

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/24/2013	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2701 FAIRLAWN AVE COLUMBUS, IN 47203			
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/22/13, 7/23/13 and 7/24/13.</p> <p>Facility Number: 001115 Provider Number: 15G665 AIMS Number: 100235410</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/31/13 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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #2) plus 1 additional client (#5), the facility failed to implement its policy and procedures to prevent potential injury for clients #1, #2 and #5 while on the facility van for AM/morning transport. The facility failed to implement its policy and procedures to conduct a thorough investigation regarding 1 of 8 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed regarding an injury of unknown origin for client #2.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 7/23/13 from 5:45 AM through 7:45 AM. MC (Medical Coordinator) #1 administered clients #2, #3, #4, #5, #6 and #7's medications in the medication administration area with no other facility staff present. At 6:25 AM MC #1 indicated she was preparing to administer client #1's medication and would need to have another staff in the room with her during the medication administration. MC #1 stated, "[Client #1] can get agitated during medication</p>	W000149	<p>QDDP responsible for investigation of unknown origin was removed from the position for failure to complete job duties including investigations of unknown origin. QDDP replacement, when in place, will be aware of need to investigate injuries of unknown origin in a timely matter. This knowledge will be ensured through training by the Director of Residential Services. The Director of Residential Services will monitor the QDDP to ensure that duties including investigations are completed. If QDDP does not complete duties as assigned, LIFE Designs, Inc disciplinary procedures will be followed as written. Documentation confirming this knowledge will be on file at the LIFE Designs, Inc office when a replacement QDDP is in place. Director of Residential Services will ensure that Network Director is aware of the need and documentation of that knowledge will be on file at the LIFE Designs, Inc office. The Network Director will be responsible for the Investigations of Unknown Origin until a QDDP is hired and trained. Client #1 does not have a history of behaviors during transportation. Two staff members will be assigned to</p>	08/21/2013	

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	<p>time with me. He tends to target certain staff and I am one of them." MC #1 indicated client #1 targeted her by pinching, head butting, grabbing and attempting to hit her. At 6:30 AM HM (Home Manager) #1 entered the medication administration room with MC #1 and client #1 for his medication administration. At 7:08 AM MC #1 prompted clients #1, #2 and #5 to load the facility van to be transported to day services. MC #1 assisted clients #1, #2 and #5 on the facility van. MC #1 indicated she was doing the morning transport with client #1 and clients #2 and #5 with no additional staff on the van. When asked if client #1 targeted MC #1 for hitting, head butting, and/or grabbing, MC #1 stated, "Yes." When asked why she was doing transport alone with client #1, MC #1 stated, "I don't know." When asked if transporting client #1 alone while driving the facility van with clients #2 and #5 was safe, MC #1 stated, "Don't know."</p> <p>HM #1 and ND (Network Director) #1 were interviewed on 7/23/13 at 7:10 AM. HM #1 indicated she had sat in the medication administration room with MC #1 while she administered client #1 his morning medications. When asked why staff needed to be in the medication administration area with MC #1 and client #1, HM #1 stated, "[Client #1] has</p>		<p>workshop transport for the next 30 days. After 30 days, an IDT will be held to discuss the transport and how Client #1's behavior has been to determine if two staff continue to be needed. This IDT will also include review of overall staffing patterns while doing transport with 4 clients. Client #1's behavior plan will be reviewed/revised at that time to ensure that it definitively states situations in which Client #1 has/would required 2 staff.</p>				

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	targeted her in the past. He has attacked her. [Client #1] tends to target the people who have been here the longest. [MC #1] has been here 10 years." When asked if client #1 had injured MC #1 as a result of his targeting her, HM #1 stated, "Well, yes. [Client #1] injured her hand. I think it was around April (2013), he grabbed her hand and hurt it." When asked if MC #1 was the only staff doing the morning transport with clients #1, #2 and #5, HM #1 stated, "Yes, she is the only staff on the van with [client #1] and the others." HM #1 indicated client #1's behaviors included screaming, charging at staff and peers, hitting, grabbing and head butting. When asked how facility staff were to manage client #1's behaviors, ND #1 stated, "[Client #1] tends to be too strong for staff. When they attempt to use CPI (Physical Management), it just makes him more agitated. We move the clients away from him and call the police. It's in his plan. We don't do CPI with him. We call the police and wait for them to assist." When asked if staff or clients #2, #3, #4, #5, #6 and/or #7 were afraid or intimidated by client #1, HM #1 stated, "[Client #1] tends to focus on staff. He will occasionally attempt to attack his peers but we move them to other areas of the house away from [client #1]. With staff, I can't really tell. [Client #1's] behaviors tend to be sporadic and						

