

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W000000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00142656 completed on 1/17/14.</p> <p>This visit was in conjunction with the investigation of complaint #IN00144572.</p> <p>Complaint #IN00142656: Not corrected.</p> <p>Survey Dates: February 27, 28, March 4, 6, 7, 10, 11, 12 and 13, 2014</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/26/14 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the governing body failed to exercise operating direction over the facility by failing to ensure: A) there was a system in place to prevent client to client abuse, client neglect, and to conduct thorough investigations and B) the staff received retraining.</p> <p>Findings include:</p> <p>A) A review of the facility's incident/investigative reports was conducted on 2/27/14 at 12:03 PM and indicated the following:</p> <p>1. On 2/14/14, the BDDS report, dated 2/15/14, indicated the facility received a call from an employee from another organization providing services to individuals with intellectual disabilities in the same city. The caller reported that on either 1/25/14 or 2/1/14, a Saturday during the last snow received, she was driving down the road and saw a young man walking naked on the road. The caller indicated it was approximately 6:30 PM and semi-dark. The caller described the man as a little thicker and wearing a</p>	W000104	<p>To correct the deficient practice, all outstanding investigations will be completed in a thorough and comprehensive fashion, following agency policies and procedures.</p> <p>Staff training recommended in the POC was not done as planned. This failure is due in large part to staff turnover. To correct the deficient practice, there will be additional Direct Support Staff and Managers hired. A new Network Director and two DSPs have begun training as of 3-31-14. Two other DSPs and a Team Lead finished training during the previous New Employee Orientation that began on 3-17-14. A new Medical Coordinator has also been identified. We anticipate that with new staff, consistent active treatment will be re-established. All training outlined in the POC will be done.</p> <p>To prevent the deficient practices from recurring, all house staff will be retrained in abuse reporting policies and procedures and on each Individual Support Plan. A formal discussion will be held about professional expectations of all employees, and each staff member will be required to sign a document declaring their understanding of these expectations. The agency will also contract with a consultant to</p>	04/12/2014	

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	fisherman-type hat. The caller indicated she stopped, got a towel around the client, looked in the direction of the foot prints (due to the fresh snow) and took the person in her vehicle to the group home. The report indicated the caller was a previous employee of this group home so she was familiar with the location. The caller reported she spoke to the young man on the way back to the group home to avoid any behavior. They talked about his hat. The client was described as having dark hair, a little long like a bowl cut, and no facial hair or acne. The caller reported there were two staff when she arrived at the group home. A blonde (female) was sitting at the table and there was food cooking. The caller indicated she spoke to a man, who was tall and thin. The young man walked into the house and thanked the caller. The caller reported she told the staff to report the incident and staff was getting on the phone when she left. The BDDS report indicated the Quality Assurance Director (QAD) received the call while at the group home. The QAD interviewed the two clients who were able to communicate verbally. Each client denied walking down the road naked. The QAD spoke with the staff who had worked on 1/25/14 and 2/1/14. The staff denied any of the clients being brought back to the home after having eloped.		review the investigation process and make recommendations for improvement. Ongoing monitoring will be accomplished through routine oversight by Network Director/QDDP and House Manager, regular documented discussion and reminders at bi-weekly house staff meetings, the weekly Network Director/QDDP meeting and during individual supervision sessions. The House Manager and Network Director/QDDP and the Director of Residential Services will complete no less than five observations per week for a period of 2 months, providing ongoing training and support to staff when issues are identified. After two months, if identified issues have been resolved, observations will be reduced to twice a week on an ongoing basis. All investigations and recommendations will be reviewed weekly in the Service Leadership Meeting, attended by the CEO and Directors of Services.		

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	<p>The QAD spoke to the Team Manager as well as the Network Directors who would have been on call those weekends, and all denied receiving a call regarding a client being brought back to the group home after having eloped. The BDDS report indicated, "This alleged incident will continue to be investigated fully. No staff have been suspended at this point, since the description of staff given does not fit the description of staff who work in the home. Immediate safety measures include daily drop-in supervisory visits by the Director of Residential Services, Director of Support Services, and CEO (Chief Executive Officer) during the course of the investigation until a determination can be made for further measures needed as a result of the outcome of the investigation."</p> <p>The follow-up BDDS report, dated 2/25/14, indicated, "An investigation was conducted which included interviewing the customers, the staff on shift at the time of the alleged incident, other group home staff, the group home manager, the group home Network Director/QDDP (Qualified Developmental Disabilities Professional) and neighbors to the group home. The individual who made the initial allegation did not respond to multiple phone calls or emails requesting additional information. Records review</p>				

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	<p>occurred, including review of staff schedules, the progress notes for the time period during which the incident was alleged to have occurred and behavior support plans. Additionally, daily observation of service provision occurred by Services Management staff during the investigation. The person making the initial allegation said that the customer she purportedly picked up and returned to the [name] group home did state what customers lived at the group home when she worked there and that it wasn't any of those individuals that she picked up. Based on the individual's allegation that she returned the individual to the home located on [name of street], it isn't possible that this incident involved other individuals living at a nearby home. No one in the [name of group home] has a fisherman's style hat. No one at the [name of group home] or any nearby home matches the description given of the individual found walking naked, nor does the description of staff present at the time the individual was returned to the group home match descriptions of the staff at the home. Based on lack of additional information from the individual making the allegation, the fact that the description of the customer who allegedly was found naked walking at the end of [name of road] doesn't match any of the customers at [name of group home]</p>			
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	<p>and the fact the description of the staff working at the time of the alleged incident doesn't match the description of either of the staff working on those days/times, neglect is not substantiated."</p> <p>The investigation, dated 2/20/14, indicated, in part, "[QAD] spoke with her (caller) on 2/14/14 via phone; [CEO] attempted to reach on 2/16/14 via phone. [Director of Community Services] attempted to reach 2/18/14 via phone, 2/19/14 via phone and 2/20/14 via phone. No response. [CEO] attempted to reach via email 2/17/14 with no response... Based on lack of additional information from the individual making the allegation, the fact that the description of the customer who allegedly was found naked walking at the end of [name of road the group home was located] doesn't match any of the customers at [name of group home] and the fact that the description of the staff working at the time of the alleged incident doesn't match the description of either of the staff working on those days/times, neglect is not substantiated."</p> <p>On 2/28/14 at 10:58 AM, Confidential Interview (CI) #2 indicated he received an email on 2/25/14 asking him to assist LifeDesigns with getting the caller to respond to LifeDesigns' emails to the</p>				

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	<p>caller. CI #2 indicated he responded on 2/25/14. CI #2 sent an email to the caller. On 2/27/14, CI #2 received another email from LifeDesigns asking for assistance. CI #2 indicated the caller told him she responded to the facility's request for additional information.</p> <p>On 2/28/14 at 11:15 AM, Confidential Interview (CI) #1 was conducted. CI #1 indicated the incident actually occurred on 1/18/14 between 7:00 and 7:30 PM. CI #1 indicated the original report of the incident occurring on 1/25/14 or 2/1/14 was incorrect. CI #1 indicated she was driving down the road leading to the road where the group home was located. CI #1 indicated a young male client was standing at the corner of the main road and the road the group home was located (0.3 miles from the group home). CI #1 indicated a child in the car stated, "I saw a naked butt." CI #1 drove her children to her house, dropped them off, grabbed some towels, and went back to check on the client. The client was still in the same spot. CI #1 indicated she saw tracks in the fresh snow indicating the client had walked from the direction of the group home. CI #1 put the towels around the client and got him into her vehicle. CI #1 indicated the client was wearing a green hat, like a fisherman would wear, and nothing else. CI #1</p>						

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	<p>indicated the client was able to respond "yes" to questions and he said "cool hat." CI #1 indicated the client had dark hair but it was hard to see due to him wearing a hat which was pulled down pretty far. CI #1 indicated the client was approximately 5 feet 9 inches tall with no facial hair or acne she could she. CI #1 indicated the client rubbed his hands together a lot and rocked in the seat on the way to his group home. CI #1 indicated she drove the client back to the group home (she knew where the group home was located due to previously working at the home approximately 10 years ago). CI #1 indicated when she and the client arrived to the home, the client walked in and she followed him. CI #1 observed a blonde female sitting at the dining room table. CI #1 indicated the female's hair went to the middle of her back and the female did not acknowledge her or say anything. CI #1 indicated she spoke to a tall (approximately 6 feet tall), skinny, short haired male staff who was unshaven. CI #1 indicated the male staff confirmed the client lived at the home. CI #1 indicated the male staff did not seem to care as evidenced by not asking any questions or showing any concern for the well being of the client. CI #1 indicated one of the towels (white) she gave the client was left at the home since he had it around him. CI #1 indicated she</p>						

