

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G665	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 FAIRLAWN AVE COLUMBUS, IN 47203
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: November 6, 9, 10, 12 and 13, 2015</p> <p>Facility Number: 001115 Provider Number: 15G665 AIM Number: 100235410</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/19/15.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 an incident observed at the group home affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to ensure staff on duty did not fall asleep while working at the group home and failed to ensure staff immediately</p>	W 0149	To correct the deficient practice and prevent it's recurrence, an investigation was completed for the incident that occurred on 11/10/15. Recommendations included written disciplinary action for staff #3, as well as a reduction in her work schedule and on-site supervisory observations. All staff will receive re-training on topics	12/13/2015

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

TITLE

(X6) DATE

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

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	<p>reported the incident to the administrator.</p> <p>Findings include:</p> <p>On 11/10/15 from 6:00 AM to 7:37 AM, an observation was conducted at the group home. At 6:03 AM when the surveyor entered the living room area, staff #3 was lying back in a recliner in the reclined position with a blanket over her asleep. Client #1 was in the living room sitting on a couch. Client #4 was in the kitchen. At 6:04 AM, the Home Manager (HM) entered the living room, shook staff #3's arm and stated, "State's here. Get up." Staff #3 sat upright quickly, put the leg rest down, took off the blanket and got out of the recliner. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/10/15 at 6:07 AM, the HM stated, "she probably just fell asleep when I came down here. I was just talking to her." The HM indicated she arrived to the group home at 4:45 AM.</p> <p>On 11/10/15 at 6:23 AM, staff #3 stated she "just fell asleep" and "drifted off." Staff #3 indicated she spoke to the HM when the HM arrived to the home. Staff #3 indicated she laid down in the recliner when the clients finished their breakfast.</p>		<p>related to abuse, neglect, and exploitation, and the requirement to report all allegations immediately. To ensure the deficient practice does not continue, and to provide ongoing monitoring, supervisory staff, including the Team Manager, Network Director/QIDP (ND/Q), and Director of Residential Services (DRS) will complete observations in the home at least 4 times per week for no less than 4 weeks. The Team Manager works full time in the home to provide ongoing support and supervision of the staff working there, and the ND/Q IDP is in the home no less than weekly. The DRS is in the home at least once per month. The Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>				

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	<p>On 11/10/15 at 9:45 AM, the HM indicated she reported staff #3's sleeping to the Network Director (ND) at 6:50 AM.</p> <p>On 11/10/15 at 9:50 AM, the ND indicated staff #3 called him to report she fell asleep this morning at 6:50 AM.</p> <p>On 11/12/15 at 11:07 AM, the ND indicated the staff should have reported the incident immediately. The ND initially indicated the staff reported the incident immediately. The ND, when told staff #3 was asleep at 6:03 AM, indicated he was not sure what time the incident occurred. The ND indicated the Director of Residential Services (DRS) was aware of the incident prior to staff reporting it to him at 6:50 AM. The ND indicated staff #3 self-reported the incident to the DRS.</p> <p>On 11/12/15 at 11:08 AM, the Chief Services Officer (CSO) indicated the incident should have been reported immediately, after ensuring the health and safety of the clients first. The CSO indicated staff #3 self-reported the incident to the DRS.</p> <p>On 11/12/15 at 11:03 AM, the Director of Support Services (DSS) indicated the staff should immediately report staff</p>			

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	<p>sleeping to the administrator.</p> <p>The HM and staff #3 failed to immediately report staff #3's sleeping while on duty to the administrator.</p> <p>On 11/12/15 at 3:02 PM, the DSS stated "yes" when asked if staff sleeping while on duty was considered neglect. The DSS indicated the facility had a policy and procedure prohibiting neglect of the clients. The DSS indicated the facility should prevent neglect of the clients.</p> <p>On 11/9/15 at 11:12 AM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Neglect: Placing a customer in a</p>			

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	<p>situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator...."</p>			

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W 0153 Bldg. 00	<p>9-3-2(a)</p> <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 on observation and interview for an incident observed at the group home affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to ensure staff immediately reported an incident of staff sleeping to the administrator.</p> <p>Findings include:</p> <p>On 11/10/15 from 6:00 AM to 7:37 AM, an observation was conducted at the group home. At 6:03 AM when the surveyor entered the living room area, staff #3 was lying back in a recliner in the reclined position with a blanket over her asleep. Client #1 was in the living room sitting on a couch. Client #4 was in the kitchen. At 6:04 AM, the Home Manager (HM) entered the living room, shook staff #3's arm and stated, "State's here. Get up." Staff #3 sat upright quickly, put the leg rest down, took off</p>	W 0153	To correct the deficient practice and ensure it does not continue, staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately, and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. The LifeDesigns investigation summary has been revised to include whether or not the staff immediately reported the allegation to an administrator, and if not, corrective action to be taken. To provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports to ensure BDDS reports are filed within 24 hours, and that investigation policies and procedures are implemented as written. The Services Leadership Team, which includes all Directors of Services,	12/13/2015