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	<p>unpredictable. I can sort of tell when he's getting ready to go off. At first I couldn't but now I can. I think if people don't know him, what to watch for they could be." When asked why MC #1 was doing the morning transport alone with client #1, ND #1 stated, "That's how its been done since I've been here."</p> <p>Client #1's record was reviewed on 7/23/13 at 1:15 PM. Client #1's Replacement Skills Plan (RSP) dated 9/12 indicated, "Because of the potential for harm to others, [Client #1] takes Haldol (behavior) 7.5 milligrams...." Client #1's RSP dated 9/12 indicated, "Because of the potential for harm to others, [Client #1] takes Remeron (behavior) ...." Client #1's RSP dated 9/12 indicated, "Targeted behavior #1: Aggression is defined as hitting, biting, grabbing and head butting." Client #1's RSP dated 9/12 indicated, "If [client #1]...is attempting to aggress on other individuals and staff, one staff person will remove other individuals from the area and monitor until behavior is over. The other staff person will monitor [client #1] until he is calm. If [client #1] is out in the community on a 1:1 outing and becomes aggressive; staff will attempt to keep [client #1] and others safe while asking someone to call 911. If [client #1] is out in the community on a group outing and becomes aggressive,</p>			

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	<p>staff will attempt to keep [client #1] safe while the other staff removes the other individuals from the area and escorts them to the van while asking someone to call 911. Note: Staff will use as little eye contact and verbalization as possible when addressing [client #1]. A CPI approved two man transport is not applicable for [client #1] because he tends to become more aggressive and extremely strong making the situation much more intense. Note: As a last resort, in situation where [client #1's] life and safety are in immediate jeopardy such as fire, a behavior in the middle of the street, etc, staff will attempt a CPI-approved 2 man transport while waiting for 911 to respond." Client #1's RSP dated 9/12 indicated two staff were needed to manage client #1's behavior and protect client #1's housemates while in the community. Client #1's RSP dated 9/12 indicated a two person CPI technique should be used to prevent injury to client #1 while in the community in emergency situations. Client #1's Medical Appointment Record (MAR) dated 2/4/13 indicated, "Checkup for work release. Recommend Haldol increase 15 milligrams day and trazodone 50 milligrams for agitation/aggression." Client #1's Psychotropic medication management review form dated 1/24/13 indicated, "Increased violent behavior,</p>			

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	<p>kicked out of workshop." Client #1's Psychotropic medication management review form dated 12/20/12 indicated, "Increasingly agitated, attacking people." Client #1's Narrative notes form dated 6/29/12 indicated client #1 had "Attacked staff" while at the hospital. Client #1's narrative report form dated 4/21/13 indicated client #1 "came after [MC #1] and grabbed her arm."</p> <p>The facility's BDDSRs (Bureau of Developmental Disabilities Services Reports) were reviewed on 7/23/13 at 9:03 AM. The review indicated the following reports:</p> <p>-BDDSR dated 4/23/13 indicated, "[Client #1] aggressed on [MC #1] grabbing her by the arm."</p> <p>-BDDSR dated 5/27/13 indicated, "[Client #1] was agitated and staff attempted to redirect him to his room for a break. [Client #1] started towards staff and turned toward [client #6] grabbing his right wrist and attempted to bite [client #6]."</p> <p>2. The facility's BDDSRs indicated the following:</p> <p>-BDDSR dated 5/22/13, "While assisting [client #2] after her shower, staff noted a</p>				

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	<p>dime size sore on her left elbow with a small scratch. It is unknown at this time how the sore got there."</p> <p>The review did not indicate documentation of an investigation regarding client #2's 5/22/13 injury of unknown origin.</p> <p>Quality Assurance Director (QAD) #1 was interviewed on 7/23/13 at 9:15 AM. QAD #1 indicated injuries of unknown origin should be investigated. QAD #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>ND #1 was interviewed on 7/23/13 at 5:15 PM. ND #1 indicated the facility's abuse and neglect policy should be implemented. ND #1 indicated clients should be protected from potential harm during morning transport. ND #1 indicated injuries of unknown origin should be investigated. ND #1 indicated client #2's 5/22/13 injury of unknown origin should have been investigated.</p> <p>The facility's policy and procedures were reviewed on 7/24/13 at 4:00 PM. The facility's abuse and neglect policy entitled, "Investigative Incident Report Process", dated 6/17/08 indicated: "The following policy specifically addressed the persons' right to be free from mental, verbal and</p>			

