

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/11/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE BLOOMINGTON, IN 47401
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W 000 Bldg. 00	<p>This visit was for a predetermined full recertification and state licensure survey.</p> <p>Survey Dates: May 6, 7, 8 and 11, 2015</p> <p>Facility Number: 000788 Provider Number: 15G268 AIM Number: 100243600</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the common area walls in the group home and the front door were free of marks, discoloration, scuffs and nicks and an area rug in the living room was free of discoloration and stains.</p> <p>Findings include:</p>	W 104	To correct the deficient practice, the trim and doors havebeen repainted, and walls in the common areas cleaned. The area rug in theliving room will be replaced. To ensure the deficient practice does notcontinue, and to provide ongoing monitoring, the Team Manager (TM) and NetworkDirector/ QDDP (ND/Q) will be re-trained on their responsibilities related toclosely monitoring the home for cleanliness and maintenance needs, and themaintenance request process. All maintenance needs, and follow up that	06/10/2015

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>Observations were conducted at the group home on 5/6/15 from 5:59 AM to 7:59 AM, 5/7/15 from 1:12 PM to 2:20 PM and 5/7/15 from 3:01 PM to 5:45 PM. During the observations, the common area walls (entry way, hallways, dining room, living room, medication room and kitchen) were marked, discolored, scuffed and nicked. The front door leading to the parking lot was also marked, discolored, scuffed and nicked. The south wall in the dining room had dried food and liquids on the wall. The area rug in the living room was discolored and stained. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 5/8/15 at 12:09 PM, the Medical Coordinator indicated the walls needed to be cleaned.</p> <p>On 5/6/15 at 1:25 PM, the Network Director (ND) indicated the walls at the group home were repainted 6 months ago. On 5/7/15 at 3:43 PM, the ND indicated the area rug needed to be cleaned or replaced due to the discolorations and stains. On 5/8/15 at 12:09 PM, the ND indicated the common area walls needed to be repainted.</p> <p>9-3-1(a)</p>		<p>occurs, will be included on the Residential Services Team Manager Weekly Report. The TMWeekly Report is submitted to the ND/Q, the Director of Residential Services(DORS), the Chief Services Officer (CSO), the Chief Executive Officer (CEO) and the Director of Support Services (DOSS) for review. Additionally, the ND/QDDP is in the home no less than weekly, and the Director of Residential Services at least monthly, and will ensure that the environment is well maintained.</p>	

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W 120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 3 of 3 clients who attended an outside services day program and workshop (#1, #3 and #5), the facility failed to ensure the outside services met the needs of the clients.</p> <p>Findings include:</p> <p>On 5/7/15 at 2:40 PM, a review of the facility's observations conducted at the day program/workshop clients #1, #3 and #5 attended was conducted. From 5/6/14 to 5/7/15, one documented observation was conducted at the day program on 4/23/15. There was no documentation the facility conducted additional observations at the day program/workshop clients #1, #3 and #5 attended during the past 12 months to ensure the outside services met the needs of the clients.</p> <p>On 5/7/15 at 2:40 PM, the Network Director (ND) indicated he did not have documentation of observations being conducted at the outside services that clients #1, #3 and #5 attended except on 4/23/15. The ND indicated the facility should conduct and document at least</p>	W 120	To correct the deficient practice and ensure is does not continue, the ND/QDDP will complete observations at each day program location by 6/10/15, and will do twice-monthly observations for the next 3 months. If the ND/QDDP is confident that services are being provided to individuals consistent with their ISPs, observations will decrease to no less than monthly at each location. Each time an observation is completed, the observer will follow up with the appropriate day program staff with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/QDDPs will be re-trained on the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, as well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/QDDP and TM for each home. Additionally, the date of the last day program observation is documented on the Residential Services Team Manager Weekly Report, which is forwarded to the	06/10/2015	