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	<p>the blanket and got out of the recliner. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/10/15 at 6:07 AM, the HM stated, "she probably just fell asleep when I came down here. I was just talking to her." The HM indicated she arrived to the group home at 4:45 AM.</p> <p>On 11/10/15 at 6:23 AM, staff #3 stated she "just fell asleep" and "drifted off." Staff #3 indicated she spoke to the HM when the HM arrived to the home. Staff #3 indicated she laid down in the recliner when the clients finished their breakfast.</p> <p>On 11/10/15 at 9:45 AM, the HM indicated she reported staff #3's sleeping to the Network Director at 6:50 AM.</p> <p>On 11/10/15 at 9:50 AM, the Network Director (ND) indicated staff #3 called him to report she fell asleep this morning at 6:50 AM.</p> <p>On 11/12/15 at 11:07 AM, the ND indicated the staff should have reported the incident immediately. The ND initially indicated the staff reported the incident immediately. The ND, when told staff #3 was asleep at 6:00 AM, indicated he was not sure what time the incident occurred. The ND indicated the</p>		<p>the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>				

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	<p>Director of Residential Services (DRS) was aware of the incident prior to staff reporting it to him at 6:50 AM. The ND indicated staff #3 self-reported the incident to the DRS.</p> <p>On 11/12/15 at 11:08 AM, the Chief Services Officer (CSO) indicated the incident should have been reported immediately, after ensuring the health and safety of the clients first. The CSO indicated staff #3 self-reported the incident to the DRS.</p> <p>On 11/12/15 at 11:03 AM, the Director of Support Services (DSS) indicated the staff should immediately report staff sleeping to the administrator.</p> <p>9-3-2(a)</p>						
W 0203 Bldg. 00	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on record review and interview for 1 of 1 client (client #7) who was discharged since 11/6/14, the facility failed to develop a final summary of the client's developmental, behavioral, social,</p>	W 0203	To correct the deficient practice and ensure it does not continue, the agency discharge summary format will be revised to include more detailed information related to the individual's developmental,	12/13/2015			

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W 0227 Bldg. 00	<p>health and nutritional status.</p> <p>Findings include:</p> <p>On 11/12/15 at 11:23 AM, a review of client #7's discharge documentation was conducted. The Leaving Services Summary, dated 2/18/15, did not include a final summary of client #7's developmental, behavioral, social, health and nutritional status.</p> <p>On 11/12/15 at 11:10 AM, the Chief Services Officer (CSO) indicated the Director of Residential Services was working on locating the information. On 11/13/15 at 2:03 PM, the CSO indicated the facility was unable to locate client #7's discharge summary.</p> <p>On 11/12/15 at 11:11 AM, the Network Director indicated he looked through client #7's record but could not locate the discharge summary.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p>		behavioral, social, health and nutritional status. The procedures related to discharge will also be reviewed and revised as necessary to ensure all discharge documentation is reviewed by the appropriate Director of Services. All supervisory staff will be re-trained on the revised format, as well as the discharge process. Ongoing monitoring will occur through the Director of Residential Services review of all discharge summaries to ensure complete information is included in all required are as previously referenced.		

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	<p>Based on observation, interview and record review for 2 of 3 clients in the sample (#2 and #6), the facility failed to ensure client #2 had a program plan to address the ingestion of his mouth wash and client #6 had a plan to use sheets on his mattress.</p> <p>Findings include:</p> <p>1) On 11/10/15 from 6:00 AM to 7:37 AM, an observation was conducted at the group home. At 7:11 AM, staff #2 gave client #2 a small cup with Peridex (mouth wash for oral hygiene). Prior to giving client #2 the cup, staff #2 told client #2 to swish and spit. Staff #2 stated, "you never do." Staff #2 stated the group home used to have toothettes (sponge on a long stick) to use to apply the Peridex to client #2's teeth but have not had any for "a long time."</p> <p>On 11/10/15 at 8:38 AM, a review of client #2's record was conducted. Client #2's 3/27/15 Individual Support Plan and 5/29/15 Behavioral Support Plan did not address client #2's ingestion of his mouth wash.</p> <p>On 11/12/15 at 11:12 AM, the Network Director (ND) indicated he was not aware of client #2 drinking/ingesting his mouth wash. The ND indicated client #2 needed</p>	W 0227	To correct the deficient practice, a plan will be developed for client #2 to address his ingestion of mouthwash, and for client #6 to use sheets on his mattress. To ensure no others were affected by the deficient practice, the ND/QIDP will review plans for all other individuals and address any identified unmet needs. All staff will be trained on the revised program plans prior to implementation. To ensure the deficient practice does not continue, the DRS will re-train all ND/QIDPs on the requirement to have program plans in place. To ensure the deficient practice does not continue, and to provide ongoing monitoring, a Comprehensive Functional Assessment (CFA) will be completed on an annual basis for each individual living in the home. The Individual Support Team (IST) will develop and Individual Support Plan (ISP) based on needs identified in the CFA, with will be reviewed quarterly and revised as necessary.	12/13/2015	