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	<p>physical abuse; the right to humane care and protection from harm and the right to be treated with consideration, respect and full recognition of his/her dignity and individuality."</p> <p>The Investigative Incident Report Process policy dated 6/17/08 indicated injuries of unknown origin should be investigated. The Investigative Incident Report Process policy dated 6/17/08 indicated the definition of neglect/abuse included "Lack of supervision of an individual with specialized behavioral needs= failure of staff to provide support, defined at 1:1 (one staff with one client), correct use of adaptive equipment, assurance of safe environment, including level III and other restrictive measures as outlined in behavior plan/protocol."</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 8 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete an investigation regarding an injury of unknown origin for client #2.</p> <p>Findings include:</p> <p>The facility's BDDSRs (Bureau of Developmental Disabilities Services Reports) were reviewed on 7/23/13 at 9:03 AM. The review indicated the following reports:</p> <p>-BDDSR dated 5/22/13, "While assisting [client #2] after her shower, staff noted a dime size sore on her left elbow with a small scratch. It is unknown at this time how the sore got there."</p> <p>The review did not indicate documentation of an investigation regarding client #2's 5/22/13 injury of unknown origin.</p> <p>Quality Assurance Director (QAD) #1 was interviewed on 7/23/13 at 9:15 AM. QAD #1 indicated injuries of unknown</p>	W000154	<p>QDDP responsible for investigation of unknown origin was removed from the position for failure to complete job duties including investigations of unknown origin. QDDP replacement, when in place, will be aware of need to investigate injuries of unknown origin in a timely matter. This knowledge will be ensured through training by the Director of Residential Services. The Director of Residential Services will monitor the QDDP to ensure that duties including investigations are completed. If QDDP does not complete duties as assigned, LIFE Designs, Inc disciplinary procedures will be followed as written. Documentation confirming this knowledge will be on file at the LIFE Designs, Inc office when a replacement QDDP is in place. Director of Residential Services will ensure that Network Director is aware of the need and documentation of that knowledge will be on file at the LIFE Designs, Inc office. The Network Director will be responsible for the Investigations of Unknown Origin until a QDDP is hired and trained. Continued compliance will be monitored through updated Life Designs, Inc cross monitoring quality assurance plan.</p>	08/21/2013			

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	<p>origin should be investigated.</p> <p>ND (Network Director) #1 was interviewed on 7/23/13 at 5:15 PM. ND #1 indicated injuries of unknown origin should be investigated. ND #1 indicated client #2's 5/22/13 injury of unknown origin should have been investigated.</p> <p>9-3-2(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>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 observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure there were adequate staff levels to implement client #1's Replacement Skills Plan (RSP) during transportation to his day service provider.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 from 5:45 AM through 7:45 AM. MC (Medical Coordinator) #1 administered clients #2, #3, #4, #5, #6 and #7's medications in the medication administration area with no other facility staff present. At 6:25 AM MC #1 indicated she was preparing to administer client #1's medication and would need to have another staff in the room with her during the medication administration. MC #1 stated, "[Client #1] can get agitated during medication time with me. He tends to target certain staff and I am one of them." MC #1 indicated client #1 targeted</p>	W000186	<p>Two staff members will be assigned to workshop transport for the next 30 days. After 30 days, an IDT will be held to discuss the transport and how Client #1's behavior has been to determine if two staff continue to be needed. This IDT will also include review of overall staffing patterns while doing transport with 4 clients. Client #1's behavior plan will be reviewed/revised at that time to ensure that it definitively states situations in which Client #1 has/would required 2 staff. Continued monitoring will be through weekly documentation review by the QDDP, TM, ND-R, or other supervisory staff.</p>	08/21/2013	