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W 149 Bldg. 00	<p>monthly observations at the day program.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 9 incident/investigative reports reviewed affecting clients #2, #3 and #4, the facility neglected to implement its policy and procedure to prevent client to client aggression and ensure a physician ordered PRN (as needed) medication was in the home to administer.</p> <p>Findings include:</p> <p>On 5/6/15 at 11:51 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 12/31/14 at 5:30 PM, client #4 threw a cup and hit his arm. Client #4 went to client #3 and pulled on client #3's shirt. Client #4 fell down. Former staff #11 took his arms and led him back to his chair to rock and calm down. Staff #11 administered one Chlorpromazine 50 milligram (mg) tablet. Client #4 was upset he received a PRN medication so</p>			W 149	<p>ND/QDDP, DORS, DOSS, CSO and CEO for review</p> <p>Investigations were completed for each of the above listed incidents, and the Director of Support Services (DOSS) will review each investigation to ensure all recommendations have been completed and documented in the investigation file. To prevent the deficient practice from recurring, all staff will be retrained at the next staff meeting on LifeDesigns policies related to abuse and neglect. Per LifeDesigns' policy 3.1.5.3 Investigations, each investigation will include recommendations that explicitly define who is to complete the recommendation and the time frame for completion, and who is to receive and monitor the completed recommendations (Director of Services and Human Resources, if applicable). The person responsible for monitoring will ensure the actions are completed within the time frame, all concerns/ issues reported ore discovered have been addressed, and documentation is forwarded to the employee personnel file</p>		06/10/2015

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	<p>he slapped himself.</p> <p>The investigation, dated 1/8/15, indicated the description of the alleged event was, "During a behavior incident on 12/31/14, staff needed to administer a PRN of Ativan for negative behaviors. At that time staff were unable to locate the PRN Ativan. They then administered another PRN. On 1/1/15 at 12:00 PM, the Team Manager reviewed all documentation and searched the home for the medication. At that time it was confirmed that the medication (Ativan) was missing." The facility substantiated (findings support the alleged event as described) the allegation.</p> <p>The summary indicated, "Based on all information available, the bubble pack containing 27 tablets of Ativan 1mg is missing, with no documentation of it's destruction, although this writer (Director of Support Services) could not determine who took the missing medications. There were 2 staff assigned to the home, [staff #11 and #12], who refused to cooperate with a requested drug screen, which appears to be suspicious. [Staff #11] subsequently resigned employment with the organization, and [staff #12's] refusal to participate, and subsequently leaving his shift, will also be documented by Human Resources as his voluntary</p>		<p>and investigation file. Ongoing monitoring will be accomplished with the Services Leadership Team, which includes the CEO, Directors of Services, and Quality Assurance Director, who review investigations at least twice monthly to ensure all recommendations are completed. Additionally, the DOSS does a quarterly analysis of all agency investigations and makes recommendations for organizational improvements based on overall trends identified.</p>		

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	<p>resignation. This investigation revealed violations of LifeDesigns' policies, including: [Staff #11] administered a PRN medication that was not included as part of [client #4's] PRN protocol. Additionally, she did so without prior approval from the agency nurse (the nurse was called after the PRN was administered). Even though [client #4] has a PRN protocol in place for Ativan 1mg, he also had a current order for Chlorpormazine (sic) (Thorazine) 50 mg. This was resolved during the course of the investigation, and the Chlorpormazine (sic) has now been discontinued. The 1mg Ativan was not included on the medication inventory sheet because controlled medications have a separate count sheet. All medications should be included on the inventory sheet, and counted on a daily basis. In talking with staff, no one seemed to know where the PRN order for Chlorpromazine came from, or how long it had been there. The physician's orders should be reviewed on a monthly basis to ensure they are accurate, and any inaccuracies addressed immediately with the pharmacy and/or physician...."</p> <p>On 5/8/15 at 12:03 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The</p>			

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	<p>ND indicated the facility had a policy and procedure prohibiting abuse of the clients. The ND indicated at the time of the incident, the facility was not doing a count of the PRN psychotropic medications. The ND indicated this was corrected. The ND indicated 27 Ativan were missing and the facility was not able to determine what happened to the medication. The ND indicated two staff did not cooperate with the investigation and were voluntarily terminated. The ND indicated one staff quit.</p> <p>2) On 8/29/14 at 11:45 AM at the facility-operated day program, client #2 attempted to kick a peer. The kick was blocked by staff. Client #2 hit another peer on the back. The investigation, dated 9/4/14, indicated there was willful intent to cause harm by client #2 toward his peer.</p> <p>On 5/8/15 at 12:03 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 4/13/15 at 4:45 PM, client #2 was making faces at client #4. Client #4 stomped his feet (sign of agitation).</p>			