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	<p>told the staff they needed to report the incident. CI #1 indicated she observed one client run from one room to another but did not recall what he looked like. CI #1 indicated she received calls and emails from the facility requesting additional information. CI #1 indicated she emailed the facility three times but the facility did not receive her emails. She indicated she attempted to return the CEO's calls but they were playing "phone tag." CI #1 indicated when she returned home after dropping the client off, a neighbor, who was walking a yellow dog, asked her if she picked up the naked kid. CI #1 indicated she responded "yes." CI #1 did not know where the neighbor lived however she saw him from time to time walking the dog.</p> <p>On 2/28/14 at 1:58 PM, the CEO was informed by the surveyor the original report received from the caller regarding the incident date was incorrect. The CEO was informed of the correct incident date of 1/18/14.</p> <p>On 2/28/14 at 1:37 PM, a review of the facility's report for hours worked at the group home indicated on 1/18/14, 1/25/14 and 2/1/14, staff #4 and #9 worked at the group home. On 1/18/14, staff #4 worked from 7:00 AM to 9:00 PM and staff #9 worked from 8:00 AM to</p>			
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	<p>10:00 PM.</p> <p>On 2/27/14 at 2:36 PM, staff #4 stated the allegation was a "bunch of smoke." Staff #4 stated she worked every weekend at the group home recently and "nothing like that has ever happened." Staff #4 indicated there were no clients living at the group home with elopement issues. Staff #4 stated it was a "bunch of nonsense."</p> <p>On 3/7/14 at 6:01 PM, former staff #9 stated, "that never happened" and "know for a fact it didn't happen." Staff #9 indicated none of the clients were ever returned to the group home naked and none of the clients ever eloped. Staff #9 indicated while employed at the group home, he worked 59 out of 60 days and an incident of someone returning a naked client to the group home did not happen.</p> <p>On 3/4/14 at 2:57 PM, client B was interviewed. Client B indicated he did not take a walk, naked, from the group home in the snow. Client B indicated he was not returned to the group home after taking a walk in the snow naked. Client B indicated he did not have a green hat.</p> <p>On 3/6/14 at 1:39 PM, the surveyor met the Network Director at the group home in order to take two pictures of pictures</p>				

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	<p>located in the home of clients A, B, C, D and E in order to get an identification from the confidential interview #1 of who she picked up on 1/18/14.</p> <p>On 3/6/14 at 2:01 PM, the surveyor received a phone call from the CEO indicating the facility had re-opened the investigation. The CEO indicated the Director of Community Services (DCS) contacted CI #2 in order to get him to facilitate obtaining information from the caller.</p> <p>On 3/6/14 at 2:21 PM, CI #2 indicated he received a call from the DCS asking for his assistance with obtaining additional information from the caller on this date right before the surveyor arrived to the office. CI #2 indicated he would assist LifeDesigns with obtaining additional information from the caller.</p> <p>An interview with CI #1 was conducted on 3/6/14 at 3:02 PM. CI #1 was shown pictures of clients A, B, C, D and E. CI #1 identified the client she picked up on 1/18/14 as client B.</p> <p>On 3/6/14 at 3:31 PM, CI #2 indicated the last contact he had with LifeDesigns was on 2/27/14. CI #2 indicated LifeDesigns knew how to reach him. CI #2 indicated he had not received a phone</p>				

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	<p>call until 3/6/14 to ask for his assistance. CI #2 indicated he was not asked to set up a meeting, which he would have facilitated, if he was asked to do so.</p> <p>On 3/6/14 at 7:02 PM, the CEO indicated in an email, "Wanted to be sure you knew we just got this today (written statement from the caller). We will review with first statement that [QAD] took and note any discrepancies and complete an investigation addendum. As was noted in our file, we last asked for this on the 24th, that time requesting help from [CI #2] to connect with [the caller]. He forwarded a message he received from [caller] stating she would send the statement she had already sent to [Director of Community Services]. [Director of Community Services] and I have both checked our email trash and spam folders for it to be sure it did not go there inadvertently. The questions we asked her to respond to originally emailed to her on the 17th are attached."</p> <p>On 3/7/14 at 6:37 AM, the CEO indicated in an email, "I am reviewing the [caller's] allegation and investigation this morning in light of the new information from [caller] and considering the events of 2/3."</p> <p>On 3/7/14 at 4:59 PM, the CEO indicated</p>				

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	<p>in an email, "Attached is the addendum I told you I would forward to update the investigation per my email yesterday." The Addendum to Investigation of Neglect, dated 3/7/14, indicated, in part, "Given the variance in the date of the incident between the verbal and email account, Accel time reporting was reviewed and the same two staff (#4 and #9) who worked on the evening of 1/25/14 and 2/1/14 worked on the evening of 1/18/14. While one of the two staff description potentially matches one of the descriptions given in both the verbal report and email report, the description of the second staff is in stark opposition to the description given in both reports from [caller]. The Additional Recommendations section indicated, "Confer with LifeDesigns' attorney regarding having their assistance in reviewing the investigation, attempting to interview with informant and making a conclusion based on that information, along with any additional recommendations they may have as a result of any additional information they may obtain."</p> <p>The facility failed to reopen the investigation when the CEO was given additional information obtained from the caller regarding originally reporting the incorrect incident date.</p>				

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	<p>2. On 3/5/14 at 7:00 AM, client C went into the kitchen and poured a bowl of cereal. Client C threw books off the table and yelled. Client C went over and shoved client E before staff could get between them. Client E hit the wall and staff immediately removed him from the room and called the Network Director. The two staff removed all the clients away from client C however client D refused to leave the area. Client C smacked client D several times and spit at him. Client D went to his room. Client E went to the walk in clinic due to an abrasion on his head from hitting the wall. The facility reported there were no signs of a concussion. Client E had an abrasion on his head and a red mark on his back from client C shoving him. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the</p>						

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	<p>cracks." The DRS indicated client to client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>3. On 2/26/14 at 4:00 PM, client E was circling the dining room table when client A got off the couch. Client A put client E's hand in client A's mouth and bit down. Staff removed client E's hand from client A's mouth. The bite did not break the skin or leave a mark. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures.</p>				

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	<p>The DRS indicated abuse should be prevented by the facility.</p> <p>4. On 2/23/14 at 9:30 AM, client A was standing in the kitchen and became upset. He began to scream and engage in self injurious behavior. Client A grabbed client E's arm and bit him on the right forearm breaking the skin. The bite broke the skin so client E was taken to the doctor where an antibiotic was prescribed. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>5. On 2/18/14 at 1:45 PM, client A was aggressive toward staff. Client A lunged</p>				

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	<p>toward client E and hit him on the head. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>6. On 2/17/14 at 1:45 PM, client D became agitated and scratched the staff. Client D sat down next to client C and scratched his neck. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated</p>						

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	<p>client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>7. On 2/16/14 at 3:30 PM, client C was agitated and became aggressive toward staff and peers. Client C threw a cup and hit clients D and E. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to</p>				

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	<p>client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>8. On 2/3/14 at 10:00 AM (reported to BDDS on 3/6/14), client A was allowed to go to school wearing long-underwear on 2/3/14. The BDDS report, dated 3/6/14, indicated, "This incident is being submitted late, as writer failed to report incident at time information was obtained, even though action was immediately taken. This writer received a report from another employee on 2/9/14 that [client A] was allowed to go to school wearing long-underwear type pants on 2/3/14. The incident was originally reported to QDDP [name] by [client A's] teacher, and [QDDP] followed up with staff on shift at the time, [name of house manager (HM)]. According to [HM], [client A] refused to change into different pants, and they had a particularly hectic morning ([client A] lives in a group home with 4 other individuals). Investigation into the incident concluded that [client A's] rights were violated by (sic) because he wasn't supported adequately to choose more socially appropriate pants, a clear lack of judgement on the part of the staff that</p>						

