community Services was visiting the home for observations, and the QAD had worked the overnight shift with staff #5 who had been called in the work the shift.</p> <p>The Director of Community Services was interviewed on 10/1/14 at 7:05 AM and indicated the purpose of the visit to the home was to observe staff to client interactions and to ensure adherence to client plans.</p> <p>The QAD was interviewed on 10/1/14 at 7:20 AM and indicated staff #5 and all staff assigned to work in the group home would receive training prior to working in the group home in regards to client plans.</p> <p>The IMMEDIATE JEOPARDY was removed on 10/2/14 at 4:40 PM based upon observation of the plan's implementation in the group home. The</p> |   |   |  |  |   |  |

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| W000149  | <p>conditions remain out of compliance to ensure the implementation of the facility's plan to protect clients from physically aggressive behavior is effective over a period of time.</p> <p>9-3-2(a)</p> <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> | W000149   | 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, | 10/02/2014           |   |

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|  |  |   | 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 on behaviors,review of communication log for issues and concerns, facility issues, finances,and interviews with staff regarding their ability to |                      |   |

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|                    |  |               | 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 meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to |                      |

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|  |  |   | 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. |                      |   |