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	<p>Client #4 lunged at client #3 and grabbed/slapped his left leg. Client #3 was not injured. The investigation indicated, "Staff noted that if [client #2's] behaviors had been addressed quicker than (sic) [client #4] would not have become agitated to the point of aggression."</p> <p>On 5/8/15 at 12:03 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 5/6/15 at 1:28 PM, a review of the facility's policies and procedures was conducted. The policy titled Individual Rights and Protections defined Physical Abuse as, "Knowingly or intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary physical or chemical restraints or isolation, practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities, application of painful or noxious stimuli, the use of electric shock and punishment resulting in physical harm or pain." The</p>			

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W 159 Bldg. 00	<p>policy defined neglect as "Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer, including seclusion alone in an area from which exit is prohibited; depriving a customer of necessary support including food, shelter, medical care, or technology."</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 clients who attended the facility-operated day program (#2, #4, #5 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to conduct observations at the facility-operated day program.</p> <p>Findings include:</p> <p>On 5/7/15 at 2:40 PM, a review of the facility's observations conducted at the facility-operated day programs clients #2, #4, #5 and #6 attended was conducted. From 5/6/14 to 5/7/15, there was no documentation the QIDP (called Network</p>	W 159	To correct the deficient practice and ensure it does not continue, the ND/QDDP will complete observations at each day program location by 6/10/15, and will do twice-monthly observations for the next 3 months. If the ND/QDDP is confident that services are being provided to individuals consistent with their ISPs, observations will decrease to no less than monthly at each location. Each time an observation is completed, the observer will follow up with the appropriate day program staff with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/QDDPs will be re-trained on	06/10/2015

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W 227 Bldg. 00	<p>Director) conducted observations at the facility-operated day program.</p> <p>On 5/7/15 at 2:40 PM, the Network Director (ND) indicated he did not have documentation of observations being conducted at the facility-operated day programs. The ND indicated the facility should conduct and document at least monthly observations at the day programs.</p> <p>9-3-3(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. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 had a plan to address his refusals to participate in emergency drills.</p> <p>Findings include:</p> <p>On 5/6/15 at 1:35 PM, a review of the facility's evacuation drills was conducted. On 1/8/15 at 8:30 AM, client #4 refused to participate in a tornado drill. The Drill Report, dated 1/8/15, indicated, "[Client</p>	W 227	<p>the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, as well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/QDDP and TM for each home. Additionally, the date of the last day program observation is documented on the Residential Services Team Manager Weekly Report, which is forwarded to the ND/QDDP, DORS, DOSS, CSO and CEO for review.</p> <p>To correct the deficient practice, the IDT will meet to develop a plan for client #4's refusal to participate in drills. Once the plan is written, all staff will be trained on it's implementation. To ensure no others are affected by the deficient practice, the ND/QDDP will review with all staff each individual's drill participation, and develop additional plans if others are identified to have difficulty with drills (i.e. slow evacuation times, refusals, etc.). To ensure the deficient practice does not continue, the ND/QDDP will</p>	06/10/2015

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W 249 Bldg. 00	<p>#4] refused to participate. Staff ran through description/explanation of drill with client." On 3/9/15 at 8:00 AM, client #4 took "5+ min (minutes)" to participate in the fire drill. The Drill Report, dated 3/9/15, indicated, "[Client #4] very slow and difficult to convince. Needs continued practice."</p> <p>On 5/8/15 at 11:04 AM, a review of client #4's record was conducted. Client #4's 5/23/14 Individual Support Plan and Behavior Support Plan did not include a training objective to increase his participation in emergency drills. Client #4 did not have a plan in his record addressing his participation in emergency drills.</p> <p>On 5/6/15 at 1:40 PM, the Network Director (ND) indicated client #4 did not have a plan to address emergency drills. The ND indicated client #4 needed a plan to address his refusals to participate in drills.</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</p>		review all drill reports and follow up on notes made by staff related to additional customer support needs. Ongoing monitoring will be accomplished through the TM Weekly Report, which includes a summary of drill activity and a space to identify any issues/ concerns.		