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	<p>morning. Based on information provided by his teacher, he appeared to be appropriately clothed otherwise, and the pants he wore provided similar warmth as other more appropriate workout pants might. Staff on shift that morning, [name], had only been employed for 1 month at the time of the incident, and had worked overtime each week since the completion of her initial training. When she arrived to her shift the morning of 2/3/14, the overnight staff was found sleeping on the couch, leaving [name] to do a great deal of the morning routine on her own with all 5 individuals in the home... [Name of former QDDP] is no longer with the organization, but this is the second instance in the last 3 months in which she failed to report an allegation. Her status will be changed to not eligible for rehire." The investigation, dated 3/6/14, indicated, "It is confirmed that [client A] did go to school wearing long underwear on 2/3/14. This is a violation of [client A's] rights, as he was not supported adequately to choose more socially appropriate pants, a clear lack of judgement on the part of staff that morning... The alleged incident was reported by [client A's] teacher to [name of former QDDP], at the time it occurred; however, [QDDP] did not report the incident to her supervisor or the agency</p>			
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	<p>administrator. [Name of former staff] reported the allegation to [name of Director of Services] who followed up with [name of Quality Assurance Director] to ensure the incident was investigated and action taken. While this was done immediately after receiving the report, no BDDS report was filed, nor formal investigation summary completed."</p> <p>9. On 2/5/14 at 10:45 PM, the Director of Support Services (DSS) received a call from the overnight shift staff (#8) who returned from a two week vacation. The BDDS report, dated 2/6/14, indicated staff #8 reported client A broke his helmet (which he wears to protect his head during episodes of self injurious behavior) in late December but the QDDP said the helmet would not be replaced right away because client A needed to learn that things cost money and he could not have things replaced immediately when they were broken. The helmet had not been replaced and client A had recent episodes of self injurious behavior. Staff #8 reported all of the clients in the house sometimes seek food, so staff are placing food on the locked porch so the clients can not access it. Staff #8 reported most staff were new and there was a general lack of training and knowledge of support plans. The</p>						

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	BDDS follow-up report, dated 2/14/14, indicated, "The allegation of neglect was substantiated, because the face mask of [client A's] helmet was broken off and has not been replaced. Staff did attempt to replace it, but could not find one that was the right size. Staff have been offering [client A] toboggans, which he seems to enjoy. [Client A's] helmet will be replaced, and the nurse will review previous OT (Occupational Therapy) recommendations to determine the source of the original recommendation for the helmet. The support team will discuss the effectiveness of toboggans versus the helmet and update his behavior support team as necessary. Staff are storing extra food on the screened in porch, but the same items are available to the boys in the kitchen. Generally, the Team Manager and QDDP are responsible for training staff; however, the Team Manager of his home has only been working there since mid-January, and the former QDDP recently resigned after having only been there for a short time herself. The Director of Residential Services is working to recruit other staff within the organization who have worked at the home to provide additional training to new staff." The investigation, dated 2/12/14, indicated, in part, "1. Allegedly [client C] had a behavior that involved breaking a window and picking up the				

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	<p>living room TV. Reportedly, [name of former QDDP] authorized and directed staff to remove the TV from the living room for 3 days and told [client C] he had to earn the TV back. 2. [Client A] wears a helmet to protect his head from SIB, and his helmet has been broken since late December. Allegedly [QDDP] told staff the helmet would not be replaced because [client A] needed to learn that things cost money. The helmet still has not been replaced. 3. [Client B] has been tearing his clothes, diminishing his wardrobe. He allegedly wore the same pair of pants to school every day for a period of 3 weeks. [QDDP] allegedly said he would have to wait for new clothes because it would teach him a lesson not to tear his clothes up. 4. In response to food seeking in the house, food has been placed on the porch behind a locked door, that customers are unable to open. 5. Allegedly some staff are implementing a discipline system that is not part of [client B's] RSP (Replacement Skills Plan) that involves giving him 3 'options.' Each time he misbehaves, he loses an option and upon losing all 'options' has to go to his room for the night. 6. There is a general lack of training of staff in the home. 7. Allegedly someone threatened one of the customers with a CPI (Crisis Prevention Institute) hold or restraint if he did not comply. It is not clear which</p>			
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	<p>staff may have made this threat, or which customer was threatened." The investigation indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The Findings section indicated, "1. This writer did confirm that the TV was moved to the office during a recent behavioral episode involving [client C]; however, it was done so to ensure the safety of the other individuals in the home. It was likely only removed for a day. 2. [Client A's] helmet is currently broken and has not yet been replaced. Staff did attempt to replace it, but could not find the right size. Staff have been improvising by offering [client A] toboggans to wear instead. Both his RSP and NCP indicate the use of the helmet. 3. This writer could not substantiate the allegation that [client B] only had one pair of pants to wear to school for 3 weeks, and that they would not be replaced right away because [client B] had to learn the value of money. [Client B] did wear the same pair of pants to school a few days in a row, and they were washed each evening, as a result of ripping up his other pants. Staff have since found additional pants for him to wear. His current RSP does not address ripping his clothing. 4. Extra food is being stored in a cabinet on the screened porch, but the same food is</p>			
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	<p>available to the boys in the house. They have access to all food in the house. Several of the boys do have issues related to food seeking, or sneaking food into their rooms. 5. This writer could not find any evidence to suggest the implementation of a behavior strategy with [client B] that involves giving him 3 options, and sending him to his room when all options are lost. 6. There does appear to be a general need for additional staff training. All staff in the house are relatively new. There is not currently an ND/Q (Network Director/QDDP) and the Team Manager has only been there a short time. 7. This writer could not substantiate the allegation that a staff threatened with the use of a CPI hold for noncompliance."</p> <p>10. On 2/3/14 at 6:00 AM, when the morning staff arrived at the group home the overnight staff was found asleep on the couch. The BDDS report, dated 2/4/14, indicated, "The group home is a 24 hr (hour) facility staffed with an awake overnight." The investigation, dated 2/3/14, indicated, "Based on witness statement by supervisor [name], as well as photo of [staff #7] sleeping, the allegation is substantiated (the findings support the alleged event as described)."</p> <p>11. On 1/18/14 at 7:00 PM, client A was</p>				

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	<p>having an aggressive behavior while in the group home. He aggressed on staff and the staff were attempting to direct him to his room. Client A ran down the hallway toward client E and pushed him backwards 10-15 steps. Client E did not fall down and was not injured. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client abuse should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents were considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>B) On 2/27/14 at 11:07 AM, a review of the facility's Plan of Correction, dated 2/16/14, for the survey completed on 1/17/14, indicated, in part, "To ensure the deficient practice does not continue, a</p>			
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	<p>cleaning checklist will be developed to ensure regular cleaning of all the areas of the home. Staff will be retrained on how to identify household needs, and whom to report those needs." The facility did not provide documentation the staff were trained.</p> <p>On 2/27/14 at 2:14 PM, the Network Director/Qualified Intellectual Disabilities Professional (ND/Q) indicated none of the staff training recommended in the POC was completed and no staff meetings had been convened since the survey on 1/17/14.</p> <p>This deficiency was cited on 1/17/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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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 record review and interview for 11 of 34 incident/investigative reports reviewed affecting 5 of 5 clients living in the group home (A, B, C, D and E), the facility neglected to implement its policies and procedures to prevent neglect and client to client abuse, conduct thorough investigations, and report an incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A) A review of the facility's incident/investigative reports was conducted on 2/27/14 at 12:03 PM and indicated the following:</p> <p>1. On 2/14/14, the BDDS report, dated 2/15/14, indicated the facility received a call from an employee from another organization providing services to individuals with intellectual disabilities in the same city. The caller reported that on either 1/25/14 or 2/1/14, a Saturday during the last snow received, she was driving down the road and saw a young man walking naked on the road. The caller indicated it was approximately 6:30</p>	W000149	To correct the deficient practice, all outstanding investigations will be completed in a thorough and comprehensive fashion, following agency policies and procedures. 1. The 2/14/14 incident was fully investigated at the time it was reported. The recommendations were as follows: 1.The IDTs for each Rhinestone customer should be consulted about using door alarms as a precautionary measure for a 90 day period of time, at which point, the teams can re-evaluate the need for this restriction. 2.Ensure that three staff are scheduled and on shift during all programming hours. 3.Continue consultation with the agency Behavior Specialist, regarding food seeking behaviors and increase in aggression and self-injurious behaviors noted over the last six weeks. The behavior specialists' recommendations: - Training on household routines and proactive measures to reduce behavioral incidents. This training should be taught by a staff that has at least one to two years of experience in the home and knows the customers well. - Use of the schedule boards hanging on the wall facing the living room. Staff should go over these schedule	04/12/2014			