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	<p>her by pinching, head butting, grabbing and attempting to hit her. At 6:30 AM HM (Home Manager) #1 entered the medication administration room with MC #1 and client #1 for his medication administration. At 7:08 AM MC #1 prompted clients #1, #2 and #5 to load the facility van for the first group of clients to be transported to day services. MC #1 assisted clients #1, #2 and #5 on the facility van. MC #1 indicated she was doing the morning transport with clients #1 and clients #2 and #5 with no additional staff on the van. When asked if client #1 targeted MC #1 for hitting, head butting, and/or grabbing, MC #1 stated, "Yes." When asked why she was doing transport alone with client #1, MC #1 stated, "I don't know." When asked if transporting client #1 alone while driving the facility van with clients #2 and #5 was safe, MC #1 stated, "Don't know."</p> <p>HM #1 and ND (Network Director) #1 was interviewed on 7/23/13 at 7:10 AM. HM #1 indicated she had sat in the medication administration room with MC #1 while she administered client #1 his morning medications. When asked why staff needed to be in the medication administration area with MC #1 and client #1, HM #1 stated, "[Client #1] has targeted her in the past. He has attacked her. [Client #1] tends to target the people</p>						

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	<p>who have been here the longest. [MC #1] has been here 10 years." When asked if client #1 had injured MC #1 as a result of his targeting her, HM #1 stated, "Well, yes. [Client #1] injured her hand. I think it was around April (2013), he grabbed her hand and hurt it." When asked if MC #1 was the only staff doing the morning transport with clients #1, #2 and #5, HM #1 stated, "Yes, she is the only staff on the van with [client #1] and the others." When asked if it was safe to have MC #1 alone on the van during a transport with client #1, HM #1 stated, "We haven't really had any issues on the van. [Client #1's] behaviors are generally here at the house." HM #1 indicated client #1's behaviors included screaming, charging at staff and peers, hitting, grabbing and head butting. When asked if how facility staff were to manage client #1's behaviors, ND #1 stated, "[Client #1] tends to be too strong for staff. When they attempt to use CPI (Physical Management), it just makes him more agitated. We move the clients away from him and call the police. It's in his plan. We don't do CPI with him. We call the police and wait for them to assist." When asked if staff or clients #2, #3, #4, #5, #6 and/or #7 were afraid or intimidated by client #1, HM #1 stated, "[Client #1] tends to focus on staff. He will occasionally attempt to attack his peers but we move them to other areas of</p>			

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	<p>the house away from [client #1]. With staff, I can't really tell. [Client #1's] behaviors tend to be sporadic and unpredictable. I can sort of tell when he's getting ready to go off. At first I couldn't but now I can. I think if people don't know him, what to watch for they could be." When asked why MC #1 was doing the morning transport alone with client #1, ND #1 stated, "That's how its been done since I've been here."</p> <p>Client #1's record was reviewed on 7/23/13 at 1:15 PM. Client #1's Replacement Skills Plan (RSP) dated 9/12 indicated, "Because of the potential for harm to others, [Client #1] takes Haldol 7.5 milligrams...." Client #1's RSP dated 9/12 indicated, "Because of the potential for harm to others, [Client #1] takes Remeron...." Client #1's RSP dated 9/12 indicated, "Targeted behavior #1: Aggression is defined as hitting, biting, grabbing and head butting." Client #1's RSP dated 9/12 indicated, "If [client #1]...is attempting to aggress on other individuals and staff, one staff person will remove other individuals from the area and monitor until behavior is over. The other staff person will monitor [client #1] until he is calm. If [client #1] is out in the community on a 1:1 outing and becomes aggressive; staff will attempt to keep [client #1] and others safe while asking</p>			

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	<p>someone to call 911. If [client #1] is out in the community on a group outing and becomes aggressive, staff will attempt to keep [client #1] safe while the other staff removes the other individuals from the area and escorts them to the van while asking someone to call 911. Note: Staff will use as little eye contact and verbalization as possible when addressing [client #1]. A CPI approved two man transport is not applicable for [client #1] because he tends to become more aggressive and extremely strong making the situation much more intense. Note: As a last resort, in situation where [client #1's] life and safety are in immediate jeopardy such as fire, a behavior in the middle of the street, etc, staff will attempt a CPI-approved 2 man transport while waiting for 911 to respond." Client #1's RSP dated 9/12 indicated two staff were needed to manage client #1's behavior and protect client #1's housemates while in the community. Client #1's RSP dated 9/12 indicated a two person CPI technique should be used to prevent injury to client #1 while in the community in emergency situations. Client #1's Medical Appointment Record (MAR) dated 2/4/13 indicated, "Checkup for work release. Recommend Haldol increase 15 milligrams day and trazodone 50 milligrams for agitation/aggression." Client #1's Psychotropic medication</p>			