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	<p>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, record review and interview for 2 of 3 non-sampled clients (#1 and #5), the facility failed to implement client #1's Nursing Care Plan (NCP) for notifying the nurse regarding his blood pressure and client #5's plan for meals.</p> <p>Findings include:</p> <p>1) On 5/7/15 at 3:28 PM, a review of client #1's NCP, dated 1/6/15, indicated, in part, "At risk for changes in hemodynamic (the study of blood flow or the circulation) status and cardiac changes due to hypertension." The plan indicated, "Monitor and document blood pressure and pulse daily. Notify nurse via phone if blood pressure is above 160/90 or below 90/60. Notify nurse via phone if pulse is lower than 60 or greater than 90."</p> <p>On 5/7/15 at 3:35 PM, a review of client #1's Medication Administration Records (MAR) was conducted on 5/7/15 at 3:35 PM and indicated the following:</p> <p>Client #1's MAR dated February 2015 indicated his blood pressure was to be taken one time weekly. The MAR did</p>	W 249	To correct the deficient practice, client #1's MAR has been revised to state the parameters for staff to contact the nurse relative to blood pressure above or below specified criteria. To ensure no others were affected by the deficient practice, the nurse will compare the MAR with the Nursing Care Plan for all individuals living in the home to ensure protocols and staff expectations are clearly documented on the MAR. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the nurse will review the MAR monthly with the NCP to ensure all information is carried over consistently from month to month, and if not, will make any corrections as needed. To address the issues related to client #5's risk for aspiration/dysphagia, the IDT will meet to review his plan, and revise as necessary, to ensure it also includes strategies to address excessive talking during meals, which could increase his risk of choking. All staff will be re-trained on the revised plan. Additionally, the ND/QDDP will develop a written prompt sheet for staff to keep in the kitchen/ dining room area that outlines dining support needs for all individuals living in the home. Ongoing monitoring	06/10/2015			

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	<p>not indicate parameters for staff to contact the nurse if his blood pressure was above or below specified criteria. The MAR did not indicate parameters for staff to contact the nurse if his pulse was above or below specified criteria. On 2/16/15 his pulse was 98. On 2/23/15 his pulse was 101. There was no documentation the nurse was notified on 2/16/15 and 2/23/15 of his pulse being elevated.</p> <p>Client #1's MAR dated March 2015 indicated his blood pressure was to be taken one time weekly. The MAR did not indicate parameters for staff to contact the nurse if his blood pressure was above or below specified criteria. The MAR did not indicate parameters for staff to contact the nurse if his pulse was above or below specified criteria. There was no documentation his blood pressure and pulse were taken 3/1/15 to 3/8/15. On 3/9/15, his pulse was 94. There was no documentation the nurse was notified of his pulse being elevated on 3/9/15. There was no documentation his blood pressure and pulse were taken 3/17/15 to 3/29/15.</p> <p>Client #1's MAR dated April 2015 indicated his blood pressure was to be taken one time weekly. The MAR did not indicate parameters for staff to</p>		<p>will be completed by the Team Manager, who works full-time in the home and is present for mealtime several times a week. The TM works alongside direct support staff to provide ongoing modeling and support.</p>		

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	<p>contact the nurse if his blood pressure was above or below specified criteria. The MAR did not indicate parameters for staff to contact the nurse if his pulse was above or below specified criteria. On 4/13/15 his pulse was 94. There was no documentation the nurse was notified of his pulse being elevated on 4/13/15. On 4/27/15 his pulse was 90. There was no documentation the nurse was notified of his pulse being elevated on 4/27/15.</p> <p>Client #1's MAR dated May 2015 indicated his blood pressure was to be taken one time daily. The MAR did not indicate parameters for staff to contact the nurse if his blood pressure was above or below specified criteria. The MAR did not indicate parameters for staff to contact the nurse if his pulse was above or below specified criteria. On 5/4/15 his blood pressure was 162/92. There was no documentation the nurse was notified of his blood pressure being elevated.</p> <p>On 5/7/15 at 2:54 PM the Network Director (ND) indicated client #1's blood pressure and pulse were being taken weekly. The ND indicated his blood pressure and pulse were supposed to be taken daily. The ND indicated the facility started taking client #1's blood pressure and pulse daily on 5/1/15 after the recently hired Quality Assurance</p>			