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	<p>a plan to address the issue. The ND indicated the facility needed to inform client #2's physician who ordered the mouth wash to see if the doctor was aware client #2 was consuming the mouth wash.</p> <p>On 11/12/15 at 11:23 AM, the Chief Services Officer (CSO) indicated client #2 needed a plan.</p> <p>2) On 11/9/15 from 3:20 PM to 5:18 PM, an observation was conducted at the group home. At 4:22 PM, client #6's mattress in his bedroom did not have sheets or a mattress protector. There were several brown, tan and yellow areas on client #6's mattress. On 11/10/15 at 6:31 AM, client #6's sheets had brown, tan and yellow discolored areas on them. On 11/10/15 at 6:31 AM, the Home Manager indicated the discolored areas were from client #6 sitting on his bed without clothes.</p> <p>On 11/9/15 at 4:22 PM, the ND indicated the facility needed to see about covering client #6's mattress to protect it.</p> <p>On 11/9/15 at 4:40 PM, staff #2 indicated client #6's mattress needed to be scrubbed. Staff #2 indicated client #6's mattress did not have the discolored areas on it over the previous weekend. Staff #2</p>			

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	<p>indicated client #6's sheets might be off his bed due to being washed.</p> <p>On 11/10/15 at 6:21 AM, the Home Manager (HM) indicated client #6 sits on the mattress while naked and he did not wipe after bowel movements very well. The HM indicated client #6 would not leave a mattress protector and sheets on his bed. The HM indicated this was an on-going issue.</p> <p>On 11/10/15 at 6:25 AM, staff #3 stated she "scrubbed and scrubbed" client #6's mattress and the discolored areas would not come off. Staff #3 indicated client #6's bed did not have sheets on it due to another staff removing them to launder.</p> <p>On 11/10/15 at 7:14 AM, staff #2 indicated client #6 did not have a goal to keep sheets on his mattress. Staff #2 indicated client #6 would not leave sheets on his bed.</p> <p>On 11/10/15 at 8:16 AM, a review of client #6's record was conducted. Client #6's 12/9/14 Individualized Support Plan indicated he did not have a training objective to increase his use of sheets and a mattress protector on his bed.</p> <p>On 11/12/15 at 11:40 AM, the Network Director indicated client #6 needed a plan</p>			

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W 0249 Bldg. 00	<p>to use sheets on his bed.</p> <p>9-3-4(a)</p> <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 on observation, interview and record review for 1 of 3 clients in the sample (#6), the facility failed to ensure staff implemented the client's program plan for wiping after toileting as written.</p> <p>Findings include:</p> <p>On 11/9/15 from 3:20 PM to 5:18 PM, an observation was conducted at the group home. At 4:22 PM, client #6's mattress in his bedroom did not have sheets or a mattress protector. There were several brown, tan and yellow areas on client #6's mattress. On 11/10/15 at 6:31 AM, client #6's sheets had brown, tan and yellow discolored areas on them. On 11/10/15 at 6:31 AM, the Home Manager (HM) indicated the discolored areas were from client #6 sitting on his bed without</p>	W 0249	To correct the deficient practice and prevent it from recurrence, the IST will review program plans for all individuals in the home to ensure all staff understand how to implement the plans, and what materials are required for complete implementation. To provide ongoing monitoring, supervisory staff, including the Team Manager, Network Director/ QIDP (ND/Q), Chief Services Officer (CSO) and Director of Residential Services (DRS) will complete observations in the home at least 4 times per week for no less than 4 weeks. On an ongoing basis, the Team Manager works full time in the home to provide ongoing support and supervision of the staff working there, and the ND/QIDP is in the home no less than weekly. The DRS is in the home at least once per month.	12/13/2015