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	<p>management review form dated 1/24/13 indicated, "Increased violent behavior, kicked out of workshop." Client #1's Psychotropic medication management review form dated 12/20/12 indicated, "Increasingly agitated, attacking people." Client #1's Narrative notes form dated 6/29/12 indicated client #1 had "Attacked staff" while at the hospital. Client #1's narrative report form dated 4/21/13 indicated client #1 "came after [MC #1] and grabbed her arm."</p> <p>The facility's BDDSRs (Bureau of Developmental Disabilities Services Reports) were reviewed on 7/23/13 at 9:03 AM. The review indicated the following reports:</p> <p>-BDDSR dated 4/23/13 indicated, "[Client #1] aggressed on [MC #1] grabbing her by the arm."</p> <p>-BDDSR dated 5/27/13 indicated, "[Client #1] was agitated and staff attempted to redirect him to his room for a break. [Client #1] started towards staff and turned toward [client #6] grabbing his right wrist and attempted to bite [client #6]."</p> <p>9-3-3(a)</p>						

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W000259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's CFA (Comprehensive Functional Assessment) was reviewed annually.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 7/23/13 at 3:21 PM. Client #3's Annual Functional Skills Assessment (AFSA) was dated 4/10/12. Client #3's record did not indicate client #3's AFSA had been reviewed or revised since 4/10/12.</p> <p>Interview with ND (Network Director) #1 on 7/23/13 at 4:05 PM indicated there was not additional documentation of an AFSA for client #3. ND #1 indicated client #3's AFSA should be reviewed annually.</p> <p>9-3-4(a)</p>	W000259	<p>QDDP responsible for Functional Assessment was removed from the position for failure to complete job duties including Functional Assessments origin. QDDP replacement, when in place, will be aware of need to complete Functional Assessments in a timely matter. Documentation confirming this knowledge will be on file at the LIFE Designs, Inc office when a replacement QDDP is in place. Director of Residential Services will ensure that Network Director is aware of the need and documentation of that knowledge will be on file at the LIFE Designs, Inc office. Monitoring will be completed through quarterly Network Director Audit submitted to the Director of Residential Services and through monthly cross monitoring audits completed by supervisory staff and submitted to Director of Support Services. Copies of these audits will be on file.</p>	08/21/2013	

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 3 additional clients (#5, #6 and #7), the facility failed to maintain the clients' medication in a secure location.</p> <p>Finding include:</p> <p>Observations were conducted at the group home on 7/23/13 from 5:45 AM through 7:45 AM. MC (Medical Coordinator) #1 administered clients #2, #3, #4, #5, #6 and #7's medications in the medication administration area. Clients #1, #2, #3, #4, #5, #6 and #7's medication was in a storage cabinet located in the medication room. The medication cabinet had a padlock hanging from the door with no latch. MC #1 indicated the medication cabinet was broken and could not be locked.</p> <p>MC #1 was interviewed on 7/23/13 at 7:00 AM. MC #1 indicated she had locked the medication cabinet keys inside the cabinet. MC #1 stated, "They had to break the lock so they could get into it. I locked the keys in the cabinet when I went home yesterday." MC #1 indicated the medication cabinet locking latch</p>	W000382	<p>Maintenance supervisor repaired the lock to the medication cabinet. Documentation of this repair will be on file at the LIFE Designs, Inc office. Team Manager will train all group home staff on the need for the office door to remain closed and locked to act as security for the medications. A copy of this training sheet will be on file at the LIFE Designs, Inc office. Continued compliance will be monitored through observations completed by Network Director, TM, QDDP, and other supervisory staff submitted to Director of Residential Services. Monitoring occurs at least one time weekly by a member of supervisory staff.</p>	08/21/2013			

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	<p>mechanism was broken and could not be secured with the padlock. MC #1 indicated clients #1, #2, #3, #4, #5, #6 and #7's medications were stored in the cabinet.</p> <p>Observations were conducted at the group home on 7/23/13 from 3:30 PM through 5:30 PM. At 3:30 PM the group home's medication administration cabinet had scotch tape holding the padlock latch mechanism in place. At 3:30 PM clients #6 and #7 entered the medication administration room with no facility staff present. From 3:43 PM until 4:01 PM client #6 paced between the medication cabinet and the medication administration room entry door with no facility staff present. The medication administration room entry door remained open and unlocked from 3:30 PM through 5:15 PM.</p> <p>ND (Network Director) #1 was interviewed on 7/23/13 at 5:15 PM. ND #1 indicated the medication cabinet contained clients #1, #2, #3, #4, #5, #6 and #7's medication. ND #1 indicated the medication cabinet door was broken and was being secured with scotch tape on the locking latch/mechanism. ND #1 indicated clients #6 and #7 had been in the medication administration area without staff supervision. ND #1 indicated the medication administration</p>			