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	<p>PM and semi-dark. The caller described the man as a little thicker and wearing a fisherman-type hat. The caller indicated she stopped, got a towel around the client, looked in the direction of the foot prints (due to the fresh snow) and took the person in her vehicle to the group home. The report indicated the caller was a previous employee of this group home so she was familiar with the location. The caller reported she spoke to the young man on the way back to the group home to avoid any behavior. They talked about his hat. The client was described as having dark hair, a little long like a bowl cut, and no facial hair or acne. The caller reported there were two staff when she arrived at the group home. A blonde (female) was sitting at the table and there was food cooking. The caller indicated she spoke to a man, who was tall and thin. The young man walked into the house and thanked the caller. The caller reported she told the staff to report the incident and staff was getting on the phone when she left. The BDDS report indicated the Quality Assurance Director (QAD) received the call while at the group home. The QAD interviewed the two clients who were able to communicate verbally. Each client denied walking down the road naked. The QAD spoke with the staff who had worked on 1/25/14 and 2/1/14. The staff</p>		<p>boards with each customer every morning when they first get up to have them plan their day. - To address the food seeking behaviors, there should be specific times during the day that is designated as the "snack time". This "snack time" should be at a consistent time each day for each customer and clearly posted in the kitchen. This will aid in decreasing the consistent food seeking behavior because the customers will know when the next snack is scheduled. - More sensory items or a sensory room in the home to address sensory deprivation issues which could be driving the self-harming behaviors. - Activity ideas and items for the staff to use with the customers to decrease the amount of free time. This will also give the customers things to look forward to and reduce the frequency of food seeking behaviors. - Regularly scheduled team meetings with the staff to discuss updates with the customers and house routines.</p> <p>1. Consider additional training for Rhinestone staff regarding behavior as a form of communication.</p> <p>2. The 3/5/14 incident investigation will be completed in a thorough and comprehensive fashion, following agency policies and procedures by 4-11-14. 3. The 2/26/14 incident investigation will be completed in a thorough and comprehensive fashion,</p>		

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	<p>denied any of the clients being brought back to the home after having eloped. The QAD spoke to the Team Manager as well as the Network Directors who would have been on call those weekends, and all denied receiving a call regarding a client being brought back to the group home after having eloped. The BDDS report indicated, "This alleged incident will continue to be investigated fully. No staff have been suspended at this point, since the description of staff given does not fit the description of staff who work in the home. Immediate safety measures include daily drop-in supervisory visits by the Director of Residential Services, Director of Support Services, and CEO (Chief Executive Officer) during the course of the investigation until a determination can be made for further measures needed as a result of the outcome of the investigation."</p> <p>The follow-up BDDS report, dated 2/25/14, indicated, "An investigation was conducted which included interviewing the customers, the staff on shift at the time of the alleged incident, other group home staff, the group home manager, the group home Network Director/QDDP (Qualified Developmental Disabilities Professional) and neighbors to the group home. The individual who made the initial allegation did not respond to</p>		<p>following agency policies and procedures by 4-11-14. 4. The 2/23/14 incident investigation will be completed in a thorough and comprehensive fashion, following agency policies and procedures by 4-11-14. 5. The 2/18/14 incident investigation will be completed in a thorough and comprehensive fashion, following agency policies and procedures by 4-11-14. 6. The 2/17/14 incident investigation will be completed in a thorough and comprehensive fashion, following agency policies and procedures by 4-11-14. 7. The 2/16/14 incident investigation will be completed in a thorough and comprehensive fashion, following agency policies and procedures by 4-11-14. 8. The 2/3/14 incident has been investigated and recommendations are as follows: a. The Network Director/QDDP is no longer with the organization, but this is the second instance in the last three months in which she failed to report an allegation. Her status should be changed to not eligible for rehire. b. The Quality Assurance Director did counseling and retraining with the House Manager after learning of the event. The House Manager, as well as all other staff working in the home, should receive additional training on customer rights. c. The Executive Director will determine appropriate corrective action for the Director</p>		

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	multiple phone calls or emails requesting additional information. Records review occurred, including review of staff schedules, the progress notes for the time period during which the incident was alleged to have occurred and behavior support plans. Additionally, daily observation of service provision occurred by Services Management staff during the investigation. The person making the initial allegation said that the customer she purportedly picked up and returned to the [name] group home did state what customers lived at the group home when she worked there and that it wasn't any of those individuals that she picked up. Based on the individual's allegation that she returned the individual to the home located on [name of street], it isn't possible that this incident involved other individuals living at a nearby home. No one in the [name of group home] has a fisherman's style hat. No one at the [name of group home] or any nearby home matches the description given of the individual found walking naked, nor does the description of staff present at the time the individual was returned to the group home match descriptions of the staff at the home. Based on lack of additional information from the individual making the allegation, the fact that the description of the customer who allegedly was found naked walking at the		of Support Services for failing to document timely investigation. 9. The 2/5/14 incident has been investigated and recommendations are as follows: 1.The customer's helmet should be replaced immediately. 2.The nurse should review previous OT recommendations to determine the source of the original recommendation for the helmet. The IST should meet to discuss the effectiveness of toboggans versus the helmet, and possibly pursue an updated OT evaluation. 3.An analysis of the customer's behavior related to ripping his clothing should be completed, and strategies to address this should be incorporated into his RSP. 4.Previous staff who are familiar with the boys should be enlisted to help provide additional training to newer staff to ensure consistency with program plans and behavioral interventions. 10. The 2/3/14 incident has been investigated and recommendations are as follows: a. The Overnight DSP's employment should be terminated effective immediately. 11. The 1/18/14 incident has been investigated and recommendations are as follows: a. Continue to review behavior plans during routine staff meetings. This will ensure staff is aware of antecedents in order to have the best opportunity to				

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	<p>end of [name of road] doesn't match any of the customers at [name of group home] and the fact the description of the staff working at the time of the alleged incident doesn't match the description of either of the staff working on those days/times, neglect is not substantiated."</p> <p>The investigation, dated 2/20/14, indicated, in part, "[QAD] spoke with her (caller) on 2/14/14 via phone; [CEO] attempted to reach on 2/16/14 via phone. [Director of Community Services] attempted to reach 2/18/14 via phone, 2/19/14 via phone and 2/20/14 via phone. No response. [CEO] attempted to reach via email 2/17/14 with no response... Based on lack of additional information from the individual making the allegation, the fact that the description of the customer who allegedly was found naked walking at the end of [name of road the group home was located] doesn't match any of the customers at [name of group home] and the fact that the description of the staff working at the time of the alleged incident doesn't match the description of either of the staff working on those days/times, neglect is not substantiated."</p> <p>On 2/28/14 at 10:58 AM, Confidential Interview (CI) #2 indicated he received an email on 2/25/14 asking him to assist</p>		<p>prevent incidents from occurring. To prevent the deficient practices from recurring, all house staff will be retrained in abuse reporting policies and procedures and on each Individual Support Plan. A formal discussion will be held about professional expectations of all employees, and each staff member will be required to sign a document declaring their understanding of these expectations. The agency will also contract with a consultant to review the investigation process and make recommendations for improvement. Ongoing monitoring will be accomplished through routine oversight by Network Director/QDDP and House Manager, regular documented discussion and reminders at bi-weekly house staff meetings, the weekly Network Director/QDDP meeting and during individual supervision sessions. The House Manager and Network Director/QDDP and the Director of Residential Services will complete no less than five observations per week for a period of 2 months, providing ongoing training and support to staff when issues are identified. After two months, if identified issues have been resolved, observations will be reduced to twice a week on an ongoing basis. All investigations and recommendations will be reviewed weekly in the Service</p>		

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	<p>LifeDesigns with getting the caller to respond to LifeDesigns' emails to the caller. CI #2 indicated he responded on 2/25/14. CI #2 sent an email to the complainant. On 2/27/14, CI #2 received another email from LifeDesigns asking for assistance. CI #2 indicated the caller told him she responded to the facility's request for additional information.</p> <p>On 2/28/14 at 11:15 AM, confidential interview (CI) #1 was conducted. CI #1 indicated the incident actually occurred on 1/18/14 between 7:00 and 7:30 PM. CI #1 indicated the original report of the incident occurring on 1/25/14 or 2/1/14 was incorrect. CI #1 indicated she was driving down the road leading to the road where the group home was located. CI #1 indicated a young male client was standing at the corner of the main road and the road the group home was located (0.3 miles from the group home). CI #1 indicated a child in the car stated, "I saw a naked butt." CI #1 drove her children to her house, dropped them off, grabbed some towels, and went back to check on the client. The client was still in the same spot. CI #1 indicated she saw tracks in the fresh snow indicating the client had walked from the direction of the group home. CI #1 put the towels around the client and got him into her vehicle. CI #1 indicated the client was</p>		Leadership Meeting, attended by the CEO and Program Directors.				