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	<p>clothes.</p> <p>On 11/9/15 at 4:22 PM, the Network Director (ND) indicated the facility needed to see about covering client #6's mattress to protect it.</p> <p>On 11/9/15 at 4:40 PM, staff #2 indicated client #6's mattress needed to be scrubbed. Staff #2 indicated his mattress did not have the discolored areas on it over the previous weekend. Staff #2 indicated client #6's sheets might be off his bed due to being washed.</p> <p>On 11/10/15 at 6:21 AM, the Home Manager HM indicated client #6 sits on the mattress while naked and he did not wipe after bowel movements very well. The HM indicated client #6 would not leave a mattress protector and sheets on his bed. The HM indicated this was an on-going issue.</p> <p>On 11/10/15 at 6:25 AM, staff #3 stated she "scrubbed and scrubbed" client #6's mattress and the discolored areas would not come off. Staff #3 indicated client #6's bed did not have sheets on it due to another staff removing them to launder.</p> <p>On 11/10/15 at 7:14 AM, staff #2 indicated client #6 did not have a goal to keep sheets on his mattress. Staff #2</p>			

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	<p>indicated client #6 had a goal to improve his skills with wiping after a bowel movement. Staff #2 stated, "Staff implement the best we can." Staff #2 indicated client #6 was not provided with wet wipes. Staff #2 stated client #6, "just uses toilet paper." Staff #2 indicated client #6 was using flushable wipes but he was using too many and it clogged the toilet. Staff #2 indicated client #6 told the staff he wanted to use toilet paper.</p> <p>On 11/12/15 at 12:59 PM, the Maintenance Supervisor (MS) stated the group home had "never had a problem with wipes" causing the toilets to clog. The MS indicated the group home did not have a septic system.</p> <p>On 11/10/15 at 8:16 AM, a review of client #6's record was conducted. Client #6's 12/9/14 Individualized Support Plan indicated he had a training objective to increase his wiping skills after toileting. The plan indicated in the Current Status section, "[Client #6] does not wipe after toileting." The Proposed Strategy section indicated, "[Client #6] will be provided with wet toilet wipes when he uses the restroom. Staff will allow [client #6] as much privacy as possible while ensuring that he is wiping until all feces is removed. Initially staff will verbally cue [client #6], '[client #6], remember to wipe</p>			

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W 0262 Bldg. 00	<p>when you are finished.' Staff will wait until [client #6] has finished having a bowel movement, staff will then enter the restroom to ensure that wiping is being done. Encourage [client #6] to 'wipe from front to back.' When [client #6] has successfully cleaned himself staff will praise [client #6]. This goal will be considered met if [client #6] has successfully cleaned his bottom after toileting."</p> <p>On 11/12/15 at 11:40 AM, the Chief Services Officer (CSO) indicated the septic system was previously clogged with wipes. The CSO indicated the staff should implement client #6's plan as written.</p> <p>On 11/10/15 at 9:40 AM, the ND indicated the staff should implement the client's goals as written. On 11/12/15 at 11:40 AM, the ND indicated the staff should be providing client #6 with wipes per his plan. The ND stated the staff was "not going to be able to always ensure" client #6 wiped thoroughly.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and</p>						

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	<p>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 3 of 3 clients in the sample with restrictive interventions in their Behavioral Support Plans (#2, #3 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the clients' program plans.</p> <p>Findings include:</p> <p>On 11/10/15 at 8:38 AM, a review of client #2's record was conducted. Client #2's 5/29/15 Behavioral Support Plan (BSP) included the use of psychotropic medications (Haldol for depression and aggression and Mirtazapine for depression). There was no documentation in client #2's record indicating the facility's HRC reviewed, approved and monitored client #2's restrictive plan.</p> <p>On 11/10/15 at 9:14 AM, a review of client #3's record was conducted. Client #3's 10/16/15 BSP included the use of psychotropic medications (Haldol for self-injurious behavior and Klonopin for mood stabilization). There was no documentation in client #3's record</p>	W 0262	To correct the deficient practice, guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/QIDPs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DRS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DRS will review the calendar with the ND/QIDP at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.	12/13/2015

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W 0263 Bldg. 00	<p>indicating the facility's HRC reviewed, approved and monitored client #3's restrictive plan.</p> <p>On 11/10/15 at 8:16 AM, a review of client #6's record was conducted. Client #6's 6/20/15 BSP included the use of psychotropic medications (Depakote and Zyprexa for aggression and Zoloft for obsessive compulsive disorder). There was no documentation in client #6's record indicating the facility's HRC reviewed, approved and monitored client #6's restrictive plan.</p> <p>On 11/10/15 at 9:37 AM, the Network Director indicated he did not know where the HRC approval documentation was located.</p> <p>On 11/10/15 at 10:45 AM, the Director of Residential Services (DRS) indicated there was no documentation the facility's HRC reviewed, approved and monitored the clients' restrictive BSPs.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal</p>			