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	<p>Director conducted a review of the client's record. The ND indicated the facility did not have documentation the nurse was notified as indicated in the NCP. The ND indicated client #1's plans should be implemented as written.</p> <p>2) An observation was conducted at the group home on 5/6/15 from 5:59 AM to 7:59 AM. At 6:06 AM, client #5 was at the dining room table eating breakfast. Client #5 was talking non-stop while at the table and eating. At 6:11 AM, staff #7 was the only staff working at the group home. Staff #7 went into the basement to check to see if there was more creamer. Staff #7 returned two minutes later. While staff #7 was in the basement, client #5 continued to eat his cereal and talked non-stop. At 6:26 AM, staff #7 prompted client #5 not to talk with his mouth full of food. At 6:37 AM, staff #7 went into the basement to get more cereal. At 6:39 AM, staff #7 returned to the dining room with a box of cereal and a container of orange juice. At 6:48 AM, client #5 finished breakfast. Client #5 talked non-stop throughout his meal with one prompt from staff #7 to not talk with his mouth full.</p> <p>On 5/6/15 at 2:24 PM, a review of client #5's NCP, dated 1/6/15, indicated, in part, "At risk for aspiration/dysphagia due to</p>			

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	<p>missing teeth." The plan indicated, "Ensure proper positioning and speed of eating. [Client #5] should sit upright with both feet on the floor. Encourage [client #5] to avoid talking while eating. Encourage small bites ½-1 tsp (teaspoon). Encourage [client #5] to put his utensil down between bites per ISP (Individual Support Plan)." On 5/6/15 at 2:26 PM, a review of client #5's ISP indicated, in part, "Chew appropriately between bites and refrain from 'shoveling' food while eating. [Client #5] has a history of shoveling food too quickly into his mouth. This behavior is often seen when his mood is not at a normal level. Due to the shoveling behavior and having few teeth, this is a choking concern for [client #5]. For this reason he should always be encouraged to take his time while eating. During mealtime, staff will monitor [client #5's] speed while he is eating. If they see that [client #5] is hurrying and not taking enough time to chew his food completely, they will verbally encourage him that he should slow down. If staff see that [client #5] is continuing to shovel the food in after the reminder, they will encourage [client #5] to set his utensil down between bites... Staff should always remind [client #5] to chew slowly and completely at every meal."</p>			

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W 382 Bldg. 00	<p>On 5/6/15 at 12:59 PM, the Network Director (ND) indicated to implement client #5's plan, the staff would need to supervise client #5 during breakfast. The ND indicated client #5's plans should be implemented as written.</p> <p>On 5/8/15 at 11:51 AM, the Team Manager indicated client #5 was prone to shovel food when his mood was low. The TM stated client #5's mood was "high" during the observation. The TM indicated client #5 had a choking risk due to shoveling food.</p> <p>9-3-4(a)</p> <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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff locked client #2's medication cabinet when the staff left the medication room.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 5/6/15 from 5:59 AM to</p>	W 382	To correct the deficient practice and prevent it from recurring, staff #7 will be re-trained on medication administration procedures. Additionally, all staff in the setting will be reminded of the requirement to lock medications at all times except when being prepared for administration. To ensure no others were affected by the deficient practice, and to provide ongoing monitoring, the ND/QDDP and TM will conduct a	06/10/2015

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	<p>7:59 AM. On 5/6/15 at 7:18 AM, staff #7 prepared client #2's medication for a breathing treatment. When staff #7 left the medication area to start client #2's breathing treatment in the living room, staff #7 did not close and lock client #2's medications. There was no door to the room to close. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 5/8/15 at 11:56 AM, the Network Director indicated the client's medication should be locked at all times except when being prepared for administration.</p> <p>On 5/8/15 at 11:56 AM, the Team Manager indicated the client's medication should be locked at all times except when being prepared for administration.</p> <p>9-3-6(a)</p>				<p>supervised medication pass with all staff by 6/10/15. Additionally, the Quality Assurance Director(QAD) will audit medication passes at least weekly for the next 4 weeks. The TM works full time in the home and is often present for medication passes. The TM works alongside direct support staff to provide ongoing modeling and support.</p>		
W 440 Bldg. 00	<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 the night shift.</p>			W 440	<p>To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the time frames in which drills must be completed, including a clarification that the requirement of "quarterly" means every 90 days (as opposed to</p>		06/10/2015