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	wearing a green hat, like a fisherman would wear, and nothing else. CI #1 indicated the client was able to respond "yes" to questions and he said "cool hat." CI #1 indicated the client had dark hair but it was hard to see due to him wearing a hat which was pulled down pretty far. CI #1 indicated the client was approximately 5 feet 9 inches tall with no facial hair or acne she could see. CI #1 indicated the client rubbed his hands together a lot and rocked in the seat on the way to his group home. CI #1 indicated she drove the client back to the group home (she knew where the group home was located due to previously working at the home approximately 10 years ago). CI #1 indicated when she and the client arrived to the home, the client walked in and she followed him. CI #1 observed a blonde female sitting at the dining room table. CI #1 indicated the female's hair went to the middle of her back and the female did not acknowledge her or say anything. CI #1 indicated she spoke to a tall (approximately 6 feet tall), skinny, short haired male staff who was unshaven. CI #1 indicated the male staff confirmed the client lived at the home. CI #1 indicated the male staff did not seem to care as evidenced by not asking any questions or showing any concern for the well being of the client. CI #1 indicated one of the towels (white) she				

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	<p>gave the client was left at the home since he had it around him. CI #1 indicated she told the staff they needed to report the incident. CI #1 indicated she observed one client run from one room to another but did not recall what he looked like. CI #1 indicated she received calls and emails from the facility requesting additional information. CI #1 indicated she emailed the facility three times but the facility did not receive her emails. She indicated she attempted to return the CEO's calls but they were playing "phone tag." CI #1 indicated when she returned home after dropping the client off, a neighbor, who was walking a yellow dog, asked her if she picked up the naked kid. CI #1 indicated she responded "yes." CI #1 did not know where the neighbor lived however she saw him from time to time walking the dog.</p> <p>On 2/28/14 at 1:58 PM, the CEO was informed by the surveyor the original report received from the caller regarding the incident date was incorrect. The CEO was informed of the correct incident date of 1/18/14.</p> <p>On 2/28/14 at 1:37 PM, a review of the facility's report for hours worked at the group home indicated on 1/18/14, 1/25/14 and 2/1/14, staff #4 and #9 worked at the group home. On 1/18/14,</p>			
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	<p>staff #4 worked from 7:00 AM to 9:00 PM and staff #9 worked from 8:00 AM to 10:00 PM.</p> <p>On 2/27/14 at 2:36 PM, staff #4 stated the allegation was a "bunch of smoke." Staff #4 stated she worked every weekend at the group home recently and "nothing like that has ever happened." Staff #4 indicated there were no clients living at the group home with elopement issues. Staff #4 stated it was a "bunch of nonsense."</p> <p>On 3/7/14 at 6:01 PM, former staff #9 stated, "that never happened" and "know for a fact it didn't happen." Staff #9 indicated none of the clients were ever returned to the group home naked and none of the clients ever eloped. Staff #9 indicated while employed at the group home, he worked 59 out of 60 days and an incident of someone returning a naked client to the group home did not happen.</p> <p>On 3/4/14 at 2:57 PM, client B was interviewed. Client B indicated he did not take a walk, naked, from the group home in the snow. Client B indicated he was not returned to the group home after taking a walk in the snow naked. Client B indicated he did not have a green hat.</p> <p>On 3/6/14 at 1:39 PM, the surveyor met</p>						

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	<p>the Network Director at the group home in order to take two pictures of pictures located in the home of clients A, B, C, D and E in order to get an identification from the caller of who she picked up on 1/18/14.</p> <p>On 3/6/14 at 2:01 PM, the surveyor received a phone call from the CEO indicating the facility had re-opened the investigation. The CEO indicated the Director of Community Services (DCS) contacted CI #2 in order to get him to facilitate obtaining information from the caller.</p> <p>On 3/6/14 at 2:21 PM, CI #2 indicated he received a call from the DCS asking for his assistance with obtaining additional information from the caller on this date right before the surveyor arrived to the office. CI #2 indicated he would assist LifeDesigns with obtaining additional information from the caller.</p> <p>An interview with CI #1 was conducted on 3/6/14 at 3:02 PM. CI #1 was shown pictures of clients A, B, C, D and E. CI #1 identified the client she picked up on 1/18/14 as client B.</p> <p>On 3/6/14 at 3:31 PM, CI #2 indicated the last contact he had with LifeDesigns was on 2/27/14. CI #2 indicated</p>				

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	<p>LifeDesigns knew how to reach him. CI #2 indicated he had not received a phone call until 3/6/14 to ask for his assistance. CI #2 indicated he was not asked to set up a meeting, which he would have facilitated, if he was asked to do so.</p> <p>On 3/6/14 at 7:02 PM, the CEO indicated in an email, "Wanted to be sure you knew we just got this today (written statement from the confidential interview #1). We will review with first statement that [QAD] took and note any discrepancies and complete an investigation addendum. As was noted in our file, we last asked for this on the 24th, that time requesting help from [CI #2] to connect with [caller]. He forwarded a message he received from [caller] stating she would send the statement she had already sent to [Director of Community Services]. [Director of Community Services] and I have both checked our email trash and spam folders for it to be sure it did not go there inadvertently. The questions we asked her to respond to originally emailed to her on the 17th are attached."</p> <p>On 3/7/14 at 6:37 AM, the CEO indicated in an email, "I am reviewing the [caller's] allegation and investigation this morning in light of the new information from [caller] and considering the events of 2/3."</p>				

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	<p>On 3/7/14 at 4:59 PM, the CEO indicated in an email, "Attached is the addendum I told you I would forward to update the investigation per my email yesterday." The Addendum to Investigation of Neglect, dated 3/7/14, indicated, in part, "Given the variance in the date of the incident between the verbal and email account, Accel time reporting was reviewed and the same two staff (#4 and #9) who worked on the evening of 1/25/14 and 2/1/14 worked on the evening of 1/18/14. While one of the two staff description potentially matches one of the descriptions given in both the verbal report and email report, the description of the second staff is in stark opposition to the description given in both reports from [the caller]. The Additional Recommendations section indicated, "Confer with LifeDesigns' attorney regarding having their assistance in reviewing the investigation, attempting to interview with informant and making a conclusion based on that information, along with any additional recommendations they may have as a result of any additional information they may obtain."</p> <p>The facility failed to reopen the investigation when the CEO was given additional information obtained from the</p>						

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	<p>caller regarding originally reporting the incorrect incident date.</p> <p>2. On 3/5/14 at 7:00 AM, client C went into the kitchen and poured a bowl of cereal. Client C threw books off the table and yelled. Client C went over and shoved client E before staff could get between them. Client E hit the wall and staff immediately removed him from the room and called the Network Director. The two staff removed all the boys away from client C however client D refused to leave the area. Client C smacked client D several times and spit at him. Client D went to his room. Client E went to the walk in clinic due to an abrasion on his head from hitting the wall. The facility reported there were no signs of a concussion. Client E had an abrasion on his head and a red mark on his back from client C shoving him. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of</p>				

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	<p>client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>3. On 2/26/14 at 4:00 PM, client E was circling the dining room table when client A got off the couch. Client A put client E's hand in client A's mouth and bit down. Staff removed client E's hand from client A's mouth. The bite did not break the skin or leave a mark. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS</p>						

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	<p>indicated abuse should be prevented by the facility.</p> <p>4. On 2/23/14 at 9:30 AM, client A was standing in the kitchen and became upset. He began to scream and engage in self injurious behavior. Client A grabbed client E's arm and hit him on the right forearm breaking the skin. The bite broke the skin so client E was taken to the doctor where an antibiotic was prescribed. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>5. On 2/18/14 at 1:45 PM, client A was aggressive toward staff. Client A lunged</p>			
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	<p>toward client E and hit him on the head. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>6. On 2/17/14 at 1:45 PM, client D became agitated and scratched the staff. Client D sat down next to client C and scratched his neck. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p>						

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	<p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>7. On 2/16/14 at 3:30 PM, client C was agitated and became aggressive toward staff and peers. Client C threw a cup and hit clients D and E. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in</p>				