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	<p>guardian. Based on record review and interview for 3 of 3 clients in the sample with restrictive interventions in their Behavioral Support Plans (#2, #3 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the clients' program plans were conducted with written informed consent of the clients' guardians.</p> <p>Findings include:</p> <p>On 11/10/15 at 8:38 AM, a review of client #2's record was conducted. Client #2's 5/29/15 Behavioral Support Plan (BSP) included the use of psychotropic medications (Haldol for depression and aggression and Mirtazapine for depression). Client #2's 3/27/15 Individualized Support Plan (ISP) indicated he had a guardian. There was no documentation in client #2's record indicating the facility's HRC ensured written informed consent was obtained from his guardian.</p> <p>On 11/10/15 at 9:14 AM, a review of client #3's record was conducted. Client #3's 10/16/15 BSP included the use of psychotropic medications (Haldol for self-injurious behavior and Klonopin for mood stabilization). Client #3's 12/9/14</p>	W 0263	To correct the deficient practice, guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/QIDPs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DRS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DRS will review the calendar with the ND/QIDP at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.	12/13/2015			

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	<p>ISP indicated he had a guardian. There was no documentation in client #3's record indicating the facility's HRC ensured written informed consent was obtained from his guardian.</p> <p>On 11/10/15 at 8:16 AM, a review of client #6's record was conducted. Client #6's 6/20/15 BSP included the use of psychotropic medications (Depakote and Zyprexa for aggression and Zoloft for obsessive compulsive disorder). Client #6's 12/9/14 ISP indicated he had a guardian. There was no documentation in client #6's record indicating the facility's HRC ensured written informed consent was obtained from his guardian.</p> <p>On 11/10/15 at 10:45 AM, the Director of Residential Services (DRS) indicated there was no documentation the facility obtained written informed consent for the clients' restrictive program plans.</p> <p>On 11/10/15 at 9:37 AM, the Network Director indicated he did not know where the clients' written informed consents were located from their guardians. On 11/12/15 at 11:50 AM, the Network Director indicated the clients' program plans were mailed yesterday (11/11/15) to obtain written informed consent from their guardians.</p>			

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W 0381 Bldg. 00	<p>9-3-4(a)</p> <p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff secured the clients' medications prior to leaving the medication administration room.</p> <p>Findings include:</p> <p>On 11/10/15 from 6:00 AM to 7:37 AM, an observation was conducted at the group home. At 6:16 AM, the Home Manager (HM) left the medication administration room to go to the restroom with client #3 to administer his mouth wash in the basement. The HM left the medication cart unlocked as well as the medication room door. Staff #3 was in the kitchen area on a separate floor at the time. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/12/15 at 11:32 AM, the Chief Services Officer indicated the clients' medications should be locked at all times except when the staff was administering the medications.</p>	W 0381	To correct the deficient practice and prevent it from recurring, all staff will be re-trained on the requirement to keep medications locked at all times, even when leaving the medication administration room for any length of time. A notice will be posted near the doorway in the medication administration room reminding staff to lock the medication cart and door to the room when exiting the room. Ongoing monitoring will be accomplished by the nurse doing a supervised medication pass with all staff working in the home. Additionally, supervisory staff, including the Team Manager, Network Director/QIDP (ND/Q), Chief Services Officer (CSO) and Director of Residential Services(DRS) will complete observations in the home at least 4 times per week for no less than 4 weeks. On an ongoing basis, the Team Manager works full time in the home to provide ongoing support and supervision of the staff working there, and the ND/QIDP is in the home no less than weekly. The DRS is in the home at least once per month.	12/13/2015

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W 0440 Bldg. 00	<p>On 11/12/15 at 11:33 AM, the Network Director indicated the clients' medications needed to be secured.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 11/9/15 at 3:37 PM, a review of the facility's evacuation drills was conducted. During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 12/18/14 to 4/6/15. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/10/15 at 9:35 AM, the Network Director indicated the facility should conduct quarterly evacuation drills for each shift.</p> <p>9-3-7(a)</p>	W 0440	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 completes 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 Weekly Report is forwarded to the ND/QIDP, DRS, Director of Support Services, Chief Services Officer and Chief Executive Officer each week for review. Additionally, the ND/QIDP completes a quarterly QA review of the home, including a review of the LifeSafety book, to ensure drills have been completed within the required timeframes.	12/13/2015