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	door should be secured until the medication cabinet was fixed to ensure clients #1, #2, #3, #4, #5, #6 and #7's medication was secured.  9-3-6(a)						

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W000407	<p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure the physical environment of the group home met client #3's ambulation needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 from 5:45 AM through 7:45 AM and 3:15 PM through 5:30 PM. The group home was a multi level home with client #3's bedroom, living room area and kitchen are located on the 2nd floor of the home. Client #3 was observed throughout the observation periods. Client #3 used a rolling walker to move throughout the home. Each time client #3 entered or exited the group home he had to negotiate a set of stairs that connected the living area of the group home with the entry/exit corridor. Client #3 parked his walker at the bottom and top of the stairs and was assisted by facility staff up and down the stairs. Client #3 was not able to negotiate the stairs independent of staff's assistance.</p>	W000407	Director of Residential Services has notified the District 8 BDDS office regarding this tag. Director of Residential Services continues to be in contact with the District 8 BDDS office and client #3's Power of Attorney and will continue to maintain this contact until an appropriate alternative placement can be obtained. Documentation of this contact can be found with the Director of Residential Services.	08/12/2013	

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	<p>The facility's BDDSRs (Bureau of Developmental Disabilities Services Reports) were reviewed on 7/23/13 at 9:03 AM. The review indicated the following reports:</p> <p>-BDDSR dated 1/23/13 indicated on 1/22/13, "[Client #3] was going downstairs to take a shower. At the bottom of the landing he fell and scraped his back against the stair banister. There is a red scrape on his back approximately 4 inches...."</p> <p>Client #3's record was reviewed on 7/23/13 at 3:21 PM. Client #3's Physicians Order form dated 5/24/13 indicated client #3's diagnosis included but was not limited to Cerebral Palsy. Client #3's Nursing care plan dated 7/15/13 indicated client #3 had a fall risk plan. Client #3's High Risk Plan for falls dated 7/15/13 indicated client #3 used a rolling walker to move around the house and needed staff assistance going up and down the group home stairs. Client #3's IDT (Interdisciplinary Team Meeting) dated 4/19/13 indicated, "Discussed stairs being an issue. Team does not feel he is safe with the fall risks."</p> <p>ND #1 (Network Director) was interviewed on 7/24/13 at 1:03 PM. ND</p>			

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	<p>#1 indicated client #3 used a walker to move through the group home. ND #1 indicated client #3's bedroom, the group home living room and kitchen area were located on the upstairs/ second floor of the home. ND #1 indicated the IDT had agreed on 4/19/13 client #3 should be placed in a single story home without stairs. ND #1 indicated the facility was in the process of finding an alternative placement for client #3.</p> <p>9-3-7(a)</p>			

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 3 additional clients (#5, #6 and #7), the facility failed to conduct evacuation drills for each quarter on each shift.</p> <p>Findings include:</p> <p>The facility's evacuation drill records were reviewed on 7/23/13 at 4:45 PM. The review indicated the facility failed to conduct an evacuation drill for 7 of 7 clients (#1, #2, #3 #4, #5, #6 and #7) for the fourth quarter, October through December 2012 for the 10:00 PM through 6:00 AM shift.</p> <p>ND #1 (Network Director) was interviewed on 7/24/13 at 1:03 PM. ND #1 indicated there were no additional evacuation drills available for review. ND #1 indicated evacuation drills should be conducted on each shift each quarter.</p> <p>9-3-7(a)</p>	W000440	The Team Manager responsible for drills during the deficient time is no longer in the position. The current Team Manager is aware of the requirements for drills and their completion. Signed confirmation of this knowledge is on file at the LIFE Designs, Inc office. A copy of a drill calendar for the month will be submitted to the Network Director by the Team Manager each month. An example of a drill schedule will be on file at the Life Designs, Inc office. Monitoring of drill completion will be documented on the Quarterly Network Director Audits submitted to the Director of Residential Services and through weekly TM audits submitted to the Network Director and the Director of Residential Services.	08/12/2013	