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	<p>their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>8. On 2/3/14 at 10:00 AM (reported to BDDS on 3/6/14), client A was allowed to go to school wearing long-underwear on 2/3/14. The BDDS report, dated 3/6/14, indicated, "This incident is being submitted late, as writer failed to report incident at time information was obtained, even though action was immediately taken. This writer received a report from another employee on 2/9/14 that [client A] was allowed to go to school wearing long-underwear type pants on 2/3/14. The incident was originally reported to QDDP [name] by [client A's] teacher, and [QDDP] followed up with staff on shift at the time, [name of house manager (HM)]. According to [HM], [client A] refused to change into different pants, and they had a particularly hectic morning ([client A] lives in a group home with 4 other individuals). Investigation into the incident concluded that [client A's] rights were violated by (sic) because he wasn't supported adequately to choose more socially appropriate pants, a clear lack of judgement on the part of the staff that morning. Based on information provided by his teacher, he appeared to be appropriately clothed otherwise, and the</p>			
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	<p>pants he wore provided similar warmth as other more appropriate workout pants might. Staff on shift that morning, [name], had only been employed for 1 month at the time of the incident, and had worked overtime each week since the completion of her initial training. When she arrived to her shift the morning of 2/3/14, the overnight staff was found sleeping on the couch, leaving [name] to do a great deal of the morning routine on her own with all 5 individuals in the home... [Name of former QDDP] is no longer with the organization, but this is the second instance in the last 3 months in which she failed to report an allegation. Her status will be changed to not eligible for rehire." The investigation, dated 3/6/14, indicated, "It is confirmed that [client A] did go to school wearing long underwear on 2/3/14. This is a violation of [client A's] rights, as he was not supported adequately to choose more socially appropriate pants, a clear lack of judgement on the part of staff that morning... The alleged incident was reported by [client A's] teacher to [name of former QDDP], at the time it occurred; however, [QDDP] did not report the incident to her supervisor or the agency administrator. [Name of former staff] reported the allegation to [name of Director of Services] who followed up</p>			
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	<p>with [name of Quality Assurance Director] to ensure the incident was investigated and action taken. While this was done immediately after receiving the report, no BDDS report was filed, nor formal investigation summary completed."</p> <p>On 3/6/14 at 2:01 PM, the Chief Executive Officer (CEO) indicated she had just found out there was an incident on 2/3/14 that client A was allowed to go to school wearing long john underwear as his pants. The CEO indicated although the facility addressed the situation at the time, the incident was not reported to BDDS.</p> <p>On 3/7/14 at 6:37 AM, the CEO indicated, in part, in an email, "It was very disconcerting to me to learn that we had not followed our reporting and investigation procedures regarding the incident on 2/3. But most importantly, that the incident happened at all."</p> <p>On 3/11/14 at 10:35 AM, the Director of Residential Services indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>9. On 2/5/14 at 10:45 PM, the Director of Support Services (DSS) received a call from the overnight shift staff (#8) who</p>						

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	<p>returned from a two week vacation. The BDDS report, dated 2/6/14, indicated staff #8 reported client A broke his helmet (which he wears to protect his head during episodes of self injurious behavior) in late December but the QDDP said the helmet would not be replaced right away because client A needed to learn that things cost money and he could not have things replaced immediately when they were broken. The helmet had not been replaced and client A had recent episodes of self injurious behavior. Staff #8 reported all of the clients in the house sometimes seek food, so staff are placing food on the locked porch so the boys can not access it. Staff #8 reported most staff were new and there was a general lack of training and knowledge of support plans. The BDDS follow-up report, dated 2/14/14, indicated, "The allegation of neglect was substantiated, because the face mask of [client A's] helmet was broken off and has not been replaced. Staff did attempt to replace it, but could not find one that was the right size. Staff have been offering [client A] toboggans, which he seems to enjoy. [Client A's] helmet will be replaced, and the nurse will review previous OT (Occupational Therapy) recommendations to determine the source of the original recommendation for the helmet. The support team will discuss</p>			
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	<p>the effectiveness of toboggans versus the helmet and update his behavior support team as necessary. Staff are storing extra food on the screened in porch, but the same items are available to the boys in the kitchen. Generally, the Team Manager and QDDP are responsible for training staff; however, the Team Manager of his home has only been working there since mid-January, and the former QDDP recently resigned after having only been there for a short time herself. The Director of Residential Services is working to recruit other staff within the organization who have worked at the home to provide additional training to new staff." The investigation, dated 2/12/14, indicated, in part, "1. Allegedly [client C] had a behavior that involved breaking a window and picking up the living room TV. Reportedly, [name of former QDDP] authorized and directed staff to remove the TV from the living room for 3 days and told [client C] he had to earn the TV back. 2. [Client A] wears a helmet to protect his head from SIB, and his helmet has been broken since late December. Allegedly [QDDP] told staff the helmet would not be replaced because [client A] needed to learn that things cost money. The helmet still has not been replaced. 3. [Client B] has been tearing his clothes, diminishing his wardrobe. He allegedly wore the same pair of pants</p>			
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	<p>to school every day for a period of 3 weeks. [QDDP] allegedly said he would have to wait for new clothes because it would teach him a lesson not to tear his clothes up. 4. In response to food seeking in the house, food has been placed on the porch behind a locked door, that customers are unable to open. 5. Allegedly some staff are implementing a discipline system that is not part of [client B's] RSP (Replacement Skills Plan) that involves giving him 3 'options.' Each time he misbehaves, he loses an option and upon losing all 'options' has to go to his room for the night. 6. There is a general lack of training of staff in the home. 7. Allegedly someone threatened one of the customers with a CPI (Crisis Prevention Institute) hold or restraint if he did not comply. It is not clear which staff may have made this threat, or which customer was threatened." The investigation indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The Findings section indicated, "1. This writer did confirm that the TV was moved to the office during a recent behavioral episode involving [client C]; however, it was done so to ensure the safety of the other individuals in the home. It was likely only removed for a day. 2. [Client A's] helmet is currently broken and has not yet</p>			
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	<p>been replaced. Staff did attempt to replace it, but could not find the right size. Staff have been improvising by offering [client A] toboggans to wear instead. Both his RSP and NCP indicate the use of the helmet. 3. This writer could not substantiate the allegation that [client B] only had one pair of pants to wear to school for 3 weeks, and that they would not be replaced right away because [client B] had to learn the value of money. [Client B] did wear the same pair of pants to school a few days in a row, and they were washed each evening, as a result of ripping up his other pants. Staff have since found additional pants for him to wear. His current RSP does not address ripping his clothing. 4. Extra food is being stored in a cabinet on the screened porch, but the same food is available to the boys in the house. They have access to all food in the house. Several of the boys do have issues related to food seeking, or sneaking food into their rooms. 5. This writer could not find any evidence to suggest the implementation of a behavior strategy with [client B] that involves giving him 3 options, and sending him to his room when all options are lost. 6. There does appear to be a general need for additional staff training. All staff in the house are relatively new. There is not currently an ND/Q (Network Director/QDDP) and the</p>			
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	<p>Team Manager has only been there a short time. 7. This writer could not substantiate the allegation that a staff threatened with the use of a CPI hold for noncompliance."</p> <p>10. On 2/3/14 at 6:00 AM, when the morning staff arrived at the group home the overnight staff was found asleep on the couch. The BDDS report, dated 2/4/14, indicated, "The group home is a 24 hr (hour) facility staffed with an awake overnight." The investigation, dated 2/3/14, indicated, "Based on witness statement by supervisor [name], as well as photo of [staff #7] sleeping, the allegation is substantiated (the findings support the alleged event as described)."</p> <p>11. On 1/18/14 at 7:00 PM, client A was having an aggressive behavior while in the group home. He aggressed on staff and the staff were attempting to direct him to his room. Client A ran down the hallway toward client E and pushed him backwards 10-15 steps. Client E did not fall down and was not injured. The facility did not conduct an investigation of client to client abuse.</p> <p>On 2/27/14 at 12:10 PM, the Director of Support Services indicated there were no investigations for the client to client abuse incidents. The DSS indicated</p>				

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	<p>client to client should be investigated.</p> <p>On 2/27/14 at 12:59 PM, the Director of Residential Services (DRS) stated the facility conducting investigations of client to client abuse "slipped through the cracks." The DRS indicated client to client incidents was considered abuse and abuse should be investigated. The DRS indicated the facility prohibited abuse in their policies and procedures. The DRS indicated abuse should be prevented by the facility.</p> <p>On 2/27/14 at 11:53 AM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and/or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding</p>						