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W 488 Bldg. 00	<p>Findings include:</p> <p>On 5/6/15 at 1:35 PM, a review of the facility's evacuation drills was conducted. During the night shift (10:00 PM to 6:00 AM), there was no drill conducted from 9/6/14 to 2/19/15. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 5/6/15 at 1:40 PM, the Network Director indicated the facility should conduct one drill per shift per quarter.</p> <p>On 5/8/15 at 12:04 PM, the Team Manager indicated the facility should conducted one drill per shift per quarter.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 3 of 3 clients observed to eat breakfast (#2, #3 and #5), the facility failed to ensure the clients were involved in making their breakfast.</p> <p>Findings include:</p>	W 488	<p>once per calendar quarter). To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager, ND/QDDP will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. The ND/QDDP will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.</p> <p>The correct the deficient practice and ensure it does not continue, the ND/QDDP and QAD will work together to re-train all staff on the expectation and requirement that individuals are support to be as independent possible in all areas of life, including meal preparation, family style dining, and serving themselves. Given that mornings</p>	06/10/2015			

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	An observation was conducted at the group home on 5/6/15 from 5:59 AM to 7:59 AM. At 6:02 AM, staff #7 placed three bowls and boxes of cereal on the dining room table. At 6:06 AM, staff #7 asked client #5 if he wanted toast. At 6:09 AM, staff #7 asked client #5 if he wanted one or two pieces of toast. Client #5 stated, "I'll take two." Client #5 sat at the table while staff #7 prepared his toast. Staff #7 put two pitchers of juice on the table. At 6:13 AM when staff #7 came to the dining room from the basement, he asked client #5, "Is milk okay instead of creamer?" Staff #7 poured client #5's coffee, added milk and gave the cup to client #5. At 6:14 AM, staff #7 stated to client #5, "I've got tea or juice there for you." At 6:17 AM, staff #7 gave client #5 a plate with two pieces of buttered toast. At 6:19 AM, staff #7 poured a cup of coffee for client #3. At 6:20 AM, staff #7 asked client #2 if he wanted one or two pieces of toast. Client #2 indicated he wanted one piece of toast. Staff #7 asked client #3 if he wanted one or two pieces of toast. Client #3 indicated he wanted two pieces of toast. At 6:22 AM, staff #7 made another pot of coffee. Staff #7 put a container of orange juice on the table. Staff #7 got client #3 a cup and put it on the table. Staff #7 took client #3's toast out of the toaster and buttered the toast. Staff #7 gave the toast to client #3.		are often busy in the home, the QAD will also work with the IDT to identify ways to streamline the morning routine to promote more independence. Ongoing monitoring will be accomplished through regular and frequent mealtime observations. The ND/QDDP, Director of Residential Services, Quality Assurance Director and Director of Support Services will conduct mealtime observations at least 4 times per week for a period of at least 4 weeks. The TM works full time in the home alongside direct support staff and is there during mealtime several times per week to provide modeling and training on an ongoing basis	

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	<p>At 6:25 AM, staff #7 told client #2 his toast was ready. Staff #7 handed client #2 a plate with his buttered toast. At 6:26 AM, staff #7 buttered client #3's toast. At 6:39 AM, staff #7 asked client #5 if he wanted more coffee. Client #5 indicated he did. Staff #7 took client #5's cup, poured more coffee, added milk and gave the cup to client #5. At 6:43 AM after client #3 took his dishes to the table, staff #7 rinsed the dishes and put the dishes into the dishwasher. At 6:48 AM, staff #7 poured client #3 a second cup of coffee and placed the cup on the table.</p> <p>On 5/6/15 at 2:07 PM, the Network Director (ND) indicated the clients should be involved with preparing their meals. The ND indicated the facility staff should promote family style dining. The ND indicated the clients should serve themselves.</p> <p>9-3-8(a)</p>			