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	incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)." The policy indicated, "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 b				

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W000227	<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> <p>Based on observation, record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure 1) client E had a program plan to increase his toothbrushing skills, 2) client B had a plan for tearing his clothes and 3) clients A, B, C, D and E had program plans addressing food seeking.</p> <p>Findings include:</p> <p>1) A review of client E's record was conducted on 3/4/14 at 2:16 PM. On 10/31/13, client E had a dental appointment. The Medical Appointment Record, dated 10/31/13, indicated, "Very poor OH (oral health). Pt (patient) was very cooperative. Pt needs to be brushed 2x (two times) daily. Brushing 2x daily w/ help." Client E's Individual Support Plan (ISP), dated 8/30/13, did not include a training objective to improve client E's toothbrushing skills.</p> <p>On 2/27/14 at 11:07 AM, a review of the facility's Plan of Correction (POC), dated 2/16/14, indicated, in part, "To correct the</p>	W000227	<p>Implementation of plans to address the following: 1)insuring client E had a program plan to increase his tooth brushing skills, 2) client B had a plan for tearing his clothes and 3) clients A, B, C, D and E had program plans addressing food seeking have been delayed due to staff turnover. To correct the deficient practice, there will be additional Direct Support Staff and Managers hired. A new Network Director and two DSPs have begun training as of 3-31-14. Two other DSPs and a Team Lead finished training during the previous New Employee Orientation that began on 3-17-14. A new Medical Coordinator has also been identified. We anticipate that behavioral issues will diminish as the customers become acquainted with new staff and consistent active treatment is re-established. The house staff will be trained and/or retrained on each customer's Individual Support and Replacement Behavior Plans. Additionally, there will be a review of Non-violent Crisis Intervention techniques with the house team. Plans for client E's teeth brushing has been written, a plan for client B for tearing his clothes will be developed and plans</p>	04/12/2014
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	<p>deficient practice, a tooth brushing objective will be developed for client E, and all staff will be trained on implementation of the objective." The facility developed a tooth brushing objective for client E however there was no documentation the staff were trained on when and how to implement the objective.</p> <p>On 2/27/14 at 2:36 PM, the Medical Coordinator (MC) indicated there had been no changes to client E's goals since 1/17/14. The MC indicated client E did not have a toothbrushing training objective.</p> <p>2) An observation was conducted at the group home on 3/4/14 from 2:00 PM to 3:30 PM. At 2:26 PM, client B was asked how his day was at school by staff #10. Client B informed staff #10 he tore up an old shirt while at school. Client B pulled a long sleeve shirt from his backpack. The shirt was torn in half.</p> <p>A review of the facility's incident/investigative reports was conducted on 2/27/14 at 12:03 PM and indicated the following: On 2/5/14 at 10:45 PM, the Director of Support Services (DSS) received a call from the overnight shift staff (#8) who returned from a two week vacation. The</p>		<p>for clients A, B, C, D and E addressing food seeking behavior will be developed.</p> <p>To prevent the deficient practices from recurring, all house staff will be trained on the new plans and routine oversight will be reestablished by the new Network Director/QDDP and House Manager. Regular bi-weekly house staff meetings will resume so as to discuss progress and adapt plans as needed.</p> <p>Ongoing monitoring will be accomplished, the weekly Network Director/QDDP meeting and during individual supervision sessions. The House Manager and Network Director/QDDP and the Director of Residential Services will complete no less than five observations per week for a period of 2 months, providing ongoing training and support to staff when issues are identified. After two months, if identified issues have been resolved, observations will be reduced to twice a week on an ongoing basis.</p>				

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	<p>investigation, dated 2/12/14, indicated, in part, "3. [Client B] has been tearing his clothes, diminishing his wardrobe. He allegedly wore the same pair of pants to school every day for a period of 3 weeks. [QDDP] allegedly said he would have to wait for new clothes because it would teach him a lesson not to tear his clothes up." The Findings section indicated, "3. This writer could not substantiate the allegation that [client B] only had one pair of pants to wear to school for 3 weeks, and that they would not be replaced right away because [client B] had to learn the value of money. [Client B] did wear the same pair of pants to school a few days in a row, and they were washed each evening, as a result of ripping up his other pants. Staff have since found additional pants for him to wear. His current RSP does not address ripping his clothing."</p> <p>A review of client B's RSP, dated 12/21/12, was conducted on 3/10/14 at 3:17 PM. The RSP indicated his targeted behaviors included, aggression (defined as slapping, punching, biting, kicking, scratching, pinching, putting in headlock), agitation (defined as placing hands in a lock and throwing arms across shoulders, yelling, getting red in the face with a smirk type grin, running up and down the hall, jumping up and down),</p>			
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	<p>and obsessive compulsive disorder (defined as focusing on physical ailments (vomiting, being sick, etc ...), anything sticky, old objects, tape, Play-Doh, asking the same questions over and over, certain food items or drinks/water). The plan indicated, "Vomiting will occur when he wants to do something and it is not time, he will sometimes drink a large amount of water and then make himself vomit." The RSP did not include a targeted behavior of tearing his clothes.</p> <p>On 3/11/14 at 10:35 AM, the Director of Residential Services (DRS) indicated client B needed a plan to address tearing his clothes. The DRS indicated she was aware of the issue occurring in the past but was not aware of any recent incidents.</p> <p>3) An observation was conducted at the group home on 2/27/14 from 2:07 PM to 4:23 PM. At 3:49 PM, client D was in the pantry looking for food. At 3:51 PM, client E ate part of client D's snack which client D left unattended on the kitchen table while he was up getting ketchup.</p> <p>An observation was conducted at the group home on 3/4/14 from 2:00 PM to 3:30 PM. At 2:35 PM, client E was walking around the kitchen, found a bowl of pretzels and ate some of the pretzels. Staff #10 redirected client E. At 2:37</p>			
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	<p>PM, client E opened the pantry door and staff #10 indicated to him, "we're done with snack, [client E]." Client E went to the trash can where the pretzels from the bowl were disposed of and attempted to eat them out of the trash can. Staff #10 redirected client E. Client E ate a pretzel that fell on the floor. At 2:40 PM, client E attempted to eat from the trash can and was redirected by staff #10.</p> <p>A review of the facility's incident/investigative reports was conducted on 2/27/14 at 12:03 PM and indicated the following: 1) An observation by the Chief Executive Officer (CEO) was conducted on 2/16/14 from 9:00 AM to 1:15 PM following an allegation of staff neglect of client B. The observation's Recommended Follow Up section indicated, in part, "[Name of Behavior Consultant] to consult with staff on the food seeking behaviors. This appears to be a great source of the agitation at the home." 2) On 2/5/14 at 10:45 PM, the Director of Support Services (DSS) received a call from the overnight shift staff (#8) who returned from a two week vacation. The investigation, dated 2/12/14, indicated, in part, "In response to food seeking in the house, food has been placed on the porch behind a locked door, that customers are unable to open." The Findings section</p>			
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	<p>indicated, in part, "Extra food is being stored in a cabinet on the screened porch, but the same food is available to the boys in the house. They have access to all food in the house. Several of the boys do have issues related to food seeking, or sneaking food into their rooms."</p> <p>A review of client A's Replacement Skills Plan (RSP), dated 12/18/12, was conducted on 3/4/14 at 2:16 PM. The RSP indicated client A's targeted behaviors included PICA (defined as eating non-edible items (sand, crayons, glue, grass, etc...)), aggression (defined as hitting, biting, slapping others, pinching others, tensing muscles or arching his back (may be a precursor to aggressive behavior)), inappropriate eating (defined as taking food out of the trash, off the floor or taking other's food or drink), fecal smearing (defined as getting bowel movement on his hand; sticking his hand in his buttocks to smell, and/or to engage in sexual experimentation, and/or to engage in stimulation of anal fissure (tear in the anus skin)), and self injurious behavior (defined as slapping his chest, legs, neck or head, tensing muscles to inflict pain, or arching his back (may be a precursor to SIB behavior)). Client A's RSP did not include a targeted behavior of food seeking.</p>			
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	<p>A review of client B's RSP, dated 12/21/12, was conducted on 3/10/14 at 3:17 PM. The RSP indicated his targeted behaviors included, aggression (defined as slapping, punching, biting, kicking, scratching, pinching, putting in headlock), agitation (defined as placing hands in a lock and throwing arms across shoulders, yelling, getting red in the face with a smirk type grin, running up and down the hall, jumping up and down), and obsessive compulsive disorder (defined as focusing on physical ailments (vomiting, being sick, etc ...), anything sticky, old objects, tape, Play-Doh, asking the same questions over and over, certain food items or drinks/water). The plan indicated, "Vomiting will occur when he wants to do something and it is not time, he will sometimes drink a large amount of water and then make himself vomit." Client B's RSP did not include a targeted behavior of food seeking.</p> <p>A review of client C's RSP, dated 12/16/12, was conducted on 3/10/14 at 3:14 PM. The RSP indicated he had the following targeted behaviors: aggression (defined as hitting, biting, slapping others and self, pinching others, and property destruction) and spitting (defined as rolling saliva in his mouth, hocking and working the saliva and then projecting it either at someone or something). Client</p>						

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	<p>C's RSP did not include a targeted behavior of food seeking.</p> <p>A review of client D's RSP, dated 5/8/13, was conducted on 3/10/14 at 3:22 PM. The RSP indicated he had the following targeted behaviors: aggression (defined as scratching others, hitting others, pushing others, and grabbing staff by collar of their shirt or necklaces), self-injurious behavior (defined as hitting, scratching, or pressing his hands to his chin, grabbing staff hands to hit himself in the head with), pilfering food (defined as taking food from cabinets, refrigerator or from other people), out of bounds (defined as going into other residents rooms, invading other's space), and inappropriate interactions (defined as running through the house naked (bathroom to bedroom) or going into others room naked, or touching staff's private areas, touching self in public area). Client D's RSP did not include a targeted behavior of food seeking.</p> <p>A review of client E's RSP, 8/30/13, was conducted on 3/10/14 at 3:27 PM. The RSP indicated he had the following targeted behaviors: tantrum (defined as crying, screaming, squealing, tensing up his muscles), self injury behavior (defined as hitting self with forearm, banging his head on the floor, walls or</p>						

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	<p>other objects), inappropriate eating (defined as stealing food, eating food out of the trash or on the floor, leaving the table, walking around while eating food) and darting/elopement (defined as running out of the house, following a peer or being out of staff's sight). Client E's RSP did not include a targeted behavior of food seeking.</p> <p>On 3/11/14 at 10:35 AM, the Director of Residential Services (DRS) indicated food seeking was an issue at the group home. The DRS indicated the facility had discussed ways to address food seeking however no changes had been implemented. The DRS indicated all five clients (A, B, C, D and E) needed to have plans addressing food seeking. The DRS indicated clients A and D had the most issues with food seeking behavior.</p> <p>This deficiency was cited on 1/17/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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 record review and interview for 1 of 3 clients in the sample (E), the facility failed to ensure staff implemented client E's Individual Support Plan (ISP) and Nursing Care Plan (NCP) as written for supervision while eating.</p> <p>Findings include:</p> <p>A review of client E's record was conducted on 3/4/14 at 2:16 PM. Client E's ISP, dated 8/30/13, indicated, "[Client E] will be safe while eating by appropriately chewing his food, sitting up at the table and using his utensils. Historically, [client E] has had 2 instances of choking while eating. The Heimlich Maneuver was implemented during both instances. [Client E] doesn't always chew his food enough before swallowing, doesn't always sit up, and prefers to use his hands/fingers instead of utensils." The plan indicated, "A staff member will sit next to [client E] at each mealtime to ensure he has needs met to eat appropriately." Client E's NCP, dated</p>	W000249	<p>Client E's plan for supervision while eating, has not been implemented in a consistent fashion. Staff training recommended in the POC was also not done as planned. These failures are due in large part to staff turnover. To correct the deficient practice, there will be additional Direct Support Staff and Managers hired. A new Network Director and two DSPs have begun training as of 3-31-14. Two other DSPs and a Team Lead finished training during the previous New Employee Orientation that began on 3-17-14. A new Medical Coordinator has also been identified. We anticipate that with new staff, consistent active treatment will be re-established. All training outlined in the POC will be done.</p> <p>To prevent the deficient practices from recurring, the house staff will be trained and/or retrained on this customer's plan following a reassessment of its necessity and appropriateness by the Staff Nurse. Routine oversight will be reestablished by the new Network Director/QDDP and House Manager.</p>	04/12/2014	

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	<p>7/1/13, indicated, "[Client E] need (sic) supervision with meals @ (at) all times in effort to intervene if a choking incident would occur as well as assisting him with cutting up meats>>to facilitate proper safe bite sizes."</p> <p>On 2/27/14 at 11:07 AM, a review of the facility's Plan of Correction (POC), dated 2/16/14, indicated, in part, "To correct the deficient practice, all staff were retrained on client E's current ISP (individual support plan) and NCP (nursing care plan) as related to his eating protocol at the last staff meeting. To ensure the deficient practice does not continue, as well as assessing the implementation of plans for other individuals to ensure no others were affected by the deficient practice, the nurse will conduct a meal assessment to determine if the level of supervision needs to remain sitting next to, instead of eyesight due to client E not having a choking incident for over one year." There was no documentation the staff received training on client E's ISP and NCP. There was no documentation the nurse conducted a meal assessment for client E.</p> <p>On 2/27/14 at 2:14 PM, the Network Director/Qualified Intellectual Disabilities Professional (ND/Q) indicated none of the staff training</p>		<p>Regular bi-weekly house staff meetings will resume so as to discuss progress and adapt plans as needed.</p> <p>Ongoing monitoring will be accomplished, the weekly Network Director/QDDP meeting and during individual supervision sessions. The House Manager and Network Director/QDDP and the Director of Residential Services will complete no less than five observations per week for a period of 2 months, providing ongoing training and support to staff when issues are identified. After two months, if identified issues have been resolved, observations will be reduced to twice a week on an ongoing basis.</p>		

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	<p>recommended in the POC was completed and no staff meetings had been convened since the survey on 1/17/14.</p> <p>This deficiency was cited on 1/17/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			
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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (E), the facility failed to ensure the client received dental procedures recommended by the dentist.</p> <p>Findings include:</p> <p>A review of client E's record was conducted on 2/27/14 at 1:58 PM. On 10/31/13, client E had a dental appointment. The Medical Appointment Record, dated 10/31/13, indicated, "Very poor OH (oral health). Pt (patient) was very cooperative. Pt needs to be brushed 2x (two times) daily. Brushing 2x daily w/ help." On 11/13/13, client E was seen by the dentist. The Medical Appointment Record, dated 11/13/13, indicated, "Dental needs requiring tx (treatment) under general anesthesia - deep cleaning, dental sealants, radiographs, resin restoration, extraction of wisdom teeth (1, 16, 17, 32). Mild gingivitis. Ellis II (Injuries in this category are fractures that involve the enamel as well as the dentin layer. These teeth are typically tender to the touch and to air exposure. A yellow</p>	W000356	Customer E was unable to receive the dental treatment scheduled not because of the reasons cited, but because the dentist refused to perform to procedure. The dentist was unwilling to do so because the customer's mother was not in attendance. The ND/QDDP had arranged for the mother's written release and was assured by the dental office staff that written permission was adequate and had been adequate in the past. The customer and ND/QDDP arrived on time, but were turned away. The customer's mother has requested that a new dentist be found. An appointment will be scheduled as soon as a new dentist can be located.	04/12/2014
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	<p>layer of dentin may be visible on examination.) fracture #9 MIFLD (M: mesial tooth surface, the part of the tooth closest to the mid-line. I: incisal tooth surface, the biting edge, of front teeth. F: facial tooth surface, the front side of anterior, or front, teeth. L: lingual, the part of the tooth that faces the tongue. D: distal surface, the part of the tooth farthest from the mid-line, or center front of the mouth.). Impacted 3rd molars 1, 16, 17, 32." There was no documentation client E received the dental services recommended by his dentist.</p> <p>On 3/4/14 at 12:31 PM, the nurse indicated client E's dental appointment on 2/28/14 was not successful. The nurse indicated client E arrived to the appointment late due to client C's behavior at the group home prior to client E leaving for the appointment. The nurse indicated client E arrived to the appointment late therefore the dentist was unwilling to perform the procedure as scheduled. The nurse indicated the facility needed to schedule another appointment for client E with a different dentist.</p> <p>This deficiency was cited on 1/17/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

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